Washington Counties Insurance Fund

Notice of HIPAA Special Enrollment Rights & Consequences of Declining Coverage

Our records show that you are eligible to participate in group health plan benefits under Washington Counties Insurance Fund (WCIF). To participate in a WCIF health plan, you must complete an enrollment form and, if applicable, pay a portion of the premium through payroll deduction.

A federal law called the Health Insurance Privacy and Portability Act of 1996 (HIPAA) requires you be notified about a very important provision in WCIF health plans. This is your right to enroll in a plan under its *Special Enrollment Provision* if you acquire a new dependent, or if you decline WCIF health coverage for yourself or an eligible dependent (including your spouse*) while other coverage is in effect and later lost that other coverage for certain qualifying reasons.

This notice also advises you of some of the other consequences of declining coverage, including your responsibility for any claims you might incur.

I. Special Enrollment Provision

Loss of Other Coverage

If you decline enrollment for yourself or for an eligible dependent (including your spouse*) while other health insurance or health plan coverage is in effect, you may be able to enroll yourself and your dependents in a WCIF health plan if you or your dependents lost eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent

If you have a new dependent as a result of marriage**, you may be able to enroll yourself or your new dependent if you request enrollment within 31 days after the marriage**. Step children may also be added within 31 days of the marriage**.

You must request enrollment within 60 days after:

- Birth
- Adoption / placement for adoption
- Foster child placement
- Grant of legal guardianship

State Medical Assistance and Children's Health Insurance Program (CHIP)

If you meet any of the following scenarios, you and your dependents may be able to enroll in WCIF health plans within 60 days if:

- You become eligible for state medical assistance and the Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective to enroll you in this plan.
- You qualify for premium assistance under the state's medical assistance program of Children's Health Insurance Program (CHIP).
- You no longer qualify for health coverage under the state's medical assistance program or CHIP.

**or Qualified Domestic Partner*
***or Qualified Domestic Partnership*

Important Warning
If you decline enrollment for yourself or for an eligible dependent, you ***must*** ***complete a "Waiver of Medical Coverage" form.*** *On the form, you are required to state that coverage under another comparable health plan is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents (including your spouse*) will not be entitled to Special Enrollment rights upon a loss of other coverage as described above, but you will still have Special Enrollment rights if you acquire a new dependent as described above. If you do not gain Special Enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in a WCIF health plan at any time other than WCIF plans' annual open enrollment period, unless Special Enrollment rights apply because of acquiring a new dependent as described above.*

To request special enrollment or to obtain more information about WCIF health plans' *Special Enrollment Provisions*, contact your employer's Human Resources Department or contact the Washington Counties Insurance Fund at 2620 RW Johnson Rd SW, Suite 300, Tumwater, Washington, 98512 | (360) 586-0466 or (800) 344-8570.

II. Consequences of Declining Coverage

WCIF health plans only cover participants who enroll and pay, or whose employer pays, for coverage. In some cases your employer may choose to pay the full cost of your coverage. If you choose to decline coverage by completing the "Waiver of Medical Coverage" form, you will not be covered by a WCIF health plan, even if such coverage would be provided at no cost to you. Declining coverage means you will not receive any benefits from a WCIF health plan, and WCIF (including any associated carriers) is not responsible for any claims you may incur. Any such claims are your responsibility or the responsibility of your other plan coverage, and under no circumstances will WCIF (including any associated carriers) be liable for or pay any such claim.

All questions about the consequences of declining coverage should be directed to your employer's Human Resources Department, or Washington Counties Insurance Fund at 2620 RW Johnson Rd SW, Suite 300, Tumwater, Washington 98512 | (360) 586-0466 or (800) 344-8570.

