County of Sonoma Employee Benefits Enrollment/Change Form

Instructions for Completing This Form

Employees must complete all sections of the form. *Enter your name and employee ID number as indicated on the top of the applicable pages.*

Section 1: Reason for Submitting Form

- Use this form to enroll for coverage as a new hire or newly eligible employee, during annual enrollment, or to change your current coverage due to a qualifying life status change (see last page).
- Indicate the reason you are submitting the form and the date of the change(s), as necessary. Check all boxes that apply.
- Newly eligible dependents may only be enrolled within 31 days of the eligibility event.

Section 2: Personal Information

- Fill in all information requested. If your spouse/domestic partner/dependent(s) is employed by or retired from the County of Sonoma, please indicate in the space provided on the form.
- If your dependent is an employee or retiree of the County of Sonoma, you may not cover them if it creates dual coverage under any of the health plans.

Section 3: Medical Plan Choice

- Indicate whether you wish to change your medical plan election during annual enrollment, enroll as a new hire/newly eligible employee, add coverage for eligible dependent(s), continue current enrollment in medical coverage for yourself and/or your dependent(s), or drop/waive medical coverage for yourself and/or your dependent(s). To waive medical coverage, the individual must have other group coverage or coverage through Covered CA. If not enrolled in other group coverage or coverage through Covered CA, select "DROP" to cancel coverage. Check all that apply.
- Complete the *Waiver of Medical Plan Acknowledgment* (Section 10 of this form) if you are waiving medical coverage due to enrollment in other group coverage.
- Select your medical plan and coverage level.
- Sign the *applicable Arbitration Agreement* if enrolling in a medical plan (Section 8 or 9 of this form).
- Complete Section *6 of this form if you have eligible dependents, even if not enrolling them in benefits.*

***Section 4*: Dental Plan Choice**

- Indicate whether you wish to enroll as a new hire/newly eligible employee or add/continue/drop/waive coverage for yourself and/or your dependent(s) through Delta Dental of CA. To waive dental coverage, the individual must have other group coverage. If not enrolled in other group coverage select "DROP" to cancel coverage. Check all that apply.
- Complete Section 6 of this form if you have eligible dependents *even if not enrolling them in benefits*.

Section 5: Life Insurance

Complete this section ONLY to:

- Designate a primary/contingent beneficiary(s) for your County-provided basic life insurance benefit or change your previous designation on file.
- Initial in the space provided if you have a beneficiary designation on file with the County of Sonoma and do not wish to update it.
- Indicate your dependent life insurance coverage election. Complete Section 6 of this form if you have eligible dependents.
- If your dependent is an employee or retiree of the County of Sonoma and has a basic life benefit, you may not cover them under dependent life insurance. Our policy does not allow dual coverage.
- Part-time employees of some bargaining units (**DSA** 46, 47, **ESC** 75, **SCLEA** 30, 40, 41, and 70) have an option to purchase life insurance. Consult the Employee Health and Welfare Benefits Booklet for more information.
- Note: If you wish to enroll in or change your supplemental life insurance election or the beneficiary for this benefit, consult the Employee Health and Welfare Benefits Booklet for information.

Section 6: Eligible Dependent Information

- Complete the information by listing your dependents and their coverage status in medical, dental, vision, and dependent life insurance. Indicate **(A)** to add coverage for an eligible dependent(s); **(D)** to drop coverage for a dependent(s); **(C)** to continue enrollment in coverage for an eligible dependent(s); **(W)** to waive coverage for an eligible dependent(s) enrolled in other group coverage or **(N/E)** if you have listed dependents that are not eligible.
- You MUST indicate whether your dependents are Full-time students, disabled dependents, and considered IRS-qualified dependents. In general, only domestic partners and their children are considered IRS non-Qualified dependents. Refer to the Health and Welfare Benefits Booklet for more details.

Section 7: Employee Authorization and Signature

- Review the Employee Authorization Agreement and sign and date your form.

Sections 8 and 9: County Health Plan Agreements and Kaiser Foundation Health Plan Arbitration Agreement

- Complete the County Health Plan Agreement (Section 8) or Kaiser Foundation Health Plan Arbitration Agreement (Section 9) if electing either of these plans.

