MAIL TO: **ASO, Inc.** PO Box 9005, Dept. 95M Lynbrook, NY 11563-9005 516-396-5500 / 800-537-1238	**NYC DISTRICT COUNCIL OF CARPENTERS WELFARE FUND** **REIMBURSEMENT CLAIM FORM-2024** **FOR CARPENTERS RETIRED FROM THE CITY NEW YORK**

CALENDAR YEAR MAXIMUM FOR 2024: RETIRED MEMBERS-$1,948 per family

COVERED EXPENSES INCLUDE: (1) Medical, Hospital, Dental, Optical and Prescription Drug Deductibles, Co-Payments, and Co-Insurance under your group health plan; **(2)** 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).); **(3)** Non-covered dental and optical expenses; **(4)** Premiums that you pay with post-tax dollars to purchase your Prescription Drug Rider or Medicare Part D prescription drug plan. In accordance with Internal Revenue Code requirements, premiums paid through payroll deductions on a pre-tax basis cannot be reimbursed; **(5)** Over-the-counter drugs, such as aspirin and allergy medicines. Such drugs and medicines must be for the treatment of illness or injury and not merely to advance general good health; and **(6)** Menstrual care products.

PATIENT(S) INFORMATION

PATIENT NAME	CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES
1			
2			
3			
4			
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. (Last 4 Digits) XXX-XX- ☐ ☐ ☐ ☐		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 CLAIM CONTAINING ANY MATERIAL OR FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT.

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

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.

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. Claims for the year ending **December 31, 2024** must be postmarked by no later than **March 31, 2025**.

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 covered expense as described below.
2. It must be incurred between **January 1, 2024 and December 31, 2024**.
3. It must be medically necessary and rendered by a licensed provider as mandate by state law.
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 ("EOB") from all other plans or, as applicable, a receipt showing the date purchased, the cost of the item, and a description of the item.

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

This Plan will reimburse deductibles, co-payments and co-insurance expenses under your hospital, medical, prescription drug, dental, and optical 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 EOB from the insurer and/or receipts for payment clearly showing deductibles, co-pay, and/or co-insurance charges.
Do not submit original receipts/document. Neither the Fund nor A.S.O. will be responsible for the loss thereof.

B. Prescription Drug Cost Reimbursement

Prescription drug costs are 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.

C. Over-the-Counter ("OTC") Drugs and Medicines

OTC drugs and medicines purchased without a prescription, such as aspirin and allergy medicines, are eligible for reimbursement. Such drugs and medicines must be for the treatment of illness or injury and not merely to advance general good health. Claims must be accompanied by a receipt showing the date purchased, the cost of the item and a description of the item.

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

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, is eligible for reimbursement 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).

E. Menstrual Care Products

Menstrual care products are eligible for reimbursement. Menstrual care products include tampons, pads, liners, cups, sponges or other similar items used in respect to menstruation. Claims must be accompanied by a receipt showing the date purchased, the cost of the item and a description of the item.

F. Non-Covered Dental and Optical Expenses

This Plan will reimburse for non-covered dental and optical expenses such as bone grafts after extractions, crown lengthening, crowns build-up, sinus lifts, palatal expanders, analgesia (nitrous oxide) or Lasik eye surgery.