MAIL TO:	
ASO, Inc. PO Box 9005, Dept. 47M Lynbrook, NY 11563-9005 516-396-5500 / 800-537-1238	**CWA LOCAL 1181 SECURITY BENEFIT FUND** **SUPPLEMENTAL WELFARE FUND BENEFIT** **REIMBURSEMENT CLAIM FORM- 2025**

CALENDAR YEAR MAXIMUM: $300 per family

COVERED EXPENSES INCLUDE:
(1) Medical, Hospital, Dental, Optical and Prescription Drug Deductibles, Co-Payments, and Co-Insurance under your group health plan;
(2) Prescription Drug Costs;
(3) Non-covered dental and optical expenses;
(4) Over-the-counter drugs and medicines purchased without a prescription, such as aspirin and allergy medicines. Such drugs and medicines **must be** for the treatment of illness or injury and not merely to advance general good health; and
(5) Menstrual care products.

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED If you are divorced, it is your responsibility to notify the Fund Office/disenroll your ex-spouse from coverage immediately. Otherwise, you will be financially liable for any amounts paid in error and you may lose your coverage under the Fund.		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
MEMBER'S SOCIAL SECURITY NO. (Last 4 Digits)		TELEPHONE NUMBER: EMAIL ADDRESS:		

PATIENT NAME	EXPENSE TYPE	CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES
1				
2				
3				
4				
TOTAL				

PLEASE SEE REVERSE SIDE OF FORM FOR CLAIM FILING REQUIREMENTS.

FAILURE TO PROVIDE THE REQUIRED DOCUMENTATION MAY DELAY THE PROCESSING OF YOUR CLAIM

IMPORTANT NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL OR FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT.

MEMBER SIGNATURE REQUIRED REIMBURSEMENTS ARE PAYABLE TO MEMBER ONLY

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE AVAILABLE TO ME OR MY DEPENDENTS. 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.

_____ _____

SIGNATURE OF MEMBER DATE

CWA LOCAL 1181 SECURITY BENEFIT FUND

SUPPLEMENTAL WELFARE FUND BENEFIT

IN ORDER TO QUALIFY FOR REIMBURSEMENT

THE OUT-OF-POCKET EXPENSE MUST MEET ALL OF THE FOLLOWING REQUIREMENTS:

1. It must be incurred between **January 1st and December 31st** and submitted by **April 30th** of the following year.
2. It must be medically necessary and rendered by a licensed provider as mandated by state law.
3. It must be documented by a detailed billing statement from the provider including the name, address, telephone number, and tax identification number of the provider and the nature of the medical services rendered and/or an explanation of benefits from all other plans or, as applicable, a receipt showing the date purchased, the cost of the item, and a description of the item. To obtain explanation of benefit vouchers (EOB's):

- For Medical and Hospital EOB's visit your medical carrier website as indicated on your health insurance ID Card
- For Prescription Drug Co-Payments request your history from your pharmacist or express-scripts.com
- For Dental EOB's go to asonet.com

A. Hospital, Medical, Prescription Drug and Dental Plan Deductibles, Co-Pays and Co-Insurance

This Plan will reimburse deductible, co-payment, and co-insurance expenses under your hospital, medical, prescription drug, dental, and optical plans that are not covered by other plans. All such expenses must first be processed through your insurance program and all claims for reimbursement must be accompanied by an explanation of benefits statement from the insurer and/or receipts for payment clearly showing deductibles, co-pay, and/or co-insurance charges.
Do not submit original receipts/documents. Neither the Fund nor A.S.O. will be responsible for loss thereof.

B. Prescription Drug Cost Reimbursement

Prescription drug costs are eligible for reimbursement, provided you are covered by a minimum value health plan, as explained above.

In order to be eligible for reimbursement, claims must be accompanied by a pharmacy printout or a copy of a receipt. The reimbursement benefit is secondary to your primary prescription drug coverage.

C. Over-the-Counter Drugs and Medicines

Over-the-counter drugs and medicines purchased without a prescription, such as aspirin and allergy medicines, are eligible for reimbursement. Such drugs and medicines must be for the treatment of illness or injury and not merely to advance general good health. Claims must be accompanied by a receipt showing the date purchased, the cost of the item, and a description of the item.

D. Menstrual Care Products

Menstrual care products include tampons, pads, liners, cups, sponges, or other similar items used in respect to menstruation. Claims must be accompanied by a receipt showing the date purchased, the cost of the item, and a description of the item.

E. Non-Covered Dental and Optical Expenses

This Plan will reimburse for non-covered dental and optical expenses such as bone grafts after extractions, crown lengthening, crowns build-up, sinus lifts, palatal expanders, analgesia (nitrous oxide), or Lasik eye surgery.