Section 10: Waiver of Medical Insurance Plan Acknowledgment

- Review and sign the *Waiver of Medical Plan Acknowledgment* if you are waiving medical coverage for yourself and/or your eligible dependents. This is ***required*** if you choose to waive coverage. To waive medical coverage, the individual must have other group coverage or coverage through Covered CA.

When Changes are Allowed

- Your benefits elections are irrevocable with a few limited exceptions Read this section in its entirety to understand the circumstances under which you are eligible to make changes to your County-offered health plan elections. See last page "When Changes are Allowed."

Submit the completed & signed form to your Department Payroll Clerk within 31 days of eligibility or a change in life or employment status event.

If you have questions, please contact the Benefits Unit: Benefits@sonoma-county.org or (707) 565-2900

County of Sonoma *Employee* Benefits Enrollment/Change Form

Employee ID #: _____

Confidential Information –Please print clearly

All employees must complete all sections of the form. Please follow the instructions included with this form.

Section 1a: Reason for Enrollment/Change

Mark all boxes that apply:

- ❑ Annual Enrollment
- ❑ New Hire (Date of Hire:_____)
- ❑ Newly Eligible Employee
  - ❑ Extra Help to Probationary (Date: _____)
  - ❑ _____ FTE to _____ FTE (Date:_____)
  - ❑ Other: _____(Date: _____)
- ❑ Loss of Other Group Coverage (Date: _____)
- ❑ Reenrollment ❑ Reinstatement (Date: _____)
- ❑ Cancel employee coverage (Date: _____)
- ❑ Name Change (Previous Name:_____)
- ❑ Address Change
- ❑ Life Insurance Beneficiary Change
- ❑ Bargaining Unit/Contract Change (Date: _____)
  Old BU:_____ New BU:_____)

Section 1b: Add/Drop Dependent Coverage

Mark all boxes that apply:

- ❑ Newly Acquired/Eligible Dependent(s) due to:
  - ❑ Marriage (Date:_____)
  - ❑ Domestic Partnership (Date:_____)
  - ❑ Birth/Adoption/Legal Guardianship (Date:_____)
  - ❑ Loss of Other Group Coverage (Date:_____)
  - ❑ Other Reason:_____ (Date:_____)
- ❑ Dropping Dependent(s) due to:
  - ❑ Divorce/Legal Separation/Termination of Domestic Partnership (Date: _____)
  - ❑ Over-age Dependent (Date: :_____)
  - ❑ Other Reason:_____ (Date:_____)

Payroll Use Only

Pay Date Processed: _____

Benefits Unit/Vendor Use Only

BU/FTE: _____
Medical Eff. Date: _____
Dental Eff. Date: _____
Vision Eff. Date: _____
Basic Life Eff. Date: _____
Dep. Life Eff. Date: _____

Section 2: Employee's Personal Information

Employee Last Name | **First Name** | **MI** | **Social Security Number**

Street Address | **City, State, Zip Code** | **Date of Birth (MM-DD-YYYY)**

Personal Phone Number | **Personal Email address**

Marital Status: ❑ Married ❑ Single ❑ Widow/Widower ❑ Divorced ❑ Domestic Partner

Is your spouse/domestic partner/dependent(s) an employee of the County of Sonoma?

❑ **Yes** ❑ **No** **If yes, list name(s):** _____

Is your spouse/domestic partner a retired employee of the County of Sonoma?

❑ **Yes** ❑ **No** **If yes, list name(s):** _____

Gender (Employee): ❑ Male ❑ Female

Section 3: Medical Plan Choice *(Check all that apply; complete Section 6 if enrolling eligible dependents.)*

- ❑ **ANNUAL ENROLLMENT CHOICE ONLY-**I am electing to **CHANGE MY MEDICAL PLAN ELECTION.**
- ❑ I am a **NEW HIRE/NEWLY ELIGIBLE** employee making my medical plan election.
- ❑ I am electing to **ADD** medical coverage for my **eligible dependent(s).**
- ❑ I am electing to **CONTINUE** current enrollment in medical coverage for **myself.**
- ❑ I am electing to **CONTINUE** current enrollment in medical coverage for my **eligible dependent(s).**
- ❑ I am electing to **DROP** medical coverage for my **dependent(s).** Use **drop** for deleting coverage for your **dependent(s)**.
- ❑ I am electing to **WAIVE** medical coverage for **myself and my eligible dependent(s) as we are enrolled in other group coverage or coverage through Covered CA.** If **waiving** medical coverage you must also complete the *Waiver of Medical Insurance Acknowledgment* (Section 10 of this form).
- ❑ I am electing to **WAIVE** medical coverage for my **eligible dependent(s).** If **waiving** medical coverage for your eligible dependent(s), you must also complete the *Waiver of Medical Insurance Acknowledgment* (Section 10 of this form). **To waive medical coverage, the dependent (s) must be enrolled in other group coverage or Covered CA.**

Select your medical plan and coverage level.

