

Eligibility to Receive Reimbursements

You can access your HCSP account for the reimbursement of eligible medical expenses when you:

- separate from service at any age,
- retire, or
- are collecting a disability benefit from a Minnesota public pension plan.

Only eligible medical expenses incurred after you leave public employment can be reimbursed. An expense is incurred the date the service is provided, ***not the date the bill is paid.***

Questions?



Contact the MSRS Service Center:
1.800.657.5757 or 651.284.7730



Email us:
info@mnretire.gov



Make an appointment to speak to a retirement specialist.

Instructions to Request a Reimbursement

1. Complete and sign the attached *Reimbursement Request form*.
2. Complete a *Direct Deposit Agreement* to have reimbursements deposited into your financial institution (not required if you previously provided banking instructions for your HCSP account or if you prefer to receive payment by check).
3. Provide documentation of the expense(s). See pages 3 & 4 of this form to learn what is acceptable documentation.
4. Keep a copy of the form and documentation for your records.
5. Mail or fax the form and documentation to MSRS. DO NOT email your request. If you fax the form and documentation, it is not necessary to also mail the form and documentation to MSRS.
6. Payment will be made to you by check mailed to your address on file with MSRS or deposited into your financial institution (if direct deposit instructions are on file for at least 10 days). See page 4 for payment timing.
7. Need additional *Reimbursement Request Forms*?



Go to www.mnretire.gov/hcsp-forms-docs

Before you begin, review Eligibility to Receive Reimbursements on page 3 to determine if you are eligible for reimbursements. **If you are eligible**, complete and return pages 1 & 2 of this form.



1. Information about you

Last name		First name		MI
10-digit Account ID or SSN		Daytime phone #		Alternate phone #
Reimbursement Eligibility Reason				
<input type="checkbox"/> Retired or Separated from Service *		Date <u> </u> / <u> </u> / <u> </u> Month Day Year		* If you have returned to work with a previous Minnesota public employer who sponsored your HCSP, contact MSRS to determine if you are eligible to request reimbursements. To learn more, see page 3.
<input type="checkbox"/> Collecting Disability from Minnesota Public Retirement Plan		Date <u> </u> / <u> </u> / <u> </u> Month Day Year		
<input type="checkbox"/> Inherited or QDRO Account				

2. Reimbursement of insurance premiums

Review the instructions on page 3. You must attach acceptable documentation of your expenses. Failure to provide the requested information or acceptable documentation may delay your request.



If you are currently receiving ongoing monthly payments from this account, please list **ALL** premiums to be reimbursed, even if there is no change to the reimbursement amount.

Type of Insurance (medical, dental, long-term care, Medicare B, C, or D)	Premium Amount/Month	Coverage Type	Reimburse Previous Months (e.g. June, July)	Reimburse Future Months Automatically
	\$	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family		<input type="checkbox"/> Yes - new installment <input type="checkbox"/> Yes - change existing installment <input type="checkbox"/> Yes - continue same amount <input type="checkbox"/> Stop installment
	\$	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family		<input type="checkbox"/> Yes - new installment <input type="checkbox"/> Yes - change existing installment <input type="checkbox"/> Yes - continue same amount <input type="checkbox"/> Stop installment
	\$	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family		<input type="checkbox"/> Yes - new installment <input type="checkbox"/> Yes - change existing installment <input type="checkbox"/> Yes - continue same amount <input type="checkbox"/> Stop installment

3. Reimbursement of one-time expenses

Review the instructions on page 3. You must attach acceptable documentation of your expenses. Failure to provide the requested information or acceptable documentation may delay your request.

Date of Service (MM/DD/YYYY)	Relationship to Participant <i>Please check appropriate box</i>	Date of Birth (Dependents only)	Description of Expense (e.g., medical, dental, vision, RX, chiropractor)	Out-of-Pocket Expense
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent *			
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent *			
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent *			
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent *			
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent *			
Claim Total				\$

Please attach extra pages if expenses exceed space provided.

* Dependents are those you claim on your tax returns or your adult children up to their 26th birthday.

