PLUMBERS LOCAL UNION No.1 WELFARE FUND
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ACCOUNT
REIMBURSEMENT GUIDE

www.ualocal1funds.org

1/2021

718-223-4313 / 718-835-2700

How to file a claim for your Health Care reimbursement arrangement account.

Account Information

1. For a list of Health Care Eligible Expenses which may be submitted, see the back of this form.
2. You must have itemized bills for each expense. An itemized bill contains the name of the patient, provider and shows the date(s) of services or supply and the type of service or supply. **Cancelled checks and balance forward statements cannot be used for claim purposes**.
3. A separate claim form must be used for Employee and each Eligible Dependent.
4. Disbursements are made only when at least $25.00 in reimbursement has been submitted and when at least $25.00 is available in the Health Reimbursement Arrangement Account.
5. Claims submitted or awaiting payment that are below the $25.00 minimum will be reimbursed quarterly.
6. All reimbursements will be made payable to the Employee. However, for claim expenses greater than $500.00, you can submit a balance forward statement and designate the HRA claim as "pay to Provider". Please contact the Fund Office for this option.
7. Employees will receive an Explanation of Benefits for each claim that is processed.
8. Account balance statements will be mailed to participants at the end of each Plan Year.

Filing Your Claim

1. Complete the personal information requested on the Reimbursement Form.
2. List each expense and attach the itemized bill within 36 months from date of service.
3. If an expense is covered in part by a health plan, the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan Explanation of Benefits must be submitted with the claim.
4. Calculate the amount of reimbursement due (net out-of-pocket expense) by subtracting the health plan payment from the actual charges incurred.
5. Sign and date the reimbursement request.
6. **With possible disruptions with the US Postal Services, and limited access to the Fund Office, all applications and related documents should be sent by e-mail or text to info@ualocal1funds.org or by fax to 718-641-8155. Any questions regarding this benefit should also be submitted by email or fax.**
7. **NEW DIRECT DEPOSIT PAYMENT OPTION SEE ATTACHED ENROLLMENT FORM**
8. For questions: Please e-mail or text to info@ualocal1funds.org or by fax to 718-641-8155. You can also call the Fund Office Welfare Department at (718) 223-4313 or visit our web site at www.ualocal1funds.org.

Remember: You may not claim any health care expenses for which you have been reimbursed on your Federal Income Tax. For more information regarding medical expenses, please refer to IRS Code Section 213(d).

(1) How to file a Claim for your HRA Benefits:

- For a list of HRA expenses which may be submitted, see list of Eligible Expenses.
- You must have itemized bills for each expense. An itemized bill contains the name of the patient, provider and the date(s) of service or the type of service or supply. Cancelled checks and balance forward statements cannot be used for claim purposes.
- Disbursements are made only when at least $25.00 in reimbursable expenses has been submitted and when at least $25.00 is available in the Health Care Reimbursement Account.
- Claims submitted or awaiting payment that are below the $25.00 minimum will be reimbursed quarterly.
- All reimbursements will be made payable to the Participant only. However, for claim expenses greater than $500.00, you can submit a balance forward statement and designate the HRA claim as "pay to Provider". Please contact the Fund Office for this option.
- Each reimbursement check stub is a statement of account.
- Employees will receive an Explanation of Benefits (EOB) for each claim that is processed.
- Account balance statements will be mailed to participants at the end of each Plan Year.

FILING YOUR CLAIM

- Complete the personal information requested on the HRA Reimbursement Request Form. (Name, address, social security number, etc.)
- List each expense and attach the itemized bills within 36 months from date of service.
- If an expense is covered in part by a health plan, the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan, explanation of benefits (EOB), or denial must be submitted with the claim. If no health plan applies write none in the plan payment column.
- Calculate the amount of reimbursement due by subtracting the plan payment from the actual billed amount.
- Sign and date the reimbursement request.
- Mail the completed form and documentation to: Plumbers Local Union No.1 Welfare Fund 50-02 Fifth Street, Long Island City, NY 11101.

Remember: *You may not claim any health care expenses for which you have been reimbursed on your Federal Income Tax Return.*

(2) Please remember to:

PART A: Fill in MEMBER information, complete item 1 through 13.
PART B: Fill in PATIENT information, complete item 14 through 22. A separate form is required for member and each eligible Dependent.
PART C: Separate expense types by patient, a separate form is required for member and each eligible Dependent.