Select Your Medical Plan

- ❑ County Health Plan PPO (175130-M051)
- ❑ County Health Plan EPO (175130-M100)
- ❑ Kaiser Permanente HMO (602484-0003)
- ❑ Kaiser Permanente Hospital Services DHMO (602484-0006)
- ❑ Kaiser Permanente Deductible First DHMO (602484-0009)

Select Your Coverage Level

- ❑ 1 – Self
- ❑ 2 – Self and 1 Dependent
- ❑ 3 – Self and 2 or More Dependents

Section 4: Dental Plan Choice *(Check all that apply; complete Section 6 if enrolling eligible dependents.)*

- ❑ **NEW HIRE/NEWLY ELIGIBLE/ANNUAL ENROLLMENT-**I am electing to enroll in a dental plan.
- ❑ I am electing to **ADD** dental coverage for my **eligible dependent(s)**.
- ❑ I am electing to **CONTINUE** current enrollment in dental coverage for **myself**.
- ❑ I am electing to **CONTINUE** current enrollment in dental coverage for my **eligible dependent(s).**
- ❑ I am electing to **DROP** dental coverage for my **dependent(s)**.
- ❑ I am electing to **WAIVE** dental coverage for **myself**. **To waive dental coverage, you must have other group coverage.**
- ❑ I am electing to **WAIVE** dental coverage for my **eligible dependent(s). To waive dental coverage, the dependent (s) must have other group coverage.**

Delta Dental Premier
#3126-0124

County of Sonoma Employee Benefits Enrollment/Change Form Employee Name: _____ Employee ID#_____

Section 5: Life Insurance (Hartford #GL-673199) *Provided to employees with an FTE of .75 or greater (60 hours or more bi-weekly). Available for purchase by part -time employees in some bargaining units. Complete this section as indicated in the instructions form.*

Employee Basic Life Insurance (Initial here _____ if you have a beneficiary designation on file with the County of Sonoma and do not wish to update it.) New Hires are required to complete the beneficiary designation below versus initialing.

Basic Life Insurance coverage is provided to eligible employees at no cost. If eligible, you are automatically enrolled. You must designate a beneficiary to receive payment of this benefit in the event of your death. Indicate your beneficiary information below, only if you do not currently have a beneficiary on file or you wish to change your current beneficiary designation. All newly eligible employees must provide beneficiary information. If you need more space, request a Beneficiary Designation Form from the Human Resources Benefits Unit or go online to the Human Resources Benefits site http://hr.sonoma-county.org/documents/HartfordGroupBeneficiaryDesignationForm.pdf or through ESS (Employee Self-Service).

Primary Beneficiary Full Name	Address	SSN	% of Benefit	Relationship	Birth Date
(Optional) Contingent Beneficiary Full Name	Address	SSN	% of Benefit	Relationship	Birth Date

This designation applies to your Basic Life Insurance benefit only; it can be changed at any time. If you are married or divorced, consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by the County.

Supplemental Life Insurance (Available for purchase to employees enrolled in Basic Life Insurance.) To apply for or change your coverage level or beneficiary, contact the Human Resources Benefits Unit or go online to the Human Resources Benefits site for the Supplemental Life Insurance Enrollment Form http://hr.sonoma-county.org/documents/Hartford-Supplemental-Life-Insurance-Form.pdf .

Dependent Life Insurance (If coverage is elected, enter your dependent information in Section 6 below.)
You may purchase dependent life insurance for your spouse, domestic partner, and eligible dependent children below. Indicate your election to purchase this coverage. **Check all that apply**.

