COUNTY OF WASHINGTON
EMPLOYEES' MEDICAL INSURANCE
OPT OUT INCENTIVE PLAN
Opt Out Incentive Enrollment Form

Name: _____ Department: _____

Address: _____

I hereby make application for participation in the County of Washington Employees' Medical Insurance Opt Out Incentive Plan.

Please specify the individual(s), such as your spouse, etc. under whose medical insurance policy you are covered. My _____ is covered under a medical insurance policy that also covers me. The coverage is indicated on the attached copy of current documentation that reflects the insurance coverage (member identification card from the insurance carrier). **THIS IS REQUIRED TO ACTIVATE YOUR OPT OUT AMOUNT.**

Insurance Carrier Name: _____ Policy No.: _____

Dependents Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

The Opt Out Incentive only applies to the opt out of medical and vision insurance. This does not include Opt Out of dental insurance.

By executing and submitting this form, I hereby elect to decline the Medical Insurance coverage that is offered by the County by virtue of my employment with the County. I further elect to receive an amount of cash, referred to as the Opt Out amount, under the County of Washington Employees' Medical Insurance Opt Out Incentive Plan. Any previous agreement under the County of Washington Employees' Medical Insurance Opt Out Incentive Plan is hereby revoked.

This Opt Out request will become effective the first of the month after approval to participate in the program by submitting appropriate required documentation. Opt Out payment will be received in the second paycheck of each month.

I agree with the County of Washington that my regular pay will be increased by the Opt Out amount as described in the Explanation of Benefits and continuing for each succeeding second pay period in the calendar month until this agreement is amended or terminated.

I understand that I cannot revoke this agreement unless the revocation is on the account of, and consistent with, a change in my family status (i.e., marriage, divorce, death of spouse), cancellation of my coverage under the medical insurance plan in which I am currently covered, commencement or termination of employment of my spouse, my or my spouse's unpaid leave of absence or change from full-time to other than full-time employment (or vice versa), and such other events as my employer determines will permit a change or revocation of an election.

Upon the occurrence of one of the events listed in the immediately preceding paragraph, I will be permitted to revoke this agreement.

Each year, during the open enrollment period, I will be offered the opportunity to change my Opt Out for the following Plan Year (January 1 to December 31). Each year I must submit my Opt Out information in effect for the new Plan Year. In addition, this agreement will continue by its terms.

The Human Resources Department may reduce or cancel the amount of my Opt Out or otherwise modify this agreement in accordance with the County of Washington Employees' Medical Insurance Opt Out Incentive Plan if it is advisable in order to satisfy certain provisions of the Internal Revenue Code. In addition, adjustment may be made to the extent provided in the County of Washington Employees' Medical Insurance Opt Out Incentive Plan, in the event of an increase or decrease in the cost of medical coverage provided by an independent third party provider.

Please return this form to the Human Resources Department.

_____ _____
Employee's Signature Date

Accepted and Agreed to by the County of Washington:

By: _____ _____
Date

Revised 7/1/2018

COUNTY OF WASHINGTON
EMPLOYEES' MEDICAL INSURANCE

OPT-OUT INCENTIVE PLAN
ACKNOWLEDGEMENT OF TERMS

Name: _____ Department: _____

Address: _____

Daytime Telephone Number: _____

This acknowledgement is to notify you of the enrollment terms that, by enrolling in the opt-out incentive program, allow you to receive the incentive.

- You must re-enroll in the opt-out program every year during an open enrollment period.
- Opt-Out incentive plan terms are not bound by any collective bargaining agreement.
- The terms of the opt-out program follow the same guidelines as the health insurance in regards to changes, open enrollment and other qualifying events.
- Forms and documentation must be received in the Human Resources Department no later than November 30th to become effective January 1st of the following year.
- If you are a union employee and hired after October 1st of the current year, you will not need to re-enroll for the following year. However, you must re-enroll every subsequent year.
- If you are a salaried employee and hired after December 1st of the current year, you will not need to re-enroll for the following year. However, you must re-enroll every subsequent year.

