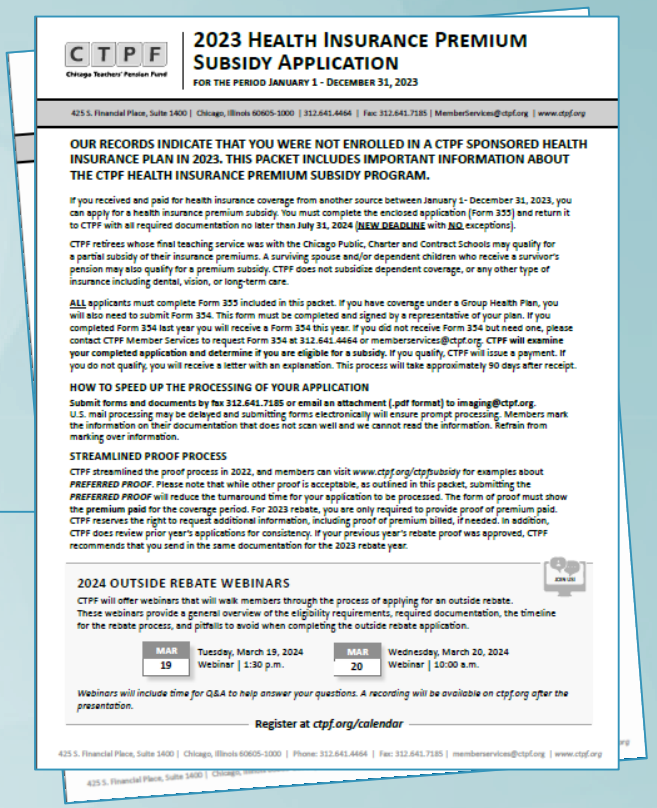
CTPF

Chicago Teachers' Pension Fund

Health Insurance Outside Rebate

Individual & Group Plans Webinar



CTPF Chicago Teachers' Pension Fund

2023 HEALTH INSURANCE PREMIUM SUBSIDY APPLICATION

FOR THE PERIOD JANUARY 1 - DECEMBER 31, 2023

425 S. Financial Place, Suite 1400 | Chicago, Illinois 60605-1000 | 312.641.4464 | Fax: 312.641.7185 | MemberServices@ctpf.org | www.ctpf.org

OUR RECORDS INDICATE THAT YOU WERE NOT ENROLLED IN A CTPF SPONSORED HEALTH INSURANCE PLAN IN 2023. THIS PACKET INCLUDES IMPORTANT INFORMATION ABOUT THE CTPF HEALTH INSURANCE PREMIUM SUBSIDY PROGRAM.

If you received and paid for health insurance coverage from another source between January 1- December 31, 2023, you can apply for a health insurance premium subsidy. You must complete the enclosed application (Form 355) and return it to CTPF with all required documentation no later than **July 31, 2024** (**NEW DEADLINE** with **NO** exceptions).

CTPF retirees whose final teaching service was with the Chicago Public, Charter and Contract Schools may qualify for a partial subsidy of their insurance premiums. A surviving spouse and/or dependent children who receive a survivor's pension may also qualify for a premium subsidy. CTPF does not subsidize dependent coverage, or any other type of insurance including dental, vision, or long-term care.

ALL applicants must complete Form 355 included in this packet. If you have coverage under a Group Health Plan, you will also need to submit Form 354. This form must be completed and signed by a representative of your plan. If you completed Form 354 last year you will receive a Form 354 this year. If you did not receive Form 354 but need one, please contact CTPF Member Services to request Form 354 at 312.641.4464 or memberservices@ctpf.org. **CTPF will examine your completed application and determine if you are eligible for a subsidy.** If you qualify, CTPF will issue a payment. If you do not qualify, you will receive a letter with an explanation. This process will take approximately 90 days after receipt.

HOW TO SPEED UP THE PROCESSING OF YOUR APPLICATION

Submit forms and documents by fax 312.641.7185 or email an attachment (.pdf format) to imaging@ctpf.org. U.S. mail processing may be delayed and submitting forms electronically will ensure prompt processing. Members mark the information on their documentation that does not scan well and we cannot read the information. Refrain from marking over information.

STREAMLINED PROOF PROCESS

CTPF streamlined the proof process in 2022, and members can visit *www.ctpf.org/ctpfsubsidy* for examples about ***PREFERRED PROOF***. Please note that while other proof is acceptable, as outlined in this packet, submitting the ***PREFERRED PROOF*** will reduce the turnaround time for your application to be processed. The form of proof must show the **premium paid** for the coverage period. For 2023 rebate, you are only required to provide proof of premium paid. CTPF reserves the right to request additional information, including proof of premium billed, if needed. In addition, CTPF does review prior year's applications for consistency. If your previous year's rebate proof was approved, CTPF recommends that you send in the same documentation for the 2023 rebate year.

2024 OUTSIDE REBATE WEBINARS

CTPF will offer webinars that will walk members through the process of applying for an outside rebate. These webinars provide a general overview of the eligibility requirements, required documentation, the timeline for the rebate process, and pitfalls to avoid when completing the outside rebate application.

MAR 19 — Tuesday, March 19, 2024 Webinar | 1:30 p.m.

MAR 20 — Wednesday, March 20, 2024 Webinar | 10:00 a.m.

Webinars will include time for Q&A to help answer your questions. A recording will be available on ctpf.org after the presentation.

Register at *ctpf.org/calendar*

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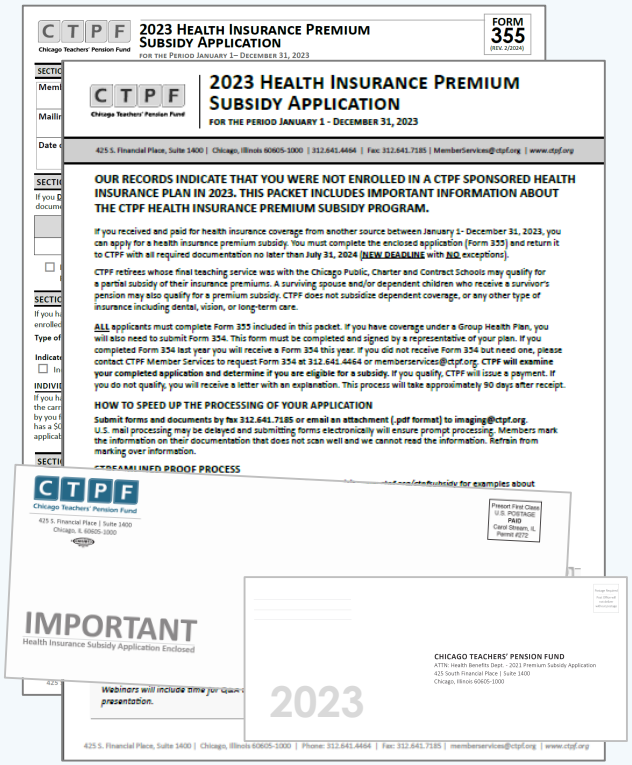
Medicare & Non-Medicare | 2023 Plan Year

Agenda

Review Health Insurance Outside Rebate:

- Overview of Eligibility Requirements
- Subsidy Application
- Required Documentation and Common Pitfalls
- Timeline
- Important Information to Consider
- Questions & Answers



Overview of Eligibility Requirements

Outside Rebate Subsidy: General Information

- CTPF retirees who are eligible for the CTPF health insurance plan but decide to enroll in an *outside* health insurance plan.
- Retirees *may* be eligible for a partial reimbursement of Medicare A*, B, D and health insurance.
- Reviewing the 2023 calendar year in this year's application.
  - Every Spring, CTPF mails applications to eligible members for the prior year. Rebates must be completed and returned to CTPF **no later** than **July 31, 2024**.

New application deadline this year!

* Pension Effective Date prior to July 1, 2016

Who is Eligible for the Outside Rebate Subsidy Program?

- **CTPF retirees** whose final teaching service was with the Chicago Public, Charter or Contract Schools *may* qualify for a partial subsidy of their insurance premiums.
- A surviving spouse/child receiving a **survivor's pension** *may* also qualify for a subsidy.
- Premium cost for dependent coverage is <u>not</u> eligible for the subsidy.

What is the Outside Rebate Subsidy Amount?

- The amount CTPF can spend on annuitant health insurance is limited by state law.
- Each year, the CTPF Board of Trustees determines the percentage of retiree health insurance premiums eligible for a subsidy. The subsidy for plan year 2023 was **60%** of the total premium cost (certain limitations may apply).
- The subsidy is subject to change at the discretion of the CTPF Board of Trustees.

What are the Outside Rebate Subsidy Limits?

CTPF limits the eligible amount to the **LOWEST** amount a member would pay if enrolled in a CTPF health insurance plan.

Type of Health Insurance in 2023	Maximum Monthly Premium Amount Considered	Maximum Monthly Reimbursement
Non-Medicare Health Insurance with Rx (under 65)	$1,017.80	$610.68
Medicare A ^	$506.00	$303.60
Medicare B *	$161.90	$97.14
Medicare D	$120.53	$72.32
Supplement to Medicare Plans (age 65 and older)	$66.60	$39.96

^ Part A premium subsidy is only available to members with a pension benefit effective date prior to July 1, 2016

* 2023 Part B premium of $164.90 includes $3 government surcharge that is not eligible for CTPF subsidy.

Type of Outside Rebates

Depending on your situation, member would generally fall into one of these categories:

CTPF

Non-Medicare Plan Outside Rebates

Member enrolled in an outside Non-Medicare (*pre-age 65*) health insurance plan:

- **Individual Health Plan:** Purchased directly from the carrier and the member pays 100% of the cost.
- **Group Health Plans:** Purchased through an employer or group and premiums are paid by the employer or group or are largely subsidized by the group.

Medicare Plan Outside Rebates

Member enrolled in an outside Medicare (*age 65+*) health insurance plan:

- **Individual Health Plan:** Purchased directly from the carrier and the member pays 100% of the cost.
- **Group Health Plans:** Purchased through an employer or group and premiums are paid by the employer or group or are largely subsidized by the group.

- Medicare Part A *(eligible if pension benefit effective date is prior to 7/1/2016)*
- Medicare Part B
- Medicare Part D

Example – Non-Medicare Individual Plan

- Outside Medical and Prescription Individual* Plan Monthly Premium Paid by Member = $1,500 (or $18,000 annually)

- Maximum Monthly **Premium** Capped = $1,017.80 (or $12,213.60 annually)

- Maximum Monthly **Reimbursement** Allowed = $610.68 (or $7,328.16 annually)

**For Group Plans, CTPF must determine how much of the monthly premium is subsidized by the Employer/Group.*

Example – Medicare Individual Plan

Medical Plan:

- Outside **Medical** Individual* Plan
  Monthly Premium Paid by Member = $200 (or $2,400 annually)
- Maximum **Medical** Monthly **Premium** Capped = $66.60 (or $799.20 annually)
- Maximum **Medical** Monthly **Reimbursement** Allowed = $39.96 (or $479.52 annually)

Prescription Plan:

- Outside **Prescription** Individual* Plan
  Monthly Premium Paid by Member = $150 (or $1,800 annually)
- Maximum **Prescription** Monthly **Premium** Capped = $120.53 (or $1,446.36 annually)
- Maximum **Prescription** Monthly **Reimbursement** Allowed = $72.32 (or $867.84 annually)

TOTAL MONTHLY REIMBURSEMENT = $39.96 + $72.32 = $112.28

**For Group Plans, CTPF must determine how much of the monthly premium is subsidized by the Employer/Group.*

Example – Medicare Part B Plan

Medicare Part B Monthly Premium Paid by Member (includes IRMAA) = $329.80 (or $3,957.60 annually)

Maximum Monthly **Premium*** Capped = $161.90 (or $1,942.80 annually)

Maximum Monthly **Reimbursement** Allowed = $97.14 (or $1,165.68 annually)