**or Qualified Domestic Partner*
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Waiver of Medical Coverage

I received and read a copy of the "Notice of HIPAA Special Enrollment Rights and Consequences of Declining Coverage" (the "Notice") at or before the time I was initially offered enrollment in group health plan benefits under Washington Counties Insurance Fund (WCIF). I am aware of the warning in the Notice that I will lose some special enrollment rights for myself and my dependents (including my spouse*) if I decline coverage, unless I give my employer this written statement that the reason I am declining coverage is that I or my dependents have other group coverage. Furthermore, I understand the warnings regarding the consequences of waiving coverage and that WCIF and its affiliated carriers are not liable for any claims I may incur when I am not enrolled and participating in a WCIF medical plan.

By signing this form, I decline coverage under WCIF for the people listed below. My reason for declining coverage for these people is that they have other coverage under another group health plan or health insurance. I have named the other coverage that is in effect for each person listed, along with the member number or subscriber number for each person.

(List all the people whom you could cover under a WCIF medical plan but are not covering because they have other comparable coverage, including you, your spouse and your dependents, if applicable. Use additional paper if necessary.)*

Name: ______________________ Other Coverage: ______________________
Member/Subscriber Number: ______________

Name: ______________________ Other Coverage: ______________________
Member/Subscriber Number: ______________

Name: ______________________ Other Coverage: ______________________
Member/Subscriber Number: ______________

Name: ______________________ Other Coverage: ______________________
Member/Subscriber Number: ______________

Name: ______________________ Other Coverage: ______________________
Member/Subscriber Number: ______________

Name: ______________________ Other Coverage: ______________________
Member/Subscriber Number: ______________

Signature: ______________________________

Name (Print): ______________________________

Date Signed: ______________________________

**or Qualified Domestic Partner*

OVER~~~

ELIGIBILITY DETERMINATION FOR ADDITIONAL WHITMAN COUNTY MEDICAL CONTRIBUTIONS

Employee Name:_______________________________________ Review Date:____________

Department: ____

Based on the Affordable Care Act (ACA) Notice 2013-54 and requirements set forth by its medical carriers, Whitman County allows members of the NonRep, CBU, SWBU and RBU employee groups to waive medical coverage in accordance with applicable requirements while retaining additional contribution provided by the County for health insurance purposes. The questions below are designed to determine such eligibility.

I, _______________________________ hereby certify I have provided to Whitman County documentation supporting that I am covered by a group medical plan other than my employer sponsored plan, and am eligible to receive contributions into a HRA or H.S.A. I understand that individual coverage purchased on the individual market or through the exchange marketplace does not allow me to receive contributions to a HRA or H.S.A. I will notify my employer as soon as possible if a change in my coverage occurs and I am no longer covered by a group medical plan. I understand that I will receive the County contribution in accordance with County policy and will have to renew my eligibility annually.

I understand this decision will make me ineligible for long term disability coverage through The Standard insurance company.

I also understand that should I retire during the time I've waived medical insurance, I will not be eligible for retiree medical coverage through Washington Counties Insurance Fund.

Further, I understand that at no time in the future may I hold my employer responsible for any expenses incurred due to a lack of this benefit. I release my employer from all liability and evidence that I have read and understand this consent form by my signature below.

Spouse Pooling employees only: I (print name) ________________________________, have voluntarily decided to waive employee medical coverage and be covered as a dependent on my spouse's medical plan.

____

Employee Signature Date

FOR HR USE ONLY:

___ The employee is eligible for medical coverage through Whitman County

___ The employee is part of NonRep, CBU, SWBU or RBU employee groups.

___ The employee intends to waive coverage as indicated by Page 1 of this form.

___ The employee is enrolled in a qualified group health plan (QGHP) as defined by the ACA (see the Waive WCIF VEBA HSA information sheet for the types of plans that do not apply)

___ The employee is enrolled in a plan that meets minimum value requirements and minimum Essential Coverage set forth by the ACA. This information may be confirmed by the plan's Summary of Benefits Certificate. Confirmation of minimum value has been provided to Human Resources.

HR Staff: Circle and initial

May waive without contribution May waive and receive contribution INIT_____