Health Reimbursement Arrangement

Sample Reimbursement Forms and Receipts

A Health Reimbursement Arrangement, or HRA, is an account funded by OPERS that provides tax-free reimbursement for qualified medical expenses. The monthly allowance deposits can accumulate from month to month and, unlike most flexible spending accounts, the balance will roll over from year to year. Via Benefits ™ administers the HRA.

This booklet contains sample reimbursement forms and receipts which are required to seek reimbursement from your HRA account with Via Benefits.

www.opers.org | 800-222-7377

OPERS

Health Reimbursement Arrangement

Sample Reimbursement Forms and Receipts

VIA BENEFITS™

Reimbursement Request Form

11122233344455566677770

Account ID: 1234567899

John Doe
123 Main Street
Columbus, OH 43215

Submit requests online

Submit requests online at **my.viabenefits.com/Funds** or on our app for processing up to **10 days faster**.

Step 1. Prepare your request

- Check your name and address above, as you can only use your own form.
- Collect your **required supporting documentation**, as we need it to process your request. (See back for details.)

Step 2. Add your expenses to the correct table

Enter premium expenses

(Your request will be considered for recurring reimbursement based on your documentation and plan rules.)

Coverage Period (e.g., 01/01/2020 - 12/31/2020)	Premium Type (e.g., Medical, Medicare Part B)	Carrier (e.g., Humana)	Individual Serviced (e.g., John Doe)	Monthly Amount (e.g., $200.00)
1/1/2020 - 12/31/2020	Medical	AARP	John Doe	$182.37
1/1/2020 - 12/31/2020	Dental	OPERS	John Doe	$36.59
1/1/2020 - 12/31/2020	Medicare Part B	Medicare	John Doe	$144.60

Enter out-of-pocket medical expenses

Date of Service (e.g., 01/01/2020)	Expense Type (e.g., Copay)	Provider (e.g., Dr. Smith, CVS)	Individual Serviced (e.g., John Doe)	Amount (e.g., $100.00)

Certification

By submitting this Reimbursement equest Form, I certify that the information provided is correct and complete. I also certify that the expenses provided were incurred for the individual serviced while eligible under the plan on or after its effective date. I certify the expenses haven't been reimbursed in any other way from another source, and the expenses won't be submitted for future reimbursement from another source. **I certify that I'll notify Via Benefits if my coverage is changed or cancelled** at **my.viabenefits.com/Funds** or 1-844-287-9945 (TTY: 711). (Continue on next page.)

Step 3. Submit this form and supporting documentation:

- By Mail: Via Benefits
  PO BOX 981155
  El Paso, TX 79998-1155
  (**Note:** Mailed documents won't be returned.)
- By F ax: 1-866-886-0879
- Online: Submit requests online at **my.viabenefits.com/Funds** or on our app for processing up to **10 days faster**.

What supporting documentation should I use?

Examples of accepted supporting documentation include premium statements, a Benefit Award Letter for Medicare Part B, a Notice of Medicare Premium Payment Due, Explanation(s) of Benefits, and itemized receipts.

When submitting supporting documentation for premium expenses:

Provide a supporting document that shows this information:

- Premium coverage period (e.g., 01/01/2020 – 12/31/2020)
- Premium type (e.g., Medical, Medicare Part B)
- Carrier (e.g., Humana, N/A for Medicare Part B)
- Individual serviced (e.g., John Doe)
- Monthly amount (e.g., $200.00)

When submitting supporting documentation for out-of-pocket expenses:

Provide a supporting document that shows this information:

- Date of service (e.g., 01/01/2020)
- Expense type (e.g., Copay)
- Provider (e.g., Dr. Smith, CVS)
- Individual serviced (e.g., John Doe)
- Amount (e.g., $100.00)

Make your reimbursements easier:

Receive reimbursements faster!
Get reimbursed faster by submitting your expenses online at **my.viabenefits.com/Funds** or on our app.

Automate your premium requests!
Sign into your online account to set up Automatic Premium Reimbursement for monthly premiums.

Get your money quickly!
Set up direct deposit for quick and easy access to your money. Sign up at **my.viabenefits.com/Funds** or on our app.

Request reimbursements on the go!
Download our mobile app from the Apple or Google Play app stores.

We're here to assist you

If you have questions, please call Via Benefits at 1-844-287-9945 (TTY: 711), Monday through Friday 8am - 9pm Eastern.

