CITY OF CHICO - HUMAN RESOURCES AND RISK MANAGEMENT OFFICE
DESIGNATION OF MEDICAL OPT OUT PAYMENT CHOICE

Employee Name: _____ **Employee #:** _____

Bargaining Unit:

- ❑ **CFM** - $200 per month
- ❑ **CNF** - $200 per month
- ❑ **CME** (MGT) - $200 per month
- ❑ **CPM** - $100 per month
- ❑ **CPOA** - $200 per month
- ❑ **CPSA** - $200 per month
- ❑ **DIR** - $200 per month
- ❑ **IAFF** - $200 per month
- ❑ **L39** - $200 per month
- ❑ **PSM** - $100 per month
- ❑ **SEIU** - $200 per month
- ❑ **UNR** - $100 per month
- ❑ **UPEC** - $200 per month

Pursuant to the provisions of the Memorandum of Understanding (MOU), Pay & Benefits Resolution (PBR) or Contractual Services Agreement (CSA) which covers my employment, I have determined to waive coverage in the City's medical insurance plan (opt out). I hereby elect to receive my opt-out payment as follows:

Opt-Out Election	Bargaining Units Eligible	Amount of Monthly Contribution Elected*
❑ **Section 125 Plan Medical Flexible Spending Account** I understand I must enroll in the Section 125 Plan, make an appropriate designation, and renew that enrollment each year, all during the open enrollment period (October), so long as I continue the Section 125 Medical Flexible Spending Account choice as the alternative payment for my opt out of the City's medical insurance plan. I further understand that I may not change this designation until the following open enrollment period.	All except UNR	$ _____
❑ **457 Deferred Compensation Plan** I understand I must establish a Deferred Compensation account and designate a total contribution which includes the City contribution for my opt out. This enrollment does not need to be renewed each year. If I terminate my opt out, I understand that the total amount of deferral into the Deferred Compensation account will not change unless I make that change by filling out the required forms. If I do not make that change in the amount of deferral, the discontinued City contribution amount will be deferred from my pay into my Deferred Compensation account. The City's alternative payment into my Deferred Compensation account is included in the total for calculation of annual maximum deferral amounts under IRS regulations.	All except CPSA, CPOA IAFF and UNR	$ _____
❑ **Cash** I understand the cash amount received will be subject to normal payroll tax withholding.	All	$ _____

*Note: The total contribution/cash amounts indicated above must equal the total opt out payment amount.

I understand I must provide verification of alternative group medical insurance coverage to receive opt-out payment for the City's medical insurance coverage. I understand if I am enrolled in an individual coverage, such as Medicare, Medi-Cal, or Covered California, I am not eligible to receive the medical insurance opt-out benefit, even if the individual coverage provides minimum value. I understand I may not enroll in the City's medical insurance plan until the next open enrollment period unless I lose my alternative insurance coverage. I further understand the City's alternative payment will continue only if I am otherwise eligible to receive a medical insurance benefit from the City and will immediately cease if I again become covered by the City's medical insurance plan or become ineligible for medical insurance coverage under the MOU, PBR or CSA.

Signature: _____ Date: _____

City of Chico
Certification of Other Medical Coverage

Complete and return this form only if you are opting out of coverage (not electing) City of Chico medical coverage.
A copy of your health insurance identification card must accompany this form.

PART ONE - CITY OF CHICO EMPLOYEE INFORMATION

Employee Name (Last, First)		Employee ID
Job Title	Department	Primary Phone Number

PART TWO - OTHER MEDICAL COVERAGE

HIPAA - The Health Insurance Portability Act of 1996 (HIPAA) requires the City of Chico to inform you of your rights to Special Enrollment under any of the medical insurance plans offered by the City of Chico when you or your eligible dependent (spouse/registered domestic partner/children) decline coverage.

- If you are declining enrollment for yourself, or your dependents (spouse/registered domestic partner/children) because of coverage under another medical plan, you may be able to enroll yourself or your dependents in a City of Chico medical plan in the future, provided you request enrollment within thirty (30) days after your other coverage ends.
- If you are declining enrollment for yourself, or your dependents (spouse/registered domestic partner/children) because of coverage under Medicare or Medicaid, you may be able to enroll yourself or your dependents in City of Chico medical plan in the future, provided you request enrollment within sixty (60) days after your other coverage ends.

In order to qualify for this special enrollment period, you must certify other coverage was the reason for declining enrollment and provide verification of the source of that other coverage below.

I am waiving City of Chico medical coverage because I have medical coverage elsewhere. I certify that I have other medical coverage (check one box):

☐ Option 1 - through another City of Chico employee (Employee Name): _____

☐ Option 2* - outside of the City of Chico through (Spouse/RDP or Parent Name): _____

with (Spouse/RDP or Parent Employer's Name): _____

☐ Option 3 - through Medicare or Medical (identify plan): _____

☐ Option 4 -through the Health Insurance Marketplace (identify plan): _____

Primary Subscriber: _____ Coverage: ☐ Single ☐ Double ☐ Family

*Coverage under Option 2 requires Part Four – Spouse/Registered Domestic Partner's Employer's Certification to be completed.

PART THREE - EMPLOYEE CERTIFICATION AND SIGNATURE

I understand that if I do not gain special enrollment rights upon a loss of other coverage, my next opportunity to enroll in a City of Chico medical plan will be the next annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, registered domestic partnership, birth, adoption or placement for adoption. I understand that I am also waiving prescription drug coverage. The information listed above is correct to the best of my knowledge.

Signature: _____ Date: _____

PART FOUR – SPOUSE/REGISTERED DOMESTIC PARTNER'S OR PARENT'S EMPLOYER'S CERTIFICATION

This certification must be completed by your spouse's/registered domestic partner's or parent's employer if you selected Option 2, above.

I hereby certify that the City of Chico employees listed above, is covered under his/her spouse/registered domestic partner's employer's medical and prescription benefit plan listed in Part Two – Other Medical Coverage.

Effective Date of Coverage: _____ Carrier Name: _____

Carrier Address: _____ ID/Group #: _____

Employer: _____

Certified By (Print Name/title): _____

Signature: _____ Date: _____

NOTE: Employees enrolled in an alternative individual coverage, such as Medicare, Medi-Cal, or Covered California, are not eligible to receive the medical insurance opt-out benefit, even if the individual coverage provides minimum value.