benefit strategies LLC

HARVARD UNIVERSITY COPAYMENT REIMBURSEMENT PROGRAM REQUEST FORM

For ATC, HUCTW (including at Dumbarton Oaks), HUPA, HUSPMGU, LOCAL 26 & SEIU Custodian

FAX: (603) 232-1854 (Max of 15 pages)
Address: PO Box 1300, Manchester, NH 03105-1300
E-Mail: hvdflex@benstrat.com

Employee Information

To update your address or email, please log into hr.harvard.edu, and select "PeopleSoft" link at the top of any HARVie page. Once in PeopleSoft, click on Self-Service>Personal Information and make all necessary updates.

Employee Name (First, Last)**:**	**Last 4 digits of SSN:** ☐☐☐☐
Primary Phone (include area code)**:**	**Email Address** (E-mail is required to receive important account notifications)**:**

Expenses: Please list out all out-of-pocket **QUALIFYING COPAYMENT REIMBURSEMENT PROGRAM EXPENSES**. If you are submitting more than eight dates of service, you may attach a list with the required information and write "see attached" on one of the lines below.

Office Visit (OV) Prescription (RX) Hospital Copay (HC)	**Date of Service**	**Full Name of Covered Person**	**Service Provided By**	**Expense Amount**
□ OV □ RX □ HC	/ /			$.
□ OV □ RX □ HC	/ /			$.
□ OV □ RX □ HC	/ /			$.
□ OV □ RX □ HC	/ /			$.
□ OV □ RX □ HC	/ /			$.
□ OV □ RX □ HC	/ /			$.
□ OV □ RX □ HC	/ /			$.

Complete below if any of the above expenses were incurred by your Spouse and/or Dependent

Last four digits of Social Security #	**Full Name**	**Date of Birth**	**Relationship to Employee**
XXX-XX-_ _ _ _		/ /	
XXX-XX-_ _ _ _		/ /	
XXX-XX-_ _ _ _		/ /	

Supporting Documents: Include with this form with all "Supporting Documentation" as defined in the *important information section on the reverse side*.

EMPLOYEE CERTIFICATION: By signing below, I hereby certify the following:

- I or my Spouse or Dependent has received the service(s) listed above on the date(s) indicated.
- The expenses listed above are "Qualifying Copayment Reimbursement Expenses" under the Harvard University Medical Reimbursement Program (the "Plan") and were incurred by me, my "Spouse" or one or more of my eligible "Dependents" as defined in the Plan.
- The expenses listed above have not previously been reimbursed from the Plan or any other reimbursement program or health FSA (for example, my Spouse's employer's reimbursement program, medical plan or health FSA), and I will not seek reimbursement for them from any other source, including the Harvard University Medical Plan, Dental Plan, Vision Plan, Health FSA or any other plan.
- I understand the Qualifying Copayment Reimbursement Expenses reimbursed may not be used to claim any federal income tax deduction or credit.

I have read both the FAQs and *the information on the reverse side of this form* and understand that I can request a copy of the Program from Harvard University if I do not currently have a copy.

PLEASE SIGN HERE:	**Date:**

IMPORTANT INFORMATION

Claims for Qualifying Copayment Reimbursement Program expenses incurred during the plan year (January 1 – December 31) MUST BE POSTMARKED by March 31 of the following year.

PLEASE NOTE: Nothing in this section of the form is intended to supersede or replace the provisions of the Harvard University Medical Reimbursement Plan (the "Plan"). If there is a conflict between this section of the form and the Plan, the Plan will control.

Eligibility You must be an active Harvard employee covered by ATC, HUCTW union (including employees of Dumbarton Oaks who are covered by HUCTW), HUPA, HUSPMGU, Local 26, or SEIU Custodian and enrolled in a Harvard/Dumbarton Oaks medical plan. You can be reimbursed for eligible expenses incurred within the plan year in excess of the following amounts:

Full Time Equivalent (FTE) Salary*	**Thresholds (based on your FTE salary at the time you submit for reimbursement)**					
	Individual coverage, or family coverage but submitting expenses for the plan year for one family member only**			**Family Coverage**** submitting expenses for the plan year for two or more family members		
	Office Visit Copays	Prescription Copays	Hospital Copays	Office Visit Copays	Prescription Copays	Hospital Copays**
Less than $75,000	$225	$500	$300	$550	$1,000	$450
$75,000+	$450	$1,000	$600	$1,100	$2,000	$900

** FTE salary is your annual salary if you work full-time or, for those who work less than full-time, the salary that would be earned working full-time at the same rate of pay. Thresholds are based on your FTE salary at the time you submit for reimbursement, not your FTE salary at the time expenses are incurred.*

*** If you submit expenses for more than one family member, you will be reimbursed for any expenses incurred above the family threshold. If you initially submit expenses for one family member and receive reimbursement for expenses above the individual threshold, but subsequently submit expenses for another family member, you will not receive additional reimbursements for any family member until the family threshold is met.*

**** Hospital copayments refer to copayments for emergency room, inpatient and outpatient hospital and high-tech imaging.*

Copayment Reimbursement Program (CRP) and Health Flexible Spending Accounts (FSA) The CRP is separate from the Health FSA, and you need not elect a Health FSA to take advantage of the CRP. You cannot be reimbursed for the same expenses through the CRP and your Health FSA; however you may choose to use funds from a Health FSA to cover the copayment thresholds shown in the chart above. Once you have met the applicable threshold, you should submit additional eligible copayments to the CRP (not to your Health FSA), and you will be reimbursed in full for eligible copayments above the threshold. You will need to submit supporting documentation for all copayments, including the threshold amounts, with the CRP reimbursement form.

Qualifying Copayment Reimbursement Expenses include in-network office visit, prescription drug, and hospital copayments incurred through your Harvard-sponsored medical plan. In order for an expense to be eligible, you must meet the participant eligibility criteria at the point the expense is incurred. Out-of-network expenses and dental plan and vision plan expenses are *not eligible*.

When To Submit Your Reimbursement Requests Reimbursement requests must be submitted by the end of the run-out period, which is March 31 following the close of the plan year (January 1 – December 31); or if March 31 falls on a Saturday, Sunday, or holiday, the next business day. Please note, your threshold will be based on your FTE salary at the time you submit for reimbursement, not your FTE salary at the time expenses are incurred.

Supporting Documentation You must provide legible receipts from the provider for all Qualifying CRP expenses, including expenses that satisfy the applicable threshold, for which you are requesting reimbursement. Receipts must clearly show:

1. Name of person receiving service
2. Nature of service or supplies
3. Name and address of care provider
4. Amount charged to patient
5. Date the service was provided

Keep copies for your records. Canceled checks and credit card receipts by themselves are **not** acceptable. Failing to submit supporting documentation will delay (or prevent) claims processing.

How to Submit Your Reimbursement Requests You may submit your reimbursement request (this form and all supporting documentation) to Benefit Strategies, LLC by fax, mail, or secure email. If your reimbursement request is denied, written notification will be mailed to you. In some cases, you may be allowed to resubmit expenses with proper documentation.