- Separate expense types by individual name.
- Complete the total requested amount.
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts – especially important on OTC items.
- Copy small receipts to standard 8.5” x 11” sheet of white paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form in the order listed on the form.
- Read Certification for Reimbursement, sign and date form. Please make a copy of form and documentation for your personal records.

(3) Please DO NOT:

- Do not submit cancelled checks or credit card receipts alone. These are not adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite items on receipts. These are not acceptable.
- Do not submit handwritten receipts for Rx or OTC and Do not submit pre-treatment estimates or estimated insurance statements.

(4) For Medical, Dental, Vision and Hearing Expenses:

- Submit your insurance carriers Explanation of Benefits (EOB) statement with your completed form. Check the MD (Medical), DN (Dental) VN (Vision) or HR (Hearing) Box on the claim form. When applicable your insurance claim must be finalized prior to submitting for reimbursement.
- For expenses that are not covered by your medical, dental, or vision insurance plan and for co-payments you must submit documentation which includes the following information:

a. Name and Address of Provider
b. Dollar amount charged
c. Date of service
d. Patient name
e. Type of service
f. Reason for non-coverage (Insurance Carrier EOB if applicable)

(5) For Prescription Drug Expenses:

- For prescription drug expenses that are not covered by your medical insurance plan and for co-payments, check the RX box on the claim form and you must submit documentation which includes the following information: a. Patient name b. Out-of-Pocket cost of drug c. Date the prescription was filled
d. Prescription name or NDC # or the word copay must be printed on the receipt*(Information usually can be found on prescription tags provided by pharmacies)

(6) Non-Prescription Over-the-Counter (OTC) Drug Expenses:

- For non-prescription drug, medicines and medical care supply expenses that are not covered by your medical insurance plan, check the OTC box on the claim form. Must be prescribed by a Physician even though a prescription is not otherwise required. Documentation must contain the following information:

a. Printed Receipt
b. Date of purchase
c. Name of the over-the counter item
d. Charges incurred

(7) Types of Reimbursable Expenses:

For Medical expenses check MD ☐, For prescription Drug expenses check RX ☐, for over the counter expenses check OTC ☐, for vision expenses check VS ☐, for dental expenses check DN ☐, for hearing expenses check HR ☐

Note: For COBRA and Continuation of Coverage check MD

What Expenses Can Be Submitted For Reimbursement?

The law provides that an HRA may reimburse expenses allowable under Section 213 (d) of the Internal Revenue Code. The following expenses will be eligible for reimbursement:

Prescription Drug co-payments	Medical co-payments and annual deductibles	COBRA & Continuation of Coverage monthly premiums
Over-the-counter and prescription drugs not covered by the prescription drug program (When Physician prescribed)	Laser eye surgery, contact lenses and solutions	Medicare Part B monthly premiums
The portion of medical, dental and/or vision expenses that exceeds the reasonable and customary limits or plan maximums		

Which Over-the-Counter Expenses Can Be Submitted For Reimbursement?

Allowable Over-the-Counter Expenses (without physician recommendation)

NOTE: To be reimbursed for the following products, you must provide a computerized receipt clearly showing the name and cost of the item purchased

Bandages	Band-Aids	Blood Pressure Kit	Cold/hot packs for injuries	Condoms
Contact Lens Solution	Contraceptive Creams	Crutches	Eye Lubricant Drops	Eye Patches
First aid kits	Gauze pads	Home Diagnostic Tests/Kits	Incontinence Products	Joint support bandages & hosiery
Liquid adhesive for small cuts	Ovulation Kits	Pregnancy test kits	Reading glasses	Thermometers

Allowable Over-the-Counter Medications (with physician prescription*)

NOTE: To be reimbursed for the following products, you must provide a computerized receipt & prescription clearly showing the name and cost of the item purchased.

Allergy Medicine	Antacids	Anti-diarrhea medicine	Bactine	Ben Gay or similar products
Bug bite medication	Calamine lotion	Cold medicine	Cough drops	Cough syrups
Diaper rash ointment	First aid cream	Hemorrhoidal cream	Lactose Intolerance supplies	Laxatives
Motion sickness pills	Nasal sinus sprays	Nasal strips	Pain relievers	Pedialyte
Sinus medication	Sleeping aids	Special creams for sunburn	Throat lozenges	Wart removal treatments

Note: *You may also request a tax-free reimbursement for medicines and/or drugs you purchase Over-the-Counter with a Physician's prescription. These Over-the-Counter drugs not otherwise covered by the Plan must be for the treatment of illness or injury (as defined by the Internal Revenue Code 213(d)), not merely to advance your general good health and must be prescribed by a Physician even though a prescription is not otherwise required.