Must equal \$75 or more

4. Required signature (please sign below)

1. I certify that all expenses for which reimbursement is claimed by submission of this form were incurred by me, my spouse, my legal tax dependent(s) or my child(ren) up to their 26th birthday.
2. I certify that the medical expenses incurred by me, my spouse, my legal tax dependent(s) or my child(ren) up to their 26th birthday are "qualifying expenses" as defined by the Internal Revenue Code in Publication 502. I understand that if these expenses are deemed not to be qualified medical expenses, I may be liable for payment of all taxes on amounts paid by the HCSP related to such unqualified expenses.
3. I certify that the medical expenses claimed have not or will not be reimbursed by any other health plan coverage or paid by insurance.
4. I take full responsibility for the accuracy and veracity of the information provided. I certify I am entitled to these benefits.

Participant Signature _____ Date _____
Electronic signatures are not accepted Month / Day / Year

Account ID or SSN _____

Mail or fax the completed form to:



Minnesota State Retirement System

60 Empire Drive, Suite 300
St. Paul, MN 55103-3000



Fax: 651.282.9909

Privacy Notice: Private data requested on this form will be used by MSRS to process your request. You are not legally required to provide the data requested. However, we may not be able to process your request without sufficient information. Your private data will not be shared with an unauthorized person without written consent except as authorized by federal or state law or a court order.

Process for Requesting Reimbursement

Eligibility to receive reimbursements

You can access your HCSP account for reimbursement of eligible medical expenses when you separate from service at any age, retire, or are collecting a disability benefit from a Minnesota public pension plan.

Only eligible medical expenses incurred **after** you leave public employment can be reimbursed. You incur an expense the date the service is provided, not when the bill is paid.

Reimbursement suspensions (HCSP & HSA)

If you or your employer or your spouse or their employer contributed to a Health Savings Account (HSA) this calendar year, you cannot request HCSP reimbursements for medical expenses. You may continue to request reimbursements for dental and vision expenses.

To learn more, see www.mnretire.gov

Returning to work after termination/retirement

- If returning to work with your previous public employer who sponsored your HCSP, please contact MSRS to determine if you're eligible to request reimbursements.
- If returning to work with a new employer, you may request reimbursements of the account balance that resulted from your previous employment. Contributions to the HCSP that result from the new employment are not available for reimbursements until you end employment.

Example: An employee terminates employment with the State of Minnesota. They have an HCSP account balance of \$500. They now work for a Minnesota county and contribute 1% of bi-weekly pay to the HCSP. They may access the HCSP account balance that resulted from State of Minnesota employment. They cannot access contributions made through the new employer until ending that employment.

For more details, see www.mnretire.gov/returning-to-work.

Reimbursement of insurance premiums

Complete Section 2 of the *Reimbursement Request* form to request reimbursement of monthly after-tax medical, dental, and long-term care insurance premiums. Dental discount plans, medical sharing plans, and life insurance are not reimbursable.

Indicate the monthly after-tax premium amount and the applicable months for which reimbursement is being requested. If requesting reimbursement for premiums paid for previous months, you must provide proof that you had insurance coverage the entire span of time.

Acceptable documentation

Attach a current statement from the insurer that includes insurer's contact information, name of person covered, the coverage dates, and the amount payable, itemized by type of insurance coverage (health, dental, or long-term care coverage). Failure to provide acceptable documentation will delay your request.

Do not send insurance coverage election/enrollment forms.

Medicare Part B

Provide a copy of your Medicare card or letter from Social Security indicating the premium amount. Higher-income beneficiaries whose premium is more than the standard amount must provide a copy of the letter from Social Security indicating the premium amount.

Medicare Part D or supplemental insurance

Provide documentation indicating the premium amount.

Long-term care maximum annual limit

The amount of qualified long-term care premiums that can be reimbursed annually per person is limited. For more detail, see Publication 502, which is available at www.irs.gov.

Reimburse future months automatically box

Check "yes" if you want MSRS to automatically reimburse you every month and indicate if this is a new installment or change to an existing installment. Automatic reimbursements are generally paid the last Friday of each month for the following month's premium. Payments will continue until the account is depleted or you instruct us to change or cancel the payments. **Exception:** Monthly reimbursements for the Medicare IRMAA surcharge will be stopped at the end of each calendar year.

