COUNTY OF COLUSA
HEALTH PLAN COVERAGE WAIVER FORM

The County of Colusa provides its employees with health insurance coverage through the CalPERS Health Insurance Program and has several HMO and PPO options available. County health plan enrollment is not mandatory as long as employees can provide proof of alternative coverage from another source. Employees who possess other non-individual market coverage (e.g., other group health plan coverage, Tricare, Veterans Affairs, Medicare) for themselves and for all individuals that they expect to claim a deduction for in the taxable year (tax family), may elect to waive the County health plan coverage and earn a cash in-lieu benefit if they can provide proof that the coverage was not obtained through the Covered California Exchange or other Affordable Care Act Marketplace plan and which provides Affordable Care Act minimum essential coverage. The amount of the cash in-lieu benefit depends on the employee's benefit resolution or memorandum of understanding.

This waiver form is to be used by an employee who wishes to waive County provided health coverage and can provide proof of alternative coverage from another source. Please complete this form and submit it along with confirmation of existing coverage to the Human Resources Department. **This form along with proof of coverage will be required annually.**

EMPLOYEE INFORMATION:

_____ _____
Last Name First Name

_____ _____ _____
Mailing Address City Zip Code

EXISTING HEALTH COVERAGE INFORMATION:
I have existing alternative coverage from another source and wish to waive the County provided health plan coverage.
Proof of coverage that states employee's name must be attached.

_____ Coverage is through subscriber's employer: □ Yes □ No
Subscriber's Name

_____ _____
Group No. ID No(s).

PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM:
I wish to decline the County provided health plan coverage as I have alternative coverage from another source. I acknowledge that as a result of this waiver, I forfeit all rights to coverage otherwise available to me under the County health plan. I realize that I will not be able to enroll in a County health plan option until the next Open Enrollment period. If I cease to be covered by my existing plan outside of Open Enrollment, I must provide proof that my other health coverage has ended and enroll in the County health plan coverage within 60 days of the qualifying event. I understand that in order to qualify for the cash in-lieu benefit I must provide proof of non-individual market coverage for myself that is non-individual market coverage which was not obtained through the Covered California Exchange or other Affordable Care Act Marketplace plan, nor is Medi-Cal, and that provides Affordable Care Act defined minimum essential coverage. Furthermore, I verify that the attached alternative coverage includes all individuals in my expected tax family.

I understand that the information provided above is a requirement if I want to waive the County health plan coverage. I certify that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Human Resources Department has received and approved my waiver application. I understand that the waiver form and proof of health coverage will be required annually to qualify for the waiver and that if I do not provide the required documentation I will not receive the cash in-lieu benefit and will be enrolled in the lowest cost County health plan at the employee only level.

_____ _____ _____
Employee signature Print Name Date

Human Resources Office Use Only: Processing Date: _____Processed by: _____

Eligible for cash in-lieu: □ Yes □ No

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HEALTH PLAN COVERAGE WAIVER FACTS

Qualification:

- Health Plan Waiver: In order to qualify for a County health plan coverage waiver, an employee must demonstrate that he/she has alternative coverage from another source. Evidence of such coverage must be provided by the employee.

- Cash In-Lieu: In order to qualify for the cash in-lieu benefit, an employee must meet the waiver requirements above and also provide proof that the plan that he/she currently has is non-individual market coverage that was not obtained through the Covered California Exchange or other Affordable Care Act Marketplace plan, nor is Medi-Cal, and which provides Affordable Care Act defined minimum essential coverage. Additionally, the alternative coverage must include all individuals in the employee's expected tax family.

Annual Recertification:

Employees receiving the health plan coverage waiver must recertify annually during the County's Open Enrollment period. Recertification consists of the completion of the appropriate County forms and evidence of coverage. If the required documentation is not received during this period, the waiver and cash in-lieu benefits will be discontinued and the employee will be enrolled in the lowest cost County health plan at the employee only level effective January 1.

Notice of Enrollment Rights:

This waiver of coverage must be completed during your initial eligibility period and annually during Open Enrollment. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

You may also be eligible to enroll in a County health plan if your other health coverage terminates as a result of any of the following:

- Termination of employment;
- Change in employment status;
- Employer no longer offers health plan coverage;
- Employer ceases premium contribution toward coverage;
- Divorce, legal separation, or death of the person (subscriber) through whom you (or your family members) are covered as a dependent; or
- Exhaustion of COBRA continuation of coverage.

DOCUMENTATION VERIFYING ALL CHANGES LISTED ABOVE WILL BE REQUIRED.