Rutland City Public Schools

6 Church Street
Rutland, VT 05701

(802) 773-1900
rcpsvt.org

TO: ALL STAFF

FROM: The Business Office

DATE: October 18, 2021

RE: **Health Insurance Buyout for January 1, 2022 – December 31, 2022**

We offer a buyout of the health insurance benefit to eligible Rutland Public School employees. If you elect to take this offer, you will be paid the applicable plan amount listed below. Payment will be subject to FICA, federal and state income taxes. Payment will be made as follows: **buyouts will be divided by 20 pay periods and distributions will begin with the January 14, 2022 paycheck and will end with the May 20, 2022 and resume in the first paycheck of the school year and end with the last paycheck in December, aligning with the health insurance premium collection period. If you have VT Health Connect as "other Documented insurance" or Medicaid coverage you are not eligible for a buyout using publicly subsidized insurance.**

Effective April 9, 2021, there was a change in eligibility for employees to receive a buy-out (or cash in lieu of receipt) for health plan care insurance. If you are receiving health care benefits through/as a result of a family member who is working for the same or another Vermont school district or supervisory union, you are NOT eligible to receive a health care plan buy-out from Rutland City Public Schools.

The breakdown of the buyout payments are listed below:

PLAN TYPE	BUYOUT PAYMENT
Single	**$4,500.00**
Two Person	**$4,500.00**
Family	**$4,500.00**

To be eligible you must:

a. **Show proof of insurability or coverage by another plan (copy of insurance cards)**
b. **Show proof of insurance coverage for under age 26 dependent (copy of insurance cards)**
c. **Complete the Sworn Statement of Alternative Health Insurance Coverage form and attach the above copies of insurance cards to it.**
d. **Complete the election form (on the back of this notice and the Declaration of Health Coverage form (attached) then return forms to the Business Office.**

This election is for a 12-month period: 1/1/22-12/31/22. There is a provision that if a qualifying event occurs, such as an involuntary loss of coverage due to a spouse's loss of employment, death or divorce, you can obtain coverage through Rutland Public Schools Plan. In that event, you are responsible to pay back your buy out on a pro-rated basis. **If the employee leaves employment with the District, he/she will be responsible to pay back the difference in insurance for the remaining months of the plan year.**

You can opt for this offering anytime during the year. Payment for the buyout will be prorated based on how many months are left in the fiscal year.

Please contact the Business Office if you need more information. Please return completed forms to Bonnie Wood in the Business Office as soon as possible.

RUTLAND CITY PUBLIC SCHOOLS
INSURANCE BUY OUT PLAN

Employer Name________________________ Employee Name________________________

Employee Address____

Employee Social Security Number:________________________ Plan Year __________through__________

Dependent Information

Section 1 - (List all eligible dependents)

LAST NAME IF DIFFERENT FROM SUBSCRIBER	FIRST NAME	DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	CHECK IF DEPENDENT IS INCAPACITATED
			Spouse/Party To A Civil Union	
			Child	
			Child	
			Child	
List below dependents turning age 26 in FY22				
			Child	
			Child	

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan

ELECTION OF CASH BENEFITS

( ) I elect a cash benefit of $__________ in lieu of accepting medical insurance coverage. I understand that this will become a taxable benefit to me.

OTHER TERMS AND CONDITIONS

I understand that:

If I leave my employment or elect to take Insurance coverage before the plan year ends I am obligated to pay back the difference in insurance for the remaining months of the plan year.

I cannot change or revoke any of my elections at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment or a spouse, change in my or my spouse's employment status from full-time to a part-time or from part-time to full-time, my spouse or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, or such other events as the Plan Administrator determines will permit a change or revocation of an election).

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION RELATING TO SUCH PLAN.

________________________ ________________________
Employee's Signature **Date**

Accepted and agreed to by the Employer's Authorized Representative.

By:________________________ **Date**________________________

Rutland City Schools Cafeteria Plan

Sworn Statement of
Alternative Health Insurance Coverage

Name:	**Social Security #**

The Rutland City Schools Cafeteria Plan requires that you enroll in their group health insurance plan, unless you receive comparable alternative group health insurance coverage. If you have comparable alternative coverage, please complete the following, sign and return this form to the Plan Administrator. ***Enrollment in an "individually purchased plan," such as coverage from Vermont Health Connect is not an eligible alternative health insurance plan.***

Alternative Coverage	
Plan Sponsor:	
Insurance Company:	
Effective for 12-Month Period Beginning:	**Please provide a copy of your health ins. ID Card***
My coverage is for (select one): ☐ Single; ☐ 2 Person; ☐ Family or ☐ Medicare/TRICARE	

I certify that I am currently receiving comparable group health benefits as listed above. To the best of my knowledge this coverage is comparable to the health insurance provided by my Employer. I understand that the Plan Administrator reserves the right to refuse this statement based on a finding that the alternative coverage is not comparable.

I understand that I will* ***not* *receive the "buy-out" if I do not supply proof of insurance coverage (health insurance ID Card and or other information that may be requested) for myself and, if applicable, my spouse and or tax dependents.*

I understand that if my health insurance status changes during the Plan Year (Jan. 1 – Dec. 31), I must notify the Human Resources department at the Rutland City Schools offices.

Under penalty of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Employee's Signature	**Date**
Authorized Delegate of the Plan Administrator	**Date**

Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547 Phone: (802) 828-2551

VT Form **HC-2**	**DECLARATION OF HEALTH CARE COVERAGE**	**This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years.**

Employer: This form is __only__ to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Employer's Legal Name ***(Please print)*** ______________________________

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

Employee's Full Name ***(Please print)***	
Employee ID or Social Security Number	**Date of Birth**

Will the employee be under the age of 18 for the entire calendar year? ☐ YES ☐ NO

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If **NO**, please continue to complete this form and submit it to your employer.

Check the box beside the statement that best describes your health care coverage.

1. My employer offers health care coverage to me.

☐ I have accepted the health care coverage offered and provided by my employer.

2. My employer offers health care coverage to me, and I have __not__ accepted my employer's coverage.

☐ I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit Exchange.

My coverage is provided through: ______________________________

☐ I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.

☐ I have Medicaid.

☐ I have no health care coverage.

3. My employer does __not__ offer health care coverage to me.

☐ I am a part-time employee who works fewer than 30 hours per week, __and__ I have coverage from a source other than Medicaid that offers hospital and physicians services.

☐ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, __and__ I have coverage from a source other than Medicaid that offers hospital and physicians services.

☐ I have health care coverage that offers hospital and physicians services.

My coverage is provided through: ______________________________

☐ I am a part-time or seasonal employee, and I do not have health care coverage __or__ I am covered by Medicaid.

☐ I have no health care coverage.

☐ **I certify the above information is accurate and true to best of my knowledge and belief.**

Employee Signature ______________________________ Date ______________

Note: If your health care coverage changes within the year, you must complete a new Declaration of Health Care Coverage.