The California Teachers Association
EMPLOYEES' HEALTH AND WELFARE BENEFITS TRUST

California Teachers Association Employees' Health & Welfare Benefits Trust
c/o Zenith American Solutions, Inc.
1141 Harbor Bay Parkway, Suite 100 | Alameda, CA 94502
Toll free: (888) 243-2325 | Local area: (650) 718-1293 | Fax: (650) 331-3920

Mail Date

«First_Name» «Last_Name»
«ADDRESS1»
«ADDRESS2»
«City» «State» «Zip_Code»

Re: California Teachers Association Employees' Health and Welfare Benefits Trust
Medicare Part B Premium Reimbursement

Dear «First_Name» «Last_Name»

Our records show that you are eligible for the Medicare Part B Premium Reimbursement program under the California Teachers Association Employees' Health and Welfare Benefits Trust ("Trust"). This letter and the enclosed materials explain the claims process for the Medicare Part B Premium Reimbursement program under the Trust. The claims process involves a **one-time** requirement to submit a completed Medicare Part B Premium Reimbursement Affidavit (copy enclosed) and supporting documentation.

To begin receiving the Part B Premium Reimbursement, an Eligible Retiree or Surviving Spouse must complete the enclosed affidavit and return it with a copy of their Medicare Health Insurance enrollment card issued by the Social Security Administration and/or if applicable, any eligible dependent's Medicare card.

We highly recommend signing up for direct deposit to receive your quarterly reimbursement, as it will enable a faster turnaround receipt time. Please return the Medicare Part B Premium Reimbursement Affidavit and the direct deposit authorization form to the Trust office in the prepaid return envelope as provided by [DATE].

If you have any questions, please contact the Trust Office at 888.243.2325.

Sincerely,

The Trustees for the California Teachers Association Employees' Health and Welfare Benefits Trust

Enclosures:
Medicare Part B Premium Reimbursement Policy
Medicare Part B Premium Reimbursement Affidavit
Medicare Part B Premium Reimbursement Direct Deposit Authorization (optional)
Self-Addressed Return Envelope

THE CALIFORNIA TEACHERS ASSOCIATION
EMPLOYEES' HEALTH AND WELFARE BENEFITS TRUST
2250 S Rancho Road, Suite 295, Las Vegas NV 89102-4454
Telephone: 650-718-1292, Toll Free: 888-243-2325, Fax: 650-331-3920

MEDICARE PART B PREMIUM REIMBURSEMENT POLICY

WHEREAS, the Second Restated Declaration of Trust and Agreement (the "Trust Agreement") establishing the California Teachers Association Employees' Health and Welfare Benefits Trust and Plan (the "Trust") authorizes the Board of Trustees (the "Board") to adopt such policies and procedures as are necessary or appropriate to administer the Trust and Plan; and

WHEREAS, the collective bargaining agreement between the California Teachers Association and the California Associate Staff and the collective bargaining agreement between the California Teachers Association and the California Staff Organization (collectively, the "CBAs"), as entered into between those parties from time to time, provide for reimbursement of the amount of the standard monthly premium for Medicare Part B coverage, as adjusted annually by the Social Security Administration, to retirees who are eligible for Retirement Medical Benefits pursuant to the CBAs, ("Eligible Retirees"), including an Eligible Retiree's eligible dependent, and who are enrolled in Medicare Part B coverage (the "Part B Premium Reimbursement"); and

WHEREAS, the CBAs further provide that, if an Eligible Retiree predeceases their spouse or domestic partner ("Surviving Spouse"), the Surviving Spouse and other eligible dependent(s) of the Eligible Retiree shall continue to be eligible for the Part B Premium Reimbursement; and

WHEREAS, the Board desires to adopt this Medicare Part B Premium Reimbursement Policy (this "Policy") to obtain substantiation of Eligible Retirees' and/or their eligible dependent(s), and Surviving Spouses' Medicare Part B enrollment and premium payment, in order for the Part B Premium Reimbursement to be treated as nontaxable pursuant to Internal Revenue Code section 105 and regulations promulgated thereunder;

NOW, THEREFORE, the Board adopts this Policy on April 5, 2023, to be effective as of that date.

I. Conditions for Receipt of the Part B Premium Reimbursement

A. To receive the Part B Premium Reimbursement, an Eligible Retiree or Surviving Spouse shall, within 12 months of enrolling in Medicare Part B, provide to the Trust's third-party administrator (the "Plan Administrator"):

i. A copy of their Medicare Health Insurance enrollment card issued by the Social Security Administration, and/or if applicable, any eligible dependent's Medicare card; *and*

ii. A signed affidavit (in the form attached hereto as Attachment 1) certifying under penalty of perjury that they (and/or, if applicable, their eligible dependent) has enrolled in Medicare Part B and pays the monthly Medicare Part B premium, including by having such premium deducted from their monthly Social Security benefit payment.

