Opt Out Form: Employee Health Benefit Plan Deschutes County/COIC 2019 Plan Year

Employees who elect not to participate in the Deschutes County/COIC Employee Health Benefit Plan (Plan) including medical, pharmacy, dental and vision coverage will be entitled to receive a monthly stipend.

Employee Name:_____Department: _____

I fully acknowledge and understand the following:

1. To be eligible to opt out of the Plan and receive the stipend, I must maintain coverage under another comprehensive employer-sponsored group medical benefit plan, or a comprehensive individual medical health insurance policy ("outside coverage").
2. The election to opt out of the Plan is entirely voluntary. The Plan is not responsible for any expenses I incur after coverage under the Plan terminates for my dependents or myself. Furthermore, once I opt out of the Plan, my covered dependents and I are not eligible for COBRA continuation coverage.
3. Elections to opt out of the Plan must be made at the time of hire, when initially meeting eligibility, or during the annual open enrollment period.
4. If I elect to opt out, I am entitled to receive a dollar amount of $50.00 per month ("stipend"). This amount will be added to my regular monthly income and is considered taxable under both state and federal law. If I elect to opt out, I will continue to be enrolled in County sponsored Life and Long Term Disability insurance provided as a benefit to eligible employees.
5. If, at a later date, I wish to enroll in the Plan, I understand I will no longer be eligible for the monthly stipend.
6. I may only enroll in the Plan during the next-occurring open enrollment period, unless my outside coverage terminates, creating a qualifying event, prior to the next-occurring open enrollment period. If my outside coverage should terminate, I may elect to enroll in the Plan upon such termination, notwithstanding the occurrence of the annual open enrollment period. If I elect to enroll in the Plan after my outside coverage terminates, I must do so within 30 days of the termination of outside coverage or wait until the next open enrollment period. My enrollment shall otherwise be consistent with and governed by the terms and conditions of the Plan.
7. I agree to return to Deschutes County all payments made in error or for fraudulent acts which include, but are not limited to the following: (a) failure to report a change and/or changes in status affecting my eligibility to opt out of the Plan in a timely manner; (b) falsifying information in order to receive the opt out stipend.
8. Retirees and COBRA participants are not eligible to participate in this opt-out program.
9. By agreeing to opt-out of the Plan, I am not able to utilize the Deschutes Onsite Clinic for medical services or participate in the Wellness Program.
10. By agreeing to opt-out of the Plan, I will not be able to utilize the DOC Pharmacy.
11. In addition to myself, all of my eligible dependents must opt-out of the plan in order to receive the monthly stipend.
12. In order to continue receiving the stipend, I must opt-out of the Plan annually at open enrollment. By signing below, I am opting out of the Plan for the current plan year only.
13. If I have previously opted out of the Plan, and wish to enroll at the next open enrollment, I must submit an application for enrollment according to the parameters of that open enrollment.

By signing below I certify that I acknowledge, understand, and agree to the foregoing statements, that I have outside coverage as defined herein, and that my employer may request at any time proof of such outside coverage. I wish to opt out of the Deschutes County/COIC Employee Benefit Plan.

Member signature:_____ Date: _____

Proof of Other Coverage:

Policy #:_____

Insurer: _____