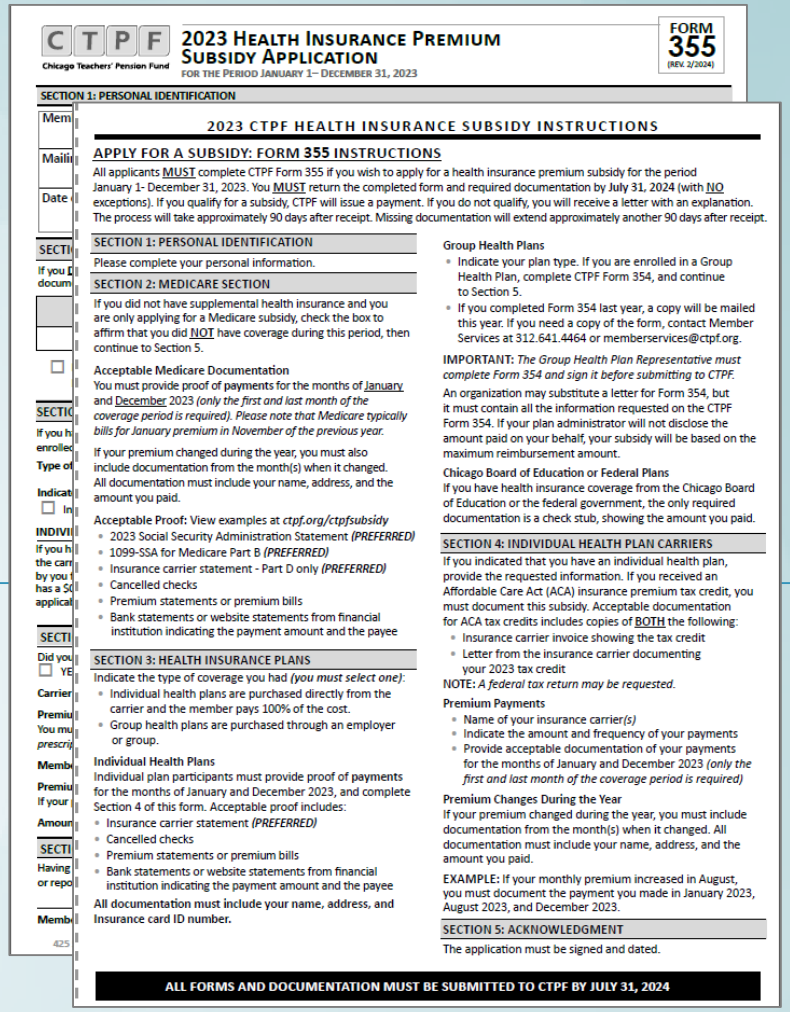
**For 2023 Part B premium, a $3 government surcharge is not eligible for CTPF subsidy.*

Costs Not Eligible for Subsidy

CTPF does ***not*** subsidize:

- Dental plans
- Vision plans
- Long term care plans
- Hospital indemnity plans
- Income Related Monthly Adjustment Amount (IRMAA)
- Late Enrollment Penalty (LEP)
- Service charges

Subsidy Application



CTPF
Chicago Teachers' Pension Fund

2023 Health Insurance Premium Subsidy Application
FOR THE PERIOD JANUARY 1– DECEMBER 31, 2023

FORM 355 (REV. 2/2024)

SECTION 1: PERSONAL IDENTIFICATION

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2023 CTPF HEALTH INSURANCE SUBSIDY INSTRUCTIONS

APPLY FOR A SUBSIDY: FORM 355 INSTRUCTIONS

All applicants MUST complete CTPF Form 355 if you wish to apply for a health insurance premium subsidy for the period January 1- December 31, 2023. You MUST return the completed form and required documentation by **July 31, 2024** (with NO exceptions). If you qualify for a subsidy, CTPF will issue a payment. If you do not qualify, you will receive a letter with an explanation. The process will take approximately 90 days after receipt. Missing documentation will extend approximately another 90 days after receipt.

SECTION 1: PERSONAL IDENTIFICATION

Please complete your personal information.

SECTION 2: MEDICARE SECTION

If you did not have supplemental health insurance and you are only applying for a Medicare subsidy, check the box to affirm that you did NOT have coverage during this period, then continue to Section 5.

Acceptable Medicare Documentation
You must provide proof of **payments** for the months of January and December 2023 *(only the first and last month of the coverage period is required). Please note that Medicare typically bills for January premium in November of the previous year.*

If your premium changed during the year, you must also include documentation from the month(s) when it changed. All documentation must include your name, address, and the amount you paid.

Acceptable Proof: View examples at *ctpf.org/ctpfsubsidy*

- 2023 Social Security Administration Statement *(PREFERRED)*
- 1099-SSA for Medicare Part B *(PREFERRED)*
- Insurance carrier statement - Part D only *(PREFERRED)*
- Cancelled checks
- Premium statements or premium bills
- Bank statements or website statements from financial institution indicating the payment amount and the payee

SECTION 3: HEALTH INSURANCE PLANS

Indicate the type of coverage you had *(you must select one)*:

- Individual health plans are purchased directly from the carrier and the member pays 100% of the cost.
- Group health plans are purchased through an employer or group.

Individual Health Plans
Individual plan participants must provide proof of **payments** for the months of January and December 2023, and complete Section 4 of this form. Acceptable proof includes:

- Insurance carrier statement *(PREFERRED)*
- Cancelled checks
- Premium statements or premium bills
- Bank statements or website statements from financial institution indicating the payment amount and the payee

All documentation must include your name, address, and Insurance card ID number.

Group Health Plans

- Indicate your plan type. If you are enrolled in a Group Health Plan, complete CTPF Form 354, and continue to Section 5.
- If you completed Form 354 last year, a copy will be mailed this year. If you need a copy of the form, contact Member Services at 312.641.4464 or memberservices@ctpf.org.

IMPORTANT: *The Group Health Plan Representative must complete Form 354 and sign it before submitting to CTPF.*

An organization may substitute a letter for Form 354, but it must contain all the information requested on the CTPF Form 354. If your plan administrator will not disclose the amount paid on your behalf, your subsidy will be based on the maximum reimbursement amount.

Chicago Board of Education or Federal Plans
If you have health insurance coverage from the Chicago Board of Education or the federal government, the only required documentation is a check stub, showing the amount you paid.

SECTION 4: INDIVIDUAL HEALTH PLAN CARRIERS

If you indicated that you have an individual health plan, provide the requested information. If you received an Affordable Care Act (ACA) insurance premium tax credit, you must document this subsidy. Acceptable documentation for ACA tax credits includes copies of BOTH the following:

- Insurance carrier invoice showing the tax credit
- Letter from the insurance carrier documenting your 2023 tax credit

NOTE: *A federal tax return may be requested.*

Premium Payments

- Name of your insurance carrier*(s)*
- Indicate the amount and frequency of your payments
- Provide acceptable documentation of your payments for the months of January and December 2023 *(only the first and last month of the coverage period is required)*

Premium Changes During the Year
If your premium changed during the year, you must include documentation from the month(s) when it changed. All documentation must include your name, address, and the amount you paid.

EXAMPLE: If your monthly premium increased in August, you must document the payment you made in January 2023, August 2023, and December 2023.

SECTION 5: ACKNOWLEDGMENT

The application must be signed and dated.

ALL FORMS AND DOCUMENTATION MUST BE SUBMITTED TO CTPF BY JULY 31, 2024

Outside Rebate Application(s)

Application(s) ***must*** be signed, dated, and ***all*** questions answered per section instructions.

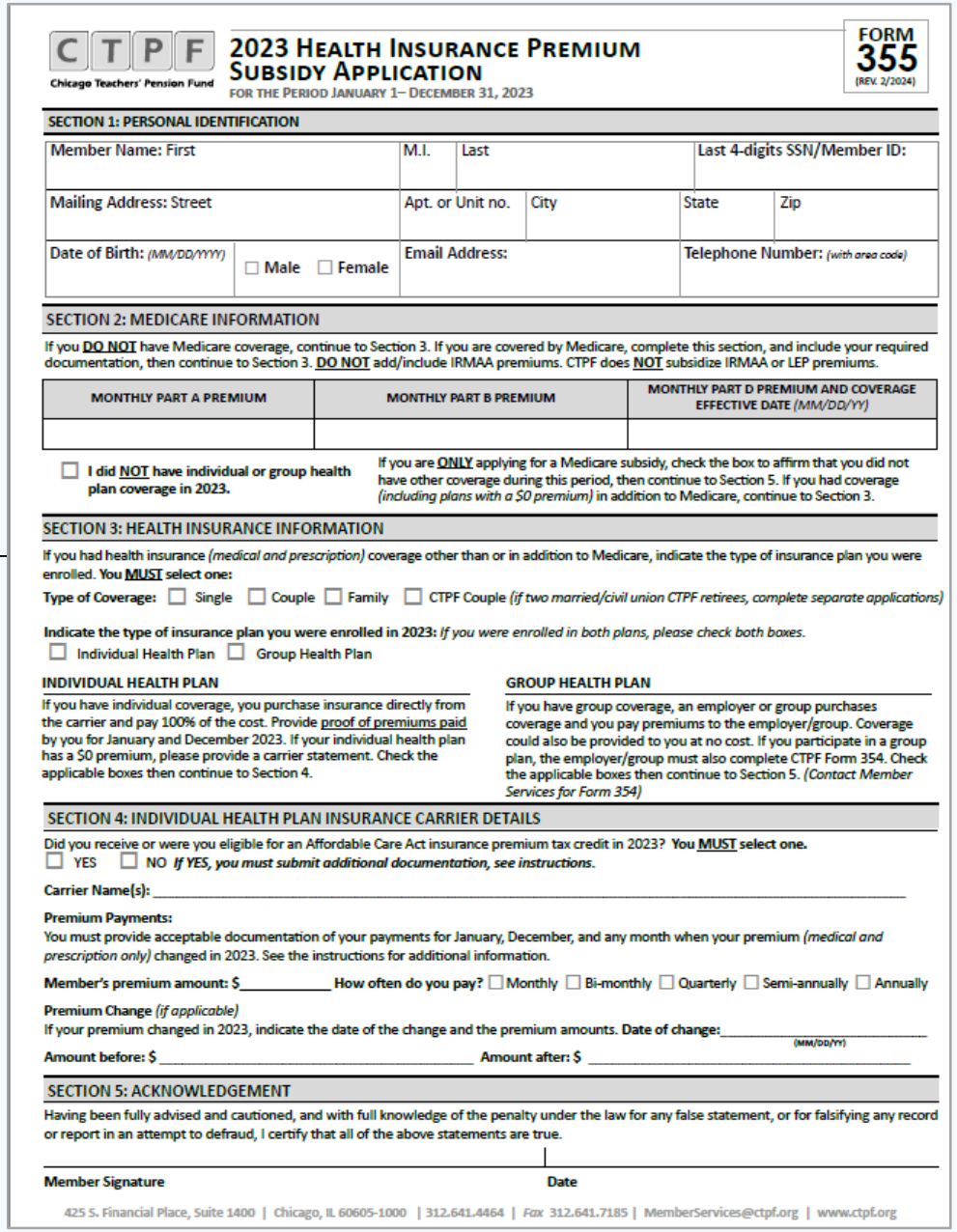
- Required Form For **ALL** Members:
  - **FORM 355: HEALTH INSURANCE PREMIUM SUBSIDY APPLICATION**

- Required Form For **GROUP** Insurance**:
  - **FORM 354: GROUP HEALTH INSURANCE PREMIUM VERIFICATION**

*** In addition to submitting Form 355, Group Form 354 must be completed and signed by your group insurance representative.*

Form 355

ALL MEMBERS MUST COMPLETE THIS FORM



CTPF
Chicago Teachers' Pension Fund

2023 Health Insurance Premium Subsidy Application

FOR THE PERIOD JANUARY 1– DECEMBER 31, 2023

FORM 355 (REV. 2/2024)

SECTION 1: PERSONAL IDENTIFICATION

Member Name: First	M.I.	Last	Last 4-digits SSN/Member ID:
Mailing Address: Street	Apt. or Unit no.	City	State / Zip
Date of Birth: (MM/DD/YYYY) ☐ Male ☐ Female	Email Address:		Telephone Number: (with area code)

SECTION 2: MEDICARE INFORMATION

If you DO NOT have Medicare coverage, continue to Section 3. If you are covered by Medicare, complete this section, and include your required documentation, then continue to Section 3. DO NOT add/include IRMAA premiums. CTPF does NOT subsidize IRMAA or LEP premiums.

MONTHLY PART A PREMIUM	MONTHLY PART B PREMIUM	MONTHLY PART D PREMIUM AND COVERAGE EFFECTIVE DATE (MM/DD/YY)

☐ I did NOT have individual or group health plan coverage in 2023.

If you are ONLY applying for a Medicare subsidy, check the box to affirm that you did not have other coverage during this period, then continue to Section 5. If you had coverage *(including plans with a $0 premium)* in addition to Medicare, continue to Section 3.

