CITY AND COUNTY OF SAN FRANCISCO

GENERAL SERVICES AGENCY
OFFICE OF LABOR STANDARDS ENFORCEMENT
PATRICK MULLIGAN, DIRECTOR

HEALTHY AIRPORT ORDINANCE (HAO)
FOR EMPLOYEES IN THE QUALITY STANDARDS PROGRAM (QSP)

VOLUNTARY WAIVER FORM

(Effective: January 1, 2027)

San Francisco International Airport Quality Standards Program (QSP) employers are required to comply with the Healthy Airport Ordinance by making Irrevocable Health Care Expenditures (IHCE), which may include offering a health plan to covered employees. Employers that offer a Cost-Efficient Health Insurance Plan (CEHIP) are deemed compliant with the IHCE requirement. Employers that offer non-CEHIP health plans must ensure that the IHCE contributions meet the required IHCE rate.

SECTION 1. TO BE COMPLETED BY THE EMPLOYER

Employer Name: _____ Employee Name: _____

Employer Address: _____ Employee Address: _____

Employer Representative: _____ Employee Telephone: _____

Employer Rep. Phone No.: _____ Employee Email: _____

Employer Rep. Email: _____

COMPLIANCE OPTIONS
(*Employer to select one by indicating with a mark,* e.g. ☒ or ☑)

☐ **OPTION 1**. **HEALTH PLAN TO MEET IRREVOCABLE HEALTH CARE EXPENDITURES (non-CEHIP plans)**

If you waive the non-CEHIP health plan offered, your employer may apply the amount it would have contributed toward your health coverage as a credit toward its required health care expenditure. If the health plan premium that would have been paid exceeds the required health care expenditure, the employer has no further obligation. If the premium is less than the required expenditure based on your hours worked, the employer must make up the difference through another allowable expenditure method. For example, if the employer would have paid $300 in premium costs and the required weekly expenditure based on your hours worked is $400, the employer must make irrevocable health care expenditures for the remaining $100.

Name of Health Plan(s) Offered: _____

☐ **OPTION 2**. **COST-EFFICIENT HEALTH INSURANCE PLAN (CEHIP)**

A CEHIP meets ALL of the following requirements:

- Is offered to a Covered Employee and their dependents.
- Provides free individual-only coverage.
- Caps individual-plus-dependent-care coverage cost to 15% of the plan premium.
- Has at least an actuarial value of at least 84%.
- Includes all services in the California Essential Health Benefit Benchmark Plan.

Employers that offer a CEHIP are not required to make any other expenditures under the HAO but must obtain a health enrollment or waiver (this official form) from each Covered Employee annually.

Name of Health Plan offered: _____

(Employee to Skip to Section 3).

SECTION 2. TO BE COMPLETED BY EMPLOYEE OFFERED OPTION ONE - NON-CEHIPS ONLY

To waive the offered non-CEHIP health plan, you must have current health coverage from another source. By completing this form, you certify that you have current alternate health coverage. If the health plan is offered to your dependents, you must also certify you have alternative health coverage for your dependents. If you decline the non-CEHIP offered to you, your Employer may take credit for the cost of the waived plan. Your Employer must still meet the spending requirement and make irrevocable Health Care Expenditures for any remaining amount not covered by that credit. If applicable, your Employer will determine how to meet the remaining spend requirement and will inform you. *If you wish to waive the health plan(s) offered by your employer, please provide the following:*

I am currently enrolled in a health plan and am providing the following proof (*select one*):

- ☐ Medical Card(s) – a copy of your card (and for each dependent if applicable)
- ☐ Enrollment Form
- ☐ Other document showing that I/we have coverage

NOTE: The waiver form is valid only for the current health plan year; however, you may revoke the waiver of health insurance if you experience a qualifying life event. All waivers automatically expire each year at open enrollment.

A waiver is valid only if the employer maintains a fully executed waiver form and proof of current health coverage by the covered employee and dependents. If waiving, a new waiver form must be completed annually.

SECTION 3. EMPLOYEE WAIVER SIGNATURE AND ATTESTATION

DO NOT sign this form if YOU WANT the health insurance plan offered by your employer. It is illegal for your employer to pressure, intimidate, entice or provide cash or other incentives to coerce you to sign this form. Call (415) 554-7903 if you do not understand or have any questions.

By signing this form, I understand that I am waiving my right to receive the health plan offered by my employer until the next open enrollment event or unless a qualifying life event occurs (i.e., loss of existing health coverage). I hereby waive the right to the Health Plan(s) offered for the current plan year.

Employee Signature: _____ Date: _____

Employee Name: _____

For questions about your employer's obligations under the HAO,
call (415) 554-7903, email HCAO@sfgov.org, or visit www.sf.gov/olse-hao.

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