# Fact Sheet

Retiree Health Insurance Allowance Program
For Retired Tier I and Tier II Members

The Health Insurance Allowance (HIA) Program provides you a monthly health insurance reimbursement to help cover the cost of your medical, dental and prescription drug premiums.

## Eligibility

- Retired General and Safety, Tier I and Tier II members with at least 10 years of SDCERA service credit

**OR**

- Tier I and Tier II members granted a disability retirement, regardless of years of service

**OR**

- Surviving spouse of eligible member who receives a monthly continuance

## Premiums covered by HIA Program

- Medical plan
- Dental plan
- Prescription drug plan

## Costs not covered by HIA Program

- Premiums for other family members, including a spouse
- Annual deductibles
- Copayments
- Coinsurance
- Out-of-pocket prescription drug expenses
- Long-term custodial care
- Late enrollment penalties
- IRMAA payments
- Vision insurance

## Your monthly HIA allowance

| Years of SDCERA service credit* | Monthly allowance if not eligible for Medicare | Monthly allowance if eligible for Medicare |
|---|---|---|
| Less than 10 | 0 | 0 |
| 10 | $200 | $300<br><br>In addition to the allowance, $93.50 may be reimbursed to use toward the cost of the monthly Medicare Part B** premium. |
| 11 | $220 | |
| 12 | $240 | |
| 13 | $260 | |
| 14 | $280 | |
| 15 | $300 | |
| 16 | $320 | |
| 17 | $340 | |
| 18 | $360 | |
| 19 | $380 | |
| 20 or more | $400 | |

* Members who retired on or before September 30, 1991, with at least 10 years of SDCERA service credit may be eligible for the maximum allowance. Members who receive a retirement benefit based on a disability are eligible for an allowance regardless of years of service credit.

** To be reimbursed, you must provide the SDCERA Health Plans Service Center with a copy of your signed Medicare card showing Part B coverage. Reimbursement begins in the month the SDCERA Health Plans Service Center receives your enrollment form and all documentation.

## Enrollment

- Your initial HIA request can be made at any time throughout the year.
- Once enrolled in the HIA Program, if you are in a non-SDCERA sponsored plan, you must re-enroll every year, even if you make no changes to your plan.
- The re-enrollment paperwork submitted each plan year becomes effective in January of that plan year, unless your new plan year begins on a different date.

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

**Proof of coverage,** showing SDCERA's member or surviving spouse's name

- 2022 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's member or surviving spouse'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)

- 2022 invoice or billing statement, or
- Letter from the carrier or the employer, or
- Renewal notification

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

- 2022 pay stub or bank statement, or
- 2022 canceled check (copy of front and back), or
- Letter from carrier or employer

## Where to submit your allowance request form and proof documents

- Mail to SDCERA Health Plans Service Center, PO Box 14464, Des Moines, IA 50306-3464
- Fax to 515.365.1520
- Upload to health.sdcera.org

## Health Program fee

A monthly administrative fee of $5.15 will be applied to each member enrolled in the HIA Program.

The Health Insurance Allowance Program is considered a Health Reimbursement Account (HRA) under the federal Patient Protection and Affordable Care Act. If you participate in a HRA Program, you are subject to the annual Patient Centered Outcomes Research Institute (PCORI) fee; this fee is determined annually by the federal government, and it is assessed in May. For questions about the Retiree Health Insurance Allowance program, please call the SDCERA Health Plans Service Center at 866.751.0256.

SDCERA
San Diego County Employees Retirement Association

# 2022 Health Insurance Allowance Form

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) | Daytime Telephone Number |
|---|---|
| | ( ) |

| City | State | ZIP | Personal Email |
|---|---|---|---|
| | | | |

## Medicare Part B Reimbursement: ◯ Copy of signed card attached

## PLAN INFORMATION

### MEDICAL ◯

Is this a Medicare plan? ◯ No ◯ Yes

Medical plan name

Monthly premium cost for 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 premium cost must be provided if requesting reimbursement.

### DENTAL

Dental plan name

Monthly premium cost for 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 premium cost must be provided if requesting reimbursement.

### PRESCRIPTION

Prescription plan name

Monthly premium cost for 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 premium cost must be provided if requesting 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 Health Plans Service Center***

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