Administered by Benefit Programs Administration
1200 Wilshire Blvd, 5th Floor • Los Angeles, CA 90017
Telephone: (877) 808-5994 • Fax (562) 463-5894
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CLAIM FORM FOR EXPENSE OR PREMIUM REIMBURSEMENT

Instructions to submit claims for reimbursement:

1. The Trust will make reimbursement benefit payments directly to the Eligible Retiree (or other eligible Beneficiary) by check or direct deposit; your benefit payment cannot be assigned to a medical provider or insurance carrier. Claims are processed once per month and reimbursement benefit payments are generally issued within 30 days following the receipt of all required documentation.
2. **Please submit your medical expenses that are covered by other medical, vision, and/or dental insurance plans to those plans first. The Trust will pursue recoupment, and other available remedies, for claims submitted in violation of the Plan rules (e.g., for expenses that are paid elsewhere).**
3. Each claim for reimbursement must have supporting documentation of health care services, supplies or premiums and proof of payment by you in order for the Trust Office to issue a reimbursement benefit payment. Supporting proof of payment documentation examples include: CalPERS statements and/or pay stubs reflecting medical/dental/vision premium payments deducted from your pension, receipts from medical providers or insurance carriers, medical/dental/vision bills marked as "paid" by the medical provider, or cancelled checks.
4. Claims and supporting documentation become the property of the Plan and cannot be returned to you; please make copies before submitting the claim, if needed.
5. All expenses must be itemized and qualify as Covered Expenses under the Plan. (For examples of tax-deductible medical expenses that can be reimbursed by this Plan, please refer to IRS Publication 502 at https://www.irs.gov/pub/irs-pdf/p502.pdf). If you are uncertain as to whether an expense is reimbursable, please contact the Trust Office by phone at (877) 808-5994 or by email at PORAC@bpabenefits.com.
6. The Plan year runs from July 1 - June 30. Expenses paid during the Plan year must be postmarked within three months of the end of the Plan year, i.e., by September 30th.
7. Medical Expenses: Please complete the following information if you are seeking reimbursement for one-time miscellaneous medical expenses (not for insurance premiums). Attach documentation, and additional pages, if necessary.
8. Reimbursements will be made directly to the retiree (or other eligible Beneficiary) by direct deposit; reimbursement payments cannot be assigned to the medical service provider or service carrier. The Trust Office will process claims once a month (typically around the 15th of each month) and generally issues payment within 30 days after receipt of all required documentation.
9. One-time claim expenses submitted are required to be accompanied by a signed and completed claim form with **each** submission.
10. All claim forms must include completed demographic information, premium and claim information being submitted, completed Summary of Request, a live signature made by the member/collecting Beneficiary, and date. Claim Forms may not be reused for multiple submissions made on different dates.
11. Premiums: Please complete the following information if you are claiming reimbursement for payment of insurance premiums. You need to submit this Claim Form to the Trust Office annually along with third-party documentation of the type of coverage, amount of premium and period of insurance coverage, and proof of payment of the insurance premiums in order to request reimbursement of your monthly insurance premiums. You need to submit proof of payment of each monthly premium that you want reimbursed (12 monthly payments, unless you pay your insurance premium on some other frequency) prior to receiving reimbursement for each monthly premium. If you are claiming reimbursement of Medicare premiums, you generally only need to provide your Social Security statement showing the Medicare deduction once per year with this Claim Form. You must provide a new Claim Form and new third-party documentation of the type of coverage, amount of premium, and period of coverage, at least annually and any time your premium amount (including Medicare premium) changes (i.e. increases or decreases).

Pretax Premiums Notice:

Taxation of Certain Premium Reimbursements from this Plan. Generally, your reimbursement benefits from this Plan are not taxable income to you. However, there are a couple exceptions to that rule (see below), and you can request a taxable benefit payment on this Claim Form for these circumstances by initialing and filling in the taxable benefit amounts requested below.

a) *Premiums paid with pre-tax income*. Payment with "pre-tax" income means that I paid the premium with income that is not taxable to me, *e.g.,* the premium amount was deducted from my spouse's income prior to taxation.

b) *Income tax deductions prohibited*. If you deduct your health insurance premium on your personal income tax return, then you cannot get reimbursement of those premiums from this Plan tax-free. If you want reimbursement and anticipate claiming a deduction on your personal income tax, then you can request a taxable benefit payment on this Claim Form.

c) *Taxable benefits and tax penalties*. If you request a taxable benefit payment on this Claim Form by filling out the statement, you will receive an IRS Form 1099 for those benefit payments from the Trust. You are responsible for any income tax on this taxable income and any penalties incurred related to improper deduction on your individual income tax return of medical expenses or premiums reimbursed by this Plan.