SECTION 3: HEALTH INSURANCE INFORMATION

If you had health insurance *(medical and prescription)* coverage other than or in addition to Medicare, indicate the type of insurance plan you were enrolled. You MUST select one:

Type of Coverage: ☐ Single ☐ Couple ☐ Family ☐ CTPF Couple *(if two married/civil union CTPF retirees, complete separate applications)*

Indicate the type of insurance plan you were enrolled in 2023: *If you were enrolled in both plans, please check both boxes.*

☐ Individual Health Plan ☐ Group Health Plan

INDIVIDUAL HEALTH PLAN

If you have individual coverage, you purchase insurance directly from the carrier and pay 100% of the cost. Provide proof of premiums paid by you for January and December 2023. If your individual health plan has a $0 premium, please provide a carrier statement. Check the applicable boxes then continue to Section 4.

GROUP HEALTH PLAN

If you have group coverage, an employer or group purchases coverage and you pay premiums to the employer/group. Coverage could also be provided to you at no cost. If you participate in a group plan, the employer/group must also complete CTPF Form 354. Check the applicable boxes then continue to Section 5. *(Contact Member Services for Form 354)*

SECTION 4: INDIVIDUAL HEALTH PLAN INSURANCE CARRIER DETAILS

Did you receive or were you eligible for an Affordable Care Act insurance premium tax credit in 2023? You MUST select one.

☐ YES ☐ NO *If YES, you must submit additional documentation, see instructions.*

Carrier Name(s): _____

Premium Payments:

You must provide acceptable documentation of your payments for January, December, and any month when your premium *(medical and prescription only)* changed in 2023. See the instructions for additional information.

Member's premium amount: $_____ **How often do you pay?** ☐ Monthly ☐ Bi-monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium Change *(if applicable)*

If your premium changed in 2023, indicate the date of the change and the premium amounts. **Date of change:**_____ (MM/DD/YY)

Amount before: $ _____ **Amount after: $** _____

SECTION 5: ACKNOWLEDGEMENT

Having been fully advised and cautioned, and with full knowledge of the penalty under the law for any false statement, or for falsifying any record or report in an attempt to defraud, I certify that all of the above statements are true.

Member Signature **Date**

425 S. Financial Place, Suite 1400 | Chicago, IL 60605-1000 | 312.641.4464 | Fax 312.641.7185 | MemberServices@ctpf.org | www.ctpf.org

Form 355 – Section 1

Complete ***all*** of the required information in this section.

CTPF
Chicago Teachers' Pension Fund

2023 HEALTH INSURANCE PREMIUM SUBSIDY APPLICATION
FOR THE PERIOD JANUARY 1– DECEMBER 31, 2023

FORM 355 (REV. 2/2024)

SECTION 1: PERSONAL IDENTIFICATION

Member Name: First		M.I.	Last		**Last 4-digits SSN/Member ID:**
Mailing Address: Street		Apt. or Unit no.	City	State	Zip
Date of Birth: *(MM/DD/YYYY)*	☐ **Male** ☐ **Female**	**Email Address:**		**Telephone Number:** *(with area code)*	

CTPF

Form 355 – Section 2

- If Medicare eligible, provide the amounts you **paid** for Medicare Parts A, B and D (include an effective date).
- If you did **not** have any health insurance in 2023, it is **critical** that you check the box below.

SECTION 2: MEDICARE INFORMATION

If you **DO NOT** have Medicare coverage, continue to Section 3. If you are covered by Medicare, complete this section, and include your required documentation, then continue to Section 3. **DO NOT** add/include IRMAA premiums. CTPF does **NOT** subsidize IRMAA or LEP premiums.

MONTHLY PART A PREMIUM	MONTHLY PART B PREMIUM	MONTHLY PART D PREMIUM AND COVERAGE EFFECTIVE DATE *(MM/DD/YY)*

☐ **I did NOT have individual or group health plan coverage in 2023.**

If you are **ONLY** applying for a Medicare subsidy, check the box to affirm that you did not have other coverage during this period, then continue to Section 5. If you had coverage *(including plans with a $0 premium)* in addition to Medicare, continue to Section 3.

Form 355 – Section 3

Any member with health insurance must complete this section:

- Check which type of coverage you had in 2023.
- Check which type of insurance (individual or group).
- If you spent a portion of the year in both types of plans, please check both boxes.

SECTION 3: HEALTH INSURANCE INFORMATION

If you had health insurance *(medical and prescription)* coverage other than or in addition to Medicare, indicate the type of insurance plan you were enrolled. **You MUST select one:**

Type of Coverage: ☐ Single ☐ Couple ☐ Family ☐ CTPF Couple *(if two married/civil union CTPF retirees, complete separate applications)*

Indicate the type of insurance plan you were enrolled in 2023: *If you were enrolled in both plans, please check both boxes.*

☐ Individual Health Plan ☐ Group Health Plan

INDIVIDUAL HEALTH PLAN

If you have individual coverage, you purchase insurance directly from the carrier and pay 100% of the cost. Provide proof of premiums paid by you for January and December 2023. If your individual health plan has a $0 premium, please provide a carrier statement. Check the applicable boxes then continue to Section 4.

GROUP HEALTH PLAN

If you have group coverage, an employer or group purchases coverage and you pay premiums to the employer/group. Coverage could also be provided to you at no cost. If you participate in a group plan, the employer/group must also complete CTPF Form 354. Check the applicable boxes then continue to Section 5. *(Contact Member Services for Form 354)*

Form 355 – Section 4

- If Section 3 was completed, Section 4 ***must*** be as well.
- Were you enrolled in the Affordable Care Act (ACA) and did you receive a monthly tax credit?
- What was the health insurance premium amount and how often did you pay? Did your premium change in 2023?

SECTION 4: INDIVIDUAL HEALTH PLAN INSURANCE CARRIER DETAILS

Did you receive or were you eligible for an Affordable Care Act insurance premium tax credit in 2023? **You MUST select one.**

☐ YES ☐ NO ***If YES, you must submit additional documentation, see instructions.***

Carrier Name(s): _____

Premium Payments:

You must provide acceptable documentation of your payments for January, December, and any month when your premium *(medical and prescription only)* changed in 2023. See the instructions for additional information.

Member's premium amount: $_____ **How often do you pay?** ☐ Monthly ☐ Bi-monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium Change *(if applicable)*

If your premium changed in 2023, indicate the date of the change and the premium amounts. **Date of change:**_____ (MM/DD/YY)

Amount before: $ _____ **Amount after: $** _____

Form 355 – Section 5

- Section 5 ***must*** be signed and dated.
- The application will be rejected if not completed.

SECTION 5: ACKNOWLEDGEMENT

Having been fully advised and cautioned, and with full knowledge of the penalty under the law for any false statement, or for falsifying any record or report in an attempt to defraud, I certify that all of the above statements are true.

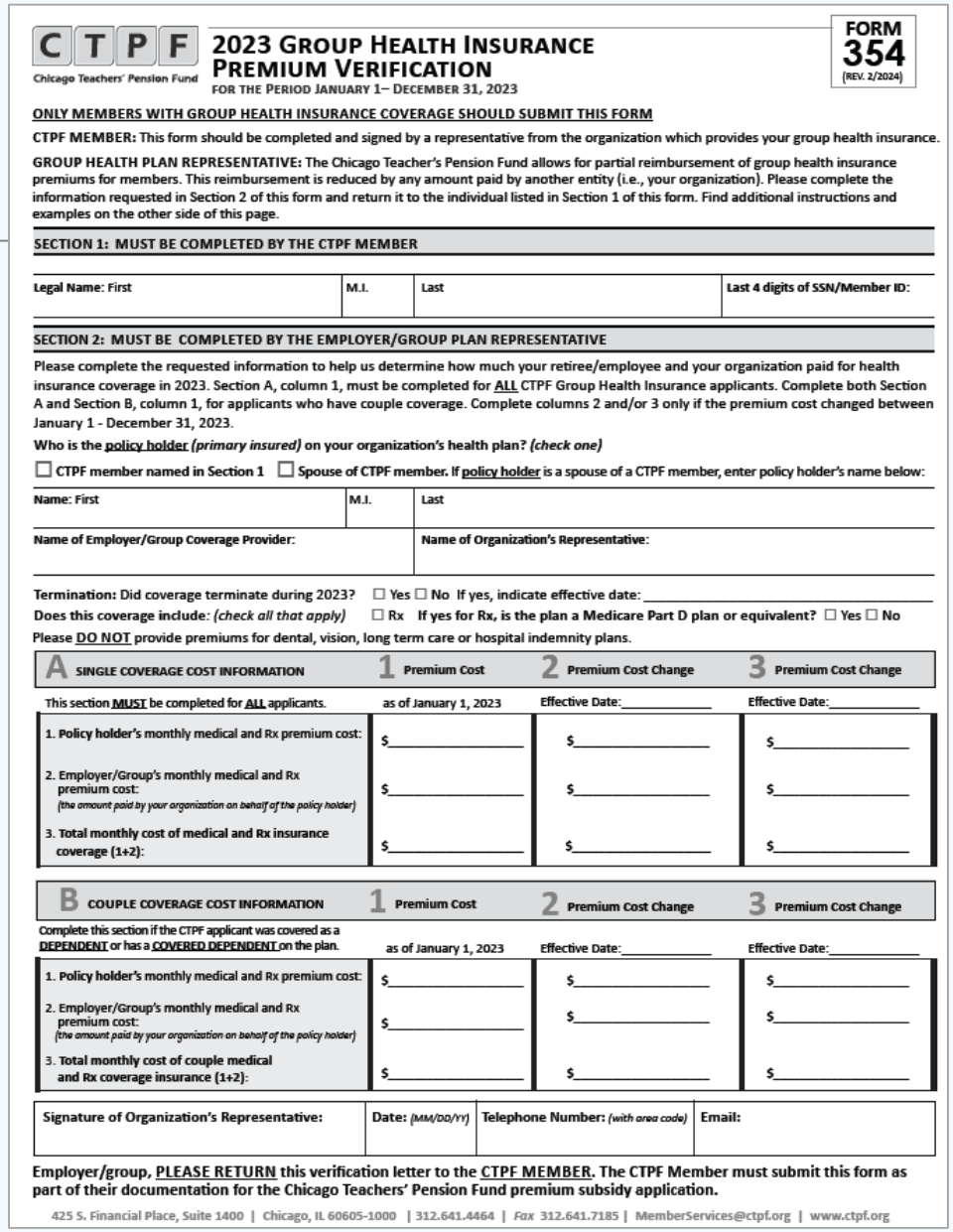
Member Signature **Date**

425 S. Financial Place, Suite 1400 | Chicago, IL 60605-1000 | 312.641.4464 | *Fax* 312.641.7185 | MemberServices@ctpf.org | www.ctpf.org

Form 354

MEMBERS WITH GROUP INSURANCE MUST COMPLETE THIS FORM

CRITICAL: PROVIDE THE INSTRUCTIONS WITH THE APPLICATION TO THE GROUP INSURANCE AGENT



CTPF Chicago Teachers' Pension Fund

2023 Group Health Insurance Premium Verification

FOR THE PERIOD JANUARY 1– DECEMBER 31, 2023

FORM 354 (REV. 2/2024)

ONLY MEMBERS WITH GROUP HEALTH INSURANCE COVERAGE SHOULD SUBMIT THIS FORM

CTPF MEMBER: This form should be completed and signed by a representative from the organization which provides your group health insurance.

GROUP HEALTH PLAN REPRESENTATIVE: The Chicago Teacher's Pension Fund allows for partial reimbursement of group health insurance premiums for members. This reimbursement is reduced by any amount paid by another entity (i.e., your organization). Please complete the information requested in Section 2 of this form and return it to the individual listed in Section 1 of this form. Find additional instructions and examples on the other side of this page.

SECTION 1: MUST BE COMPLETED BY THE CTPF MEMBER

Legal Name: First	M.I.	Last	Last 4 digits of SSN/Member ID:

SECTION 2: MUST BE COMPLETED BY THE EMPLOYER/GROUP PLAN REPRESENTATIVE

Please complete the requested information to help us determine how much your retiree/employee and your organization paid for health insurance coverage in 2023. Section A, column 1, must be completed for ALL CTPF Group Health Insurance applicants. Complete both Section A and Section B, column 1, for applicants who have couple coverage. Complete columns 2 and/or 3 only if the premium cost changed between January 1 - December 31, 2023.

Who is the policy holder *(primary insured)* on your organization's health plan? *(check one)*

☐ CTPF member named in Section 1 ☐ Spouse of CTPF member. If policy holder is a spouse of a CTPF member, enter policy holder's name below:

Name: First	M.I.	Last

Name of Employer/Group Coverage Provider:	Name of Organization's Representative:

Termination: Did coverage terminate during 2023? ☐ Yes ☐ No If yes, indicate effective date: _____

Does this coverage include: *(check all that apply)* ☐ Rx If yes for Rx, is the plan a Medicare Part D plan or equivalent? ☐ Yes ☐ No

Please DO NOT provide premiums for dental, vision, long term care or hospital indemnity plans.

