LOS RIOS COMMUNITY COLLEGE DISTRICT

ADJUNCT MEDICAL PLAN WAIVER FORM

SECTION I: PERSONAL INFORMATION – Please Print	
LAST NAME:	FIRST NAME:
LOS RIOS EMPLOYEE ID #:	EFFECTIVE DATE:

SECTION II: WAIVING COVERAGE

DECLINATION OF COVERAGE: Medical and dental coverage has been offered to me and the coverage has been explained by Los Rios. I have been given the opportunity to enroll in medical and dental coverage for myself and all of my qualified dependents, if any, and I have decided not to enroll. The following plans are available to me for the 2021-22 Plan Year, provided I continue to qualify for adjunct benefits. The tenthly employee contribution rates listed below are for 0.60 FTE (for full District contribution) and 0.30 FTE (minimum FTE for adjunct benefits). I understand that my contribution would fall somewhere in this range and is recalculated according to my FTE in place on August 23rd for the fall semester and February 10th for the spring. FTE changes after these dates will not affect my eligibility or contribution during the corresponding semester unless my Tentative Class Schedule (TCS) is canceled in its entirety. I also understand that if I teach credit courses for the Sierra Community College District and my combined FTE is *greater than* 0.60, I may be able to include such courses to qualify for the full District contribution to my Los Rios medical benefits. The list of eligibility requirements and details on the Joint District Medical Insurance Program can be found in the Adjunct Faculty Employee Benefits Guide located on the Los Rios Employee Benefits website: https://employees.losrios.edu/employee-groups/certificated-employees/adjunct-lrcft-benefits.

The premiums are composite, which means I would pay the same rate whether I covered just myself or I covered my entire family, i.e. there is no additional cost to me to cover my eligible family members.

	0.60 FTE	0.30 FTE
Kaiser HMO	$227.27/tenthly	$1,058.57/tenthly
Kaiser Deductible HMO	$149.22/tenthly	$980.52/tenthly
Kaiser HDHP HMO	$0.00/tenthly	$407.10/tenthly
Sutter Health Plus HMO	$202.20/tenthly	$1,033.50/tenthly
Sutter Health Plus HDHP	$0.00/tenthly	$702.90/tenthly
Western Health Advantage HMO	$0.00/tenthly	$794.35/tenthly
Western Health Advantage 1800 HSA HMO	$0.00/tenthly	$400.16/tenthly
Delta Dental	$0.00/tenthly	$70.20/tenthly

By declining coverage, I acknowledge that my dependents and I have been offered coverage and that we must wait until the next adjunct enrollment period or submit timely paperwork after experiencing a qualified change-in-status event or HIPAA special enrollment event to (re)enroll in the Los Rios group plan(s).

I am declining ☐ medical / ☐ dental coverage for myself and all of my dependents. In order to waive coverage, documentation of the other medical coverage must be provided. Examples include a letter on employer's/group's letterhead, copy of insurance card specifying coverage periods and covered individuals, etc.

Reason for Declining Coverage:

☐ Covered by an employer's group plan* ☐ Enrolled as a dependent on a Los Rios group plan *EMPLID*:

☐ Covered by Medicare or Tricare

☐ Other _____

Date other coverage began: _____

*Carrier Name(s) & ID #(s): _____

I understand that I will not be able to (re)enroll in these benefits until the next adjunct enrollment period or until I experience a qualified change-in-status event or HIPAA special enrollment event (see below).

To make election changes mid-semester, **original enrollment forms must be postmarked and mailed to the Employee Benefits Department within 31-days of the qualifying event**. (If the event is gaining or losing eligibility for coverage or premium assistance under Medicaid or CHIP, I have up to 60 days to request a change.) Exceptions will not be made—if you miss this deadline, you must wait until the adjunct enrollment period to (re)enroll in coverage.

Qualified Change-in-Status Events

- Employment Status Change of the Employee or Spouse/Domestic Partner
- Change in other coverage (Spouse/Domestic Partner loses eligibility for coverage under another plan, or other employer stops contributing toward the other coverage)
- A change in residence or work site of the Employee or Spouse/Domestic Partner
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage

The plan's official documents govern enrollment changes during the semester and may allow additional qualified change-in-status events. The enrollment change must be consistent with the qualifying event and proof of that event is required.

I have read and understand the above notification. I understand that, if I decline coverage, I will be not be able to enroll in coverage until the next adjunct enrollment period or until I experience a qualified change-in-status or HIPAA special enrollment event as outlined above. I understand that there may be an 18-month waiting period to reenroll if I voluntarily cancel coverage. By signing below, I certify that I understand I have been offered coverage which may be affordable under Affordable Care Act regulations, and that the reason I am declining coverage is accurate. In the event of any discrepancy between this document and any coverage policy, the terms of the policy prevail.

Employee Signature: _____ **Date:** _____

Completed form can be scanned and emailed to Employee Benefits at Benefits@losrios.edu.

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