# Certification of Other Comparable Coverage
# Opt-Out of Medical Coverage

**Instructions** *(Please print clearly)*

1. Attach proof of comparable medical Minimum Essential Coverage (MEC) as defined by the Affordable Care Act (ACA) that shows you (and anyone else you expect to claim as a tax deduction in 2025) as a covered member (ID card, letter from insurance company, copy of enrollment information.) The plan effective date must be included.
2. Return this form with proof of other comparable medical coverage to the Human Resources Department by the applicable deadline.
3. Check one box only and enter the dates requested.

☐ **New-Hire**
Hire Date _____
Due within 14 days of hire date

☐ **Annual Enrollment**
Due on or before October 28

☐ **Qualified Change in Status Event**
Event Date _____
Notification Date _____
Opt-Out begins 1st of month following notification date, provided documents received within 31 days of qualified change in status event

| Last Name | First Name | MI | Email Address |
|---|---|---|---|
| Last 4 Digits of Social Security Number | Work/Cell Phone | | Medicare ID Number (if enrolled in Medicare) |
| Home Address | City | State | Zip |

**Comparable Coverage**: *Insurance coverage obtained through the individual market, including through the Health Insurance Marketplace is* ***not valid****. Insurance coverage by a short-term health plan, limited benefit health plan, subscription health plan, discount health plan, association health plan or health care sharing program* ***is not*** *considered comparable medical coverage.*

Coverage Type: ☐ Traditional Plan (ex. PPO, HMO) ☐ Qualified High Deductible Plan ☐ Government (TRICARE, VA) ☐ Other

**Primary cardholder (Person whose plan you are enrolled in)** _____ Relationship _____

I elect to opt-out of my employer's sponsored medical plan. This opt-out election is conditioned on timely receipt of a signed Certification of Other Comparable Coverage (MEC) form with valid proof of other coverage, and is subject to the provisions of my Employer's Cafeteria Plan, benefit plans and personnel policies. Any reference to "other coverage" or "comparable coverage" generally refers to another employer's group health plan which is considered affordable Minimum Essential Coverage (MEC) as defined by the Affordable Care Act (ACA). Examples of other coverage may also include TRICARE medical plan (not a TRICARE supplement) or care provided at a Veteran's medical facility. Medicaid is not considered other comparable coverage for Opt-Out purposes. I have been given an opportunity to ask questions about the opt-out election and understand and agree to all of the conditions listed below. I acknowledge the information I provide is subject to verification. If it cannot be verified, I am ineligible to opt-out.

1. **My Employer can disregard this form.** If my Employer has reason to believe this Certification is incorrect, invalid, or that I do not have other comparable coverage, my Employer reserves the right to disregard this Certification. My employer can request proof of other comparable coverage at any time.

2. **I cannot change this election unless specific circumstances apply.** Once I opt-out of medical coverage, the election cannot be changed until the next annual enrollment period, unless I experience a Qualified Change in Status Event. If I experience a Qualified Change in Status Event, I can make a new election for medical coverage as long as the election is consistent with the Qualified Change in Status Event.

3. **I must turn in my documents before the deadline.** My employer must receive this signed Certification and proof of other comparable coverage, no later than the employer's applicable deadline. The information is considered received by my employer when received by my employer's Human Resources Office.

4. **If I do not turn in my documents on time, I cannot opt-out, even if I have other comparable medical coverage.** If I elect to opt-out of my employer's sponsored medical plan but fail to provide the signed Certification of Other Comparable Coverage Form and valid proof of other comparable medical coverage by the date due, and:

   **a) I am a newly-hired employee**, I will be enrolled in my employer's designated default election plan, employee coverage only (no dependent coverage); or if

   **b) I am currently enrolled** in my employer's medical plan, then this opt-out election is considered void and I will remain enrolled in the plan and coverage level in force as if this election was not made, subject to the terms of the underlying plans.

5. **Employer non-elective contributions to my FLEX Spending Account (subject to employer participation) are not guaranteed.** As a result of this election, my employer may, in its sole discretion, make a non-elective contribution to a general purpose or limited purpose Health Care FLEX Spending Account on my behalf, and all Flexible Spending Account rules apply. If I am enrolled in the retiree group medical plan or am enrolled due to my COBRA status, I understand I am ineligible for employer non-elective contributions to a FLEX account. The annual non-elective contribution is prorated for partial year eligibility and in no event can exceed the Employer established annual maximum. If my employer makes a non-elective contribution, the amount of the non-elective contribution is subject to change without notice. If I fail to provide the required documents by the applicable deadline or if this election is found to be invalid, my employer may, without notice, discontinue any non-elective FLEX account contributions and/or require I repay FLEX reimbursements made to me during the period of time this election was in force.

6. **If I am required to provide insurance coverage to a dependent(s) under a court order, evidence of other comparable coverage for the dependent(s) has been provided.** Court orders include Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

7. **It is my responsibility to notify my employer within 31 days of the date my comparable medical insurance coverage ends.** If I fail to do so, I acknowledge I may be enrolled in my employer's designated default election plan, employee coverage only, and I authorize payroll deductions for premium due.

**Signature:** I certify that all information provided is true and correct, and that I (and anyone else I expect to claim as a tax deduction) have other minimum essential coverage which is not obtained in the individual market, including through the Health Care Marketplace, and I agree to comply with all conditions as described above.

_____ Signature

_____ Date