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NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND MEDICAL REIMBURSEMENT PROGRAM (MRP) FORM FOR ACTIVE MEMBERS

ANNUAL MAXIMUM: The NJDCEA MRP provides up to a total of $900 per Active employee per calendar year (total for the whole family) for reimbursement of qualifying medical expenses incurred during the 2020 and 2021 calendar years.

Please visit www.njdcea.org for additional plan information and claim forms
Please visit www.asonet.com to track your claims and claim history

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE ☐ FEMALE ☐		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
U.S. SOCIAL SECURITY NO.	WORK LOCATION	DAYTIME TELEPHONE NO	EVENING TELEPHONE NO	

PATIENT INFORMATION

PATIENT NAME	BIRTH DATE	MALE ☐ FEMALE ☐	RELATIONSHIP TO MEMBER: SELF ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ CHILD ☐

CLAIM INFORMATION-PLEASE ATTACH EXPLANATION OF BENEFITS FROM ALLCARRIERS

CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES	

ENROLLMENT STATEMENT

You can participate in in the MRP if you provide proof that you have New York State sponsored health care coverage and certify that it is compliant with the Affordable Care Act. New York State Health Insurance Program ("NYSHIP") coverage through either Empire or any of the HMO plans is compliant. You may claim reimbursement for your eligible dependents' expenses if you enroll them with the MRP. If you are receiving only dental and optical coverage from NYSHIP, that alone is not deemed to be ACA compliant.

Every year, in order to remain enrolled, you must provide valid proof of medical coverage and either certify that such coverage is NYSHIP Empire or HMO coverage or, if coverage is through another insurance policy, is compliant with the Affordable Care Act.

☐ **I am enrolled in the group health benefit plan provided by the State of NY**

Note: *Please submit a copy of your group health plan ID card with this reimbursement claim.*

☐ **I am enrolled in a group benefit plan provided by my spouse's employer**

Note: *Please submit a copy of your group health plan ID card with this reimbursement claim.*

MEMBER SIGNATURE – REIMBURSEMENT PAYABLE TO MEMBER ONLY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.
I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. 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. I HEREBY CERTIFY THAT I AM ENROLLED IN A GROUP HEALTH PLAN THAT MEETS MINIMUM VALUE STANDARDS UNDER THE AFFORDABLE CARE ACT. I AM SUBMITTING A COPY OF MY GROUP HEALTH PLAN ID CARD FOR THAT COVERAGE ALONG WITH THIS REIMBURSEMENT CLAIM.

______________________________ SIGNATURE OF MEMBER

______________________________ DATE

Covered Expenses include

Medical expenses that can be reimbursed under the MRP can be expenses that are not paid in full under your other medical coverage. In order to qualify for reimbursement under the MRP, a health care expense must meet all of the following requirements:

- It is incurred after the effective date of your coverage by this Plan;
- It is on one of the lists of qualifying expenses that appear below;
- It has not been and will not reimbursed by any other coverage you have;
- It is submitted with **appropriate documentation** including a detailed statement or bill and a copy of an Explanation of Benefits or other statement showing denial of reimbursement or proof that the expense is not reimbursable by your other insurance coverage.
- It must be rendered by a licensed provider in accordance with applicable U.S. law.

How to File a Claim

1. Complete the claim form and attach all copies of the itemized bills for the expenses incurred and the corresponding explanation of benefits vouchers FROM ALL GROUP HEALTH INSURANCE PLANS covering the patient.
2. Please submit a copy of your group health plan ID card.
3. File a separate claim form for each family member.
4. Do not submit your claim until the end of the plan year unless you have already met the full amount of the benefit.
5. All claims for benefits must be postmarked no later than April 30 of the following Plan year in which the expense was incurred.

FAILURE TO FILE REQUIRED DOCUMENTATION AND/OR SIGN EACH CLAIM FORM WILL CAUSE DELAY IN THE PROCESSING OF YOUR CLAIM, AND MAY CAUSE A DENIAL OF YOUR CLAIM.

PLEASE VISIT WWW.NJDCEA.ORG FOR ADDITIONAL PLAN INFORMATION

Please note that dental, optical or hearing expenses (other than those listed) are NOT covered expenses under this Medical Reimbursement Plan

PARTIAL LIST AND EXPLANATION OF EXPENSES THAT CAN QUALIFY FOR REIMBURSEMENT

- Abdominal supports
- Legal abortions
- Acupuncture
- Alcohol/substance abuse treatment
- Ambulance
- Anesthetist
- Annual physical exam
- Arch supports
- Artificial limbs
- Autoette when used for relief of sickness or disability.
- Blood tests
- Blood transfusions
- Cardiographs
- Chiropractors
- Convalescent home for medical treatment only.
- Corrective optical laser surgery
- Cosmetic surgery only if necessary to improve a deformity arising from or directly attributable to a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease.
- Crutches
- Dental expenses
- Dental implants
- Dermatologist
- Diagnostic fees
- Diathermy
- Durable medical equipment
- Deductibles, copays and coinsurance payments under your medical coverage
- Diapers/diaper service (must be for a person 3 years of age or older and required to relieve the effects of a particular disease).
- Elastic hosiery by prescription.
- Guide dog
- Insulin and diabetic testing supplies
- Laboratory fees
- Medicine by prescription purchased only in the U.S.
- Nursing services (must be for services connected with caring for the patient's condition).
- Oxygen for medical purposes
- Psychiatric care, psychoanalysis and psychologists
- Radium therapy
- Spinal fluid test
- Special school costs for the handicapped
- Splints
- Sterilization
- Surgeon
- Physical, occupational, cardiac and speech therapy as ordered by a qualified physician and performed by the appropriate licenses therapist.
- Transplants
- Ultraviolet ray treatment
- Vaccines
- Vasectomy
- Wheelchair
- X-rays, MRIs and similar diagnostic procedures ordered by a qualified physician not otherwise covered by your health plan.
- Vision therapy for enrolled dependent children as ordered by a qualified physician and performed by the appropriate licensed therapist for treatment related to a neurological disorder.