RIVCO 1HR benefits division

Opt-Out Program Attestation 2024 Plan year

Employee Name:	Employee ID:	Department:
Telephone:	Email:	

You have the option to waive coverage under the County health plan. In deciding to waive coverage you should be aware of the following information:

Unless you sign a waiver stating that you are covered under another group health plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the County's health plan until the next open enrollment period. However, if you are covered under another group health plan, and that coverage is lost, you can enroll in the County's health plan immediately. There's a time limit for enrolling after the other coverage is lost; you must request to enroll in a County plan within 60 days of losing the other group coverage.

If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and all other eligible dependents at that time, but you must do so within 60 days of gaining the new dependent. If you miss the 60-day enrollment deadline, you must wait until the next open enrollment period.

Indicate (check) the reason you are declining County coverage below and read and sign the attached Waiver Statement for the following reason:

☐ I am covered as a dependent on my Spouse's plan and my Spouse is another County employee: Spouse Name:_____ Employee ID:_____

☐ I am enrolled in another group plan as a dependent of my _____

☐ I am covered by other coverage under a government plan, such as _____

☐ I am covered by an individual plan _____

☐ My reason is not listed. Explain: _____

_____

_____

Note: If you waive coverage for yourself, you may not cover dependents under the County's health plan.

Return to: County of Riverside- Employee Benefits Division Mail: P.O. BOX 1569 Riverside, CA 92502
Email: benefits@rivco.org
Fax: 1-951-955-3490

Employee Name:_____ **Employee ID:**_____

Waiver Statement

The County of Riverside "County" has offered a Health Insurance Benefit consisting of minimum essential coverage to myself and my dependents for the 2024 plan year, and I am choosing to decline coverage. I understand that if I enroll in the County's Health Insurance Benefit, the County will contribute ("Employer Contribution") a Flexible Credit to be applied toward the cost of that coverage if I am a Regular status employee. This amount cannot be applied toward other benefits or taken in cash. Employees covered under the DDAA and LEMU bargaining units are still entitled to receive Flexible Credits as cash back, if enrolled in a County sponsored medical plan.

I elect to decline coverage through the County of Riverside's group health plan for the plan year beginning on **January 1, 2024 and ending on December 31, 2024**.

I understand that, by declining health coverage through the County of Riverside that I cannot revoke or change this election during the plan year, unless I have a qualifying change in status as defined by the IRS and the requested change is on account of and consistent with my change of election. I may then revoke my prior election and sign a new Agreement if a qualifying change in election event occurs.

I have read the information above. I understand the consequences of my waiver of coverage.

Signed:_____ Date: _____

Additional Opt-Out (Medical Waiver Statement) You MUST complete this statement if you are eligible and electing a Medical Waiver option.

I have reviewed the Medical Waiver rules and confirm that I meet all eligibility requirements. I hereby elect to receive taxable cash-in-lieu of enrolling in the County's health insurance benefit. I understand that the taxable cash benefit is not subject to PERS retirement credit and that I am responsible for any tax consequences.

I hereby provide proof and attest that all individuals for whom I expect to claim a personal exemption deduction for 2024 ("Tax Family") and myself have alternative minimum essential coverage (other than coverage in the individual market and other than individual coverage through Covered California), for the 2024 plan year. I understand the County must not and will not pay cash-in-lieu, if the County knows or has reason to know that myself or an individual in my Tax Family does not have the alternative coverage.

I understand that I am required to inform the County immediately should I or another member of my Tax Family experience a loss in qualifying coverage

I understand that I am required to complete a new Opt-Out attestation statement each plan year to maintain this election.

In exchange for my waiver of health care coverage, the County will deposit an amount defined by the Memorandum of Understanding or Management Resolution that governs my employment each pay period (24 pay periods per plan year) into the cash benefit component of my cafeteria plan account for the 2024 plan year.

I understand this contribution from my cafeteria plan is ordinary taxable income.

Signed:_____ Date: _____

Return to: County of Riverside- Employee Benefits Division Mail: P.O. BOX 1569 Riverside, CA 92502
Email: benefits@rivco.org
Fax: 1-951-955-3490