

SHEET METAL WORKERS LOCAL 263
HEALTH AND WELFARE FUND
 150 First Avenue NE, Suite 450
 Cedar Rapids, IA 52401
 319-365-2810

Healthcare Reimbursement Account PAYMENT REQUEST FORM

DATE _____ MEMBER'S SS # _____ PHONE # (____) _____

NAME _____

ADDRESS _____

IS THIS A CHANGE OF ADDRESS? _____ YES

REQUEST FOR MISCELLANEOUS EXPENSES	OFFICE USE ONLY _____	
MEDICAL EXPENSES \$ _____	CODE _____	CODE _____
DENTAL EXPENSES \$ _____	DOS _____	DOS _____
VISION EXPENSES \$ _____	AMT _____	AMT _____
OVER-THE-COUNTER DRUGS \$ _____	_____ HR	_____ HR
OTHER EXPENSES \$ _____	CODE _____	CODE _____
TOTAL \$ _____	DOS _____	DOS _____
	AMT _____	AMT _____
	_____ HR	_____ HR

YOU MUST ENCLOSE A COPY OF THE ITEMIZED BILL OR EXPLANATION OF BENEFITS (EOB) FORM FROM THE PPO FOR MEDICAL EXPENSES. **(INSTRUCTIONS AND COVERED EXPENSES ARE LISTED ON THE REVERSE SIDE.)**

By signing this request form, you certify that you have not taken and will not take a tax deduction for items submitted for reimbursement and that there is no other source available for payment. You also certify that any over-the-counter (OTC) medications are ONLY for use by you or a covered family member. Last, you certify that you have not submitted these expenses on a prior request form.

SIGNATURE _____

DATE _____

PLEASE SUBMIT THE ORIGINAL FORM TO THE FUND OFFICE.
 THE OTHER COPY MAY BE MAINTAINED FOR YOUR RECORDS.

IMPORTANT REMINDER

Your Healthcare Reimbursement Account is not a savings account and you are not vested in the balance. Amounts in the account can be used only for the expenses shown on the reverse side of this form. The Board of Trustees can change the list of covered expenses and any of the Healthcare Reimbursement Account's rules and procedures at any time.

COVERED EXPENSES THAT CAN BE REIMBURSED FROM THE HEALTHCARE REIMBURSEMENT ACCOUNT

(Only expenses incurred after the employee's participation date are eligible to be reimbursed.)

- Deductibles and co-payments from the regular benefit plan
- Wellness exams & immunizations
- Lasik surgery
- Medical/dental/vision expenses in excess of regular plan maximums
- Hearing aids
- Birth control pills
- Retiree self-payments for Welfare Fund coverage
- Fertility enhancement
- Psychiatric care
- Smoking cessation programs
- Medically supervised weight loss programs (but not food/supplements)
- Acupuncture
- Special telephone and television equipment for hearing impaired persons
- Guide dogs for blind or deaf persons
- Subject to special IRS rules:
 - Certain costs of modifying the home or car of a disabled person
 - Certain lodging expenses while accompanying a patient
 - Certain transportation expenses for medical treatment
 - Qualified special schooling expenses for mentally impaired or physically disabled
- Over-the-counter drugs as follows:

Allergy medications	Cough drops & throat lozenges	Anti-diarrhea medicine
Antibiotic ointments	Calamine lotion	Cold medicine
Antacids	First aid creams	Motion sickness pills
Nicotine medications	Pain relievers	Sinus medications & nasal sprays
Sleep aids	Hemorrhoid suppositories & creams	Wart removal medication

NON-COVERED EXPENSES

- Cosmetic surgery and treatments.
- Household help.
- Charges incurred by a person not covered by the Plan.
- Health club memberships/expenses.
- Child and dependent/elder care expenses.
- Burial expenses.
- Sales tax, shipping & handling fees.
- Long-term care insurance premiums.
- Expenses reimbursed by some other source.
- College tuition/books.
- Environmental devices such as, air conditioners, air purifiers, or humidifiers.
- OTC products such as acne treatments, cosmetics, dietary supplements, fiber supplements, herbs, lip balm, shampoos and soaps, suntan lotion, toiletries, weight loss drugs and vitamins.

In addition, previously paid self-payments that were paid in cash or by check or money order cannot be reimbursed at a later date from the Healthcare Reimbursement Account.

INSTRUCTIONS

- Claims for OTC (over-the-counter) medications must include store cash register receipts on which the name of the product has been imprinted by the cash register. Non-imprinted, or hand-annotated cash register receipts will not be accepted. It is your responsibility to purchase these products at stores that properly document the name of the product purchased. You may only claim OTC products that are used for yourself and your covered family members.
- For all other types of claims you must enclose an itemized copy of the bill stating the provider's name and address, patient name, and date of service or a copy of the Explanation of Benefits from the PPO. **Collection notices and bills indicating only a balance due are not acceptable. (Cash register receipts from providers are also NOT acceptable.)**
- The minimum amount requested should be \$50 unless you have accumulated less than \$50 in a year.
- You have *one year* from the date of service to submit a request for reimbursement.