Opt Out or Opt Down Health Insurance Policy

The Auglaize County Commissioners will be offering to employees the opportunity to **opt out** or **opt down** of the health insurance plan per ORC 305.171 (G). Employees opting out or opting down such that they are no longer covered by the County's insurance plan must provide the requested information and statement affirming that they have health insurance through another source. Employees must notify the County Auditor in writing by November 30th of each year their intent to exercise this option, which will take effect January 1st of the following year. Opt out/opt down payments will be made quarterly; the last pay day of March, June, September, and December. A mid year request for opt out/opt down may be made but may or may not be granted depending on the position of the program at such time.

A. To be eligible for the opt out/opt down option, the employee must currently be enrolled in the County Health Insurance Plan and must have been enrolled at the current level of insurance (i.e. family plan or single plan) for the preceding four (4) years, or elected the opt out/opt down option in 2018. An employee enrolled in a combination of single and/or family coverage for the preceding four years may be eligible but will be treated as having only been enrolled at the single coverage level for purposes of this policy.

B. Once the opt out/opt down option has been exercised, no Employee shall be allowed to return to the County Health Insurance Plan unless the employee meets the Special Enrollment period criteria or enrolls during the annual enrollment period.
   1. If the employee needs to return to the County Health Insurance Plan through the Special Enrollment method established in the Health Insurance Plan after accepting the opt out/opt down option, the employee shall forfeit the opt out/opt down payment for the quarter in which the employee has returned to the health insurance plan by the special enrollment.

C. An employee opting out of a family plan will receive $3000.00 in 2019. **The monetary amount is not guaranteed year to year but will be reviewed by the BOCC annually.**

D. An employee (a) opting down from a family plan to a single plan or (b) opting out from a single plan to no coverage will receive $1500.00 in 2019. **The monetary amount is not guaranteed year to year but will be reviewed by the BOCC annually.**

E. An employee opting out will not be eligible for the County provided flex plan benefit or health savings account benefit of $300.00 or $150.00 a year, whichever is applicable, and an employee opting down will be reduced to a flex plan benefit or health savings benefit amount of $150.00 a year.

F. Annually, the County must have five (5) employees that choose to participate in this program or it will not be offered.

G. If an employee retires or employment is terminated for any reason while on the opt out/opt down option, the employee will forfeit the opt out/opt down payment for the quarter in which employment has been terminated.

H. If the Individual Appointing Authority is paying the Employer share, the Individual Appointing Authority will be paying the opt out/opt down monetary amount.

I. THE BOCC RESERVES THE RIGHT TO DISCONTINUE THIS PROGRAM AT ANY TIME DURING THE YEAR. AN EMPLOYEE SHALL ONLY BE ENTITLED TO QUARTERLY PAYMENTS WHEN THIS PROGRAM IS IN EFFECT. NO PAYMENTS SHALL BE MADE UPON A DECISION TO DISCONTINUE THIS PROGRAM.

Opt out is defined as transitioning from (a) a family plan to no coverage by the County or (b) a single plan to no coverage by the County.
Opt down is defined as transitioning from a family plan to a single plan.

OPT OUT OR OPT DOWN

I am currently enrolled in the County plan (or participated in the opt out/opt down program last year). I have read and I understand the opt down/opt out options.

If I am interested in the opt out/opt down option, I need to complete this form using one of the following options:

I exercised my option to (circle one) opt down or opt out

1- **OPT DOWN to a single plan** **check here** ☐

_____ _____
Employee's signature date

2- A. **OPT OUT from a single plan to no coverage** **check here** ☐

B. **OPT OUT from a family plan to no coverage** **check here** ☐

If either item 2A. or 2B. above is checked, please fully complete and sign as indicated. No payment can be made unless all items are completed.

I hereby affirm that I am covered under the following health insurance or health care policy, contract or plan:

_____	_____	_____
Name of employer Sponsoring plan (if applicable)	Name of carrier providing coverage	Identifying number of policy, contract or plan

_____ _____
Employee's signature date

Return all forms to the Auditors office.