2017

SDCERA

*Strength. Service. Commitment.*

# Health Insurance Reimbursement Request form

## Retired Tier I and Tier II Members

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# Health Insurance Reimbursement Request form instructions

Eligible retired Tier I and Tier II Members who enroll in a medical, dental or prescription plan not sponsored by SDCERA may request a reimbursement for the out-of-pocket cost of the insurance premium, up to the retired Member's monthly Health Insurance Allowance amount. For information on allowance eligibility and fees for participation, please review the *Health Insurance Allowance and Health Insurance Reimbursement Program* fact sheets available on the Health page of **www.sdcera.org.**

You may make an initial request for Health Insurance Reimbursement (HIR) any time throughout the year. You must re-enroll each year to continue your reimbursement into the new plan year. If you enroll in a dental plan offered by the Retired Employees of San Diego County (RESDC) or the Deputy Sheriffs' Association (DSA), do not complete this form; your reimbursement will be processed by separate authorization from those agencies. Please note, if you enroll in a health plan through the Health Insurance Marketplace (Exchange) and request reimbursement from SDCERA through the HIR program for premiums, you will be ineligible to receive any federal subsidies (tax credit) for your coverage in the Marketplace. If your medical coverage is provided through an employer based plan, your reimbursement from SDCERA will be taxable. For more information about eligibility for the federal subsidies (tax credit), consult with a tax advisor.

Once you are enrolled in the HIR program for the current year, if your current plan or premium amount changes, you must report the change to SDCERA within 30 days following the effective date of the change; your reimbursement amount may need to be adjusted. You will be responsible for the repayment of any incorrect payments made to you.

SDCERA only reimburses the out-of-pocket cost for the SDCERA Member's premium—not the cost of other family Members' coverage.

## Expenses not eligible for reimbursement

- Retroactive premium payments
- Premiums for non-SDCERA Members
- Annual deductibles
- Copays
- Out-of-pocket prescription expenses
- Long-term custodial care
- SDCERA group plan premiums
- Medicare Part B premiums
- Late fees and penalties

## You are required to attach documentation verifying each of the requirements below

Submit one proof of each (coverage, premium cost, and payment) for each type of insurance. An invoice or letter showing all three types of proof is sufficient. Please see the back page of this form for an example.

**Proof of coverage,** showing SDCERA Member's name

Acceptable forms:

- **Most recent** invoice or billing statement showing effective date, or
- Letter from your insurance company or employer, or
- Plan identification card (copy of front and back)

**Proof of 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)

Acceptable forms:

- Letter from the carrier or the employer, or
- **Most recent** invoice or billing statement, or
- Renewal notification

**Proof of payment,** showing SDCERA Member's name, the payment amount and paid date

Acceptable forms:

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

**Your reimbursement will be effective beginning the month SDCERA receives this form and all required documentation.**

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# Health Insurance Reimbursement Request form

Complete this form and provide all proofs necessary for reimbursement. See the instructions page for more information.

## EVENT TYPE *Check one.*

◯ Open Enrollment ◯ Initial Request ◯ Plan / Premium Change 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 *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

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: $ _____

### 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: $ _____

### 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: $ _____

## 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 used for the reimbursement requested on this form is not guaranteed and may be reduced or eliminated at any time. My Health Insurance Reimbursement (HIR) 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 HIR program, which includes enabling my reimbursement. I understand HIR program participants pay the monthly administrative fee and the federal PCORI fee, if applicable. If I have exhausted my maximum allowance amount, I agree to have my monthly retirement payment reduced by the necessary fees.

**Signature** X _____ Date _____

***Submit this completed form to the SDCERA Health Plans Service Center***

SDCERA Health Plans Service Center • 866.751.0256 • **www.sdcera.org**

SAMPLES

**Use this sample to help complete your Health Insurance Reimbursement request.**

**PLAN INFORMATION** *Supporting documentation required. See instructions.*

**MEDICAL** ◯ Check here if your plan was obtained through the Health Insurance Marketplace. | Is this a Medicare plan? ◯ No ◯ Yes

Medical plan name: ABC Medical Group, 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 $250.00, 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 $25.00. }

{ The SDCERA Member is the policy holder for her prescription plan, and the cost of her individual coverage is $25.00, after the $50.00 subsidy her former employer covers. }

**ABC Medical Group**

November 3, 2016

Member Name
123 Address, # 456
City, ST 92108

Dear Member Name,

Thank you for choosing us for your health insurance needs. Effective January 1, 2016, your individual new premium amount for ABC Medical Group, Plan E will be $250 per month. We will continue to automatically debit your monthly premium from your checking account. As you requested, we've outlined the 2016 premium payments you have paid for your ABC Medical Group, Plan E.

{ Proof of coverage }

{ Proof of premium }

{ Proof of payment }

| | |
|---|---|
| January | 240.00 |
| February | 240.00 |
| March | 240.00 |
| April | 240.00 |
| May | 240.00 |
| June | 240.00 |
| July | 240.00 |
| August | 240.00 |
| September | 240.00 |
| October | 240.00 |
| November | 0.00 |
| December | 0.00 |

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

Thank you,
ABC Medical Group

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