Allowable Over-the-Counter Expenses that require a Letter of Medical Necessity from your physician that specializes in the field of your diagnosis:

Feminine hygiene products for specific medical condition.	Fiber supplements for specific medical condition	Glucosamine/Chondrotin for arthritis	Hydrogen peroxide	Massage Therapy
Medical Alert device	Medicated shampoo	Medicated soap	Menopause therapy	Nasal sprays for snoring
Nicotine gum / patches	OTC hormone therapy	Prenatal vitamins	Rubbing alcohol	Special toothbrushes
St. John Wort – for depression	Sunglasses	Sunscreens	Supplements or herbal meds	Weight loss drugs

NOTE: To be reimbursed for the above over-the-counter products, you must provide a computerized receipt clearly showing the name and cost of the item purchased and a signed statement from your physician confirming the medical necessity of this item.

Excluded Expenses

The following expenses are NOT eligible for reimbursement:

Cosmetic Surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease	*Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.*
Funeral and burial expenses	*Marijuana and other controlled substances the possession of which are in violation of federal laws, even if prescribed by a physician*
Long-term care services (excluding premiums)	
Maternity clothes, diaper service or diapers, salary of nurse to care for healthy newborn at home, babysitting, child care, formula	*Death Benefits or life insurance benefits including the portion of the Plan's COBRA premium that pays for life insurance*
Psychotherapy (including psychoanalysis)	*Home improvements, Household and domestic help*
Any item that does not constitute "medical care" as defined under Code § 213	

Therefore, you cannot be reimbursed for the following products:

Chap stick / Lip Balms	*Cosmetics*	*Denture Adhesive Products*	*Deodorant*	*Face creams*	*Hand lotion*
Moisturizers	*Mouthwash*	*Suntan lotion*	*Toothpaste*		

Plumbers Local Union No.1 Health Reimbursement Arrangement (HRA) Claim Request Form

www.ualocal1funds.org

INSTRUCTIONS: For reimbursement from your HRA account for **medical** expenses, fill out this form and sign it. The minimum reimbursement from your account is $25. Reimbursement checks will only be made payable to the Participant only. **Please see Reimbursement guide below for How to file a claim for your Health Care reimbursement arrangement account.** Also, include the proper documentation
Deadline: Expenses incurred must be submitted within 36 months from date of service.

(A) MEMBER INFORMATION

1/2021

(1) SOCIAL SECURITY NO. ☐☐☐-☐☐-☐☐☐☐ | (2) LAST NAME | (3) FIRST NAME | (4) INITIAL

(5) STREET | (6) CITY | (7) STATE | (8) ZIP CODE

(9) BIRTH DATE ☐☐/☐☐/☐☐☐☐ | ☐ (10) MALE ☐ (11) FEMALE | (12) DAYTIME TELEPHONE NUMBER: ☐☐☐/☐☐☐/☐☐☐☐ | (13) OTHER TELEPHONE NUMBER: ☐☐☐/☐☐☐/☐☐☐☐

(B) PATIENT INFORMATION: A separate form must be filled out for each eligible dependent

(14) PATIENT NAME | (15) BIRTH DATE ☐☐/☐☐/☐☐☐☐ | ☐ (16) MALE ☐ (17) FEMALE | (18) RELATIONSHIP TO MEMBER ☐SELF ☐SPOUSE ☐CHILD ☐Qualified Relative

DOES THIS PATIENT HAVE COVERAGE OTHER THAN LOCAL 1: (19) MEDICAL PLAN ☐ **YES** ☐ **NO** **(20)** PRESCRIPTION PLAN ☐ **YES** ☐ **NO** **(21)** VISION PLAN ☐ **YES** ☐ **NO** **(22)** DENTAL PLAN ☐ **YES** ☐ **NO**

(C) CLAIM INFORMATION: Remember to list each expense and attach the itemized bills. Attach another form if you need additional space I Final Payment ☐ YES ☐ NO

