Health Insurance Opt-Out Program

Fiscal Year 2026

Under these terms of the Town of Andover's Health Insurance Opt-Out Program, eligible active service employees who obtain alternate health insurance coverage from another source may voluntarily cancel their Town coverage, and receive 12 monthly payments in the corresponding amount listed below (in bold), which will be based on 25% of the total FY26 annual premium cost of the specific health insurance plan type (HMO or PPO) and coverage type (individual or family) that the employee was enrolled in prior to participating in this opt-out program.

To qualify for this opt-out program you must meet both of the following requirements:

1) **You were an active employee of the Town of Andover covered by one of its health insurance plans for at least the last six months preceding your enrollment in this program;**
2) **You must provide documentation of alternate comparable health insurance plan coverage from another source.**

Once enrolled in this opt-out program, you must maintain your alternate health insurance coverage, and you may not re-enroll in the Town's health insurance plans unless one of the following occurs:

1) You involuntarily lose your alternate health coverage through no fault of your own;
2) There is a change in your family status (e.g., marriage, divorce, birth or adoption of a child);
3) The termination of your spouse's employment, or a reduction of his/her hours, resulting in the loss of your alternate health insurance coverage;
4) At least 12 months have passed, and you choose to re-enroll in one of the Town's health insurance plans during the annual open enrollment period.

BCBS Plans	FY26 Annual Cost	25% of Cost	Monthly Payment
Network Blue NE (HMO) – Individual	$12,037.44	$3,009.36	**$250.78**
Network Blue NE (HMO) – Family	$32,451.00	$8,112.75	**$676.06**
Blue Care Elect (PPO) – Individual	$14,632.68	$3,658.17	**$304.85**
Blue Care Elect (PPO) – Family	$39,215.76	$9,803.94	**$817.00**

* *These monthly payments are considered income and are subject to withholdings.*

The open enrollment period to sign up for this opt-out program in Fiscal Year 2026 is as follows:

- **April 15, 2025 – May 9, 2025 for the 12 month period of 7/01/2025– 06/30/2026**

The monthly payments will end after 12 months, or will cease earlier if you must re-enroll in the Town's health insurance due to a qualifying event, you are no longer employed by the Town of Andover, or you voluntarily reduce your hours below the qualifying threshold.

Town of Andover

Health Insurance Opt-Out Election Form

PLEASE READ PAGE ONE BEFORE COMPLETING FORM – PRINT CLEARLY

Insured Name (First) (MI) (Last)

Street Address

City State Zip Code

1. I hereby elect a monetary allowance in lieu of participating in a Town of Andover sponsored group health insurance plan. I understand that the allowance will be paid monthly, in twelve equal payments beginning in July, 2025 and that taxes will be withheld from these payments.
2. I was covered by a Town of Andover health insurance plan on January 1, 2025 and that coverage remains active at present.

   Type of coverage on January 1, 2025: ☐ Individual ☐ Family

   Plan Enrolled in: Network Blue New England _____ Blue Care Elect _____
3. I have compared my other alternate health insurance coverage with my Town of Andover coverage. The coverage is comparable.
4. I understand that I may cancel this election only:
   a. You involuntarily lose your alternate health coverage through no fault of your own;
   b. There is a change in your family status (e.g., marriage, divorce, birth or adoption of a child);
   c. The termination of your spouse's employment, or a reduction of his/her hours, resulting in the loss of your alternate health insurance coverage;
   d. At least 12 months have passed, and you choose to re-enroll in one of the Town's health insurance plans during the annual open enrollment period.

Signature of Insured Date

FOR TOWN USE ONLY

1. Current Health Plan Terminated Yes____No____
2. Effective Date _____
3. Buy-out period From _____ To _____
4. Processed by _____
5. Monthly Amount to be paid: _____