MAIL TO:	NYC DISTRICT COUNCIL OF CARPENTERS WELFARE FUND
Administrative Services Only, Inc. PO Box 9005, Dept. 95M Lynbrook, NY 11563-9005 516-396-5500 / 800-537-1238	**DEDUCTIBLE, CO-PAYMENT, CO-INSURANCE, PRESCRIPTION DRUG RIDER AND MEDICARE PART D PREMIUM** **REIMBURSEMENT CLAIM FORM - 2020** **FOR RETIRED CITY CARPENTERS**

ELIGIBILITY: For Carpenters Retired from the City of New York
CALENDAR YEAR MAXIMUM FOR 2020: $1,685 per family
COVERED EXPENSES INCLUDE: Medical, Hospital, Dental and Prescription Drug Deductibles, Co-Payments, and Co-Insurance under your group health plan and Prescription Drug Costs. (For prescription drug reimbursement, you must submit proof that you are enrolled in a health plan that satisfies the minimum value requirement under the Affordable Care Act (ACA).) You are also eligible for reimbursement for premiums that you pay on a post-tax basis to purchase your Prescription Drug Rider or Medicare Part D prescription drug plan.

PATIENT(S) INFORMATION

PATIENT NAME	CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES
1			
2			
3			
TOTAL			

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED If you are divorced, it is your responsibility to notify the Fund Office/disenroll your ex-spouse from coverage immediately. Otherwise you will be financially liable for any amounts paid in error and you may lose your coverage under the Fund.		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
MEMBER/S SOCIAL SECURITY NO. XXX-XX- ☐ ☐ ☐ ☐		DAYTIME TELEPHONE NUMBER: EVENING TELEPHONE NUMBER: EMAIL ADDRESS:		

IF YOU ARE ENROLLED IN A CITY HEALTH PLAN, PLEASE INDICATE INSURANCE PLAN AND ATTACH COPY OF YOUR INSURANCE ID CARD.

☐ AETNA EPO ☐ CIGNA HEALTH	☐ EMPIRE HMO ☐ EMPIRE PPO	☐ GHI-CBP/EBCBS ☐ GHI HMO	☐ HIP PRIME HMO ☐ HIP PRIME POS	☐ METRO PLUS GOLD ☐ VYTRA HEATLH PLANS

IF YOU ARE COVERED UNDER A PLAN OTHER THAN THROUGH THE CITY OF NEW YORK, PLEASE SEND A COPY OF YOUR INSURANCE CARD AND A COPY OF YOUR SUMMARY OF BENEFITS AND COVERAGE (SBC).

Insurance Carrier: _____ Is this a Minimum Value Health Plan? ___ Yes ___ No

Employer Name: _____ Phone Number: _____

IMPORTANT NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE AVAILABLE TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.
REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY.

_____ _____
SIGNATURE OF MEMBER DATE

DEDUCTIBLE, CO-PAYMENT, CO-INSURANCE, RX, AND PREMIUM REIMBURSEMENT

CLAIM FORM - 2020

The following is a brief description of the reimbursement program. If there are any discrepancies between this document and the Plan documents (Summary Plan Description and Summary of Material Modifications), the Plan documents shall govern.

What is covered? Under this program, you will receive reimbursement for out-of-pocket expenses that you incur due to your annual medical, hospital, dental and prescription drug plan deductibles, co-payments or co-insurance. In addition, beginning in 2016, reimbursement is available for prescription drug costs and premiums that you pay on a post-tax basis for the Prescription Drug Rider or a Medicare Part D prescription drug plan.

Is there an Annual Maximum? Yes. The maximum reimbursement **for Retirees is $1,685 per family.**

How Do I File for Benefits?

1. **Complete the claim form and attach all copies of the itemized bills for the expenses incurred and/or the corresponding Explanations of Benefits FROM ALL HEALTH PLANS covering the patient(s).**
2. **All claims for the year ending December 31, 2020 must be postmarked by no later than March 31, 2021.**

FAILURE TO FILE REQUIRED DOCUMENTATION OR TO SIGN EACH CLAIM FORM WILL DELAY THE PROCESSING OF YOUR CLAIM, AND MAY RESULT IN DENIAL OF YOUR CLAIM.

IN ORDER TO QUALIFY FOR REIMBURSEMENT
THE OUT-OF-POCKET EXPENSE MUST MEET ALL OF THE FOLLOWING REQUIREMENTS:

1. It must be a co-payment, co-insurance or deductible paid under a medical, hospital, dental or prescription drug plan or a prescription drug cost. In order be eligible for reimbursement of prescription drug costs, you must submit proof that you are enrolled in a health plan that satisfies the minimum value requirement of the ACA. Most City of New York health plans meet this requirement, but there are a few that do not. Please check with the City of New York or your insurance carrier if you have any questions on whether your plan satisfies the minimum value requirement.
2. It must be incurred between **January 1, 2020 and December 31, 2020**.
3. It must be medically necessary.
4. It must be documented by a detailed billing statement from the provider including the name, address, telephone number and tax identification number of the provider and nature of the medical services rendered and/or an explanation of benefits from all other plans.
5. It must be rendered by a licensed provider as mandated by state law.

A. Hospital, Medical, Prescription Drug and Dental Plan Deductibles, Co-Pays and Co-Insurance

This Plan will reimburse deductible, co-payments and co-insurance expenses under your hospital, medical, prescription drug and dental plans that are not covered by other plans. All such expenses must first be processed through your insurance program and all claims for reimbursement must be accompanied by an explanation of benefits statement from the insurer and/or receipts for payment clearly showing deductibles, co-pay, and/or co-insurance charges.
Do not submit original receipts. The Fund is not responsible for loss if originals are submitted.

B. Prescription Drug Cost Reimbursement

Prescription drug costs are now eligible for reimbursement, provided that you are covered by a minimum value health plan, as explained above. In order to be eligible for reimbursement, claims must be accompanied by a pharmacy printout or a copy of a receipt. The reimbursement benefit is secondary to your primary prescription drug coverage.

No coverage is provided for: "over the counter" drugs, vitamins, diet supplements, etc., which even though prescribed by a physician, can legally be purchased without a prescription; allergy prescriptions unable to be filled by a licensed pharmacy; drugs prescribed for cosmetic purposes.

C. Premium for Prescription Drug Rider or Medicare Part D Premium

Beginning in 2016, this program will now reimburse you for the premium you pay for the prescription drug rider to your retiree medical coverage or for Medicare Part D prescription coverage for you and your eligible dependents, up to the annual maximum (provided the premium is paid on a post-tax basis). You must submit proof of your premium payment (e.g., a copy of your NYCERS pension stubs/quarterly statements, Social Security payment advice or other premium statement showing the premium you paid for prescription drug coverage for each month you are seeking reimbursement).