To request changes to monthly payments

Complete a new *Reimbursement Request* form and provide documentation of the expense. Note: Your insurance provider does not notify MSRS of premium amount or coverage changes.

To stop or decrease existing monthly payments

Call MSRS at 1.800.657.5757.

You cannot choose specific funds from which the reimbursement will be taken. Funds are pro-rated across all investment options.

Reimbursement of one-time expenses

Refer to *IRS Publication 502* at www.irs.gov for a complete list of eligible expenses.

Complete Section 3 of the *Reimbursement Request* form after you have incurred eligible healthcare expenses totaling \$75 or more. You may include multiple expenses on one form and attach additional pages, if necessary.

Indicate the date the expense was incurred, for whom the expense was incurred, and a brief description of the out-of-pocket expense. If requesting reimbursement for a legal tax dependent or an adult child, you must indicate their date of birth.

Acceptable documentation

Acceptable documentation can be all pages of an itemized statement from a provider or an insurance company's Explanation of Benefits (EOB). Failure to provide acceptable documentation that an expense was incurred will delay your request. **Documentation must include the provider's name and contact information, date of service, amount charged for the service, the insurance reimbursement amount, person for whom service was provided, and treatment/service provided.**

Process for Requesting Reimbursement

Unacceptable documentation

Examples of unacceptable documentation includes the following: Canceled checks, copies of checks, bank or credit card statements, handwritten receipts, an estimate of service not yet provided, balance forward statements, or balance-due statements of expense.

Dependents

Dependents are those you can claim on your tax returns or an adult child up to their 26th birthday. An adult child includes biological, adopted, step and foster children. The young adult does not have to be a legal tax dependent and can qualify regardless of marital status, status as a full-time student or place of residence. The reimbursement extension does not include a young adult's spouse or children.

Over-the-counter (OTC) drugs

Over-the-counter drugs, such as aspirin, antacids and allergy medicine, purchased January 1, 2020, or after can be reimbursed. Documentation can be an original sales receipt that specifies that name of the drug or medication. OTC drugs/medications purchased prior to January 1, 2020, cannot be reimbursed.

Reimbursable expenses with physician's note

Some medical expenses can only be reimbursed if you have a written prescription or a *Letter of Medical Necessity* form signed by a qualified medical practitioner that specifies a) the name/type of treatment; and b) the specific medical condition that requires the treatment/expense. The provider must update written documentation on an annual basis to continue to be eligible for reimbursement.

Maximum annual reimbursement limits

An annual reimbursement limit applies. The limit does not include medical, dental, or long-term care insurance premiums. Please visit www.msrs.state.mn.us for information regarding the annual limit amount.

You cannot choose specific funds from which the reimbursement will be taken. Funds are pro-rated across all investment options.

Payment timing

The timing of your payment assumes the reimbursement request is received in good order. "Good order" means:

- a) the form is completed correctly;
- b) the form is signed and dated by the participant; **and**
- c) acceptable documentation of the expense has been included with the form (see page 3 for more detail).

Automatic reimbursement of monthly insurance premiums

Payment is mailed to you or deposited into your bank account the last Friday of each month. *Please note:* Some financial institutions may not post your payment until 2 or 3 business days after the last Friday of the month.

Teletypewriter users and telecommunications-device-for-the-deaf (TDD) users call the Minnesota Relay Service at 1.800.627.3529, and ask to be connected to MSRS at 651.284.7730.

Reimbursement of one-time expenses

If using direct deposit, assume deposit will be posted to your bank account 7-10 business days after the date MSRS receives your paperwork. If receiving reimbursement by check, please allow additional time for mailing.

Important!

Processing time may vary depending on the volume of requests received by MSRS.

Delivery options

Reimbursements are always paid to you, not your provider or insurance company.

Reimbursements are made payable to you and mailed to your address on file or deposited into your financial institution, if you previously provided MSRS with banking information.

Direct deposits to your financial institution

Please complete a *Direct Deposit Agreement* form to have reimbursements electronically transferred to your financial institution. The form can be obtained online at www.msrs.state.mn.us or by calling MSRS.

Banking information must be on file at least 10 days before it is available for use. If banking information is not on file at least 10 days, your reimbursement will be sent to you by check. Subsequent reimbursements will be deposited into your designated bank account.