

2018 Retiree Health Insurance Allowance Request

For Retired Tier I and Tier II Members enrolled in non-SDCERA-sponsored medical, dental, or prescription drug plans, including Medicare Part B



2018 Retiree Health Insurance Request Instructions

Eligible retired Tier I and Tier II Members or their surviving spouse who enroll in a medical, dental or prescription drug plan not sponsored by SDCERA, may request a Health Insurance Allowance (HIA) to help cover the cost of their premiums.

The HIA can only be used to offset the Member's premiums or, after the Member's death, their surviving spouse's premiums.

The HIA cannot be used to cover the following:

- Premiums for other family members including the spouse of a living Member
- · Annual Deductibles
- Copayments
- Coinsurance

- Out-of-pocket prescription drug expenses
- · Long-term custodial care
- Late enrollment penalties
- · IRMAA payments
- Vision insurance

If your medical coverage is provided through an employer-based plan, your reimbursement from SDCERA will be taxable to you.

If you enroll in a health plan through a Health Insurance Marketplace (Exchange) and participate in SDCERA's HIA program, you will not be eligible to receive any federal subsidies for your coverage from the Marketplace.

You must submit the following documentation for each insurance plan you enroll in: medical, dental and/or, prescription.

Proof of coverage, showing SDCERA member's name

- 2018 invoice or billing statement showing effective date, and premium amount for single coverage, or
- Letter from your insurance company or employer.

Proof of monthly premium cost, showing SDCERA member's name, the rate breakdown and any discount, tax credit or subsidy, and the **cost for the policy holder separate from the cost of dependents** (if any)

- 2018 invoice or billing statement, or
- Letter from the carrier or the employer, or
- Renewal notification.

Proof of payment, showing SDCERA member's name, the premium and payment amount for single coverage, and paid date

- 2018 pay stub or bank statement, or
- 2018 canceled check (copy of front and back), or
- Letter from carrier or employer.

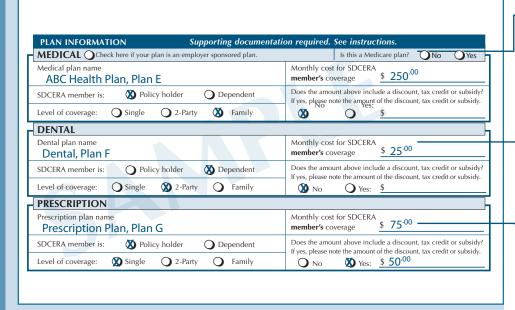
Submitting your SDCERA retirement benefit statement is not an acceptable proof of payment.



2018 Health Insurance Allowance Request

Complete this form and provide all required documentation. Eff	ective Date:				
MEMBER INFORMATION					
First name MI Last name	Last name		Social Security number		
Permanent Residence address	City		State	e ZIP	
Mailing address (if different than Permanent Residence)					
City State	ZIP	Daytime (elephone nun	nber	
PLAN INFORMATION					
MEDICAL O Check here if your plan is an employer-sponsore Medical plan name	d plan.	Monthly cost for SDCE Member's coverage		plan? No Yes	
DUTNA HEHIDELIS. I ALTOHUV HOJUGI I ALTOGUCHUCH I		Does the amount above include a discount, tax credit or subsidy If yes, please note the amount of the discount, tax credit or subsidy.			
Level of coverage: Single 2-Party Famil	•	O No O Ye	s: <u>\$</u>		
Medicare Part B Reimbursement: O Copy of signe	d card attached	d 			
DENTAL					
Dental plan name		Monthly cost for SDCERA Member's coverage \$			
SDCERA member is: O Policy holder O Dependent		Does the amount above include a discount, tax credit or subsidy If yes, please note the amount of the discount, tax credit or subsidy.			
Level of coverage:	У	O No O Ye	φ.		
PRESCRIPTION					
Prescription plan name		Monthly cost for SDCERA Member's coverage \$			
SDCERA member is: O Policy holder O Depend	lent	Does the amount above include a disco- If yes, please note the amount of the disc			
Level of coverage: O Single O 2-Party Famil	У	O No O Ye			
AUTHORIZATION					
I have read and understand the information and instructions information provided is correct. I understand that the Health II is not guaranteed and may be reduced or eliminated at any tip prescription insurance premiums that are paid for my individual these expenses must qualify for reimbursement under the Interrany other benefit plan. I further certify that I will not claim the not been, and are not eligible to be, deducted on a pre-tax bas penalties that may be assessed for any disallowed deductions/agree to notify SDCERA immediately if my plan(s) or premium cost of my coverage, I agree to repayment terms determined by in the HIA program, which includes enabling my reimburseme fee and the federal PCORI fee, if applicable.	nsurance Allome. My Heal II coverage an all Revenue Gese expenses is through a Scredits. The Gese ease or Gese SDCERA. It	owance and/or Part B reinth Insurance Allowance of the Insurance Allowance of the Insurance Allowance of the Insurance Allowance of the Insurance	nbursement is covers only rechase Medica een or will nation and that . I assume all above is cumbursement in this form to personers on the covers of the cov	requested on this form medical, dental and/or are Part B. I certify that ot be reimbursed from these premiums have I liability for taxes and urrently in effect and I in excess of the actual process my enrollment	
Signature X			•••••	Date	

Use this sample to help complete your Health Insurance Allowance request.



Based on the supporting documentation below, the SDCERA member is the policy holder for her family's medical plan, and the cost of her individual coverage is \$250, with no discount, tax credit or subsidy.

The SDCERA member is the dependent for her family's dental plan, and the cost of her individual coverage is \$25.

The SDCERA member is the policy holder for her prescription plan, and the cost of her individual coverage is \$25, after the \$50 subsidy her former employer covers.

ABC Health Plan

January 15, 2018

Member Name 123 Address, # 456 City, ST 92108

Dear Member Name,

Thank you for choosing us for your health insurance needs. Effective January 1, 2018, your total premium amount for ABC Health Plan, Plan Efamily coverage is \$800.00 per month. The cost for your **individual** portion of this coverage is \$250.00 per month. Our records indicate that we debited \$800 from your checking account on January 8, 2018, for your monthly premium payment. We will continue to automatically debit your monthly premium from your checking account on the 5th business day of each month for the 2018 plan year.

If you have any questions, please call us at 800.123.4567.

Thank you, ABC Health Plan { Proof of coverage }

{ Proof of monthly }
 premium

{Proof of payment }

When the SDCERA member in this sample submits their completed *Health Insurance Allowance Request* form with this letter (which meets all the proof requirements), they will be eligible for a reimbursement of her medical premium. Other documentation is acceptable. See form instructions.

SAMPLES

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