

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.

**THE CALIFORNIA TEACHERS ASSOCIATION
EMPLOYEES' HEALTH AND WELFARE BENEFITS TRUST**

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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.

The California Teachers Association
Employees' Health and Welfare Benefits Trust

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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.