



2024 Election of Cash-in-Lieu

Benefit eligible active employees may decline the District's medical coverage and receive a cash-in-lieu payment if they are enrolled in another group coverage through a spouse's or parent's employer.

- *Per Affordable Care Act (ACA) guidelines, alternative group medical coverage must NOT be coverage in the individual market, including the Individual Marketplace and Covered California and other government programs (Medi-Cal, TriCare, Medicare)*

To be eligible for a cash payment in lieu of medical insurance, the employee must:

- ❖ Complete the attached Cash-in-lieu of Medical Insurance form
- ❖ Provide a copy of current medical insurance card to the Risk Management office during 2023-2024 open enrollment.
- Medical cards must state the name of the employer, if your medical card does not state the name of your employer you may submit a letter stating proof of group coverage from the insurance company. Please be aware that independent, individual/family type plans will not be accepted, as these plans do not qualify as "Group Coverage."

Deadline to submit: October 13, 2023

Rowland Unified School District - Risk Management Department - Phone: 626-854-8382



Eligible Opt-Out Cash-in-lieu of Medical Insurance Form 2023-2024 School Year

Employee's Name (Last, First): _____

Employee's Address: _____
(Street, City, State, Zip)

Employee's ID Number or Social Security Number: _____

ATTESTATION OF OTHER QUALIFYING GROUP HEALTH COVERAGE

Please read each of the following statements and initial each line:

_____ I certify that the District's group insurance plans have been offered to me, and I decline to enroll because I am covered by another group health plan through my spouse's or parent's employer. Coverage in the individual market, including the Marketplace (e.g., Covered California) and federal-sponsored programs (e.g., Medi-Cal, Medicare, TriCare) are not group health plan.

_____ I certify that my tax family will have minimum essential coverage for the entire plan year. I understand "tax family" includes myself and all other individuals for whom I reasonably expect to claim a personal exemption deduction for the taxable year covered the by opt-out time period.

_____ I understand that my eligibility for cash-in-lieu is subject to an annual recertification process.

_____ I understand that the cash-in-lieu payments are taxable.

COPY OF GROUP INSURANCE CARD/PROOF IS REQUIRED.

Please sign, date and mail or email this form along with a copy of insurance carrier medical card to:

Mail: 1830 S Nogales St, Rowland Heights, CA 91748 – Attn: Risk Management

Email: riskmanagement@rowlandschools.org

Signature _____

Date _____

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