B. Upon receipt of the above documentation in good order, the Plan Administrator shall reimburse the Eligible Retiree or Surviving Spouse for the Part B Premium Reimbursement, retroactive to the applicable Medicare Part B enrollment date. If substantiation documentation is not received by the Plan Administrator within 12 months of enrolling in Medicare Part B coverage, the Trust will reimburse the Eligible Retiree or Surviving Spouse for the Part B Premium Reimbursement, prospectively, beginning with the first month following the date the substantiation is received in good order.

II. Notice of Changes to Medicare Part B Enrollment and Repayment of Overpayments

A. Eligible Retirees and Surviving Spouses shall agree that, in the event they or their eligible dependent ceases to: (i) be enrolled in Medicare Part B, or (ii) pay a Medicare Part B premium, their eligibility shall cease and the retiree shall notify the Plan Administrator as soon as practicable, but no later than within 30 days.

B. Eligible Retirees and Surviving Spouses shall agree that, if a retiree is reimbursed for any amounts after they or their dependent becomes ineligible for the Part B Premium Reimbursement, they will repay the overpaid amounts to the Trust in the time and manner requested by the Plan Administrator.

ATTACHMENT 1

THE CALIFORNIA TEACHERS ASSOCIATION
EMPLOYEES' HEALTH AND WELFARE BENEFITS TRUST

MEDICARE PART B PREMIUM REIMBURSEMENT AFFIDAVIT

1. I certify that, based on my eligibility for health coverage under the California Teachers Association Employees' Health and Welfare Benefits Trust ("Trust"), I am eligible to receive reimbursement for the amount of the standard monthly premium for Medicare Part B coverage, as adjusted annually by the Social Security Administration, for myself, and, if applicable, my eligible dependent(s), from the Trust (the "Part B Premium Reimbursement").

2. I certify that I (and/or my eligible dependent(s)) am enrolled in Medicare Part B and paying monthly Medicare Part B premiums, including, if applicable, by having such premium deducted from my and/or my eligible dependent's monthly Social Security benefit payment.

3. I further certify that I have attached hereto a true and correct copy of my, and/or my eligible dependent's Medicare Health Insurance enrollment card(s) issued by the Social Security Administration.

4. I understand that my, and/or my dependent's, eligibility for the Part B Premium Reimbursement will cease as of the earliest date I or my dependent are no longer: (i) enrolled in Medicare Part B, (ii) paying a Medicare Part B premium, or (iii) eligible for health coverage under the Trust. I agree that if I (and/or my eligible dependent) cease to be eligible for the Part B Premium Reimbursement, I will notify the Plan Administrator within 30 days. I further agree to repay, in the time and manner determined by the Plan Administrator, any amount paid to me after I and/or my eligible dependent(s) cease to be eligible to receive the Part B Premium Reimbursement.

5. I certify under penalty of perjury, that all the above statements are true and correct to the best of my knowledge and belief. I understand that a false statement or falsified Medicare Health Insurance enrollment card may permanently disqualify me from eligibility for the Part B Premium Reimbursement, and that the Trust shall have the right to recover any amounts paid to me because of such false statement or falsified Medicare Health Insurance enrollment card.

Retired Participant Signature: x _____

Retired Participant Name (please print) _____

SSN (last 3 digits) XXX-XX-X _____

Date of Birth (MM/DD/YYYY) _____

Medicare Part B Enrollment Date _____

Participant Date of Death (if applicable) _____

Spouse, Surviving Spouse or Dependent Signature: x _____

Spouse, Surviving Spouse, or Dependent Name _____

SSN (last 3 digits) XXX-XX-X _____

Date of Birth _____

Medicare Part B Enrollment Date _____

Return the signed Medicare Part B Premium Reimbursement Affidavit along with a copy of your Medicare Health Insurance Enrollment Card to the Trust Office. Please retain a copy of the completed, signed form for your records.

California Teachers Association
Employees' Health & Welfare Benefits
2250 S Rancho Road, Suite 295 ♦ Las Vegas NV 89102-4454 ♦ (888) 243-2325

MEDICARE PART B REIMBURSEMENT
DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize California Teachers Association Employees' Health & Welfare Benefits to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account listed below, in the financial institution shown below. I further authorize the financial institution named to credit and/or debit such account. I understand that this authorization remains in effect until the Trust Fund receives from me, in writing, notification to terminate the authorization in such a time and manner as to afford the Trust Fund and my financial institution a reasonable time to act on it.

Participant Information

Participant Name (please print) _____ XXX-XX-X _____ Social Security Number

Mailing Address _____ Email _____

City _____ State _____ ZIP - Z+4 _____ Telephone Number _____

Account Information

Account Number: _____ ☐ Checking ☐ Savings

Transit / ABA (Routing) Number _____ Name of Financial Institution _____

Financial Institution's Street Address:

_____

Participant Authorization

I certify that the above information is correct:

x _____ _____
Signature of Participant Date