MEDICAL INSURANCE "OPT-OUT"
WAIVER OF MEDICAL COVERAGE FORM

Clackamas County has offered me the opportunity to enroll in medical coverage under Providence Health Plan or Kaiser Permanente. Both of these plans offer minimum essential coverage (MEC) that provides minimum value as defined under the Affordable Care Act. Clackamas County also provides an opt-out payment per month if I and my "expected tax family" will be covered by other MEC for the relevant period and if I complete this attestation and waive coverage under a County plan.

I hereby certify that the following statements are true and correct:

- I am declining medical coverage through Clackamas County for myself, my spouse and all tax dependents, if any, for whom I reasonably expect to claim personal exemption deduction on my federal income tax return ("expected tax family"). I and all other members of my expected tax family, if any, have or will have MEC that is NOT coverage obtained in the individual market or Health Insurance Marketplace for the period covered by the opt-out payment (as defined below).

I understand and agree to the following:

- The plan year for Clackamas County is January 1, 2026 to December 31, 2026.
- The period covered by the opt-out payment is:
  - *through the end of the current plan year, if the declination of coverage is related to initial enrollment, or*
  - *through the end of the next plan year, if the declination of coverage is related to open enrollment, or*
  - *through the end of the month prior to enrollment of medical coverage through Clackamas County due to a qualified life event*
- If my employer knows or has reason to know that I or any other member of my expected tax family does not have (or will not have) the required MEC coverage, my employer is obligated to terminate the opt-out payment.
- I and all other members of my expected tax family will only be eligible to enroll in medical coverage through Clackamas County during Open Enrollment and/or within 60 days of a qualified life event. See Clackamas County Benefit Handbook for detailed information.

Print Employee Name	Employee ID
Employee Signature	Date