HealthEquity | WageWorks

www.healthequity.com/wageworks

MAKE A FAMILY BENEFIT REIMBURSEMENT

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Amount

$10,000 per calendar year; amount is not prorated based on how long employed during the calendar year, the full amount is available to anyone employed in the calendar year.

Eligibility

An "Eligible Employee" is a regular Autodesk employee on the U.S. payroll regularly scheduled to work at least 20 hours per week. Services for the employee and their spouse/domestic partner are covered under this benefit. Interns, independent contractors, consultants and project employees are not eligible for this benefit.

Reimbursement and taxes

The benefit is taxable income to you. After your submitted claim is approved by HealthEquity, you will receive reimbursement, minus applicable taxes, in your paycheck within a month.

Eligible expenses

The Make a Family Reimbursement Program covers four major expense categories:

1. Adoption
2. Surrogacy/gestational carrier, through an agency
3. Agency fees associated with acquiring donor egg/embryo/sperm
4. Elective fertility preservation costs, including cryopreservation of egg/embryo/sperm

A more detailed list of eligible expenses under each category can be found when you log in to EZ Receipt/HealthEquity. If your expense does not appear on the list of eligible expenses, it is not eligible for reimbursement under Benefits My Way.

Ineligible expenses

Any expense that is a covered Infertility Service as defined under a national Autodesk medical plan through UnitedHealthcare (UHC), even if the employee has not elected coverage under a UHC plan.

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Making the most of your benefit

To learn about the fertility coverage available to you under all the Autodesk medical plans, please contact CareCounsel at 888-227-3334 or start a chat at www.carecounsel.com. If you are enrolled in a UnitedHealthcare (UHC) medical plan through Autodesk, you can also request a consultation with a UHC Fertility Solutions nurse by calling 866-774-4626.
Kaiser members can contact their member support team with questions about their fertility coverage.

Instructions to file a claim for reimbursement

There are three methods to file a claim:

Method 1: Submit the claim online through the HealthEquity website:

1. Register and login at www.healthequity.com > EZ Receipts > Members. If this is your first time logging in, select Register and use the last 4 digits of your SSN as your ID Code.
2. Under "Dashboard," click on "Submit Receipt or Claim" and follow the prompts to submit a claim.

Method 2: Submit the claim through the mobile app:

1. Download the EZ Receipts app.
2. Follow the instructions in the app to submit a claim.

Method 3: Submit a hard copy claim form:

1. Fill out the claim form below, or it can be found on the HealthEquity participant site at www.healthequity.com
2. Fax or email the form, along with the receipt.

Proof of expense

Along with submitting a claim form, you will need to provide proof of your expense(s) in the form of a receipt or other proof of payment. Proof will need to include the service provider name, date or period, amount, description of service, and must list the recipient's and employee's name. If you submit a claim on behalf of your domestic partner, additional proof will be requested from you.

Timing to submit claims

You can submit a claim form any time during the year. You have until March 31st of the following year to submit expenses for the previous year. Eligible expenses must be incurred and submitted for reimbursement while being an active employee. Specifically, services must be provided after an employee's hire date and a request for reimbursement must be complete before termination date.

Note to new employees: It can take up to two weeks before you show as active in the HealthEquity system, so it is suggested that you wait at least two weeks from your hire date before submitting any claims.

Contact with questions

You may contact HealthEquity at 877-924-3967 or visit their website at www.healthequity.com.