- ❑ **NEW HIRE/NEWLY ELIGIBLE/ANNUAL ENROLLMENT** I am electing to **ENROLL** my eligible dependent(s) in dependent life insurance coverage.
- ❑ I am electing to **ADD** dependent life insurance coverage for my eligible dependent(s).
- ❑ I am electing to **CONTINUE** current enrollment in dependent life insurance coverage for my eligible dependents).
- ❑ I am electing to **DROP** dependent life insurance coverage for my ineligible dependent(s). Your next opportunity to purchase coverage will be during next year's Annual Enrollment period.
- ❑ **N/A**-No eligible dependent(s) or I am electing to **DECLINE** OR **WAIVE** dependent life insurance coverage.

Basic Life Ins. – P.T. EE's in Ltd BU's
❑ I am in an eligible bargaining unit and I am electing to ❑ **ENROLL**
❑ **CONTINUE** basic employee life insurance at my own expense.
❑ I am electing to **DROP** basic employee life insurance

County Use Only
_____ **Bargaining Unit**
❑ **Confirmed eligible. Effective:** _____

Section 6: Eligible Dependent Information *(List ALL eligible dependents, including spouse/domestic partner. Attach an additional sheet to list more than six dependents.)*

Proof of full-time student status is required to enroll dependents ages 19 until 23 in County-offered dental or vision coverage. Disabled over-age dependents must meet the eligibility requirement for permanently disabled over-age dependent(s). Refer to the plans' evidence of coverage booklets or summary plan description for more information.

*Complete the information below and indicate your choice for your dependent(s). **A**=Add coverage, **D**=Drop coverage, **C**=Continue enrollment in coverage, **W**=Waive coverage, **DECLINE**=Decline coverage, **N/E**=Not eligible*

Dependent Name (First, MI, Last)	Gender (M/F)	Date of Birth (MM-DD-YY)	Social Security Number	Relationship	Enroll in Medical Coverage? (Enter A, D, C, W, or N/E)	Enroll in Dental Coverage? (Enter A, D, C, W, or N/E)	Enroll in Vision Coverage? (Enter A, D, C, W, or N/E)	Enroll in Dependent Life Insurance Coverage? (Enter A, D, C, W, DECLINE, or N/E)	Full-Time Student? (Y/N)	Permanently Disabled Dependent? (Y/N)	Tax Purposes Only Place a ✓ below to indicate dependent status	
											IRS Qual	Non-IRS Qual

Section 7: Employee Authorization and Signature

I agree to comply with the terms of the benefits group contracts in which I am enrolled. I also declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements and all eligible dependents listed as IRS Qualified dependents meet the IRC Section 152 definition of a qualified dependent. I will complete a new **County of Sonoma Employee Benefits Enrollment/Change Form** within 31 days of a change in this qualification or a change of benefit eligibility. I understand that the employee portion of the benefit premiums will be pre-tax only for IRS Qualified dependents. Further, I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatement made on this declaration, or even in the absence of a misstatement, should the IRS or the State of California so determine that the benefits I am receiving for dependents listed as Qualified are found to be Non-Qualified. I authorize the County of Sonoma to withhold insurance premiums for the benefits requested in this document in accordance with the applicable Memorandum of Understanding or Board of Supervisor's resolution. I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

Employee Signature_____ **Date** _____

Section 8: County Health Plan Agreement *(If electing one of the County Health Plans, sign this agreement.)*

County Health Plan PPO, County Health Plan EPO

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Arbitration Agreement

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO , THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

_____ _____ _____

Signature Required for All County Health Plans **Date**

Section 9: Kaiser Permanente Benefit Plan Agreement *(If electing Kaiser Permanente, complete the agreement below.)*

Kaiser Permanente HMO, Hospital Services Deductible HMO and Deductible First HMO Plan

Kaiser Foundation Health Plan, Inc., Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

_____ _____

Signature Required for All Kaiser Permanente Plans **Date**

Section 10: Waiver of Medical Plan Acknowledgment *(You must complete this section if you are waiving medical coverage.)*

If you wish to waive coverage for yourself or your eligible dependents under County-offered medical plans, you must complete the information below. **To waive medical coverage, the individual must have other group coverage or coverage through Covered CA, otherwise the election is to drop or decline coverage rather than waive.**

Continuous coverage in other group insurance is a requirement for mid-year re-enrollment upon the loss of other group coverage or through Covered CA.

