

Modesto City Schools Cash-in-Lieu Request 2022 (Certificated & Management)

Employee Name: _____ Employee ID _____
Phone number: _____ Site Location: _____
Position: _____ Hire Date: _____

*New hires are not eligible for cash in lieu effective 7/1/20.
Use medical opt-out form.*

Please read each of the following statements and check each box:

_____ I understand that I am eligible for medical reimbursement, if I meet the “**conditional opt-outs**” arrangement. You are required to provide proof of other minimum essential coverage that is not individual market coverage (Exchange or other). Examples of other non-individual market insurance could be one of the following:

- Spouse’s employer group medical plan,
- Government sponsored plan (Excludes Individual Covered California Plans) that meets definition of minimum essential coverage,
- Medicare
- Tricare
- Medi-Cal

Name of Medical Plan (**see attached for acceptable proof of coverage**): _____

_____ I understand that, by exercising the election to receive cash-in-lieu payments, I will receive no benefits or coverage from any Modesto City Schools Health Plan. If I wish to enroll in a Modesto City Schools Health Plan, I must do so during the annual Open Enrollment period or within 30 days of a qualifying event.

_____ I understand this verification must be provided and must state that I am currently covered under another group health insurance plan. **Without proof of coverage uploaded with this document, this form cannot be processed.**

_____ In order to receive cash-in-lieu payment effective January 1, 2022, I understand that this completed form and proof of coverage must be received no later than **October 29, 2021**. There will be no retroactive payment for late submissions.

_____ In order for me to continue to qualify for this option, I must annually re-certify by submitting a form with updated proof of other health plan coverage during the Open Enrollment period. My failure to do so will result in automatic ineligibility for cash-in-lieu, and the cash-in-lieu payments will be terminated for the plan year unless there is a qualifying event.

_____ I understand that I must notify Modesto City Schools Benefits Department of any changes to my health plan coverage within 30 days of the change.

_____ I have been offered health insurance coverage through Modesto City Schools under the CalPERS Health Program. The lowest cost plan available to me is PERS Gold and the cost to me is \$ _____ per month (for employee-only coverage), after application of Modesto City Schools’ contribution. I have chosen to decline this plan and have provided proof of qualifying group health coverage. Qualifying group health insurance coverage is defined as employer-sponsored health insurance, job-based health insurance or (TRICARE, Medicare, Medi-Cal). Qualifying group health insurance coverage does not include individual coverage, such as, Covered California (unless an employer-based plan).

_____ I have reviewed the list of acceptable documents for proof of coverage and am submitting documentation for the 2022 plan year (January 1, 2022 to December 31, 2022).

I therefore and hereby agree to all terms and conditions as contained in this cash-in-lieu of Medical Form and that the terms and conditions are fully understood. I further certify that the information furnished is true and correct and I understand that falsification of this form may result in disciplinary action and my repayment of cash-in-lieu payments.

Signature of Employee: _____ Date: _____

Effective Date: 1/1/2022 Notes: