BULLETIN

SUBJECT:	**TEACHER RETIREE OPT OUT PLAN**		**2023-24 NO. BS-18**
TO:	All Eligible SCTA Retirees		
DATE:	September 28, 2023		
PREPARED BY:	Keyshun Marshall, Director II	**DEPARTMENT:**	Risk Management /Employee Benefits
REVIEWED BY:	Amber Pena Benefits Analyst, Risk Management/ Employee Benefits	**APPROVED:**	Jesse Castillo Jesse Castillo, Assistant Superintendent, Business Services

Effective January 1, 2024, 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 **$395.59 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 **$395.59** per month for qualifying expenses incurred during the period of January 1, 2024 through December 31, 2024. Additionally, a retiree may return to a District health program due to qualifying events.

Basic 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:

- Login to Google Chrome https://cda.basiconline.com/login and create an account.
- Once set-up, you have the option to:
    - Check your balance
    - Submit for reimbursement
    - Upload insurance receipts
    - Add a checking/savings account for reimbursement

Important Information for 2023

PLEASE DO NOT MAIL CLAIM FORMS TO THE DISTRICT, BASIC 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, 2024 through December 31, 2024.
- Intent is that retirees are reimbursed monthly. All 2023 requests must be received by BASIC before the **January 15, 2024 deadline**.
- Be sure to retain a copy of all claims and receipts for your records.

Feel free to reach out to Basic by phone at **800-372-3539 or** by submitting a Support Request at https://cda.basiconline.com/login , or Sacramento City Unified School District Employee Benefits department at 916- 643-9432, benefits@scusd.edu.

RECURRING INDIVIDUAL PREMIUM REIMBURSEMENT REQUEST FORM

Submit this form and your coverage documents via one of the following methods:	Online or Mobile App	Fax	Mail
	Sign into your account and submit via support request (select *Contact Us*).	608-245-3623	BASIC, PO Box 7308 Madison, WI 53704-7308

Important: A new form must be submitted each year when your policy rate changes (beginning of new plan year or policy end date) to update your recurring reimbursements with your new rate. Refer to Additional Instructions on page 2.

PARTICIPANT INFORMATION

Employer Name: *(Former Employer for Retirees)*						
First Name:		MI:		Last Name:		
BASIC ID:		Email Address:				
Primary Phone:		Mobile Phone:				
Primary Address: *(cannot be PO Box)*	Address 1:				Apt:	
	Address 2:					
	City:					
	State:		ZIP Code:		+4:	

INDIVIDUAL POLICY INFORMATION & REQUEST FOR REIMBURSEMENT

Name of Insured Person:			
Name of Insurance Carrier:			
Type of Coverage:			
Start Date for Premium Reimbursement:	_____/____/_____	End Date for this Premium Reimbursement Amount*:	_____/____/_____
Monthly Premium Amount Requested:	$_____	Total Plan Year Premium Amount Requested:	$_____

ADDITIONAL INSTRUCTIONS

Easily submit this form and your coverage documents via your online account.

1. Sign into your account at cda.basiconline.com/login.
2. From the *Overview* page, select *Contact Us*.
3. Select the offering type *Benefit Plans*, the topic *Expenditures*, then choose *Create or adjust a recurring claim*.
4. Complete the requested information and click *Upload a file for reference*.
5. Select your form and documentation to attach and click *Open*. Please note, uploaded files must be in JPG, JPEG, PNG, or PDF format.

Set up Direct Deposit.

1. Sign into your account at cda.basiconline.com/login.
2. From the Overview page, select *Settings* and then *Bank accounts*.
3. Click *Link new bank account*.
4. Enter your banking information and click *Link*.
5. Go back to the *Overview* page and select *MyCash balance* and *Manage MyCash transfer schedules*.
6. Click *Schedule a new transfer*, select your schedule preference and click *Submit*.

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RECURRING INDIVIDUAL PREMIUM REIMBURSEMENT REQUEST FORM

AUTHORIZATION – Section 1

Initial next to each line below to indicate you acknowledge the terms of this recurring premium reimbursement request.

_____I understand that (1) I will be set up for a monthly recurring reimbursement as requested above and this recurring reimbursement will continue through the "End Date for this Premium Reimbursement Amount" indicated above. (2) If no end date is listed, the reimbursements will stop at the end of my employer's premium benefit plan year and will not continue until a new Recurring Individual Premium Reimbursement Request Form is submitted. (3) The amount reimbursed is limited to my current available account balance.

_____I understand that insurance premiums are considered to be incurred on the first day of the month of coverage and that I cannot be reimbursed for expenses prior to that, regardless of the date the insurance bill was paid.

_____I have attached a proof of my insurance coverage that includes the type of coverage, premium amount, and contract period. Acceptable documents include a letter from the insurance company that includes the above information, a copy of a contract renewal letter, or a letter from the former employer sponsoring the plan.

_____I understand that I am required to complete a new Recurring Reimbursement Request form for each plan year and sendproof of insurance coverage when my insurance premiums change (at the start of the new plan year, the end of the policy contract,or for any other reason).

_____I understand that I am required to have direct deposit set up with BASIC to receive reimbursements.

_____In the event that my coverage is terminated for any reason, I am required to inform BASIC within five (5) days of the termination so that future reimbursements can be stopped.

_____I certify the above information is correct and the expenses claimed will incur on a regular basis by me or my eligible dependents after my effective date of coverage in my employer's benefit plan. I certify these expenses are not eligible for reimbursement under any other plan and comply with the requirements of this plan. I have not and will not claim these expenses onmy personal income tax return and I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

AUTHORIZATION – Section 2

I certify that I have read, understand and agree to the requirements above. I request the monthly premium amount indicated above to be reimbursed from my available account balance each month.

_____ _____

Authorized Signature (may be digital signature) **Date**

_____

Please Print Name