WAIVER OF COVERAGE

I am waiving enrollment for the following under a County of Sonoma offered medical plan:

Waive Coverage For…	**Name of eligible individual(s) covered under another group Medical Plan or through Covered CA.**	
Employee		
Spouse/Domestic Partner		
Eligible Dependent(s)		

By signing below, I acknowledge that I have been given the opportunity to enroll myself and my eligible dependents in a County-offered medical plan. I understand I will not be eligible to enroll in a County-offered medical plan until the plan's next annual enrollment period or in accordance with the loss of eligibility for other group coverage or coverage through Covered CA, as outlined above in Section 10 of this form. If I become eligible to make a change during the plan year, I must request enrollment within 31 days of the qualifying event.

_____ _____

Employee Signature Date

When Changes are Allowed **Change of Status Events and Mid-Year Enrollment Changes Allowed for Employees Under a Health Plan**

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code[1]. The chart summarizes most permitted health plan changes.

If you experience the following Event...	You may make the following change(s) within 31 days of the Event…	YOU MAY NOT make these types of changes...
Life / Family Events		
Marriage or Commencement of Domestic Partnership (DP)	• Enroll yourself, if applicable • Enroll your new spouse/DP/other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans	• Drop health coverage and not enroll in spouse/DP's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	• Drop your spouse/DP from your health coverage • Enroll yourself and your dependent children if you or they were previously enrolled in your spouse/DP's plan	• Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents o Adoption placement papers are required • Change health plans	• Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (*e.g.,* child reaches the maximum age for coverage or is no longer a full-time student (dental and/or vision coverage)	• Drop the child who lost eligibility from your health coverage • Child will be offered COBRA	• Change health plans • Drop health coverage for yourself or any other covered individuals
Regain eligibility (e.g. full-time student (dental and/or vision coverage)	• Add child who regained eligibility to your dental and/or vision coverage o Documentation of full-time student status is required	• Add any additional eligible dependents to your dental or vision coverage
Death of a dependent (spouse/DP or child)	• Drop the dependent from your health coverage ☐ • Change health plans	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to (or lost entitlement to) Medicare, Medicaid, Medi-Cal, or SCHIP[2]	• Drop coverage for the person who became entitled to Medicare, Medicaid, Medi-Cal, or SCHIP • Add the person who lost entitlement to Medicare, Medicaid, Medi-Cal, or SCHIP o Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible
Change of home address outside of plan service area	• If you are enrolled in an HMO and move out of their service area, then you can elect new coverage	• Does not apply to County Health Plan, dental or vision coverage
Employment Status Events		
You become newly eligible for benefits due to change in employment status or bargaining group	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents • Drop health coverage • Drop your spouse/DP and other eligible dependents • Change health plans	• Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits
Spouse/DP obtains health benefits in another group health plan	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself o Proof of coverage in the other health plan required	• Change health plans • Add any eligible dependents to your health coverage
Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage for health benefits in another group health plan. You or your dependents exhaust COBRA coverage under other group health plan	• Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans o Proof of loss of other coverage is required	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your spouse/DP's plan, if available • Elect temporary COBRA coverage for the qualified beneficiaries (you and your covered dependents)	
You experience a reduction in hours (e.g. full-time to part-time) that results in a significant cost increase or an unpaid leave (e.g. leave without pay) not covered by FMLA, CFRA etc. where the County will no longer be making a contribution.	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself • Change health plans to a less expensive plan	• No change is allowed unless the reduction in hours causes a loss of eligibility or a loss or significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.

[1] Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.

[2] Have 60 days from loss or eligibility determination of Medicare, Medicaid, Medi-Cal, or SCHIP to request special enrollment.

March 2015

If you experience the following Event...	You may make the following change(s) within 31 days of the Event…	YOU MAY NOT make these types of changes...
You experience an increase in hours (e.g. part-time to full-time) that results in a significant cost decrease or return from an unpaid leave (e.g. leave without pay) when the County was not making a benefit contribution	• Add coverage for yourself • Add your spouse/DP, or dependent children to your health coverage • Change health plans	• No change is allowed unless the increase in hours results in new eligibility or a significant change in the employer subsidy for medical (not FSA) coverage.
You return from Military Leave	Enroll yourself, your spouse/DP, and other eligible dependents and/or change health plans	
You, your spouse, or dependents enroll in a Qualified Health Plan through a Public Health Insurance Marketplace	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself	

Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.
Have 60 days from loss or eligibility determination of Medicare, Medicaid, Medi-Cal, or SCHIP to request special enrollment.