

**Mid Central Operating Engineers Health and Welfare Fund
Health Reimbursement (HRA) Account Reimbursement Form**

P.O. Box 9605, Terre Haute, IN 47808
(812) 232-4384

Complete **ONE** Form **per** Individual

Check if new address *

Participant's Name:		MCO # or Last 4 SSN	
Address:		City:	
State:	Zip Code:	Phone:	
Person for Whom Expenses Incurred	Name	Relationship	

Attach an Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) reflecting the amount of your reimbursement request. **Requests for reimbursement must total a minimum of \$200.00 and "Account Balance" must be equal/greater than your request. Any request for reimbursement that exceeds your current HRA balance will be forfeited. REIMBURSEMENT REQUESTS ARE BASED ON EXPENSES INCURRED NOT YOUR PAID RECEIPT.**

To print an EOB and/or other forms go to www.midcentral.org **No balance due statements will be accepted**

(medical, Dental, Vision or Prescription)	Name of Service Provider	Date of Service	Net Amount	Is this request for Deductible/Co-Pay Or Non-Covered Service?
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
Total Reimbursement (this individual)	\$			

Please complete this portion when requesting reimbursement for more than one individual

Total Number of Reimbursement Forms Submitted		Total Amount of Reimbursement Requested	\$
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By signing below, I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating the claim for reimbursement on this form. I certify that the eligible expenses have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source, have not been paid on a pre-tax basis, and have not been taken, nor intend to be taken, as a tax deduction. I understand that the Internal Revenue Code permits reimbursement only for eligible health care expenses, which means amounts paid for diagnosis, cure, mitigation, and treatment or prevention of disease. I understand that I alone am liable for payment of expenses and that if an expense is not eligible for reimbursement under the Fund's HRA, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

Participant's Signature

Date

Health Reimbursement Account (HRA) Instructions

- You must submit a claim for reimbursement of any eligible expense within 18 months of the date you incurred the expense.
- **The Plan requires that any requests for reimbursement be for a minimum of \$200.** Therefore, you generally have to hold your requests for reimbursement until you have at least \$200 in eligible expenses. However, you may submit a request for reimbursement for claims totaling less than \$200 once per year each February if your total claims for the prior year are not going to reach the \$200 minimum. In addition, the amount reimbursed for any eligible expense will not exceed your HRA balance at the time reimbursement is requested. In the event your Plan coverage ends, you may submit eligible expenses totaling less than \$200 to close out your HRA.
- **Requests for reimbursement must total a minimum of \$200.00 and “Account Balance” must be equal/greater than your request.**

Reimbursement requests must be accompanied by a properly completed form, which can be obtained from the Fund Office.

- Have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source;
- For premiums paid for other coverage, have not been paid or are not eligible for payment on a pre-tax basis; and
- Have not been taken, nor intend to be taken, as a tax deduction.

Along with this form, you must provide any of the following, as applicable:

- An Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) when requesting reimbursement. **No Balance due statement will be accepted.**
- A copy of your pharmacy receipt that includes the name of the person incurring the charges, date of charge, Drug dispensed, Rx number, name of pharmacy provider, and amount of charge.
- Any additional documentation requested by the Plan.
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse’s group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC Section 125 plan.

An eligible expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care.

Expenses incurred before an Employee, retired Employee or eligible Dependent first becomes covered by the HRA are not eligible for reimbursement from the HRA.

Tax Status

Contributions credited to your HRA are not taxable income when made and generally are not taxable when paid out as benefits. Certain actions may cause your HRA to be taxable, such as if:

- You receive reimbursement from your HRA for contributions for health coverage that are paid or could have been paid pre-tax from an IRC Section 125 plan;
- Reimbursements are made for individuals that are not “dependents,” as defined under IRC Section 152; and
- Cash payments are made to an individual from an HRA as a “death benefit” in the event of the death of a Participant (however, this does not apply to reimbursements of eligible expenses).