

Harvard University Supplemental Health Fund (SHF) FAQ

For Local 26 members



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?

Active Harvard employee covered under Local 26 who are enrolled in one of the Harvard University sponsored medical plans are eligible.

What are qualifying SHF expenses?

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

How does this benefit work?

You Incur Qualifying Reimbursement



You submit Claim Form and detailed receipt(s) to the SHF – submit receipts as they are incurred or collect and submit

How do I request payment?

Submit detailed and legible receipts with a completed SHF Claim Form to Benefit Strategies via fax, mail, or secure email (see contact information at the bottom of the page).

What is Supporting Documentation?

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.

When and how will my expenses be paid?

Once the completed form and 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. If you don't want the payment sent directly to the provider, you can be reimbursed by check or direct deposit. You will need to 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 for reimbursement?

The plan year is **January 1, 2021 – December 31, 2021**. 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, 2022**.

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 Apple App Store or Google Play Store.
 - Create your username and password.

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

Who administers the Harvard University SHF?

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

What can I expect from Benefit Strategies?

- Claims will be paid in a timely manner.
- Benefit Strategies representatives can explain the details of the program for questions about your medical insurance plan, including what services are covered you will need to contact your medical insurance carrier directly.

How do I contact Benefit Strategies?

- **Phone:** 855-HVD-FLEX (855-483-3539) Monday - Thursday from 8:00 AM to 6:00 PM EST; Fridays 8:00 AM to 5:00 PM EST
- **Email:** hvdflex@benstrat.com
- **Web/Online Chat:** www.benstrat.com
- **Fax:** (603) 232-1854
- **Mail:** The Dunlap Building | 967 Elm Street | PO Box 1300 | Manchester, NH 03105-1300

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 Supplemental Health Fund Plan (the "Plan"). If there is a conflict between this section of the form and the Plan, the Plan will control.

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

Qualifying Supplemental Health Care Fund Expenses:

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.

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.

Employee Information

To update your address or email, please log on to hr.harvard.edu, and select "PeopleSoft" link at the top of any HARVie page and log in. Once in PeopleSoft, click on the My Personal Details tile and make all necessary updates.

Employee Name (First, Last):	Employee HUDID:
Primary Phone (include area code):	Email Address (E-mail is required to receive important account notifications):

Copayment Expense: Please list **QUALIFYING SUPPLEMENTAL HEALTH FUND PROGRAM EXPENSE.**

Inpatient Hospital (IH) Outpatient Hospital (OH) Emergency Room (ER) High-Tech Imaging (HTI)	Date of Service	Full Name of Person Receiving Service	Service Provider	Expense Amount
<input type="checkbox"/> IH <input type="checkbox"/> OH <input type="checkbox"/> ER <input type="checkbox"/> HTI	/ /			\$.
<input type="checkbox"/> IH <input type="checkbox"/> OH <input type="checkbox"/> ER <input type="checkbox"/> HTI	/ /			\$.
<input type="checkbox"/> IH <input type="checkbox"/> OH <input type="checkbox"/> ER <input type="checkbox"/> HTI	/ /			\$.
<input type="checkbox"/> IH <input type="checkbox"/> OH <input type="checkbox"/> ER <input type="checkbox"/> HTI	/ /			\$.
<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
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
- ✓ Nature of the service
- ✓ Name and address of care provided
- ✓ Amount charged to the patient
- ✓ 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 expenses under the Harvard University Supplemental Health Fund Plan (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 previously 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 or any other plan.
- I understand the qualifying expenses reimbursed may not be used to claim any federal income tax deduction or credit.

I have read the FAQ and understand that I can request a copy of the Plan from Harvard University if I do not currently have a copy.

SIGN HERE:	Date:
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Form Submission:

E-Mail: hvdflex@benstrat.com **Mail:** PO Box 1300, Manchester, NH 03105-1300 **FAX:** (603) 232-1854 (15 page max)