A SINGLE COVERAGE COST INFORMATION	1 Premium Cost	2 Premium Cost Change	3 Premium Cost Change
This section MUST be completed for ALL applicants.	as of January 1, 2023	Effective Date: _____	Effective Date: _____
1. Policy holder's monthly medical and Rx premium cost:	$_____	$_____	$_____
2. Employer/Group's monthly medical and Rx premium cost: *(the amount paid by your organization on behalf of the policy holder)*	$_____	$_____	$_____
3. Total monthly cost of medical and Rx insurance coverage (1+2):	$_____	$_____	$_____

B COUPLE COVERAGE COST INFORMATION	1 Premium Cost	2 Premium Cost Change	3 Premium Cost Change
Complete this section if the CTPF applicant was covered as a DEPENDENT or has a COVERED DEPENDENT on the plan.	as of January 1, 2023	Effective Date: _____	Effective Date: _____
1. Policy holder's monthly medical and Rx premium cost:	$_____	$_____	$_____
2. Employer/Group's monthly medical and Rx premium cost: *(the amount paid by your organization on behalf of the policy holder)*	$_____	$_____	$_____
3. Total monthly cost of couple medical and Rx coverage insurance (1+2):	$_____	$_____	$_____

Signature of Organization's Representative:	Date: *(MM/DD/YY)*	Telephone Number: *(with area code)*	Email:

Employer/group, PLEASE RETURN this verification letter to the CTPF MEMBER. The CTPF Member must submit this form as part of their documentation for the Chicago Teachers' Pension Fund premium subsidy application.

425 S. Financial Place, Suite 1400 | Chicago, IL 60605-1000 | 312.641.4464 | Fax 312.641.7185 | MemberServices@ctpf.org | www.ctpf.org

CTPF

Form 354 – Section 1

- Member needs to complete ***all*** of the required information in this section.
- Please provide your group administrator both Form 354 and the 354 instructions.

CTPF
Chicago Teachers' Pension Fund

2023 Group Health Insurance Premium Verification

FOR THE PERIOD JANUARY 1– DECEMBER 31, 2023

FORM 354 (REV. 2/2024)

ONLY MEMBERS WITH GROUP HEALTH INSURANCE COVERAGE SHOULD SUBMIT THIS FORM

CTPF MEMBER: This form should be completed and signed by a representative from the organization which provides your group health insurance.

GROUP HEALTH PLAN REPRESENTATIVE: The Chicago Teacher's Pension Fund allows for partial reimbursement of group health insurance premiums for members. This reimbursement is reduced by any amount paid by another entity (i.e., your organization). Please complete the information requested in Section 2 of this form and return it to the individual listed in Section 1 of this form. Find additional instructions and examples on the other side of this page.

SECTION 1: MUST BE COMPLETED BY THE CTPF MEMBER

Legal Name: First	M.I.	Last	**Last 4 digits of SSN/Member ID:**

Form 354 – Section 2

- Completed by the Employer/Group Plan Representative, **not** the member.
- Provide the instructions with the application.

SECTION 2: MUST BE COMPLETED BY THE EMPLOYER/GROUP PLAN REPRESENTATIVE

Please complete the requested information to help us determine how much your retiree/employee and your organization paid for health insurance coverage in 2023. Section A, column 1, must be completed for **ALL** CTPF Group Health Insurance applicants. Complete both Section A and Section B, column 1, for applicants who have couple coverage. Complete columns 2 and/or 3 only if the premium cost changed between January 1 - December 31, 2023.

Who is the policy holder *(primary insured)* on your organization's health plan? *(check one)*

☐ **CTPF member named in Section 1** ☐ **Spouse of CTPF member.** If **policy holder** is a spouse of a CTPF member, enter policy holder's name below:

Name: First	M.I.	Last
Name of Employer/Group Coverage Provider:		**Name of Organization's Representative:**

Termination: Did coverage terminate during 2023? ☐ Yes ☐ No If yes, indicate effective date: _____

Does this coverage include*: (check all that apply)* ☐ Rx **If yes for Rx, is the plan a Medicare Part D plan or equivalent?** ☐ Yes ☐ No

Please **DO NOT** provide premiums for dental, vision, long term care or hospital indemnity plans.

Form 354 – Section 2A

- Completed by the Employer/Group Plan Representative, **not** the member.
- This is ***only*** for medical and prescription coverage.
- All group plan members ***must*** have this section completed.

A SINGLE COVERAGE COST INFORMATION	1 Premium Cost	2 Premium Cost Change	3 Premium Cost Change
This section **MUST** be completed for **ALL** applicants.	as of January 1, 2023	Effective Date:_____	Effective Date:_____
1. **Policy holder's** monthly medical and Rx premium cost:	$_____	$_____	$_____
2. Employer/Group's monthly medical and Rx premium cost: *(the amount paid by your organization on behalf of the policy holder)*	$_____	$_____	$_____
3. **Total monthly cost of medical and Rx insurance coverage (1+2)**:	$_____	$_____	$_____

Form 354 – Section 2B

- Completed by the Employer/Group Plan Representative, **not** the member.
- This is ***only*** for medical and prescription coverage.
- If CTPF member is a dependent, this section ***must*** be completed.

B COUPLE COVERAGE COST INFORMATION	1 Premium Cost	2 Premium Cost Change	3 Premium Cost Change
Complete this section if the CTPF applicant was covered as a **DEPENDENT** or has a **COVERED DEPENDENT** on the plan.	as of January 1, 2023	Effective Date:_____	Effective Date:_____
1. **Policy holder's** monthly medical and Rx premium cost:	$_____	$_____	$_____
2. Employer/Group's monthly medical and Rx premium cost: *(the amount paid by your organization on behalf of the policy holder)*	$_____	$_____	$_____
3. **Total monthly cost of couple medical and Rx coverage insurance (1+2)**:	$_____	$_____	$_____

Form 354 – Section 2

- The last part ***must*** be signed and dated **by** the Employer /Group Plan Representative.
- The application will be rejected if not completed correctly.
- This form should be returned to the member and submitted **with** the Form 355 and all other required evidence.

Signature of Organization's Representative:	Date: *(MM/DD/YY)*	Telephone Number: *(with area code)*	Email:

Employer/group, PLEASE RETURN this verification letter to the CTPF MEMBER. The CTPF Member must submit this form as part of their documentation for the Chicago Teachers' Pension Fund premium subsidy application.

425 S. Financial Place, Suite 1400 | Chicago, IL 60605-1000 | 312.641.4464 | *Fax* 312.641.7185 | MemberServices@ctpf.org | www.ctpf.org

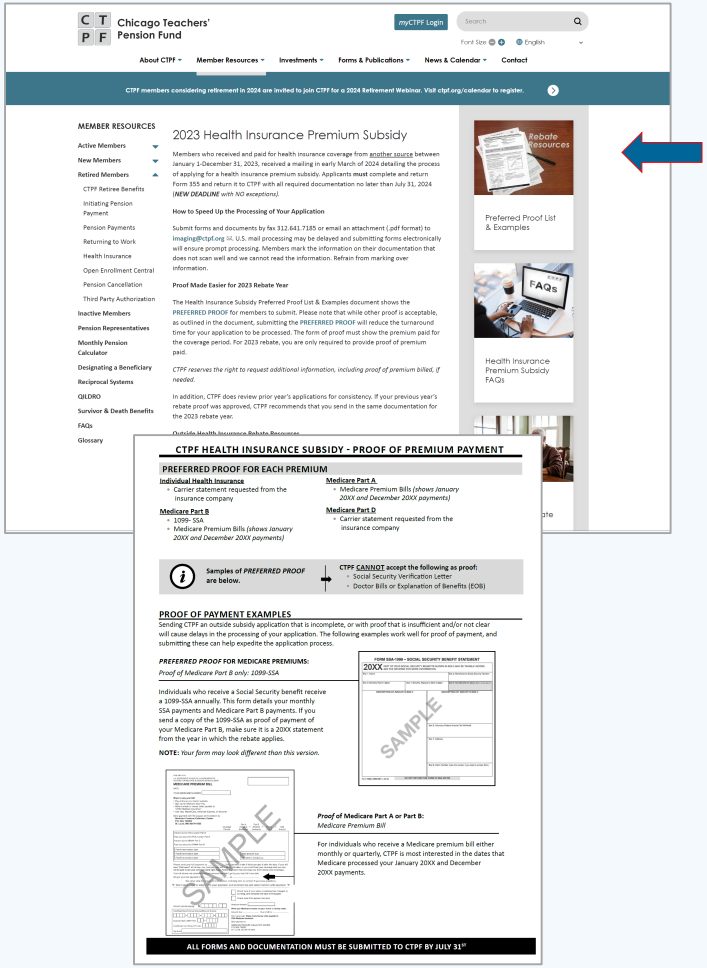
Required Documentation and Common Pitfalls

Where To Find Examples

- This year, we reduced the number of pages sent to our members. You can find the information at your fingertips! Go to:

www.ctpf.org/ctpfsubsidy

- If you do not have access to the internet, call Member Services at 312-641-4464 to request copies of the examples and frequently asked questions.



Proof Required to Process Outside Rebate

Preferred Proof for each Premium:

Individual Health Insurance:

- Carrier statement requested from the insurance company

Medicare Part A:

- Social Security statement requested from SSA or
- Social Security benefit letter (available online) or
- Medicare premium bills (shows January 2023 and December 2023 payments)

Medicare Part B:

- 1099-SSA or
- Social Security statement requested from SSA or
- Social Security benefit letter (available online) or
- Medicare premium bills (shows January 2023 and December 2023 payments)

Medicare Part D:

- Carrier statement requested from the insurance company or
- Social Security benefit letter (available online)

Proof Required to Process Outside Rebate

Continued Easier Process for 2023:

When providing proof, it is critical that member supplies proof of **premium paid**.

Consider it in this manner:

1. Proof of the **period** member is **paying for** health insurance (Ex: **January 2023** coverage).
2. Proof of **payment** for the period being charged for (Ex: Proof that member **paid** $200 for **January 2023** coverage).
3. Proof that the coverage period and premiums are for **MEMBER only** (Sometimes members and their spouse are billed on the same invoice).

Examples of Proof for Outside Rebates

Preferred Proof for Each Premium:

Individual Health Insurance:

Carrier statement requested from the insurance company

Upon request, most insurance carriers will send a printed statement detailing **payments made for the coverage period** requested. Each carrier will present this information differently on their statement, but there is some essential information that **MUST** be included in order for CTPF to accept:

- Member's name
- Member's ID
- Coverage period
- Premium paid for that coverage period
- Insurance company name or logo

Examples of Proof for Outside Rebates

Preferred Proof for Each Premium:

Individual Health Insurance – Blue Cross Blue Shield:

Acceptable Proof

BlueCross BlueShield of Illinois
Experience, Wellness, Everywhere. SM
P.O. Box 3004 Naperville, IL 60566

Member Name	Member ID	Invoice Date / Payment Received Date	Transaction Type	Check # / Payment Mode	Coverage Paid From	Coverage Paid Through	Debit Amt	Credit Amt	Balance
Ms. Jane Doe Sims	84656742	2/12/20XX	Transfer	Bank Draft	2/1/20XX	2/28/20XX	$220.00	$0.00	$207.00
Ms. Jane Doe Sims	84656742	3/15/20XX	Payment		3/1/20XX	3/31/20XX	$220.00	$0.00	$220.00
Ms. Jane Doe Sims	84656742	4/2/20XX	Transfer	Bank D[illegible]	[illegible]/20XX	4/30/20XX	$0.00	$220.00	$0.00
Ms. Jane Doe Sims	84656742	5/12/20XX	Payment	Ch[illegible] 10[illegible]	4/1/20XX	4/30/20XX	$0.00	$220.00	$0.00
Ms. Jane Doe Sims	84656742	5/23/20XX	Invoice		5/1/20XX	5/31/20XX	$220.00		$0.00
Ms. Jane Doe Sims	84656742	5/25/20XX	Transfer	[illegible]	5/1/20XX	5/31/20XX	$0.00		$0.00
Ms. Jane Doe Sims	84656742	6/12/20XX	Transfer	[illegible]	6/1/20XX	6/30/20XX	$0.00		$0.00
Ms. Jane Doe Sims	84656742	7/3/20XX	Invoice		6/1/20XX	6/30/20XX	$220.00		$220.00
Ms. Jane Doe Sims	84656742	7/20/20XX	[illegible]		7/1/20XX	7/31/20XX	$220.00		$220.00
Ms. Jane Doe Sims	84656742	8/29/20XX	[illegible]	Check 100732	8/1/20XX	8/31/20XX	$0.00		$0.00
Ms. Jane Doe Sims	84656742	9/12/20XX	[illegible]	Bank Draft	9/1/20XX	9/30/20XX	$220.00	$220.00	$0.00
Ms. Jane Doe Sims	84656742	9/20/20XX	Invoice		9/1/20XX	9/30/20XX	$220.00		$220.00
Ms. Jane Doe Sims	84656742	10/2/20XX	Invoice		10/1/20XX	10/31/20XX	$220.00		$220.00
Ms. Jane Doe Sims	84656742	11/12/20XX	Payment	Bank Draft	11/1/20XX	11/30/20XX	$0.00	$220.00	$0.00
Ms. Jane Doe Sims	84656742	11/23/20XX	Invoice		11/1/20XX	11/30/20XX	$220.00		$0.00
Ms. Jane Doe Sims	84656742	12/4/20XX	Payment	Bank Draft	12/1/20XX	12/31/20XX	$0.00	$220.00	$0.00

