Sacramento City Unified School District

# BULLETIN

**SUBJECT:** **TEACHER RETIREE OPT OUT PLAN** **2024-25 NO. BS - 15**

**TO:** All Eligible SCTA Retirees

**DATE:** October 1, 2024

**PREPARED BY:** Keyshun Marshall, Director II

**DEPARTMENT:** Risk Management / Employee Health Benefits

**REVIEWED BY:** Amber Peña Manager II, Risk Management/ Employee Benefits

**APPROVED:** Janea Marking, Chief Business and Operations Officer

Effective January 1, 2025, SCTA retirees may elect to participate in the Retiree Opt Out option, which allows retirees to purchase other insurance coverage of their choice. Examples of other insurance coverage include dental, vision, life, long term disability, long term care, cancer insurance and Medicare insurance costs per retiree's choice. In addition, the Opt Out option offers a medical health premium reimbursement up to **$442.46 per month**. A retiree utilizing the Opt Out option must show proof of other health insurance coverage in order to receive an Opt Out reimbursement. The reimbursement amount is up to **$442.46** per month for qualifying expenses incurred during the period of January 1, 2025 through December 31, 2025. Additionally, a retiree may return to a District health program due to qualifying events.

Navia is the SCUSD third party administrator that will handle Opt Out reimbursements, and related administrative processing on behalf of the District. For Opt Out reimbursement, retiree's must:

- Go to https://www.naviabenefits.com/ and create an account. **ABC** is the employer code.
- Once set-up, you have the option to:
  - Check your balance
  - Submit for reimbursement
  - Upload insurance receipts
  - Add a checking/savings account for direct deposit reimbursement

**Important Information for 2025**

**PLEASE DO NOT MAIL CLAIM FORMS TO THE DISTRICT, NAVIA HANDLES ALL CLAIMS/REIMBURSEMENTS.**

- Proof of other coverage must be provided before any reimbursements will be made.
- Claims must be for services provided during the plan year commencing January 1, 2025 through December 31, 2025.
- To close out the 2024 plan year, all 2024 requests must be received by Basic before the **March 31, 2025 deadline**. Call Basic at 800-372-3539 or submit Support request to https://cda.basiconline.com/login
- Be sure to retain a copy of all claims and receipts for your records.

Feel free to reach out to Navia by phone at (425) 452-3421, email 105@naviabenefits.com or Sacramento City Unified School District Employee Benefits department at (916) 643-9432, benefits@scusd.edu.

## Standard Request – PREMIUMS ONLY

**Participant Information –** *Instructions for filling out this form are on the back of this page.*

| Retiree Last Name, First Name | Retiree SSN *(Use last 4 digits if emailing form)* |
|---|---|
| | |
| Eligible Dependent(s) Last Name, First Name, Relation | Dependent SSN *(Use last 4 digits if emailing form)* |
| | |
| Employer Name | Email Address |
| | |

**Premium Information for Monthly Standard Request –** *Instructions for filling out this form are on the back of this page.*

| Add, Remove, Change, or Continue | Policy Type | For Whom | Relation (*Self, Spouse, etc*) | Policy Start or End Date | Monthly Premium |
|---|---|---|---|---|---|
| *EXAMPLE* *Add* | *EXAMPLE* *Medicare Supplement* | *EXAMPLE* *Jane Doe* | *EXAMPLE* *Self* | *EXAMPLE* *1/1/2021* | *EXAMPLE* *$235.50* |
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**Premium Substantiation:** Attaching substantiation of your premium(s) with this form is required. Valid documentation may be an Insurance Premium Statement, a bank statement, a credit/debit card statement, and/or a letter from the Social Security Administration. Documentation must include the participant's name, coverage type or insurance company name, and premium amount.

### Participant Authorization

To the best of my knowledge, my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Health Reimbursement Arrangement (HRA) and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HRA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HRA which relate to such expense. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for reimbursement of a non-qualifying expense. This authority will remain in full force and effect until Navia Benefit Solutions has received written notification from me of its termination in such time and in such manner as to afford Navia Benefit Solutions and the banking institution a reasonable opportunity to act on it.

❑ **I authorize Navia Benefit Solutions to automatically reimburse me for the above health insurance premiums.**

| Signature | Date |
|---|---|
| **X** | |

**QUESTIONS? Call Navia Benefit Solutions at (866) 897-1996**

# INSTRUCTIONS FOR COMPLETING THIS FORM

## Accountholder/Participant Information

**Retiree Last Name, First Name:** Enter the last name and first name of the Retiree*

**Retiree SSN / ID #:** Enter the Retiree's employee ID or social security number. Use ID # or last 4 digits of your SSN if e-mailing this form.

**Eligible Dependent(s) Last Name, First Name, Relation:** Enter the last name and first name of the eligible dependent* then indicate the dependent's relation to the retiree, such as "Spouse," or "Child"

**Dependent SSN:** Enter the Dependent's social security number. Use last 4 digits if e-mailing this form.

**Employer Name:** Please enter the Employer/Plan Sponsor name

**Email Address:** Please enter your email address to receive important account notifications electronically.

## Premium Information for Monthly Standard Request – PREMIUMS ONLY

*If already set up for recurring premium reimbursement and filling out this form to make changes to your existing monthly reimbursement, please also include the expenses you would like to continue being reimbursed for so that Navia can accurately calculate your new monthly reimbursement total.*

**Add, Remove, Change, or Continue:** Indicate "Add," "Remove," "Change," or "Continue"** a recurring expense.

**Policy Type:** Indicate the type of policy you are requesting monthly reimbursement for, such as "Medicare Supplement" or "Medicare Part B" or "Dental/Vision"

**For Whom:** Indicate the name of the person who the policy is for.

**Relation:** Indicate the relationship of the person to the Account holder, such as "Self" or "Spouse"

**Policy Start or End Date:** For adding or changing a premium expense, enter the date the new premium or policy goes/ went into effect. For removing a premium expense, indicate the date the policy is/was canceled.

**Monthly Premium:** Enter the monthly premium.

***A "Change" indicates an increase/decrease in premium for a policy you are currently being reimbursed for. "Remove" indicates a policy cancellation. "Add" indicates a new policy you want included in your monthly reimbursement total.*

## Participant Authorization

**Read the Agreement** and mark the authorization box

**Sign and Date** the Agreement

# FORM SUBMITTAL

Attach any necessary premium substantiation to this form and submit to Navia Benefit Solutions via:

**E-mail** 105@naviabenefits.com **Mail** P.O. Box 53250, Bellevue, WA 98015