RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT TRUST

Administered By: Benefit Programs Administration
Telephone: (562) 463-5050 Fax: (562) 463-5894 E-Mail: smpoatrust@bpabenefits.com Website: www.smpoatrust.org

Instructions for Completing Premiums/Expenses
Reimbursement Request Form

Premium/Expense[1] Reimbursement Forms should be completed according to the instructions below. To expedite timely reimbursements, you must accurately complete the form.

You must submit reimbursements for dates of service each quarter within the calendar year and no later than 90-days from the date on which payment for the Premium/Expense was made.

Reimbursements are limited to the monthly benefit limit for each member. If expenses submitted in any given quarter exceed the quarterly benefit limit, the excess will be carried into the following quarter until paid in full, but in no event will a member receive reimbursement within a calendar year greater than 12 times their monthly benefit limit. Claims may not be carried into subsequent years.

Box no. 1: Premium Reimbursement Only – This section is primarily for those who have CalPERS premium deductions taken directly from their monthly retirement checks, including other health insurance premiums, such as for: Medicare, spouses' payment towards employer health coverage, dental, optical, and AFLAC and long-term care. Premiums are for qualifying medical expenses only and do not include coverage for medical or prescription drug coverage that is purchased on a federal or state Exchange.

Box no. 2: Receipts for Medical Expenses (Reimbursement Only) – You must submit medical expenses (other than premiums paid), such as co-payments, office visit fees, deductibles, durable medical equipment (other than for prescription drug). Each line should have supporting receipts. An Explanation of Benefits (EOB) from your medical insurer is acceptable. Please list all expenses in chronological order.

Receipt No. - Each receipt must list the same number that corresponds to the claimed expense on the form. The receipt also should have the date of service and fee charged.
Patient(s) Covered – The member, spouse and dependent, if any, must be named.
Providers Name – Name of doctor, facility, or provider.
Service Date – Date that you received services from the provider
Fee Charged – Fee that you paid after insurance adjustments, if any.
Date Paid - Date that you made payment for the service provided and fee charged.
Amount Paid – Copy of the cancelled check or dated receipt showing the amount that you paid towards the fee charged.

Box no. 3: Receipt of Prescription Drug Expense (Reimbursement Only) – A doctor ordered prescription of any drugs, durable medical equipment that is a qualifying medical expense (otherwise excludable under section 213(d) of the Internal Revenue Code (Code)). Best record would be the prescription instruction information, which is the receipt with the price paid and is normally stapled to the bag containing the prescription medication. Members should follow the instructions under "Receipts for Medical Expenses." Purchases of over the counter items such as vitamins, supplements, cough syrup, aspirin, Tylenol and alike are not reimbursable expenses.

Box no. 4: Receipt of Miscellaneous Expense (Reimbursement Only) – A qualifying medical expense otherwise excludable under section 213(d) of Code and that is not included in the two categories directly above (Medical and Prescription Drug). The Plan will follow federal guidelines as defined by the IRS, publication 502, which can be found at the following website: https://www.irs.gov/pub/irs-pdf/p502.pdf. Members should follow the instructions as detailed above, under Medical Expenses.

[1] "Premium" is defined as both medical premiums and qualifying medical expenses in section 1.16 of the Plan Document and in the Summary Plan Description. Here "Premium" refers to medical premiums and Expenses" refers to qualifying medical expenses. To clarify the difference here when submitting claims, "Premium" refers to medical premiums and "Expenses" refers to qualifying medical expenses.

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1200 Wilshire Blvd., Fifth Floor, Los Angeles, California 90017-1906

Claim Form for Reimbursement of Medical Insurance Premiums and/or Medical Expenses

Name of Participant:

Address:

City State Zip:

Primary Contact Phone: **Claims for the Quarter ending:**

Email Address:

PLEASE NOTE: REIMBURSEMENT WILL NOT EXCEED YOUR MAXIMUM MONTHLY BENEFIT.

Box No. 1 **Premium Reimbursement Only:**

Name of Patient(s) Covered	Insurance Provider	Date of Payment	Amount of Payment
		Total Amount You Paid:	

Box No. 2 **Medical Expense Reimbursement Only - In Date Order**

Receipt No.	Patient(s) Covered	Provider's Name	Service Date	Fee Charged	Date Paid	Amount Paid
		Total Amount You Paid:				

Box No. 3 **Prescription Drug Expense (Reimbursement Only) - In Date Order**

Receipt No.	Patient(s) Covered	Providers Name	Service Date	Fee Charged	Date Paid	Amount Paid
		Total Amount You Paid:				

Box No. 4 **Miscellaneous Medical Expense (Reimbursement Only) - In Date Order**

Receipt No.	Patient(s) Covered	Expense Type	Service Date	Fee Charged	Date Paid	Amount Paid
		Total Amount You Paid:				

Attach copies of receipts and proofs of medical expenditures. Reimbursement will not be made without verification of expenditure. Use additional forms if necessary. This form can be emailed to you upon request.