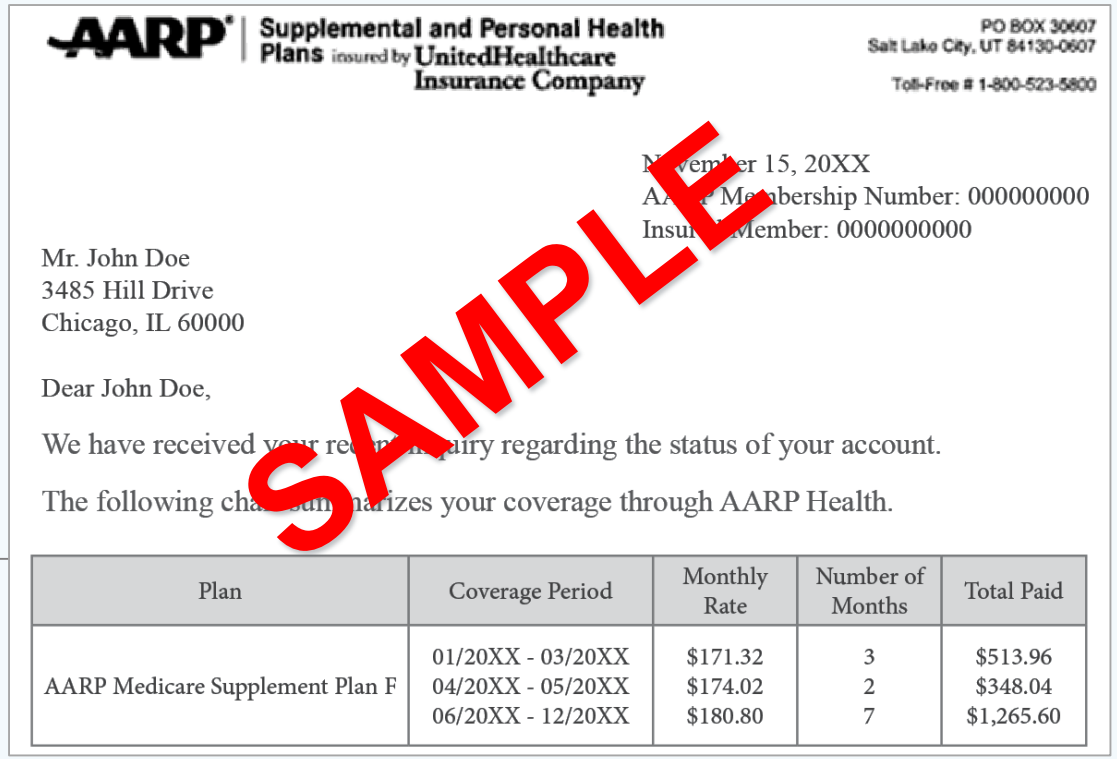
SAMPLE

CTPF

Examples of Proof for Outside Rebates

Preferred Proof for Each Premium:

- **Individual Health Insurance- AARP UHC: Acceptable Proof**



AARP | Supplemental and Personal Health Plans insured by UnitedHealthcare Insurance Company

PO BOX 30607
Salt Lake City, UT 84130-0607

Toll-Free # 1-800-523-5800

November 15, 20XX
AARP Membership Number: 000000000
Insured Member: 0000000000

Mr. John Doe
3485 Hill Drive
Chicago, IL 60000

Dear John Doe,

We have received your recent inquiry regarding the status of your account.

The following chart summarizes your coverage through AARP Health.

SAMPLE

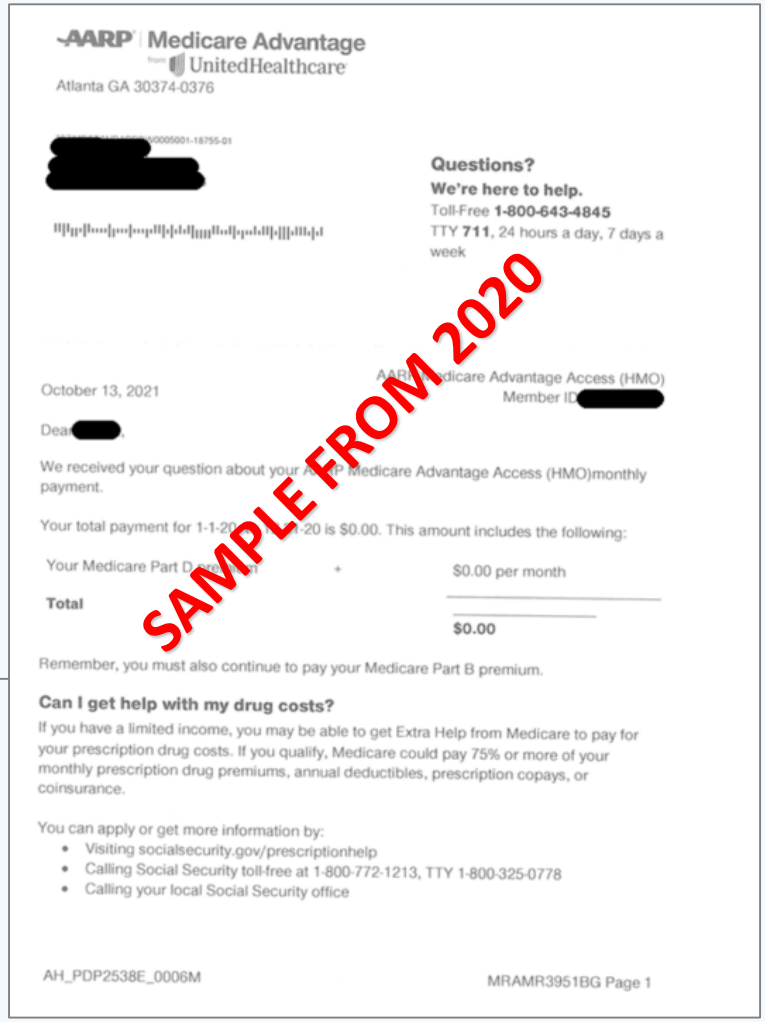
Plan	Coverage Period	Monthly Rate	Number of Months	Total Paid
AARP Medicare Supplement Plan F	01/20XX - 03/20XX 04/20XX - 05/20XX 06/20XX - 12/20XX	$171.32 $174.02 $180.80	3 2 7	$513.96 $348.04 $1,265.60

Examples of Proof for Outside Rebates

Preferred Proof for Each Premium:

Individual Health Insurance – AARP UHC:

- $0 Premium **acceptable proof**



AARP Medicare Advantage
from UnitedHealthcare
Atlanta GA 30374-0376

[redacted]

Questions?
We're here to help.
Toll-Free 1-800-643-4845
TTY 711, 24 hours a day, 7 days a week

SAMPLE FROM 2020

October 13, 2021

AARP Medicare Advantage Access (HMO)
Member ID [redacted]

Dear [redacted],

We received your question about your AARP Medicare Advantage Access (HMO)monthly payment.

Your total payment for 1-1-20[redacted]1-20 is $0.00. This amount includes the following:

Your Medicare Part D [redacted]	+	$0.00 per month
Total		**$0.00**

Remember, you must also continue to pay your Medicare Part B premium.

Can I get help with my drug costs?

If you have a limited income, you may be able to get Extra Help from Medicare to pay for your prescription drug costs. If you qualify, Medicare could pay 75% or more of your monthly prescription drug premiums, annual deductibles, prescription copays, or coinsurance.

You can apply or get more information by:

- Visiting socialsecurity.gov/prescriptionhelp
- Calling Social Security toll-free at 1-800-772-1213, TTY 1-800-325-0778
- Calling your local Social Security office

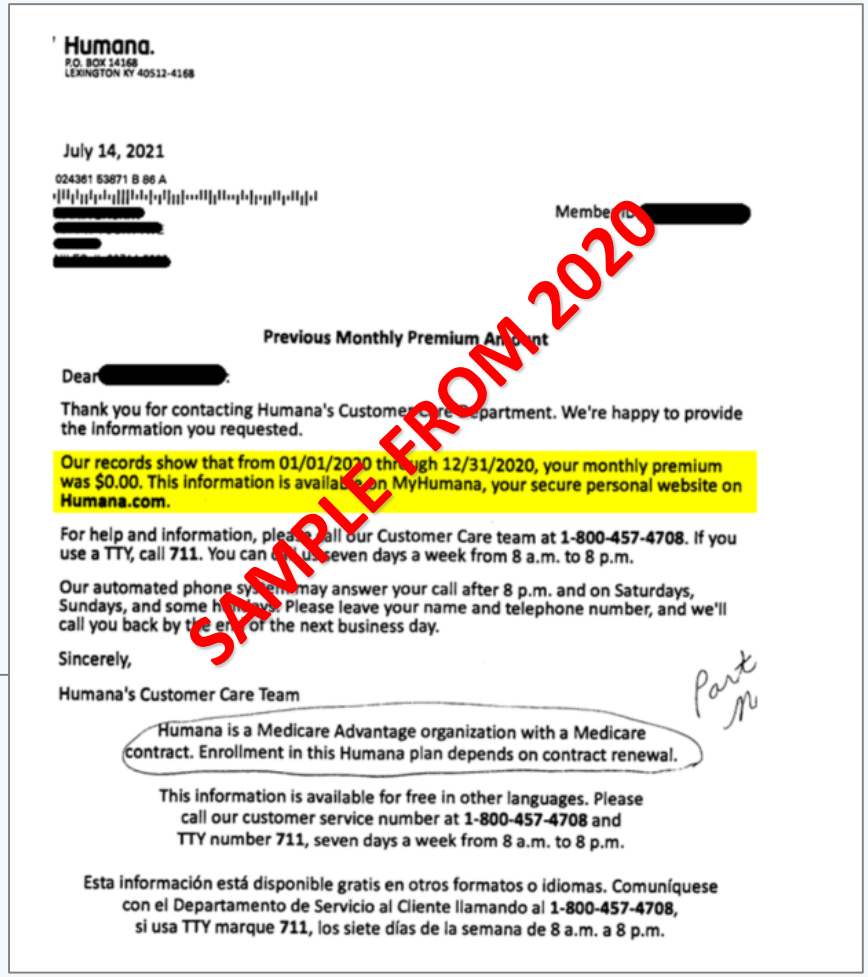
AH_PDP2538E_0006M MRAMR3951BG Page 1

CTPF

Examples of Proof for Outside Rebates

Preferred Proof for Each Premium:

- **Individual Health Insurance - Humana: $0 Premium acceptable proof**



Humana.
P.O. BOX 14168
LEXINGTON KY 40512-4168

July 14, 2021

024361 53871 B 86 A

[redacted]

Member ID [redacted]

Previous Monthly Premium Amount

Dear [redacted]:

Thank you for contacting Humana's Customer Care Department. We're happy to provide the information you requested.

Our records show that from 01/01/2020 through 12/31/2020, your monthly premium was $0.00. This information is available on MyHumana, your secure personal website on Humana.com.

For help and information, please call our Customer Care team at 1-800-457-4708. If you use a TTY, call 711. You can call us seven days a week from 8 a.m. to 8 p.m.

Our automated phone system may answer your call after 8 p.m. and on Saturdays, Sundays, and some holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

Sincerely,

Humana's Customer Care Team

Part M

Humana is a Medicare Advantage organization with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

This information is available for free in other languages. Please call our customer service number at 1-800-457-4708 and TTY number 711, seven days a week from 8 a.m. to 8 p.m.

