KEEPING LAwell
City of Los Angeles Employee Benefits

CHOOSEwell

Cash-In-Lieu Affidavit

For City Employees

City of Los Angeles
Personnel Department
Employee Benefits
Division
213-978-1655

What is the Cash-In-Lieu option?

If you have health coverage through your spouse, domestic partner or parent's employer, through a second employer, or as a retiree from your previous employer, you may waive LAwell health coverage and in return receive a taxable $100 a month "Cash-In-Lieu." You may also be eligible for Cash-In-Lieu if you are enrolled in Medicare, Medi-Cal, or Tricare when you become eligible for LAwell. With Cash-In-Lieu, you will receive an additional $50 in taxable income in your paycheck each pay day. (Note that half-time employees hired after July 1989 receive one half of these amounts.)

Who is eligible?

To be eligible for this option you must be an active civilian employee of the City who:

- is compensated for at least forty (40) hours or more per pay period as a full-time employee or at least twenty (20) hours or more in a pay period if a half-time employee (excludes Part-Time, Intermittent, and like positions); and
- is a contributing member of the Los Angeles City Employees' Retirement System (LACERS); and
- is not represented by an employee representation unit; or
- is eligible for membership in one of the employee representation units for which a City-sponsored health plan has been negotiated in Memorandum Of Understanding (MOU);
- is a Port Police Officer (MOU 27 or MOU 38) or an Airport Police Officer (MOU 30, MOU 39, or MOU 40) and a member of Tier 5 and Tier 6 of the Fire and Police Pension System; or
- is an Elected Official of the City or a full-time Member of the Board of Public Works

How do I apply?

An employee who wants to participate in the Cash-In-Lieu option must go online at keepingLAwell.com to select Cash-In-Lieu during enrollment and complete this affidavit (see other side) verifying coverage under another employer group health plan through a spouse or domestic partner and return it to:

Employee Benefits Division, 200 N. Spring Street, Room 867, Los Angeles, CA 90012
(Located in City Hall; include "Mail Stop #621" if using inter-departmental mail)

When will the "Cash-In-Lieu" begin?

If you enroll during Open Enrollment, your participation is effective January 1, 2021. If you participate, your LAwell health coverage will terminate December 31, 2020. Your first $50 "Cash-In-Lieu" will be reflected in your gross wages on the paycheck you receive on January 13, 2021, for the pay period ending January 2, 2021. If you do not submit a Cash-In-Lieu Affidavit by December 10, 2020 for 2021 Open Enrollment or within 60 days of a qualifying life event change that you have in 2021, your participation in Cash-In-Lieu will be canceled and you will be enrolled in employee-only health coverage.

If you enroll as a new hire, your first $50 "Cash-In-Lieu" will be reflected in your gross wages within 2-3 pay periods after you enroll.

What if I change my mind?

Re-enrollment in a LAwell health plan will be allowed only under the regular policies; if you experience a qualifying life event change (i.e., spouse/domestic partner loses health coverage) or during the LAwell Open Enrollment Period. A request for enrollment must be made within 30 calendar days following a qualifying life event change.

Questions?

If you have further questions, please contact the Employee Benefits Division at (213) 978-1655.
Si tiene preguntas adicionales, por favor llame a la División de Beneficios para Empleados: 213-978-1655.

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In addition to completing this form, you must go online at www.keepingLAwell.com (click "Enroll in Benefits or Make Changes") and select Cash-In-Lieu during enrollment to receive Cash-In-Lieu. Call the Benefits Service Center at 833-4LA-WELL or 800-735-2922 if hearing or speech impaired if you need assistance. Si necesita ayuda en Español, por favor llame al 1-833-4LA-WELL.

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IMPORTANT!
If you enroll into Cash-in-Lieu, you may later request coverage under a City-sponsored health-plan only if you experience a qualifying life event change or during a civilian Open Enrollment period

Send Completed Form & Supporting Documents To:
Mail: Employee Benefits Division, City Hall, 200 N. Spring Street, Room 867, Los Angeles, CA 90012
(For inter-departmental mail: use "Mail Stop #621")
Email: per.empbenefits@lacity.org **Fax:** 213-978-1623

Step 1: Enter Employee Information

First name and middle initial	Last name	Employee ID Number
Address		
City or town, state, and ZIP code		

Step 2: For Cash-In-Lieu Coverage With

- ☐ Spouse/Domestic Partner or Parent – Complete Section A & B
- ☐ A second/former employer or retiree benefit – Complete Section B only
- ☐ Medicare, Medi-Cal, or TRICARE – Complete Section C only

A — NAME OF SPOUSE/DOMESTIC PARTNER OR PARENT WHOM COVERAGE IS PROVIDED THROUGH

Name (Last, First, Middle Initial)	**Employee ID of Spouse/DP** *(Only for City Employees)*
Relationship	

B — HEALTHCARE COVERAGE VERIFICATION

Must be completed by the Spouse, Domestic Partner, or Parent's Employer, your second employer or retiree benefits administrator. If both you and your spouse/domestic partner are City employees, must be completed by the Employee Benefits Division.

Name of Insurance Company/Provider/Administrator		Policy/Membership Number
Health Plan/Insurance Telephone Number	Name of Employer Offering Coverage	
Name of Authorized Signer	Signature of Employer or Provider	Date Signed
Title	Telephone Number	

C — GOVERNMENT INSURANCE

Indicate program and provide the required enrollment proof	
	☐ MEDICARE - Attach a Copy of Your Medicare Card
	☐ MEDI-CAL - Attach a Copy of Your Medi-Cal Card
	☐ TRICARE - Attach Proof of Insurance Letter www.tricare.mil/Plans/Eligibility/DEERS/milConnect/Proof

Step 3: Sign Here

I certify that my dependents and I have health coverage under the health benefit plan listed above. I further certify that all information and documentation provided are true and accurate. I understand that any false, deceptive or otherwise improper act may result in the cancelation of my participation in the Cash-In-Lieu Program, and I may be considered ineligible for enrollment in any City health, dental, or other benefit plan.

Employee's signature (This form is not valid unless you sign it.) **Date**