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MAKE A FAMILY BENEFIT REIMBURSEMENT Pay Me Back Claim Form

Claim Filing Options:
- Toll-free fax: (877) 353-9236
- Or, Mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

ACCOUNT HOLDER:

Last Name | First Name

ID Code (last 4 digits) * | Employer / Program Sponsor's Name: AUTODESK INC

Zip Code | Date of Birth (MM/DD) | Email address (Complete only if new)

* Your ID Code is the last 4 digits of your Social Security number

RECIPIENT OF SERVICE:

☐ Self ☐ Spouse ☐ Domestic Partner (if Domestic Partner is selected, the certification on page 4 is required)

(For same sex fertility) Sex: ☐ M ☐ F Sex of spouse/partner: ☐ M ☐ F

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form and attached receipts are accurate and complete. I am requesting reimbursement only for recipients who are listed as eligible under this program. I have not and will not seek reimbursement for these expenses from any other program or party. If my spouse/partner is eligible to receive reimbursement under this program as an Autodesk employee, we will only submit this receipt for reimbursement once per household. If this reimbursement is for a surrogacy/gestational carrier, I certify the surrogacy is through an agency. Use of this service indicates my acceptance of the HealthEquity User Agreement (available upon registration at www.healthequity.com; enter username and password or click on "First Time User?" link). I understand this reimbursement must be taxed due to IRS regulations.

ELIGIBLE EXPENSES

See full list of all eligible expenses on the participant website under "Eligible Expense List" section.

INELIGIBLE RELATED EXPENSES

Any expense that is a covered Infertility Service as defined under a national Autodesk medical plan through UnitedHealthcare (UHC), even if the employee has not elected coverage under a UHC plan.

OUT-OF-POCKET EXPENSES

Itemize your eligible expenses below and attach supporting documentation along with proof of payment.

NAME OF SERVICE PROVIDER	DESCRIPTION OF EXPENSE	PAYMENT DATE	AMOUNT
1	☐ Adoption ☐ Surrogacy/Gestational Carrier, through an agency ☐ Agency fees associated with acquiring donor egg/embryo/sperm ☐ Elective fertility preservation cost, including cryopreservation ☐ Egg/Embryo/Sperm Freezing Costs		$
2	☐ Adoption ☐ Surrogacy/Gestational Carrier, through an agency ☐ Agency fees associated with acquiring donor egg/embryo/sperm ☐ Elective fertility preservation cost, including cryopreservation ☐ Egg/Embryo/Sperm Freezing Costs		$
		TOTAL THIS FORM	$

This form does not add your domestic partner to insurance coverage.
If you have questions about how to add a dependent to insurance coverage, visit AskPPL.

AUTODESK, INC.

ELIGIBILITY CERTIFICATION FOR NON-REGISTERED DOMESTIC PARTNERSHIP

This form does not need to be completed if your partnership is registered with a state or city.

I. Declaration

We, _____, and _____, certify:
employee name (print) non-registered domestic partner name (print)

Employee Initial	Non-Reg DP Initial	Employee and Non-Registered Domestic Partner - each initial to confirm you meet all of the following requirements.
		We are each other's sole domestic partner and intend to remain so indefinitely.
		We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare and financial obligations.
		We are both at least eighteen (18) years of age and mentally competent to consent to a contract.
		We are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we legally reside.
		We maintain the same residence(S) and intend to do so indefinitely.
		Neither of us is married to or legally separated from anyone else.

II. Acknowledgments

1. We have provided the information in this Certification for use by Autodesk, Inc. for the sole purpose of determining our eligibility for certain registered domestic partner benefits. We understand that the information provided in this form will be treated as confidential by Autodesk, Inc., but will be subject to disclosure; a) upon the express written authorization of the undersigned employee, or b) if otherwise required by law.

2. We understand that this Certification may have legal implications relating, for example, to our ownership of property, and that before signing this Certification we should seek competent legal advice concerning such matters.

3. We acknowledge that our Non-Registered Domestic Partnership began on or about:

Date _____.

We affirm, under penalty of perjury, that the statements in this Certification are true and correct. Falsification of this document in any way will require the undersigned employee to reimburse Autodesk for all company paid benefits based on these representations and may additionally result in termination of the employee's employment with Autodesk, at its sole discretion.

_____ _____
Employee Signature Date

_____ _____
Non-Registered Domestic Partner Signature Date

Please submit this form with your HealthEquity claim.