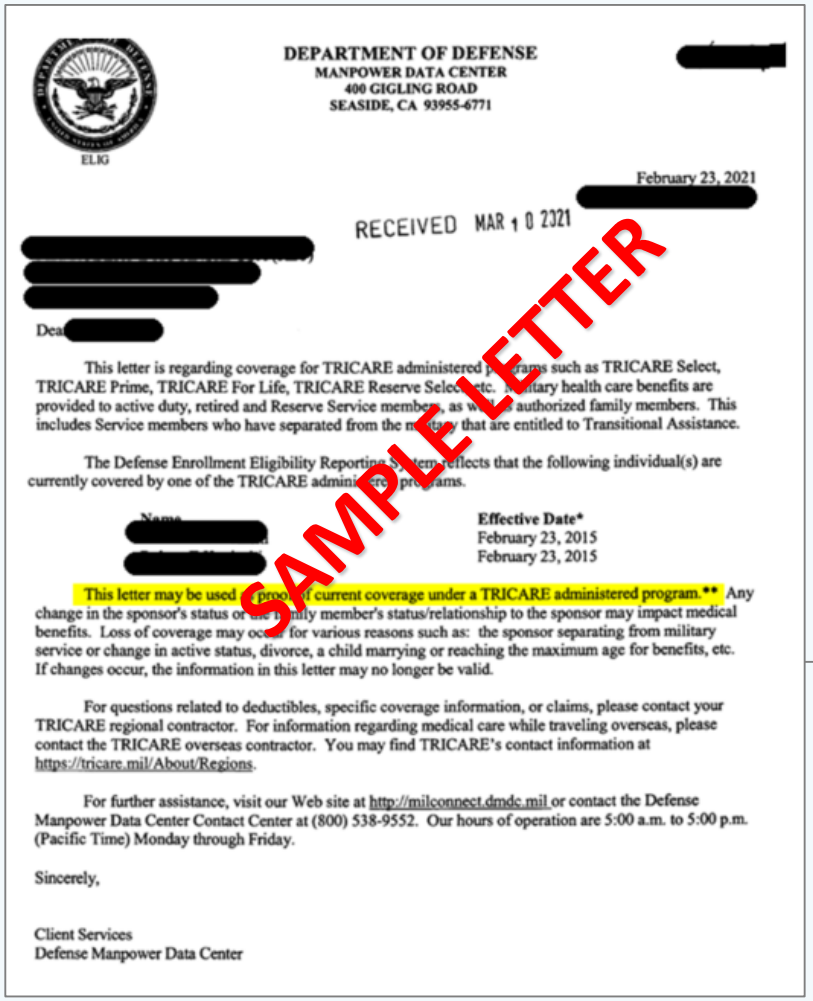
Esta información está disponible gratis en otros formatos o idiomas. Comuníquese con el Departamento de Servicio al Cliente llamando al 1-800-457-4708, si usa TTY marque 711, los siete días de la semana de 8 a.m. a 8 p.m.

SAMPLE FROM 2020

Common Pitfalls CTPF Observes

- **Wellcare statements** provide annual premiums. CTPF will still need a monthly breakdown from the carrier. Please call Wellcare for this detail.
- **Marketplace** with ACA tax credits must provide proof from the insurance carrier. The 1095 is not acceptable. *Need monthly breakdown and statement from carrier showing tax credit applied.*
- For **Tricare**, proof of enrollment must be provided. Please submit proof of 1095 or letter from VA agency or Department of Defense. If applicable, provide proof of supplemental health insurance.

Examples of Proof for Outside Rebates



DEPARTMENT OF DEFENSE
MANPOWER DATA CENTER
400 GIGLING ROAD
SEASIDE, CA 93955-6771

[redacted]

ELIG

February 23, 2021

[redacted]

RECEIVED MAR 1 0 2021

[redacted]

Dear [redacted]

SAMPLE LETTER

This letter is regarding coverage for TRICARE administered programs such as TRICARE Select, TRICARE Prime, TRICARE For Life, TRICARE Reserve Select, etc. Military health care benefits are provided to active duty, retired and Reserve Service members, as well as authorized family members. This includes Service members who have separated from the military that are entitled to Transitional Assistance.

The Defense Enrollment Eligibility Reporting System reflects that the following individual(s) are currently covered by one of the TRICARE administered programs.

Name	Effective Date*
[redacted]	February 23, 2015
[redacted]	February 23, 2015

This letter may be used as proof of current coverage under a TRICARE administered program.** Any change in the sponsor's status or the family member's status/relationship to the sponsor may impact medical benefits. Loss of coverage may occur for various reasons such as: the sponsor separating from military service or change in active status, divorce, a child marrying or reaching the maximum age for benefits, etc. If changes occur, the information in this letter may no longer be valid.

For questions related to deductibles, specific coverage information, or claims, please contact your TRICARE regional contractor. For information regarding medical care while traveling overseas, please contact the TRICARE overseas contractor. You may find TRICARE's contact information at https://tricare.mil/About/Regions.

For further assistance, visit our Web site at http://milconnect.dmdc.mil or contact the Defense Manpower Data Center Contact Center at (800) 538-9552. Our hours of operation are 5:00 a.m. to 5:00 p.m. (Pacific Time) Monday through Friday.

Sincerely,

Client Services
Defense Manpower Data Center

Preferred Proof for Each Premium:

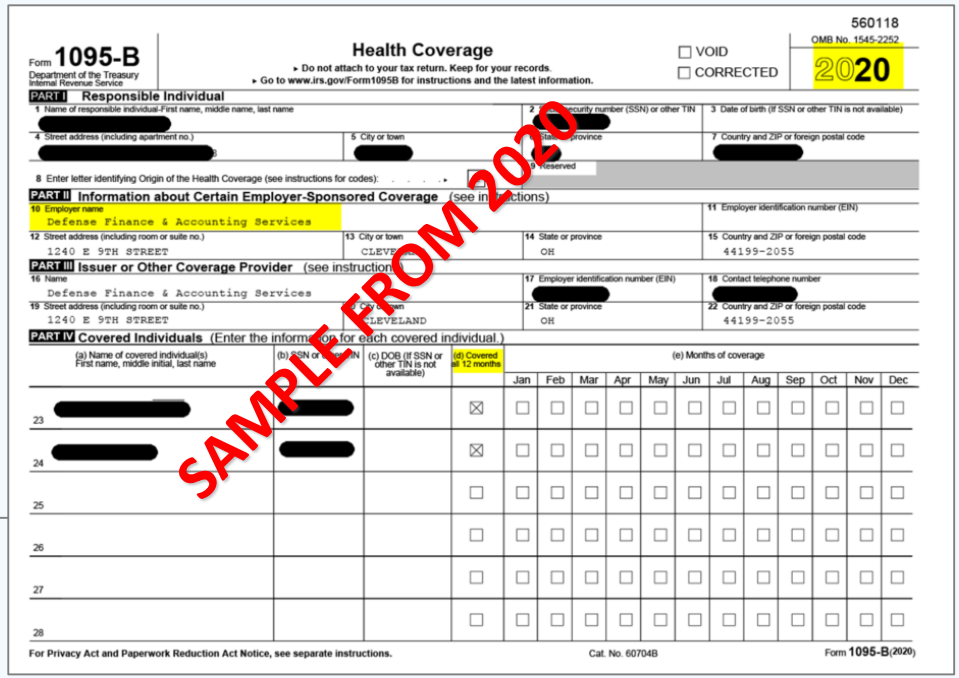
Individual Health Insurance – Tri-Care:

- **Acceptable proof**

Examples of Proof for Outside Rebates

Preferred Proof for Each Premium:

Individual Health Insurance – Tri-Care:
Acceptable proof



560118

Form **1095-B** Department of the Treasury Internal Revenue Service

Health Coverage

▸ Do not attach to your tax return. Keep for your records.
▸ Go to www.irs.gov/Form1095B for instructions and the latest information.

☐ VOID ☐ CORRECTED

OMB No. 1545-2252

2020

PART I Responsible Individual

1 Name of responsible individual-First name, middle name, last name [redacted]
2 Social security number (SSN) or other TIN [redacted]
3 Date of birth (If SSN or other TIN is not available)
4 Street address (including apartment no.) [redacted]
5 City or town [redacted]
6 State or province [redacted]
7 Country and ZIP or foreign postal code [redacted]
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes):
9 Reserved

PART II Information about Certain Employer-Sponsored Coverage (see instructions)

10 Employer name: Defense Finance & Accounting Services
11 Employer identification number (EIN)
12 Street address (including room or suite no.): 1240 E 9TH STREET
13 City or town: CLEVELAND
14 State or province: OH
15 Country and ZIP or foreign postal code: 44199-2055

PART III Issuer or Other Coverage Provider (see instructions)

16 Name: Defense Finance & Accounting Services
17 Employer identification number (EIN) [redacted]
18 Contact telephone number [redacted]
19 Street address (including room or suite no.): 1240 E 9TH STREET
20 City or town: CLEVELAND
21 State or province: OH
22 Country and ZIP or foreign postal code: 44199-2055

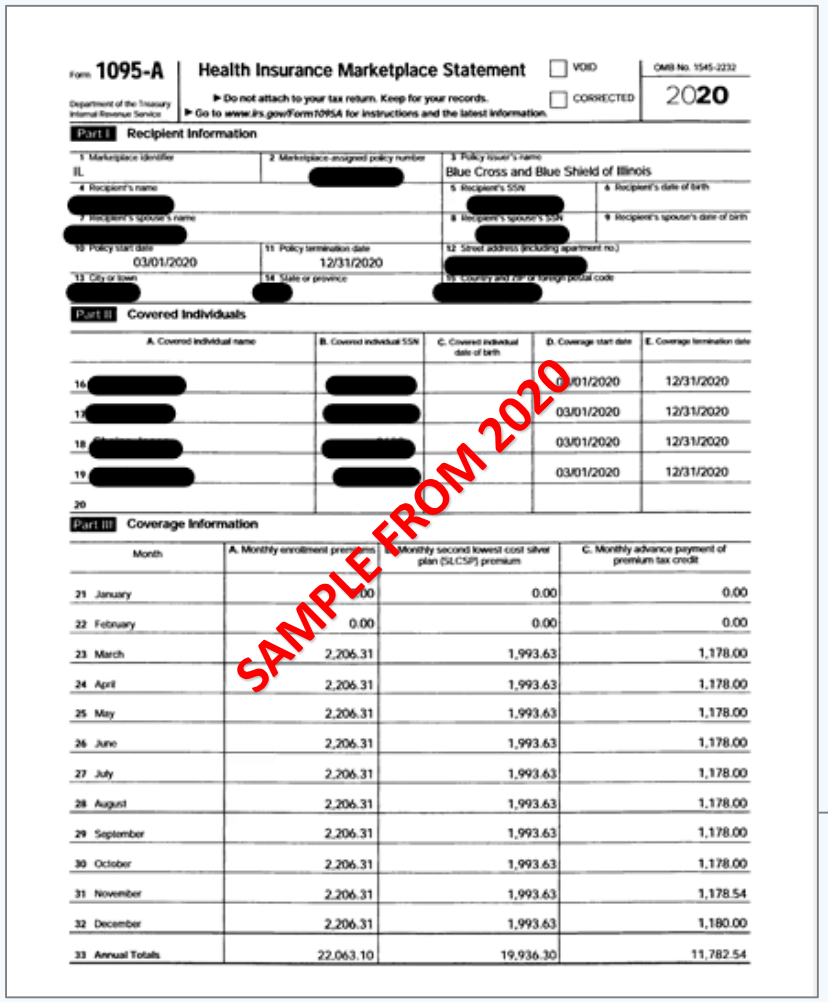
PART IV Covered Individuals (Enter the information for each covered individual.)

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	[redacted]	[redacted]		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24	[redacted]	[redacted]		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SAMPLE FROM 2020

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form **1095-B**(2020)

Examples of Proof for Outside Rebates



Form **1095-A** Health Insurance Marketplace Statement — VOID — CORRECTED — OMB No. 1545-2232 — **2020**

Department of the Treasury Internal Revenue Service

▶ Do not attach to your tax return. Keep for your records.
▶ Go to www.irs.gov/Form1095A for instructions and the latest information.

