CITY OF NEWPORTBEACH
HUMAN RESOURCES DEPARTMENT

WHAT YOU NEED TO KNOW ABOUT THE HEALTH BENEFITS OPT-OUT PROVISION

The health benefits opt out provision is a benefit found and defined in the Memorandum of Understanding (MOU) of all City bargaining groups. This packet of information has been developed in order to facilitate employee's understanding of the benefit and to provide all the forms necessary for implementation.

WHEN CAN I UTILIZE THIS BENEFIT?

This benefit becomes available when a covered City employee obtains coverage through their spouse's group sponsored medical coverage that meets the minimum value requirements as defined by the Affordable Care Act (ACA) regulations **OR** when a covered City employee obtains group sponsored medical coverage outside the City's plans, that also meets the minimum value requirements within the last 60 days. Opting out can also occur during the open enrollment period as well.

The opt-out is not available to a covered City employee whose spouse is also a covered City employee except during open enrollment periods. This is a requirement of the health plans.

HOW DO I OBTAIN MY OPT-OUT BENEFIT?

You must read and complete the waiver and release agreement and attach proof of active and current alternative group sponsored medical coverage as stipulated in the waiver form. **Employees who select health care plans through the health insurance marketplace under the Affordable Care Act will not receive a cafeteria allowance.**

Employees who do not elect a medical plan with the City or provide proof of other group sponsored medical coverage will be enrolled in the lowest cost single coverage plan effective January 1, 2020.

WHEN WILL MY COVERAGE ACTUALLY BE CANCELED?

Your coverage under a City health plan will cease on the last day of the month you successfully complete your paperwork to cancel your insurance.

HOW SOON WILL I START TO RECEIVE MY BENEFIT?

You will begin to receive your benefit in the second pay period of the month following the month in which your insurance was canceled.

Please note: Benefits will begin as stated above provided you submit your waiver to Human Resources and it is approved by the 15 of the month, otherwise benefits will be delayed for an additional month.

HOW DO I GET REINSTATED IN A CITY HEALTH PLAN AFTER WAIVING COVERAGE?

The medical, dental and vision plans require that reinstatement occur only during open enrollment periods, unless you experience a qualifying event.

WHAT IS A QUALIFYING EVENT?

Marriage, divorce, birth of a child, death, loss of coverage, gaining other group sponsored coverage, placement of an adopted child, and gaining stepchildren through marriage are all considered qualifying events. You only have 60 days after a qualifying event to make any adjustments.

WHO CAN I TALK TO FOR MORE INFORMATION?

Please feel free to contact any member of the Human Resources Office staff about this benefit. The office phone number is (949) 644-3294.

CITY OF NEWPORT BEACH WAIVER OF BENEFITS & RELEASE AGREEMENT

The City of Newport Beach provides health benefits, which are defined to be medical, dental and vision to all regular full- time City employees. Employees are allowed to waive the City's health benefits, and receive opt-out money. To qualify, the employee would be required to supply evidence of alternative group sponsored medical coverage and sign this agreement. The opt-out amounts are as follows:

Association	Per Month	Per Pay Period	Per Month	Per Pay Period
Key & Management	$1,000.00 (Hired on or before 4/12/2019)	$461.54	$500.00 (Hired on or after 4/13/2019)	$230.77
Fire Management Association	$1,000.00 (Hired on or before 6/21/2019)	$461.54	$500.00 (Hired on or after 6/22/2019)	$230.77
Professional & Technical Association	$1,000.00 (Hired on or before 3/15/2019)	$461.54	$500.00 (Hired on or after 3/16/2019)	$230.77
City Employees Association	$1,000.00 (Hired on or before 3/15/2019)	$461.54	$500.00 (Hired on or after 3/16/2019)	$230.77
Lifeguard Management Association	$1,000.00	$461.54		
Police Association	$1,000.00	$461.54		
Police Management Association	$1,000.00	$461.54		
League	$1,000.00	$461.54		
Fire Association	$1,000.00	$461.54		

I,_____am in_____Association and eligible for $_____per/mo.
Print Name

1. Employee has group sponsored medical coverage, or for current employees gained group sponsored medical coverage within the last 60 days, and would like to waive his/her rights to participate in the City offered medical coverage in order to receive the opt-out money per month.
2. Employee has provided the City with proof of current group sponsored medical coverage in one of the following forms and attached it to this waiver and incorporated by reference. **Copies of or presentation of other insurance member identification cards are not accepted as proof of coverage.**
   A. Letter from Employee's spouse's employer or covered person's employer, or
   B. Letter from the other insurance plan verifying that Employee is covered as a subscriber or dependent under their coverage. **Note: the proof of coverage must be in effect for the duration of the following plan year.**
3. By signing this waiver:
   A. Employee agrees to release the City of Newport Beach from any responsibility as their employer to provide medical coverage to Employee. Employees may only waive health benefits once per plan year, unless a qualifying event occurs.
   B. Employee agrees to indemnify and hold harmless the City of Newport Beach from any responsibility, damages, losses, causes of action or other claims as a result of Employee's request to waive City provided medical coverage and the City's cancellation of coverage in Employee's name in response to Employee's execution of this waiver.
4. This waiver and release agreement shall remain in full effect until the next Open Enrollment period at which time I acknowledge that I will be required to provide updated proof of other group coverage, should I wish to opt-out for the following plan year. By submitting your medical election, you are attesting that all tax eligible dependents are covered with minimum essential coverage through other group coverage.

Waiving: ☐ **PERS Medical** ☐ **Dental** ☐ **Vision**

Employee Signature: _____ **Date:** _____

Human Resources Department Use Only

Proof of valid coverage attached

Cancel forms attached ☐

_____ _____
Authorized H.R. Personnel Date