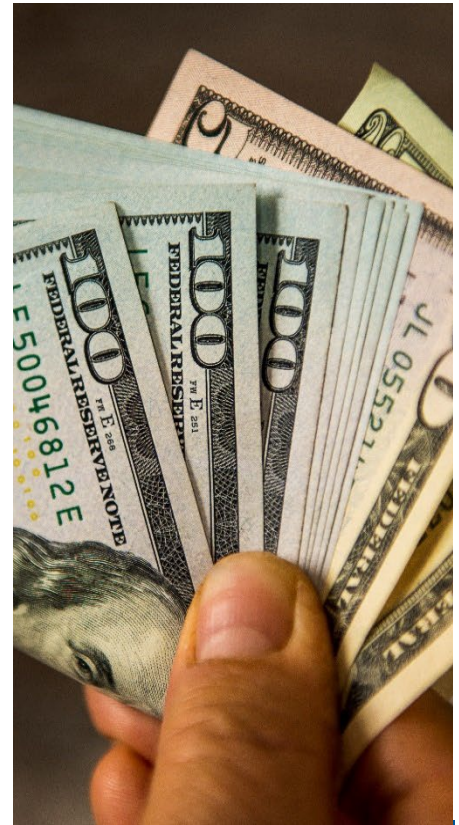


## NEW! OPT-OUT BENEFIT OPTION

If you are an employee that has been with Allstate Peterbilt Group for more than 20 years, you may qualify for \$200/per month benefit by waiving coverage on the Allstate Peterbilt Group medical plan. In order to qualify, you must show proof of other qualifying coverage. Other qualifying coverage may include but is not limited to; spouse’s plan, Medicare, Medicaid, Healthcare.gov, Tri-Care or an ACA qualified individual plan.

### Opt-Out Payment Requirements:

- Must be eligible for the medical plan today.
- Must show proof of qualifying coverage through an alternate source.
- If you are Medicare or Medicaid eligible, a qualifying event is not required and coverage can be dropped any time throughout the year.
- Additional qualifying events that could make you eligible for this benefit may include marriage, divorce, birth of child, newly eligible for other coverage (spouse’s plan, HealthCare.gov, Tri-Care, etc.).
- You must complete the Opt-Out Benefit Request Form (must be done annually or at time of qualifying event, along with proof of coverage).



### 2024 Opt-Out Payment Program

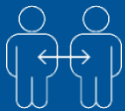
Lenth of Full-Time Service	Monthly Opt-Out Benefit
20 or More Years	\$200



### Questions?

Contact: Jodi Eiberger-Collins

### ITEMS TO NOTE



All dependents (if applicable) must also be dropped from coverage. If you are enrolled as a dependent on the Allstate Peterbilt Group medical plan through a spouse (if both spouses work here) you are not eligible for the opt-out incentive.



This only applies to the medical plan. You may keep all other coverages and still qualify for the opt-out benefit. You may opt back onto the medical plan later with a qualifying event. However, this opt-out benefit will cease upon re-enrollment.



This opt-out payment is taxable. Employees receiving this benefit must remain actively employed full-time in in order to qualify for the payment.

# WAIVER OF MEDICAL COVERAGE FORM

Allstate Peterbilt Group

Plan Year January 1, 2024 – December 31, 2024

Name: \_\_\_\_\_

Address: \_\_\_\_\_

I, \_\_\_\_\_, waive coverage through Allstate Peterbilt Group's group medical plan for the plan year beginning on January 1, 2024, and ending on December 31, 2024. This waiver applies to me and my eligible dependents.

I am declining to enroll for the reason shown below:

Covered by spouse's group coverage

Carrier name/member ID: \_\_\_\_\_

Enrolled in other group health insurance coverage

Carrier name/member ID: \_\_\_\_\_


Enrolled in Medicare or Medicaid

Covered by TRICARE

Other (Please explain) \_\_\_\_\_

In return for your agreement to waive medical insurance coverage offered through Allstate Peterbilt Group, you may be eligible to receive the opt-out benefit of \$200/per month. This benefit is available to employees who are currently enrolled on Allstate Peterbilt Group medical plan and show proof of qualified medical coverage through an alternate source.

Qualifying health insurance may include (but is not limited to) coverage on a spouse's group medical plan, Medicare, Medicare Supplements, Tri-Care, Marketplace or ACA plans, Individual medical plans, etc. This insurance must meet the ACA Minimum Value requirements. Proof of coverage can be a letter or certificate from the insurance carrier or a copy of your medical ID card.



I understand that, by declining coverage offered through Allstate Peterbilt Group group medical plan I am still eligible to participate in other optional coverages offered by Allstate Peterbilt Group's Section 125 Cafeteria Plan. By waiving this medical coverage for the plan year designated above, I acknowledge that I may be required to wait until the next plan year to re-enroll for group medical coverage unless I have a qualifying event. In exchange for my waiver of medical coverage, Allstate Peterbilt Group will pay me \$200/ per month for the plan year of January 1, 2024, through December 31, 2024. I understand that I must be working full-time to receive this benefit and that these payments are taxable compensation.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_