Part I Recipient Information

1 Marketplace identifier	2 Marketplace assigned policy number	3 Policy issuer's name
IL	[redacted]	Blue Cross and Blue Shield of Illinois

4 Recipient's name	5 Recipient's SSN	6 Recipient's date of birth
[redacted]	[redacted]	

7 Recipient's spouse's name	8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth
[redacted]	[redacted]	

10 Policy start date	11 Policy termination date	12 Street address (including apartment no.)
03/01/2020	12/31/2020	[redacted]

13 City or town	14 State or province	15 Country and ZIP or foreign postal code
[redacted]	[redacted]	[redacted]

Part II Covered Individuals

	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16	[redacted]	[redacted]		03/01/2020	12/31/2020
17	[redacted]	[redacted]		03/01/2020	12/31/2020
18	[redacted]	[redacted]		03/01/2020	12/31/2020
19	[redacted]	[redacted]		03/01/2020	12/31/2020
20					

Part III Coverage Information

Month	A. Monthly enrollment premium	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January	0.00	0.00	0.00
22 February	0.00	0.00	0.00
23 March	2,206.31	1,993.63	1,178.00
24 April	2,206.31	1,993.63	1,178.00
25 May	2,206.31	1,993.63	1,178.00
26 June	2,206.31	1,993.63	1,178.00
27 July	2,206.31	1,993.63	1,178.00
28 August	2,206.31	1,993.63	1,178.00
29 September	2,206.31	1,993.63	1,178.00
30 October	2,206.31	1,993.63	1,178.00
31 November	2,206.31	1,993.63	1,178.54
32 December	2,206.31	1,993.63	1,180.00
33 Annual Totals	22,063.10	19,936.30	11,782.54

SAMPLE FROM 2020

Preferred Proof for Each Premium:

Individual Health Insurance – Marketplace with ACA Tax Credit:

- **MUST** provide proof from the insurance carrier
- 1095-A: **NOT** sufficient proof

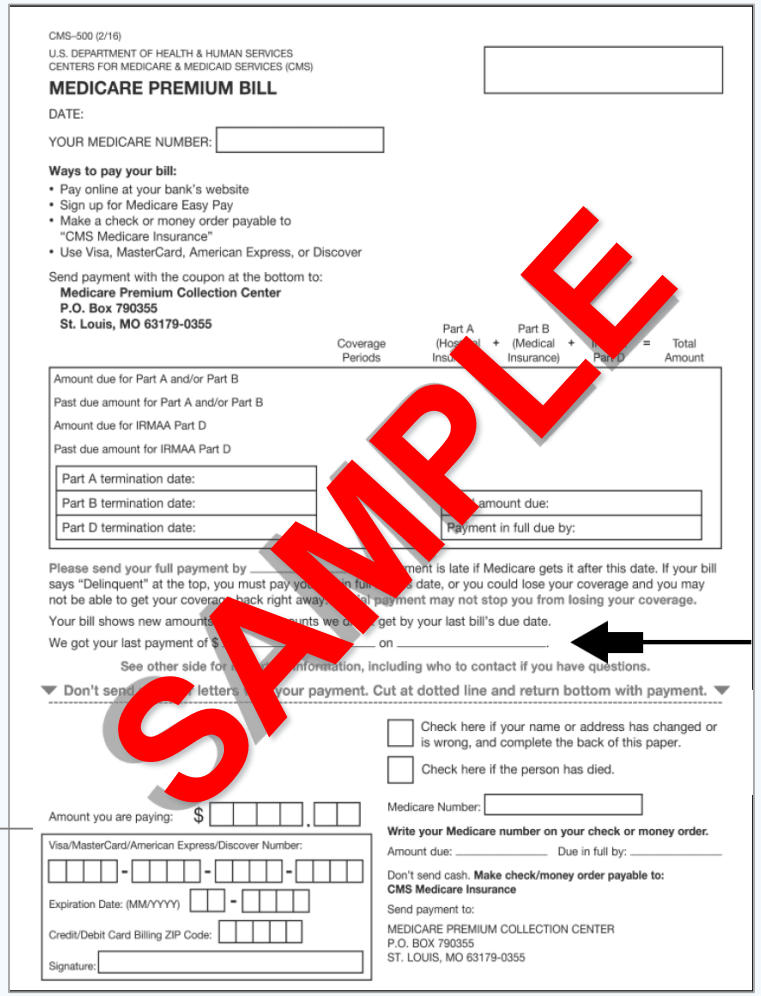
CTPF

Examples of Proof for Outside Rebates

Preferred Proof for Each Premium:

Medicare Parts A, B and D:

- Medicare premium bill is **acceptable proof**
  - For individuals who receive a Medicare premium bill either monthly or quarterly, CTPF is most interested in the dates that Medicare processed your January 2023 and December 2023 payments.


CMS–500 (2/16)

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

MEDICARE PREMIUM BILL

DATE:

YOUR MEDICARE NUMBER:

Ways to pay your bill:
- Pay online at your bank's website
- Sign up for Medicare Easy Pay
- Make a check or money order payable to "CMS Medicare Insurance"
- Use Visa, MasterCard, American Express, or Discover

Send payment with the coupon at the bottom to:
Medicare Premium Collection Center
P.O. Box 790355
St. Louis, MO 63179-0355

Coverage Periods	Part A (Hospital Insurance)	+	Part B (Medical Insurance)	+	Part D	=	Total Amount
Amount due for Part A and/or Part B							
Past due amount for Part A and/or Part B							
Amount due for IRMAA Part D							
Past due amount for IRMAA Part D							

Part A termination date:
Part B termination date:
Part D termination date:

amount due:
Payment in full due by:

Please send your full payment by ___ ment is late if Medicare gets it after this date. If your bill says "Delinquent" at the top, you must pay yo ___ full ___ date, or you could lose your coverage and you may not be able to get your coverag back right away. al payment may not stop you from losing your coverage.

Your bill shows new amounts ___ unts we d ___ get by your last bill's due date.

We got your last payment of $ ___ on ___

See other side for ___ nformation, including who to contact if you have questions.

Don't send ___ letters ___ your payment. Cut at dotted line and return bottom with payment.

Amount you are paying: $ ____.__

Visa/MasterCard/American Express/Discover Number:
____-____-____-____

Expiration Date: (MM/YYYY) __-____

Credit/Debit Card Billing ZIP Code: _____

Signature: _____

☐ Check here if your name or address has changed or is wrong, and complete the back of this paper.

☐ Check here if the person has died.

Medicare Number: _____

Write your Medicare number on your check or money order.

Amount due: _____ Due in full by: _____

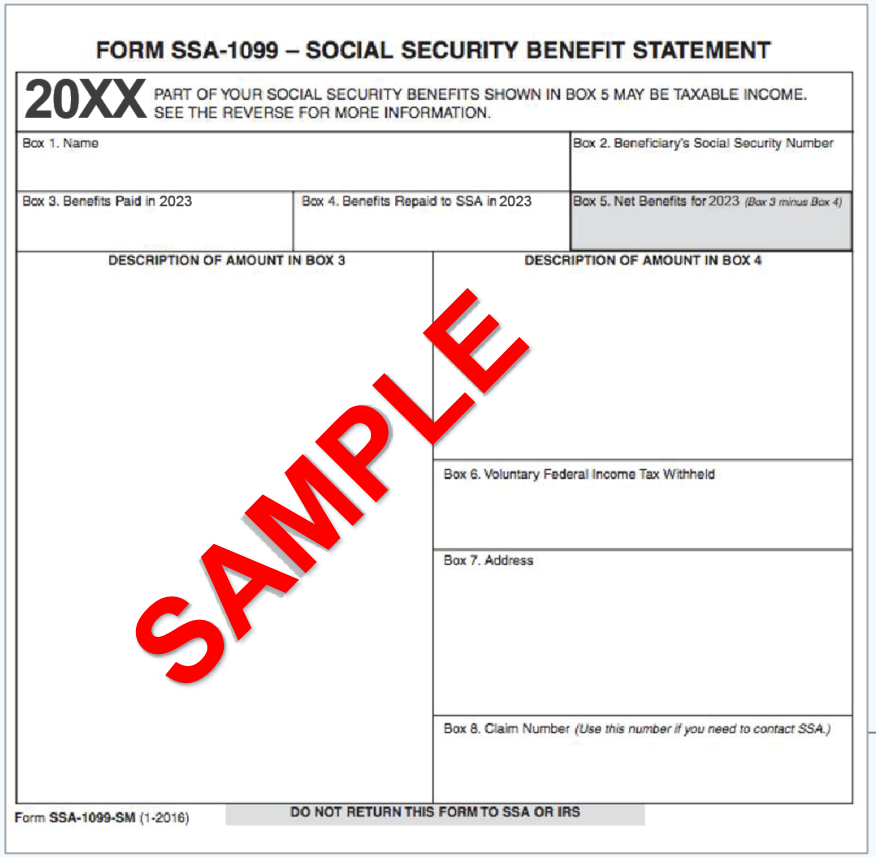
Don't send cash. **Make check/money order payable to: CMS Medicare Insurance**

Send payment to:

MEDICARE PREMIUM COLLECTION CENTER
P.O. BOX 790355
ST. LOUIS, MO 63179-0355

SAMPLE

Examples of Proof for Outside Rebates



FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT

20XX PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME. SEE THE REVERSE FOR MORE INFORMATION.

Box 1. Name

Box 2. Beneficiary's Social Security Number

Box 3. Benefits Paid in 2023

Box 4. Benefits Repaid to SSA in 2023

Box 5. Net Benefits for 2023 *(Box 3 minus Box 4)*

DESCRIPTION OF AMOUNT IN BOX 3

DESCRIPTION OF AMOUNT IN BOX 4

Box 6. Voluntary Federal Income Tax Withheld

Box 7. Address

Box 8. Claim Number *(Use this number if you need to contact SSA.)*

SAMPLE

Form SSA-1099-SM (1-2016)

DO NOT RETURN THIS FORM TO SSA OR IRS

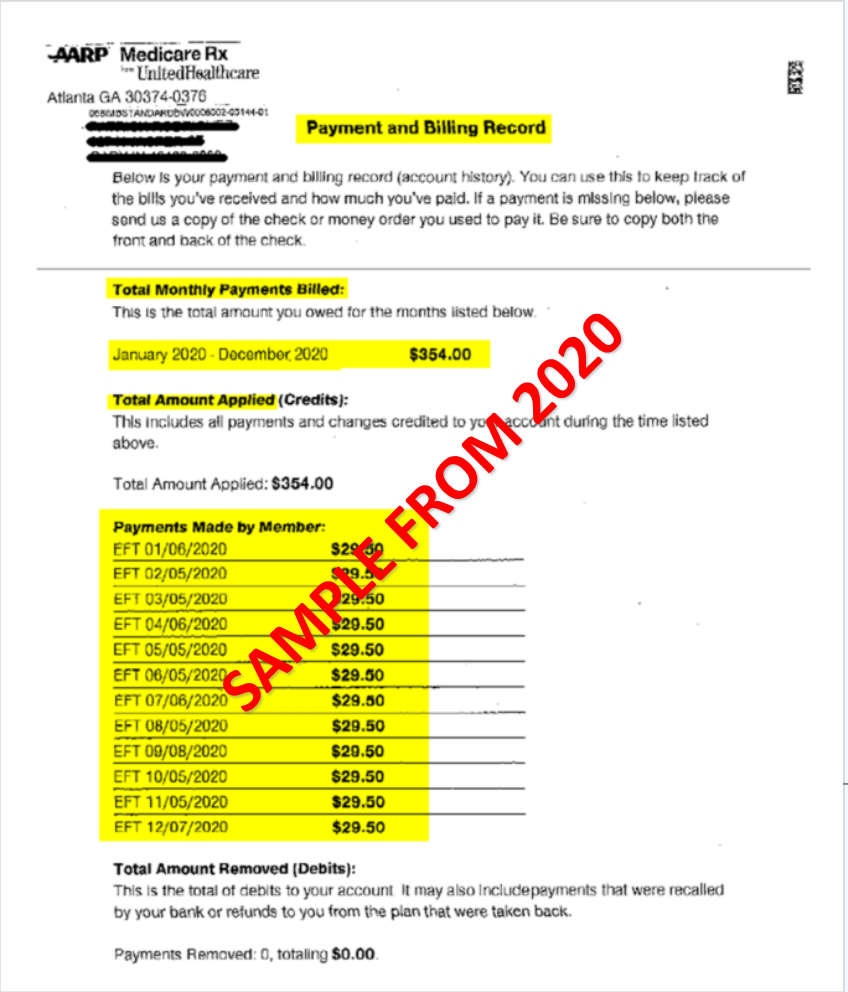
Preferred Proof for Each Premium:

Medicare Part B - Form SSA-1099:

- **Acceptable proof for Med B** but **NOT** sufficient for Medicare Part D proof

CTPF

Examples of Proof for Outside Rebates



AARP Medicare Rx
UnitedHealthcare

Atlanta GA 30374-0376

[redacted]

Payment and Billing Record

Below is your payment and billing record (account history). You can use this to keep track of the bills you've received and how much you've paid. If a payment is missing below, please send us a copy of the check or money order you used to pay it. Be sure to copy both the front and back of the check.

