Los Angeles Unified School District
OFFICE OF THE GENERAL COUNSEL
DIVISION OF RISK MANAGEMENT & INSURANCE SERVICES
BENEFITS ADMINISTRATION
333 S. Beaudry Avenue, 28th Floor, Los Angeles, CA 90017
Tel (213) 241-4262; Fax (213) 241-4247

MICHELLE KING
Superintendent of Schools

DAVID HOLMQUIST
General Counsel

JANICE J. SAWYER
Chief Risk Officer

November 2016

Action Required

MEDICAL OPT-OUT CASH BACK ATTESTATION

Dear LAUSD Employee:

Our records indicate that you are currently enrolled in the Medical Opt-Out Cash Back plan. In an effort to comply with the guidelines set forth by the Affordable Care Act, Benefits Administration requires your attestation to certify you and your eligible dependents have minimum essential coverage. To continue enrollment into calendar year 2017, you must attest that you and your eligible dependents have "minimum essential coverage" through a group health plan, and the minimum essential coverage is not individual market coverage (such as through Covered California).

Please read the attached Medical Opt-Out Cash Back Attestation Form. Complete and return the form via mail, fax, or email to:

Benefits Administration
P.O. Box 513307
Los Angeles, CA 90051-1307
Phone: (213) 241-4262
Fax: (213) 241-4247
Email: benefits@lausd.net

You must submit your attestation no later than November 30, 2016. Failure to comply may result in the termination of enrollment in the Medical Opt-Out Cash Back plan. This termination will result in the discontinuation of the $250 monthly opt-out amount beginning January 1, 2017.

If you have any questions, please contact our office at (213) 241-4262.

Sincerely,

Janice J. Sawyer
Chief Risk Officer

Medical Opt-Out Cash Back Attestation Form

a. I understand that I have been offered the opportunity to enroll myself and my eligible dependents in LAUSD sponsored medical plan(s) and that the medical plan(s) are considered to be minimum essential coverage (MEC) in accordance with the Affordable Care Act (Health Reform).

b. I understand that without medical plan coverage I (and my dependents, if any) could have a financial penalty applied when my/our personal income taxes are filed with the Internal Revenue Service (IRS). I understand I can learn more about the financial penalty, called the Individual Mandate penalty, at this government website: https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/.

c. I understand that without an IRS-approved mid-year life change event (a Special Enrollment event), **if I decline coverage now**, I will not be permitted the opportunity to enroll myself or my eligible dependents in my employer's medical plan option(s) again until my employer's next annual open enrollment time (if I am benefits-eligible at that time).

d. I understand that there is additional compensation of $250 per month provided to me if I decline coverage. I understand that **I am only able to receive this additional compensation for declining coverage if I, and all members of my expected tax family (tax family refers to dependents on the employee's tax return), have or will have for the 2017 calendar year other minimum essential coverage through** another employer's group medical plan, Medicare, Medicaid, Tricare, VA or Indian Health Services (IHS) medical plan coverage.

- I also understand that I am not eligible to receive this compensation if I or any member of my expected tax family is enrolled in individual market coverage, whether obtained through Covered California, another Marketplace established under Health Reform, or outside of the Marketplaces established under Health Reform.
- I also understand that LAUSD will not make any payment to me if LAUSD knows or has reason to know that I or any member of my expected tax family (tax family refers to dependents on the employee's tax return), does not have or will not have the required alternative coverage.
- I agree to notify LAUSD promptly if I or any member of my expected tax family (tax family refers to dependents on the employee's tax return), loses this alternative coverage, and I understand that compensation payments will be stopped at that time.
- I also understand that I will be required to attest to this alternative coverage each plan year that I decline coverage under LAUSD's group medical plan.

My signature below means that I have read and understand the above statements.

Print Name: _____ Employee #: _____

Signed: _____ Date: _____, 20____

Please keep a copy of this form for your records and return it via mail, fax, or email to Benefits Administration.

Visit http://benefits.lausd.net for benefit information and forms
Risk Management and Insurance Services, Benefits Administration
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Email: benefits@lausd.net