This form must be submitted along with your opt-out enrollment form to the Human Resources Department.

I hereby acknowledge and understand the terms as set forth above.

_____ _____

Employee's Signature Date

Revised 03/2018

COUNTY OF WASHINGTON

EMPLOYEES MEDICAL INSURANCE OPT OUT INCENTIVE PLAN

EXPLANATION OF BENEFITS

I. ELIGIBILITY REQUIREMENTS

1. Must be an elected official, full time salaried employee, or a full time bargaining unit employee.

2. Employee must be eligible for coverage under the County's medical insurance program.

3. Employee must be covered by a medical insurance plan other than the County's and show proof of such alternate coverage.

4. Newly hired employees may choose to opt out of their County medical insurance program effective the date they are eligible for the County's medical insurance program.

II. ENROLLMENT PROCEDURE

1. Employees wishing to opt out of the County medical insurance program must opt out for the calendar year of 2020, unless certain qualifying events occur. In November of 2019, during the open enrollment period, the employee will have the opportunity to re-establish coverage in the County's medical insurance program **or** re-enroll in the Opt Out Incentive Plan.

2. Employees will be permitted to change their election once a year and only during the open enrollment period established for the plan. The only exception to this rule is when a qualifying event occurs as outlined in Section III.

3. The Opt Out amount an employee will receive monthly for opting out of the County medical insurance program is $200.00. This amount applies to 2020. An amount will be distributed to employees each year that the Opt Out Plan is available. The monthly allowance for opting out of the medical insurance program will be included in the employee's second paycheck of each month and will be subject to all normal payroll taxes, retirement plan contributions and any other payroll deductions based on gross pay.

III. QUALIFYING EVENTS

1. In accordance with Federal law, an employee will only be permitted to withdraw from or enroll in the medical insurance Opt Out Plan **during the plan year** if one of the following qualifying events occur and is applicable to the employee's situation, and **within 30 days of the qualifying event.**

   a. **Change in Family Status**

   - marriage or divorce of employee
   - death of the employee's spouse

b. **Change in Spouse's Employment**

- termination of employment or the commencement of employment
- a significant change in health coverage attributable to spouse's employment
- spouse's employment status changes from full time to other than full time

c. **Change in the County Employee's Employment Status**

- switching from full time to a less than full time employment status

d. **Either Spouse Takes an Unpaid Leave of Absence**

- The unpaid leave of absence must result in the loss of medical insurance coverage. This does not apply if the employee or the spouse is on a Family Medical Leave.

e. **Special Enrollment Under the Health Insurance Portability and Accountability Act of 1996**

f. **Court Order**

g. **Change of Worksite or Residence**

IV. REINSTATEMENT TO MEDICAL INSURANCE COVERAGE

1. In the event employees who are enrolled in the Opt Out Incentive Plan experience a qualifying event during the plan year and as a result, want to withdraw from the plan and be reinstated to the County's medical insurance program, the employee must submit an enrollment form with proof of a qualifying event to the Human Resources Department within 30 days of the event.

2. Reinstatement to the County medical insurance program, for those employees who qualify, will occur on the first of the month following the date the Human Resources Department approves the enrollment form and qualifying event.

3. The employee's Opt Out Incentive Plan allowance will cease when the employee is reinstated to the County medical insurance program. **Under no circumstances will employees be entitled to receive both an opt out allowance and coverage in the County medical insurance plan within the same month. Employees are responsible to the County for any opt-out monies paid in error.**

V. TERMS AND CONDITIONS

1. All terms and conditions of the County of Washington Employees Medical Insurance Opt Out Incentive Plan are subject to the provisions detailed in the respective plan documents and summary plan description.

2. Except as modified by labor agreement, the County reserves the right to unilaterally change, alter or discontinue the program (in total or in part) without notice.

3. In the event the Opt Out Incentive Plan is terminated, employees who have elected to waive medical insurance coverage will have the option to be immediately reinstated to the County medical insurance program upon completion of the necessary enrollment forms.