3

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642 1-800-222-7377

JOHN DOE
ADDRESS
CITY, ST ZIP

0500

Health Care Premium Receipt

Receipt Period Start Date: 01/01/2020

Receipt Period End Date: 12/31/2020

Total Amount Paid: $85.46

1 2 4 5

Coverage Period	Type of Coverage	Covered Participant	Relationship	Total Premium Paid
2020-01-01 – 2020-12-31	Vision	John Doe	Self	$6.14
2020-01-01 – 2020-12-31	Vision	Jane Doe	Spouse	$6.14
2020-01-01 – 2020-12-31	Dental	John Doe	Self	$36.59
2020-01-01 – 2020-12-31	Dental	Jane Doe	Spouse	$36.59

It is your responsibility to report to Via Benefits any refunds of, reversals to or adjustments in your OPERS premium payments for which you have already been reimbursed from your HRA Account.

Supporting documentation must contain these items:

1) Premium Coverage Period (e.g., 01/01/XXXX - 12/31/XXXX)
2) Premium Type (e.g., Medical, Medicare Part B)
3) Carrier (e.g., Humana, AARP)
4) Individual serviced (e.g., John Doe)
5) Monthly amount (e.g., $200.00)

Form SSA-4926-SM (1-2020)

3

US GOVERNMENT PUBLISHING OFFICE: 2020 XXX-XXX/60004

Your New Benefit Amount

4

BENEFICIARY"S NAME: JOHN DOE

Your Social Security benefits will increase by 1.6% in 2020 because of a rise in the cost of living. You can use this letter as proof of your benefit amount if you need to apply for food, rent or energy assistance. You can also use it to apply for bank loans or for other business. Keep this letter with your important financial records.

How Much Will I Get And When?

• Your monthly amount (before deductions) is 1 & 2	$1,152.00
• The amount we deduct for Medicare medical insurance is (If you did not have Medicare as of November 17, 2019, or if someone else pays your premium, we show $0.00.)	5 $144.60
• The amount we deduct for your Medicare Prescription drug plan is (We will notify you if the amount changes in 2020. If you did not elect withholding as of November 1, 2019, we show $0.00)	$0.00
• The amount we deduct for voluntary Federal tax withholding is (If you did not elect voluntary tax withholding as of November 17, 2019, we show $0.00.)	$0.00
• After we take any other deductions, you will receive on or about January 10, 2020.	$1,007.40

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. We would be happy to review the amounts.

If you receive a paper check and want to switch to an electronic payment, please visit the Department of the Treasury's Go Direct website at *www.godirect.org* online.

What If

- Visit o
- Call us

Supporting documentation must contain these items:

1) Premium Coverage Period (e.g., 01/01/XXXX - 12/31/XXXX)
2) Premium Type (e.g., Medical, Medicare Part B)
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4) Individual serviced (e.g., John Doe)
5) Monthly amount (e.g., $200.00)

3

Social Security Administration

4

JOHN DOE
ADDRESS
CITY, ST ZIP

Date: December 19, 2019
Claim Number: 40B-XX-0432M

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Current Social Security Benefits

1

Beginning January 2020, the monthly Social Security benefit before any deductions is $1,029.70.

5 2

We deduction $144.60 for medical insurance premiums each month.

The regular monthly Social Security payment is $885.10 (We must round down to the nearest dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the third of each month.

Information About Past Social Security Benefits

Supporting documentation must contain these items:

1) Premium Coverage Period (e.g., 01/01/XXXX - 12/31/XXXX)
2) Premium Type (e.g., Medical, Medicare Part B)
3) Carrier (e.g., Humana, AARP)
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Enter premium expenses

(Your request will be considered for recurring reimbursement based on your documentation and plan rules.)

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1/1/2020 - 12/31/2020	Dental	OPERS	John Doe	$36.59
1/1/2020 - 12/31/2020	Medicare Part B	Medicare	John Doe	$144.60

Enter out-of-pocket medical expenses

Date of Service (e.g., 01/01/2020)	Expense Type (e.g., Copay)	Provider (e.g., Dr. Smith, CVS)	Individual Serviced (e.g., John Doe)	Amount (e.g., $100.00)
1/8/2020	Medical	Your Medical Facility	John Doe	$30.00
1/6/2020	Prescription	Your Pharmacy	John Doe	$18.00
2/7/2020	Dental	Your Street Dentistry	John Doe	$195.00

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  (e.g., 01/01/2020 – 12/31/2020)
- Premium type
  (e.g., Medical, Medicare Part B)
- Carrier
  (e.g., Humana, N/A for Medicare Part B)
- Individual serviced
  (e.g., John Doe)
- Monthly amount
  (e.g., $200.00)

When submitting supporting documentation for out-of-pocket expenses:

Provide a supporting document that shows this information:

- Date of service
  (e.g., 01/01/2020)
- Expense type
  (e.g., Copay)
- Provider
  (e.g., Dr. Smith, CVS)
- Individual serviced
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- Amount
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Medical Receipt Example

