

# ANNUAL City of Reedley 2018 Offer of Coverage & Waiver Form for Part-Time Employees Averaging a Minimum of 30 Hours Per Week

The City of Reedley has determined that the employee named herein meets the Patient Protection & Affordable Care Act (ACA) coverage eligibility criteria. This document constitutes an offer of coverage to the employee and the employee's eligible dependents as defined in the ACA. The employee may waive coverage only if the employee provides proof of other coverage.

Employee Name: \_\_\_\_\_ Employee #: \_\_\_\_\_  
 Department: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

**CITY OF REEDLEY**  
 MONTHLY PREMIUM RATES & EMPLOYEE/EMPLOYER CONTRIBUTIONS  
 EFFECTIVE JANUARY 1, 2018  
 ACA Eligible Employees Averaging 30 Hours or More per Week

Total Monthly Cost	Employee Only	Employee + 1	Employee + 2 or more
Blue Shield PPO	\$ 580.41	\$ 1,214.94	\$ 1,734.11
Blue Shield HMO	\$ 602.92	\$ 1,262.23	\$ 1,801.66
Kaiser	\$ 714.53	\$ 1,425.52	\$ 1,852.11
City's Monthly Contribution			
<u>Lowest Cost Self-Only</u>	\$ 443.70	\$ 443.70	\$ 443.70
Employee Monthly Contribution	Employee Only	Employee + 1	Employee + 2 or more
Blue Shield PPO	\$ 136.71	\$ 771.24	\$ 1,290.41
Blue Shield HMO	\$ 159.22	\$ 818.53	\$ 1,357.96
Kaiser	\$ 270.83	\$ 981.82	\$ 1,408.41
Employee Annual Contribution	Employee Only	Employee + 1	Employee + 2 or more
Blue Shield PPO (*)	\$ 1,640.52	\$ 9,254.88	\$ 15,484.92
Blue Shield HMO	\$ 1,910.64	\$ 9,822.36	\$ 16,295.52
Kaiser	\$ 3,249.96	\$ 11,781.84	\$ 16,900.92

(\*) 2018 Minimum Wage of \$11.00/Hour \* 30 Hours per Week \* 52 Weeks \* 9.56%

ACA 2018 Percentage of CONUS Federal Poverty Level threshold is 9.56%

In the month preceding the insurance service month, half of the employee's monthly premium contribution will be deducted on the first and second pay periods of that month. (Example: \$65.93 will be deducted on December 2nd and December 16th for January's premium, which is due on January 1.)

- I elect to enroll in a City sponsored insurance for \_\_\_\_\_ myself \_\_\_\_\_ and/or eligible dependents  
 (an enrollment form must be completed for the plan chosen)
- I elect to waive City sponsored insurance for \_\_\_\_\_ myself \_\_\_\_\_ and/or eligible dependents. **I will provide proof of other coverage for myself and/or eligible dependent.**

Participating Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PROOF of Other Medical Coverage is REQUIRED to be submitted with this form**

Subscriber/Employee Name:	Subscriber's Relationship to Subscriber:
Subscriber's Employer:	
Employer Address:	
Telephone # (Personnel/Benefits Office):	
<b>MEDICAL:</b> Other Insurance Company	
Group Name:	Emp. Medical I.D. Number:
<b>DENTAL:</b> Other Insurance Company	
Group Name:	Emp. Dental I.D. Number:
<b>VISION:</b> Other Insurance Company	
Group Name:	Emp. Vision I.D. Number:

**PROOF of other coverage can be a medical card or a print-out from the subscriber/employee's insurance company, the Marketplace exchange or subscriber's employer showing the City of Reedley employee's name on the list of covered persons.**

If the employee elects to enroll in a City sponsored plan, the premium contribution may be deducted on a pre-tax basis only when the employee completes a Salary Redirection Agreement (SRA) choosing the Premium Only Plan option.