Opt-Out Form

AlaskaCare Employee Health Plan

(To be completed only in conjunction with online benefits enrollment/opt out)

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
alaska.gov/drb

Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203

Juneau: (907) 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086

In accordance with the opt-out provisions under 2 AAC 39.950-990, members who elect not to participate in the AlaskaCare Employee Health Plan (the health plan) including medical/pharmacy, dental, and vision coverage may opt out of coverage for their dependents or for the employee and dependents. To opt out of coverage, the Division of Retirement and Benefits must have a completed Opt-Out form on file. The form is required to be completed when you initially waive/decline coverage, and each year during the open enrollment period. If you wish to continue to waive/decline/opt out of coverage, you must complete a new Opt-Out form. Failure to return this Opt-Out form to the Division of Retirement and Benefits will result in your enrollment in the default health plan with appropriate per-pay-period deductions and forfeiture of your right to opt out until the following open enrollment period.

Opting out of coverage is a two-step process:

1. **Go online to myRnB.alaska.gov to make your elections/opt-out.**
2. **Complete and sign this Opt-Out form, then scan and email it to doa.drb.benefits@alaska.gov or fax it to (907) 465-3086.**

Our Division of Retirement and Benefits Member Services Contact Center is available if you have any additional benefit questions:

Hours: Monday – Thursday 8:30 a.m. - 4 p.m. | Friday 8:30 a.m. - 3 p.m.
Toll-Free: (800) 821-2251 | In Juneau: (907) 465-4460 | Fax: (907) 465-3086 | TDD: (907) 465-2805
alaska.gov/drb | doa.drb.benefits@alaska.gov

MEMBER NAME (PRINT)	EMPLOYEE ID#

I fully understand and certify the following:

a. I have been offered the opportunity to enroll myself and my eligible dependent spouse and eligible dependent children in my employer-sponsored health plan coverage (called the AlaskaCare Employee Health Plan), which includes medical plan coverage that meets the minimum essential coverage requirements of the Affordable Care Act.

b. **To be eligible to opt out of the health plan, I must maintain coverage under another medical benefit plan.** I understand that the AlaskaCare medical plan meets the Affordable Care Act (ACA) definition of affordable and minimum value coverage, and if I fail to maintain coverage under another medical benefit plan, I and/or my dependents may be subject to a penalty on our federal income taxes.

c. The election to opt out of the health plan is entirely voluntary. I understand that by opting out as an employee, neither I, nor any of my eligible dependents, are covered under the health plan. However, if my spouse also works for the State of Alaska and is offered coverage and elects that coverage, I can be added as a dependent on that coverage so I will be able to receive coverage as his/her dependent. I understand that I may choose to remain enrolled and waive coverage for my eligible dependents under the health plan. The health plan is not responsible for any expenses incurred after the coverage termination date for my dependents and/or myself. Furthermore, if I opt out, my covered dependents and I are not eligible for COBRA continuation coverage.

d. Elections to opt out of the health plan must be made at the time of hire, when initially meeting eligibility requirements, or during the annual open enrollment period. **An opt-out election will not carry over from one benefit year to the next.** I must complete and submit a new Opt-Out form during the annual open enrollment period to maintain opt-out status for each new benefit year.

e. If I elect to opt out of the health plan, I will continue to be enrolled in the Basic Life and Accidental Death and Dismemberment (AD&D) plan. I understand I am eligible to participate in the Select Life and AD&D and Voluntary Supplemental Benefit plans.

f. If I elect to opt out of the medical plan for myself or my eligible dependents, I may enroll myself and my eligible dependents, or only myself, in the dental and/or vision benefit plans.

g. If, at a later date, I wish to re-enroll as a member of the AlaskaCare Employee Health Plan, I may enroll during the next open enrollment period, or if I have a mid-year qualifying change in status or other applicable event as defined under section 1.8.2 of the AlaskaCare Employee Health Plan booklet, I may request to re-enroll in the health plan within 30 days (60 days if otherwise noted in the booklet) of the mid-year change in status event. I understand that any change made to benefits must be determined by the Division of Retirement and Benefits or its designee to be necessary, appropriate to and consistent with the change in status and consistent with the terms and conditions of the benefit option.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. Because of other health insurance or group health plan coverage I am declining/waiving/opting out of enrollment from the following AlaskaCare Employee Health Plan benefits *(check all that apply)*:

☐ MEDICAL FOR:	☐ MY FAMILY ONLY	***or***	☐ MYSELF AND MY FAMILY
☐ DENTAL FOR:	☐ MY FAMILY ONLY	***or***	☐ MYSELF AND MY FAMILY
☐ VISION FOR:	☐ MY FAMILY ONLY	***or***	☐ MYSELF AND MY FAMILY

MEMBER SIGNATURE	DATE