	EXPENSE TYPE (See back of form)	DATE OF SERVICE	PROVIDER NAME	CHARGES INCURRED	HEALTH PLAN PAYMENT	NET OUT-OF-POCKET EXPENSES
1.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
2.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
3.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
4.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
5.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
6.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
7.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
8.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
9.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
10.	MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐	☐☐/☐☐/☐☐☐☐		$	$	$
					TOTAL	$

(D) MEMBER SIGNATURE/CERTIFICATION FOR REIMBURSEMENT: Reimbursements are payable to the Participant only

By signing this form you certify that: (1) You or your eligible dependents have incurred the listed expenses. (2) All applicable insurance and/or other health plan benefits have been exhausted. (3) You will not deduct or take a tax credit on your Federal Income Tax Return for the listed expenses. (4) You assume all responsibility for taxes or penalties arising out of disallowed deductions. (5) You authorize any insurance company, prepayment organization, employer, hospital, or provider to release all information with respect to yourself or any of your dependents that may have 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 that all charges claimed was the amount billed.

MEMBER SIGNATURE ______________________________ **DATE** ☐☐/☐☐/☐☐☐☐

Date Received	Date Entered	Control No.	Check Date	Amt Paid

Plumbers Local Union No.1 WELFARE FUND

50-02 5th Street, Long Island City, New York 11101 Tel. (718) 223-4313 / (718) 835-2700 www.ualocal1funds.org

Date Received	Date Complete WF-4/20
FOR OFFICE USE ONLY	

Direct Deposit Enrollment/Change Form

(A) Member Information *Use a ballpoint pen to complete form*

(1) Social Security Number (2) Last (3) First (4) Init.

(5) Street (6) City (7) State (8) Zip

(9) Date of Birth (10) Phone Number

(12) E-mail Address ______

☐ (11) **New Authorization** ☐ (12) **Changing Authorization** ☐ (13) **Cancel Authorization** (14) **Effective Date (MM/DD/YYYY)**

(B) Complete to Enroll / Add / Change Bank Accounts – please print clearly in black or blue ink only

Type of Account* ☐ *Checking* ☐ *Savings/Money market* ***Routing/Transit Number***

*Checking/Savings Account Number***

Financial Institution (Bank) Name

Use this deposit for my ☐ Weekly Unemployment ☐ *HRA* ☐ Welfare ASB ☐ Weekly Disability ☐ Refund ☐ *Death Benefit*

*Member must be Bank Account Holder
**Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.

(C) Member Confirmation Statement

Please sign in blue or black ink only – *Electronic Signatues* are NOT VALID

I authorize the Plumbers Local Union No. 1 Welfare Fund (FUND) to deposit my benefit payment(s) into the bank account specified above (this includes my authorization to correct entries made in error). I certify that my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am the accountholder to authorize the FUND to make direct deposits into the named account under penalty of perjury. This authorization will remain in effect until I give written notice to cancel.

(ORIGINAL SIGNATURE OF APPLICANT) – Wet Ink Signatures ONLY! (DATE) MM/DD/YYYY

(D) Common Questions

Q1. Can I use my US Alliance Federal Credit Union Account for this Direct Deposit?
A1. Yes- If you have an account with Alliance Federal Credit Union, you can use this authorization form.

Q2. When will I receive my Direct Deposit
A2: Your funds (Benefit Payment) will be available sometime after 12:01 AM on the same day that your Benefit Payment is processed. Instead of receiving a paper check several days later, depositing that check, and then waiting for funds availability, direct deposit gets your funds to you sooner.

Q3: Must I participate in the Direct Deposit Program
A3: Direct Deposit is voluntary. With the Fund Office temporarily closed and staff working remotely from home, processing a regular check will be significantly delayed.

Q4: Will all my Benefit Payments be Direct Deposited
A4: All Benefit payments elected in Section B above will be paid with direct deposit. Yo can cancel this option by submitting a new form.

Q5: What if I decide to change banks. What do I have to do
A5: Simply complete and submit a new Direct Deposit Enrollment/Change Form with the new bank information.

Retain a copy of this form for your records. Return the original to the Fund Office.

With possible disruptions with the US Postal Services, and limited access to the Fund Office, all applications and related documents should be sent by e-mail or text to info@ualocal1funds.org or by fax to 718-641-8155. Any questions regarding this benefit should also be submitted by email or fax.

For questions: Please e-mail or text to info@ualocal1funds.org or by fax to 718-641-8155. You can also call the Fund Office Welfare Department at (718) 223-4313 or visit our web site at www.ualocal1funds.org.

CLAIM DATE