

SCAPPOOSE SCHOOL DISTRICT

Confidential Employee Medical Opt-Out Selection Form

IMPORTANT REQUIREMENT

In order to receive opt-out benefits, proof of other primary health insurance **MUST** be provided to the District Office upon benefit selection.

1. CONFIDENTIAL EMPLOYEE OPT-OUT POLICY

- **Definition:** Medical Insurance is defined as primary medical insurance plus administrative costs required by the administering agency.
- **Eligibility:** Subject to carrier rules and regulations, and as allowed by law, employees who are eligible for a District insurance contribution but choose not to obtain insurance coverage may "opt out" for the insurance year in accordance with OEGB underwriting rules.
- **Benefit Amount:** Members who opt out will receive a **\$575 per month** contribution into a Standard Health Reimbursement Arrangement Voluntary Employee's Benefit Association (HRA VEBA) Trust.
- **Fees & Penalties:** Any OEGB or IRS fees/penalties associated with a member opt-out are the responsibility of the member and will reduce the total monthly contribution amount.

2. BENEFIT SELECTION

- ☐ I elect to opt out of district insurance and receive a **\$575 per month** contribution into a Standard Health Reimbursement Arrangement Voluntary Employee's Benefit Association (HRA VEBA) Trust.

3. EMPLOYEE ACKNOWLEDGMENT & SIGNATURE

By signing below, I certify that I meet the eligibility criteria for opting out of coverage and acknowledge that I have read and understand the terms of the opt-out policy above.

Employee Name (Print): _____

Employee Signature: _____ Date: _____