CLAIM FORM FOR EXPENSE OR PREMIUM REIMBURSEMENT

Retiree/Beneficiary Name: _____ Date of Birth: _____

Spouse's Name: _____ Date of Birth: _____

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Phone Number: _____

Email address: _____ Cell Phone Number: _____

SUMMARY OF REIMBURSEMENT REQUEST

Total Out-of-pocket Premiums: **$**_____

Total Out-of-pocket Pre-tax Premiums: **$**_____

Total Out-of-pocket Claims: **$**_____

Total Payment Requested: **$**_____

Individual Account Balance Authorization:

If your total requested reimbursement claim exceeds your Monthly Benefit Level, the Trust Office will automatically pay the excess claimed amount from your Individual Account balance, if any. Please indicate using the provided options to allow or restrict the use of any applicable Individual Account funds. Forms submitted without a selection will have the default applied allowing reimbursement

☐**Yes** – I authorize the use of available Individual Account funds ☐ **No** – Do not issue from my Individual Account

Explanation of Benefits (EOB):

☐ I am submitting an Explanation of Benefits (EOB) from my health insurance carrier or plan and requesting reimbursement of my share of medical costs as indicated on the EOB. By checking this box, I certify that I have paid the amount indicated as my share of costs, that this claimed amount has not been reimbursed by insurance or otherwise, and that I will not seek reimbursement of this claim amount from any other plan covering health costs.

CLAIMS REIMBURSMENT DETAILS

Service Date/Premium Period	Date Paid	Patient Name	Provider/Carrier	Type of Coverage/Service	Amount Requested
				☐Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐Pre-Tax Premium ☐Post-Tax Premium ☐Other:____________________________________	$________

Service Date/Premium Period	Date Paid	Patient Name	Provider/Carrier	Type of Coverage/Service	Amount Requested
				☐Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐Pre-Tax Premium ☐Post-Tax Premium ☐Other:____________________________________	$________
				☐Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐Pre-Tax Premium ☐Post-Tax Premium ☐Other:____________________________________	$________
				☐Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐Pre-Tax Premium ☐Post-Tax Premium ☐Other:____________________________________	$________
				☐Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐Pre-Tax Premium ☐Post-Tax Premium ☐Other:____________________________________	$________
				☐Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐Pre-Tax Premium ☐Post-Tax Premium ☐Other:____________________________________	$________

Certifications and Agreements of Beneficiary

a) I certify that the above claim(s) were incurred for services and/or premiums on behalf of me or my eligible Beneficiaries. These expenses have not been reimbursed, and I will not seek reimbursements from any other source.

b) If I request and receive reimbursement from the Trust for an expense that does not qualify for reimbursement under this Plan, or that does not have sufficient documentation, I understand that the Trust may pursue recoupment of overpaid benefits or penalties for failure to withhold taxes, including offsetting future benefits.

c) I understand that the benefits paid to me by the Trust cannot exceed the actual premiums and/or medical expenses paid by eligible Beneficiaries.

d) I understand that I am responsible for all premium payments to the insurance carrier(s) and that the Trust will reimburse me - not the insurance carrier.

e) I understand that I must submit proof of payment of each insurance premium prior to receiving reimbursement of the premium.

f) **I understand that at least annually I will be required to furnish a new Claim Form and new third-party documentation of my insurance coverage and**

proof of payment of premiums. I agree to notify the Trust within 30 days of termination or reduction of any of the claimed insurance premiums. If I fail to do so, I will be obligated to reimburse the Trust for any overpayments to me, as well as to pay the Trust for penalties and interest.

g) I understand that these benefit payments are not taxable, and thus, reimbursed expenses and premiums are not allowed as deductions when filing my individual income tax return. I understand that the Plan cannot reimburse, on a tax-free basis, insurance premiums that are paid with pre-tax income and that I must request a taxable benefit payment on page 2 of this Claim Form for reimbursement of premiums paid with pre-tax income. I understand that the amount requested as a taxable benefit payment on page 1 will be taxable income to me, and that I am responsible for any income tax penalties incurred related to improper deduction on my individual income tax return of medical expenses or premiums reimbursed pursuant to this claim.

h) I affirm that I am not currently employed by any Trust Participating Employer (including part-time or contract work) and was not employed by a participating employer when the attached expenses were incurred. I affirm that I do not intend to start employment with a participating employer within the next year, and if I do return to work, I will inform the Trust Office prior to my first day of work. I acknowledge that this Plan is a retiree-only plan, and therefore, a Beneficiary cannot receive benefits while employed by a Participating Employer. I understand the Trust could be subject to penalties under federal law, if benefits are paid during employment, and the Trust may seek to recover those penalties from me.

i) I understand that the Plan may pursue legal and equitable remedies against me for any false, fraudulent, or misleading information provided on this Claim Form. I agree to indemnify and reimburse the Trust on demand for overpayment of benefits, and any liabilities or damages incurred, as a result of a fraudulent claim payment.

I certify under penalty of perjury that I have read and understood all 3 pages of this Claim Form, and all information on this Form is true, accurate and correct, to the best of my knowledge.

Eligible Retiree (or Beneficiary) Signature	Print Name and Relationship to Retiree	Date Signed