2019 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

Retiree Health Insurance Allowance Request forms **must be** sent to:
SDCERA Retiree Health Program Service Center, PO Box 14464, Des Moines, IA 50306-3464

2019 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

- **2019** 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)

- **2019** 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

- **2019** pay stub or bank statement, or
- **2019** 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.

Please submit all proofs along with your completed and signed enrollment form to:
SDCERA Retiree health Program Service Center, PO Box 14464, Des Moines, IA 50306-3464.

SDCERA

2019 Health Insurance Allowance Request

Complete this form and provide all required documentation. Effective Date: _____

MEMBER INFORMATION

First name	MI	Last name	Social Security number

Permanent Residence address	City	State	ZIP

Mailing address (if different than Permanent Residence)

City	State	ZIP	Daytime telephone number
			( )

PLAN INFORMATION

MEDICAL

◯ Check here if your plan is an employer-sponsored plan.

Is this a Medicare plan? ◯ No ◯ Yes

Medical plan name

Monthly cost for SDCERA **Member's** coverage $

SDCERA member is: ◯ Policy holder ◯ Dependent

Level of coverage: ◯ Single ◯ 2-Party ◯ Family

Does the amount above include a discount, tax credit or subsidy? If yes, please note the amount of the discount, tax credit or subsidy.

◯ No ◯ Yes: $

Monthly cost amount must be completed if you are selecting it for reimbursement.

Medicare Part B Reimbursement:

◯ Copy of signed card attached

DENTAL

Dental plan name

Monthly cost for SDCERA **Member's** coverage $

SDCERA member is: ◯ Policy holder ◯ Dependent

Level of coverage: ◯ Single ◯ 2-Party ◯ Family

Does the amount above include a discount, tax credit or subsidy? If yes, please note the amount of the discount, tax credit or subsidy.

◯ No ◯ Yes: $

Monthly cost amount must be completed if you are selecting it for reimbursement.

PRESCRIPTION

Prescription plan name

Monthly cost for SDCERA **Member's** coverage $

SDCERA member is: ◯ Policy holder ◯ Dependent

Level of coverage: ◯ Single ◯ 2-Party ◯ Family

Does the amount above include a discount, tax credit or subsidy? If yes, please note the amount of the discount, tax credit or subsidy.

◯ No ◯ Yes: $

Monthly cost amount must be completed if you are selecting it for reimbursement.

AUTHORIZATION

I have read and understand the information and instructions provided with this form. I certify, under penalty of perjury, that the information provided is correct. I understand that the Health Insurance Allowance and/or Part B reimbursement requested on this form is not guaranteed and may be reduced or eliminated at any time. My Health Insurance Allowance covers only medical, dental and/or prescription insurance premiums that are paid for my individual coverage and cannot be used to purchase Medicare Part B. I certify that these expenses must qualify for reimbursement under the Internal Revenue Code and they have not been or will not be reimbursed from any other benefit plan. I further certify that I will not claim these expenses as an income tax deduction and that these premiums have not been, and are not eligible to be, deducted on a pre-tax basis through a Section 125 cafeteria plan. I assume all liability for taxes and penalties that may be assessed for any disallowed deductions/credits. The coverage I have indicated above is currently in effect and I agree to notify SDCERA immediately if my plan(s) or premium(s) cease or change. If I receive a reimbursement in excess of the actual cost of my coverage, I agree to repayment terms determined by SDCERA. I understand SDCERA uses this form to process my enrollment in the HIA program, which includes enabling my reimbursement. I understand HIA program participants pay the monthly administrative fee and the federal PCORI fee, if applicable.

Signature X ..... Date .....

Submit this completed form to the SDCERA Retiree Health Program Service Center

SDCERA Retiree Health Program Service Center • 866.751.0256 • **www.sdcera.org** • **PO Box 14464 • Des Moines, IA 50306-3464**

SAMPLES

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

PLAN INFORMATION *Supporting documentation required. See instructions.*

MEDICAL ◯ Check here if your plan is an employer sponsored plan. | Is this a Medicare plan? ◯ No ◯ Yes

Medical plan name: ABC Health Plan, Plan E
Monthly cost for SDCERA **member's** coverage: $ 250.00
SDCERA member is: ☒ Policy holder ◯ Dependent
Level of coverage: ◯ Single ◯ 2-Party ☒ Family
Does the amount above include a discount, tax credit or subsidy? If yes, please note the amount of the discount, tax credit or subsidy.
☒ No ◯ Yes: $

DENTAL

Dental plan name: Dental, Plan F
Monthly cost for SDCERA **member's** coverage: $ 25.00
SDCERA member is: ◯ Policy holder ☒ Dependent
Level of coverage: ◯ Single ☒ 2-Party ◯ Family
Does the amount above include a discount, tax credit or subsidy? If yes, please note the amount of the discount, tax credit or subsidy.
☒ No ◯ Yes: $

PRESCRIPTION

Prescription plan name: Prescription Plan, Plan G
Monthly cost for SDCERA **member's** coverage: $ 75.00
SDCERA member is: ☒ Policy holder ◯ Dependent
Level of coverage: ☒ Single ◯ 2-Party ◯ Family
Does the amount above include a discount, tax credit or subsidy? If yes, please note the amount of the discount, tax credit or subsidy.
◯ No ☒ Yes: $ 50.00

{ 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, 2019

{ All proofs must show a 2019 date. }

Member Name
123 Address, # 456
City, ST 92108

Dear Member Name,

Thank you for choosing us for your health insurance needs. Effective January 1, 2019, your total premium amount for ABC Health Plan, Plan E family 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, 2019, 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 2019 plan year.

{ Proof of coverage }

{ Proof of monthly premium }

{ Proof of payment }

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

Thank you,
ABC Health Plan

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.