

Harvard University Supplemental Health Care Fund (SHF) FAQ

For Local 26 members only



What is the SHF?

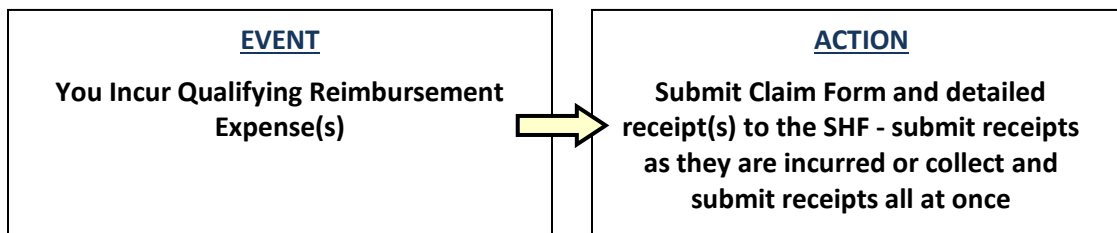
Harvard University provides a unique program to assist employees who face high medical costs during the plan year. You do not need to enroll in this coverage, but you do need to meet the eligibility requirements and request reimbursement.

Who is eligible for the SHF?

You must be an active Harvard employee covered under Local 26 and enrolled in one of the Harvard University-sponsored Medical Plans.

How does this benefit work?

The SHF is designed to assist in covering the costs of inpatient and outpatient hospital, emergency room, and high-tech imaging copays.



What are Qualifying Supplemental Health Care Fund Expenses?

The SHF covers copayments for inpatient and outpatient hospital, emergency room, and high-tech imaging.

Who administers the Harvard University Supplemental Health Care Fund?

Benefit Strategies, LLC is Harvard's administrator for this benefit.

How do I submit for payment?

If you are enrolled in an individual or family plan you can submit detailed and legible receipts with a completed SHF Claim Form to Benefit Strategies.

What is Supporting Documentation/Detailed Receipt?

Detailed, legible receipts or Explanations of Benefits (EOBs) from in-network medical providers are considered supporting documentation. Cancelled checks and credit card receipts by themselves are not acceptable.

How do I obtain a SHF Claim Form?

There are several ways to obtain this form:

- Go to www.benstrat.com. Click on *Client Links*, located in the top right corner of the home page, to access the link for Harvard University. Under Plan Information, click on Supplemental Health Care Fund for the Supplemental Health Care Fund Reimbursement FAQ and Request Form.
- Go to the [HARVie Forms page](#)
- Request a form be sent to you by contacting Benefit Strategies at 855-HVD-FLEX (855-483-3539) or hvdflex@benstrat.com.

When and how will my expenses be paid?

Once the completed form and all required supporting documentation is received, payment will be issued in 2-10 business days. Payment will be sent directly to the provider unless otherwise indicated on the claim form. Participants who do not want the payment sent directly to the provider can choose to be reimbursed by check or direct deposit. You can provide direct deposit information by logging in to your secure account at www.benstrat.com or completing a Benefit Strategies Direct Deposit Authorization Form.

What is the plan year and deadline for submitting expenses?

The plan year is **January 1, 2020 – December 31, 2020**. Reimbursement requests for expenses *incurred during the plan year* can be sent in at any point in the plan year but no later than **January 31, 2021**.

How do I submit the SHF Claim Form?

You can submit the claim form and supporting documentation to Benefit Strategies via fax, mail or secure email (see contact information at the bottom of the page).

Can I view my claims?

Yes. There are two ways you can view your claims:

- Through the Benefit Strategies portal
 - Log in to your secure account by visiting www.benstrat.com.
 - Click on **Client Links**, located in the top right corner of home page, to access the link for Harvard University.
 - Click on the **Secure Account Login** button (if you are a first-time user, click on the **New User** link to create your username and password).
- With the Benefit Strategies mobile application:
 - Download on iTunes or Google Play Store.
 - Create your username and password.

Once you log in, you will be able to access all of your Benefit Strategies plans and view your claims history.

What can I expect from Benefit Strategies?

- Claims will be paid in a timely manner.
- Benefit Strategies representatives can explain how the program works and how to submit for payment or reimbursement. However, for any questions regarding your medical insurance plan and what constitutes covered expenses, please contact your medical insurance carrier directly.
- Our Customer Service Representatives are available Monday through Thursday from 8:00 AM to 6:00 PM (Eastern Time) and on Friday from 8:00 AM – 5:00 PM (Eastern Time) via telephone at 855-HVD-FLEX (855-483-, online chat at benstrat.com, and email at hvdflex@benstrat.com. Language translators are available, please call for details.



**HARVARD UNIVERSITY SUPPLEMENTAL HEALTH CARE FUND
CLAIM FORM**

For Local 26

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

Employee Information:

Employee Name (First, Last):		Last 4 digits of SSN: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Primary Phone (include area code):		Email Address* (E-mail if you want to receive important account notifications):	

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

Copayment Expenses: Please list **QUALIFYING SUPPLEMENTAL HEALTH FUND PROGRAM EXPENSES.**

Inpatient Hospital (IH) Outpatient Hospital (OH) Emergency Room (ER) High-Tech Imaging (HTI)	Date of Service	Full Name of Covered Person	Service Provider	Expense Amount
<input type="checkbox"/> IH <input type="checkbox"/> OH <input type="checkbox"/> ER <input type="checkbox"/> HTI	/ /			\$.

Payment will be sent to the Service Provider. If you have already paid the provider and want the payment sent to you, check this box

Dependent Information: Complete this section only if the expense was incurred by your eligible dependent

<i>Complete below if any of the above expenses were incurred by your Spouse and/or Dependent</i>			
Last four digits SSN XXX-XX-	Full Name	Date of Birth / /	Relationship to Employee

SUPPORTING DOCUMENTATION: Submit this completed form along with a detailed receipt, invoice, or explanation of benefits (EOB) that includes the following information:

- | | |
|--|--|
| ✓ Name of the person receiving the service | ✓ Amount charged to the patient |
| ✓ Nature of the service | ✓ Name and address of care provider |
| ✓ Date the service was provided | ✓ Address where payment should be sent |

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 Supplemental Health Care Fund 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 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, CRP or any other plan.
- I understand that expenses reimbursed through the Supplemental Health Care Fund cannot 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:
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IMPORTANT INFORMATION

Claims for Qualifying Supplemental Health Care Fund expenses incurred during the plan year (January 1 – December 31) MUST BE POSTMARKED by January 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 member of Local 26 and enrolled in a Harvard University sponsored medical plan.

The Supplemental Health Care Fund the Supplemental Health Care Fund (SHF) is designed to assist in paying for hospital, emergency room, and high-tech imaging copayments.

Qualifying Supplemental Health Care Fund Expenses are limited to copayments only for inpatient and outpatient hospital services as well as emergency room and high-tech imaging. This fund is set up only to assist with copayment costs and those costs alone.

When to Submit Your Requests: requests must be submitted by January 31 of the following calendar year.

Supporting Documentation You must provide legible receipts from the provider for all Qualifying Supplemental Health Care Fund Reimbursement expenses for which you are requesting reimbursement. Receipts must clearly show:

1. Name of person receiving service
2. Nature of service
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 Claim Request You may submit your claim request (this form and all supporting documentation) to Benefit Strategies, LLC by fax, mail, or secure email. If your claim request is denied, written notification will be mailed to you. In some cases, you may be allowed to resubmit expenses with proper documentation.