

2020
INGHAM COUNTY
WAIVER OF HEALTH INSURANCE ELECTION FORM

Name: _____ Employee #: _____

Pursuant to the terms of the Ingham County Section 125 Flexible Benefit Plan, I hereby agree to waive all rights to group health plan coverage by Ingham County and further agree to hold harmless Ingham County from any claims as a result of such waiver.

I am eligible to participate in the Group Health Plan provided by the Ingham County and understand I may select one of two options when waiving my coverage:

_____ Option 1: GROUP HEALTH PLAN WAIVER. I do not wish to be enrolled in the Ingham County Group Health Plan as authorized under the collective bargaining agreement and/or personnel manual applicable to me, and I choose to waive such coverage. I need not provide any proof of other coverage, nor will I receive any consideration in return for such waiver.

_____ Option 2: GROUP HEALTH PLAN WAIVER; PROOF OF OTHER COVERAGE; CASH PAYMENT. I do not wish to be enrolled in the Ingham County Group Health Plan as authorized under the collective bargaining agreement and/or personnel manual applicable to me, and I choose to waive such coverage.

In lieu of coverage, I elect to receive a monthly Cash Waiver payment in the amount set forth below for the Plan Year beginning on January 1, 2020 and ending on December 31, 2020 (or during such portion of the Plan Year to which this Agreement applies).

Family - \$249.66 _____
2-Person - \$222.22 _____
Single - \$131.22 _____

In order to receive the Cash Waiver payment, I must sign this Agreement and provide evidence at least one time each year that:

- (1) I am enrolled in alternative minimum essential coverage from another employer-sponsored group health plan (other than Ingham County, unless as otherwise specified in a collective bargaining agreement); and
- (2) Each member of my 2020 expected tax family are enrolled in alternative minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace).
 - a. My expected tax family includes all individuals for whom I reasonably expect to claim a personal exemption deduction on my 2020 taxes.
 - b. Minimum essential coverage is any insurance plan that meets the Affordable Care Act requirement for having health coverage and is described in Code section 5000A(f) (other than coverage in the individual market, whether or not obtained through the Marketplace).

Additionally, my employer will not make the opt-out payment to me if it knows or has reason to know that I, or any member of my expected tax family, do not (or will not) have alternative minimum essential coverage during the eligible Plan Year. If after the start of the 2020 Plan Year, the alternative coverage subsequently terminates for myself and/or any member of my expected tax family, I must immediately notify my Employer, at which time the opt-out payment will cease.

Attestation: I attest that:

_____ I have (or will have) minimum essential coverage from another employer-sponsored group health plan for the 2020 Plan Year (other than Ingham County, unless as otherwise specified in a collective bargaining agreement).

_____ Each member of my 2020 expected tax family has (or will have) alternative minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) for the 2020 Plan Year.

_____ I understand that as soon as one of the above answers changes, I am to notify my Employer immediately.

I have received and read my enrollment package and I hereby understand that by signing and submitting this Agreement I am making a binding election concerning my benefits and compensation for this Plan Year. I understand that:

(a) I cannot change or revoke this Agreement at any time during the Plan Year unless I have a “change in status” as defined by the Section 125 Plan and as allowed by the underlying Group Medical Plan (which may include marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Plan Administrator determines will permit a change or revocation).

(b) This Agreement will automatically terminate if the Plan is terminated or discontinued.

(c) If I am a Highly Compensated Employee or a Key Employee, as defined in the Section 125 Plan, the Plan Administrator may modify this Agreement to the extent necessary to satisfy certain non-discrimination requirements of the Internal Revenue Code.

(d) Prior to December 31 of each Plan Year, I will be offered the opportunity again to waive health insurance coverage offered by Employer for an opt-out payment. If I do not timely submit this Agreement again, my opt-out payment will cease. I understand that this Agreement may be amended or revoked during the annual open enrollment period or upon the occurrence of certain limited "changes in status" as described in the Plan.

This Agreement is subject to the terms of the Section 125 Plan and to the approval of the Plan Administrator; it shall be governed by and construed in accordance with the laws of the State of Michigan.

Employee Signature: _____

Date: _____