Date	Description	Charges	Pmt/Adjs	Patient Balance
Visit to Your Medical Facility 3				
Hospital/Facility Charges 2				
Patient Name: Doe, John 4	MRN: XXXXXXXXXXX			
Account: XXXXXXXXXXX				
Visit Date: Jan 8, 2020 1				
Insurance Coverage: INSURANCE PLAN				
1/8/2020	CLINIC VISIT	95.75		
1/8/2020	INSURANCE PAYMENT		-30.00	
	Coinsurance: 30.00			
1/8/2020	INSURANCE ADJUSTMENTS		-35.75	5
	Your Responsibility			30.00

Supporting documentation must contain these items:

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2) Expense Type (e.g., Copay)
3) Provider (e.g., Dr. Smith)
4) Individual serviced (e.g., John Doe)
5) Amount (e.g., $100.00)

FACILITY NAME
FACILITY ADDRESS
CITY, ST ZIP

TERMINAL ID: 3576
MERCHANT #: 3489754

MASTERCARD
**********4578 EXP:XX/XX SWIPED
SALE
BATCH: 000476 INV: 0000054
Jan 8, 2020 09:43
AUTH:000343

AUTH/TKT 001774

5
AMOUNT $30.00

John Doe

SIGNATURE

CUSTOMER COPY

Pharmacy Receipt Example

Total: $18.00
Total RX: 1

3 Your Pharmacy

If you have any questions, please feel free to contact your Pharmacist at (800) 555-5555.
Call your doctor for medical advice about side effects. You may report side effects to the DFA at 1-800-FDA-1088.

JOHN DOE 4
YOUR
ADDRESS

OC# 000 000 122 454 632 012

RX: 48588393 Ref = 0 DATE: 1/6/2020
1

5
Patient Pays: $18.00

YOUR PHARMACY 211-234 PRIORITY: WILL PICKUP
PHARMACY
ADDRESS
NABP: 45932350442
PRESCRIPTION NAME 50MG TAB NDC 000045-22
2
PHARMACIST NAME
QTY: 90 DAW:0 DAY SUPPLY: 90

PHARMACY NAME

800-555-5555
MANAGER ASHLEY JONES
PHARMACY ADDRESS
CITY, ST ZIP
ST# 03487 OP# 68494 TE# 00 TR# 9554
RX: 65003204 0001 QTY 1H 18.00
SUBTOTAL 18.00
TOTAL 18.00
5 CASH TEND 18.00
CHANGE DUE 0.00

ITEMS SOLD 1

TC# 0000 1000 2000 9999 9999

1/6/2020 16:55:31

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3) Provider (e.g., Dr. Smith)
4) Individual serviced (e.g., John Doe)
5) Amount (e.g., $100.00)

Dental Receipt Example

3 Your Street Dentistry
Address
City, ST ZIP

1 Date	4 Patient	2 Description	Performed By	Amount
2-7-20	John Doe	Panoramic Film	Dr. Foster	$80.00
2-7-20	John Doe	Extraction – A	Dr. Foster	$90.00
2-7-20	John Doe	Extraction – K	Dr. Foster	$90.00
2-19-20		Insurance Payment		($65.00)
2-7-20		Patient Visa Payment		5 ($195.00)
			New Balance:	$0.00

Supporting documentation must contain these items:

1) Date of service (e.g., 01/01/XXXX)
2) Expense Type (e.g., Copay)
3) Provider (e.g., Dr. Smith)
4) Individual serviced (e.g., John Doe)
5) Amount (e.g., $100.00)

Your Street Dentistry
ADDRESS, CITY, ST ZIP

TERMINAL ID: 5675
MERCHANT #: 9258844

MASTERCARD
**********1221 EXP:XX/XX SWIPED
SALE

BATCH: 000116 INV: 0000078
Feb 7, 2020 09:12

AUTH/TKT 024879

5
AMOUNT **$195.00**

John Doe

SIGNATURE

CUSTOMER COPY

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Form SSA-4926-SM (1-2019)

3

US GOVERNMENT PUBLISHING OFFICE: 2019 XXX-XXX/60004

Your New Benefit Amount

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How Much Will I Get And When?

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• The amount we deduct for Medicare medical insurance is (If you did not have Medicare as of November 17, 2018 or if someone else pays your premium, we show $0.00.)	5	$135.50
• The amount we deduct for your Medicare Prescription drug plan is (We will notify you if the amount changes in 2019. If you did not elect withholding as of November 1, 2018. we show $0.00)		$0.00
• The amount we deduct for voluntary Federal tax withholding is (If you did not elect voluntary tax withholding as of November 17, 2018, we show $0.00.)		$0.00
• After we take any other deductions, you will receive on or about January 10, 2019.		$1,000.50

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- Call us

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8/13/2020