

## 2020 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



## 2020 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

- 2020 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)

- **2020** 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

- 2020 pay stub or bank statement, or
- 2020 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.



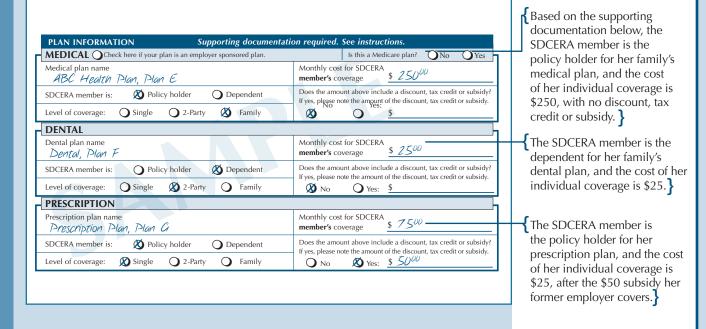
## 2020 Health Insurance Allowance Request

MEMBER INFORMATION				
First name MI Last name		Social Security nu	mber	
Permanent Residence address Ci	ity		State	ZIP
Mailing address (if different than Permanent Residence)				
City State	ZIP Daytime telepho		e number	
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PLAN INFORMATION				
MEDICAL O Check here if your plan is an employer-sponsored pla	an.	Is this a Med	dicare plan?	No Yes
Medical plan name	Monthly cost for SDC  Member's coverage	ERA \$		Moni
SDCERA member is: O Policy holder O Dependent	Does the amount above include a discount, tax credit or subsidy:		, , , '   II you	
Level of coverage: O Single O 2-Party O Family	, ,			selection reimle
	Monthly cost for SDC	ERA		Mon
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PRESCRIPTION Prescription plan name  SDCERA member is:  Policy holder Dependent	Member's coverage  Does the amount above If yes, please note the am  No  No  Monthly cost for SDC  Member's coverage  Does the amount above If yes, please note the am	include a discount, ount of the discount /es:  EERA  include a discount, ount of the discount, ount of the discount	, tax credit or st	ubsidy? ubsidy.  amou be co if you select reiml  Montamou be co if you select reiml  which is the contamou of

Date \_\_\_\_\_

Signature X

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



January 15, 2020 -

ABC Health

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 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, 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.

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

Thank you, ABC Health Plan { All proofs must show} a 2020 date.

{ 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

87616 B13005 (12/19) Rev. 12/19