Total Monthly Payments Billed:
This is the total amount you owed for the months listed below.

January 2020 - December 2020	**$354.00**

Total Amount Applied (Credits):
This includes all payments and changes credited to your account during the time listed above.

Total Amount Applied: **$354.00**

Payments Made by Member:

EFT 01/06/2020	$29.50
EFT 02/05/2020	$29.50
EFT 03/05/2020	$29.50
EFT 04/06/2020	$29.50
EFT 05/05/2020	$29.50
EFT 06/05/2020	$29.50
EFT 07/06/2020	$29.50
EFT 08/05/2020	$29.50
EFT 09/08/2020	$29.50
EFT 10/05/2020	$29.50
EFT 11/05/2020	$29.50
EFT 12/07/2020	$29.50

SAMPLE FROM 2020

Total Amount Removed (Debits):
This is the total of debits to your account. It may also includepayments that were recalled by your bank or refunds to you from the plan that were taken back.

Payments Removed: 0, totaling **$0.00**.

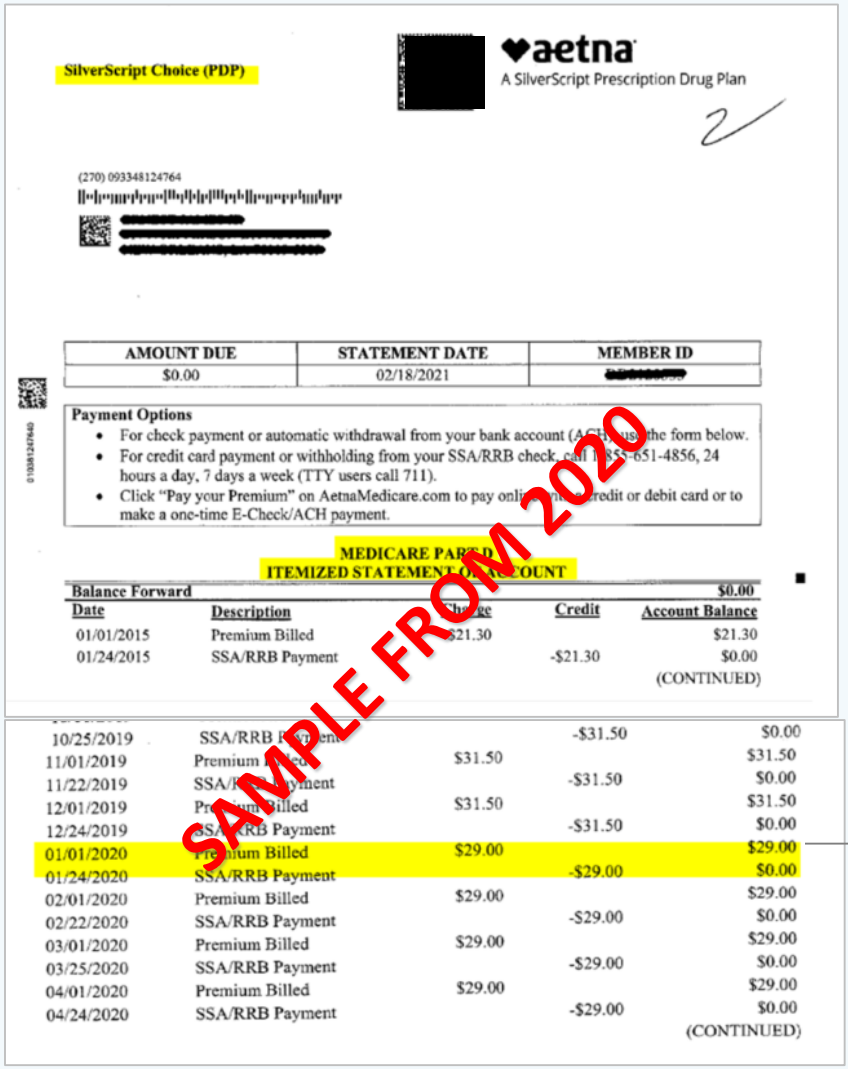
Preferred Proof for Each Premium:

Medicare Part D – AARP UHC:

- Prescription coverage **acceptable proof**

CTPF

Examples of Proof for Outside Rebates



SilverScript Choice (PDP)

aetna
A SilverScript Prescription Drug Plan

(270) 093348124764

AMOUNT DUE	STATEMENT DATE	MEMBER ID
$0.00	02/18/2021	

Payment Options

- For check payment or automatic withdrawal from your bank account (ACH), use the form below.
- For credit card payment or withholding from your SSA/RRB check, call 1-855-651-4856, 24 hours a day, 7 days a week (TTY users call 711).
- Click "Pay your Premium" on AetnaMedicare.com to pay online with a credit or debit card or to make a one-time E-Check/ACH payment.

MEDICARE PART D
ITEMIZED STATEMENT OF ACCOUNT

Balance Forward				$0.00
Date	Description	Charge	Credit	Account Balance
01/01/2015	Premium Billed	$21.30		$21.30
01/24/2015	SSA/RRB Payment		-$21.30	$0.00
				(CONTINUED)

SAMPLE FROM 2020

10/25/2019	SSA/RRB Payment		-$31.50	$0.00
11/01/2019	Premium Billed	$31.50		$31.50
11/22/2019	SSA/RRB Payment		-$31.50	$0.00
12/01/2019	Premium Billed	$31.50		$31.50
12/24/2019	SSA/RRB Payment		-$31.50	$0.00
01/01/2020	Premium Billed	$29.00		$29.00
01/24/2020	SSA/RRB Payment		-$29.00	$0.00
02/01/2020	Premium Billed	$29.00		$29.00
02/22/2020	SSA/RRB Payment		-$29.00	$0.00
03/01/2020	Premium Billed	$29.00		$29.00
03/25/2020	SSA/RRB Payment		-$29.00	$0.00
04/01/2020	Premium Billed	$29.00		$29.00
04/24/2020	SSA/RRB Payment		-$29.00	$0.00
				(CONTINUED)

Preferred Proof for Each Premium:

Medicare Part D - Aetna:

- Prescription coverage **acceptable proof**

CTPF

Insufficient Proof

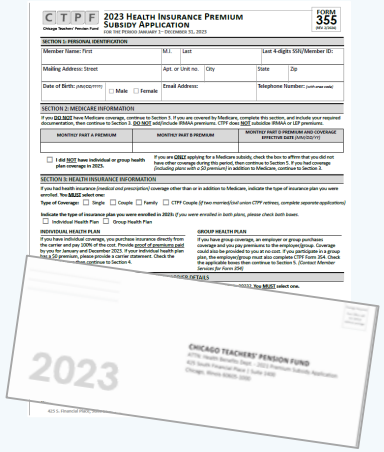
Do **NOT** provide the following items as proof as they are not acceptable:

Doctor Bills

Explanation of Benefits (EOB)

Timeline

When is the Outside Rebate Application Due?



2023 Rebates: Due by **July 31, 2024**

- Must be postmarked by July 31, 2024 ***OR***
- Must be faxed or emailed (*preferred method*) by July 31, 2024.
  - CTPF advises all members to submit forms and documentation electronically. Send your forms by Fax 312.641.7185 or email an attachment (.pdf format) to imaging@ctpf.org.
- **NO** exceptions after due date

How Long Will It Take for CTPF to Process My Outside Rebate Application?

- Applications are processed in the order received.
- Each application takes approximately **90 days after receipt** for CTPF to process payment, assuming proof is sufficient and member is eligible for a subsidy.
- Insufficient proof is treated as a **new** application and requires full review.
- If CTPF has to send a missing documentation (proof) letter, this **will** delay payment. Once CTPF receives the missing evidence, the new documentation will take approximately **another 90 days after receipt** for CTPF to process.

Important Information to Consider

Helpful Information

Available on:
www.ctpf.org/ctpfsubsidy

- CTPF attempts to pay rebates at the end of each month.
- CTPF reviews previous year's rebate to ensure consistency from year to year.
- If after 90 days, member has questions about rebate status, please send an email to memberservices@ctpf.org for a status.
- If a member passes away before the application is signed, the survivor will need to submit an application as a survivor (and will be effective the first of the month following the member's date of death).
- Power of Attorney ceases when a member passes away.
- CTPF does check to ensure member was not enrolled in CTPF's health insurance during 2023.

Helpful Information

- Some members are not eligible for a rebate because the subsidies they receive elsewhere are more than CTPF would provide.
- If a member has health insurance coverage from the **Chicago Board of Education** or the **Federal Government**, the only required documentation is a check stub (for January and December 2023), showing the amount paid for the coverage.
- Remember if a member had a **premium change** for health insurance and/or Medicare payments, note the change on the application and in the proof provided.

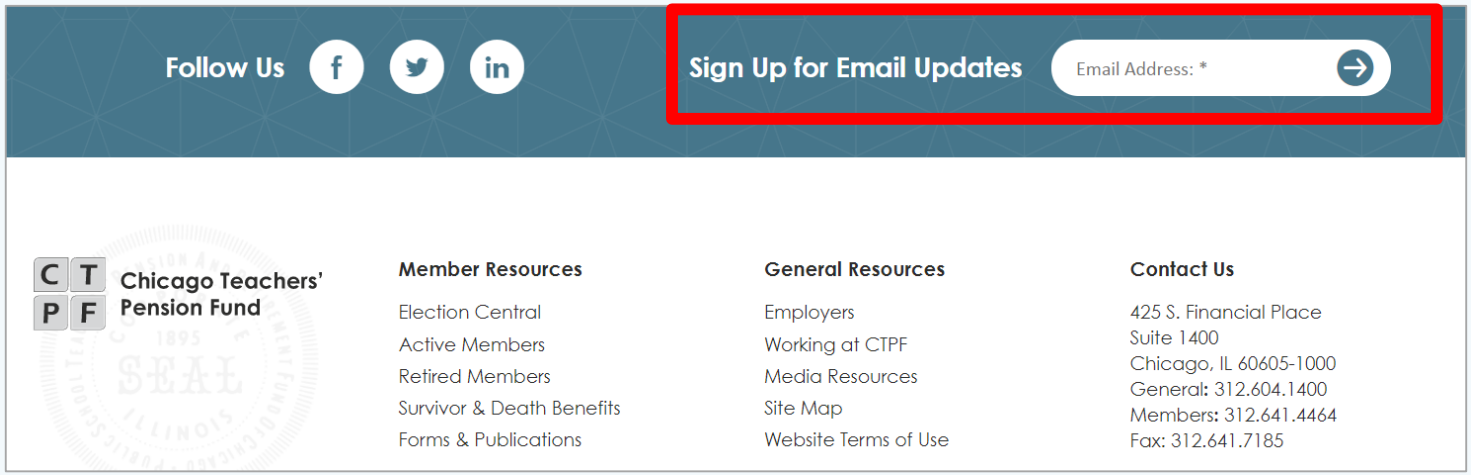
Helpful Information

- If a member is in a group plan and CTPF has not been able to reach the group insurance plan representative after two attempts, member will receive a missing evidence letter to work with their group provider.
  - If not received timely, this *will* impact the member's outside rebate calculation and ultimately, the payout.
- CTPF is **not** responsible for incomplete or incorrect information provided.
- CTPF sends email reminders monthly to ensure members submit their rebate application by **July 31, 2024**.

Don’t Miss Important Information

Stay up-to-date on changes by having your email on file at CTPF

- Contact Member Services to update your email address: email **memberservices@ctpf.org** , or call **312.641.4464**
- Submit documents to **imaging@ctpf.org** or via fax at **312.641.7185**
- Register for email updates at ***ctpf.org***
  - Scroll down to bottom and enter your email address



Register for *my*CTPF

CTPF has launched its new Self-Service Portal, *my*CTPF. Members who register for *my*CTPF create their own unique User ID and password. Once an account is created, members can use *my*CTPF to securely access CTPF documents and information.

Registered members can:

- View and update address/contact information on file with CTPF.
- Retirees and surviving spouses can view and download a 1099-R and pay advice(s).
- Active and inactive members can view and download their annual Member Statement and request a pension estimate, if eligible.
- *my*CTPF is available to all CTPF members who complete the one-time registration process.

Thank You

CTPF Member Services
Members: 312.641.4464 **Fax:** 312.641.7185
Email: memberservices@ctpf.org
Documents: imaging@ctpf.org
Call Center Hours: Mon- Fri: 8AM-5PM
ctpf.org |