Five River Carpenters District Council Health & Welfare Fund
HRA Account Reimbursement Form

REQUEST FOR DIRECT PAYMENT TO PROVIDER

This Claim Form **ONLY** applies to the following types of claims:

Orthodontic care
Lasik eye surgery
Hearing aids
Dental claims above the Maximum Benefit Payable Amount in the Schedule of Benefits

PLEASE USE ONE CLAIM FORM PER PERSON

(See instructions on reverse side) ☐ 1st submission ☐ Adjustment ☐ Appeal

MEMBER INFORMATION – MUST BE COMPLETED (Please Print)

_____ **SS #** _____
Member's Name (Last, First, MI)

_____ _____ _____ _____ (_____) _____
Address City State Zip Code Daytime Phone Number

HEALTH CARE EXPENSES (HRA) – MUST BE COMPLETED (see instructions on reverse)

	Date of Service					
Patient's Name			**Type of Service (i.e. orthodontic, Lasik eye surgery, hearing aids, dental claim)**	**Provider Name (i.e. physician, hospital, dentist, pharmacy)**	**Do you have other coverage for this service (attach EOB)**	**Amount of Expense to be Reimbursed**
1.						
2.						
3.						
4.						
5.						
			Total reimbursement requested from your HRA Account **REIMBURSEMENT WILL BE SENT DIRECTLY TO THE PROVIDER**			$

❖ I hereby certify that:

- The information given on this reimbursement form is complete and correct.
- I have not received reimbursement for these expenses from the reimbursement account or from any other source.
- All health care expenses listed above comply with requirements and guidelines listed on page 2 of this form.

This authorizes any, hospital, physician, or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

X _____ ___/___/___
Member's Signature (If submitted without signature claim(s) will be denied) Date

Mail your completed form to: **Five River Carpenters H&W Fund**
5001 J Street SW, Suite 100
Cedar Rapids, IA 52404

A CLAIM FORM FROM THE PROVIDER MUST ALSO BE SUBMITTED WITH YOUR REQUEST. IT MUST SHOW THE PROVIDER'S TIN #, ADDRESS, DATE OF SERVICE AND AMOUNT OF CHARGE TO BE PAID.

RETURN THIS PAGE ONLY ALONG WITH THE REQUIRED PROPER DOCUMENTATION
FORMS WILL BE RETURNED IF NOT COMPLETED PROPERLY

Instructions:

1. Complete Member Information section (please print).
2. Complete Health Care Expense section as appropriate. **Service must be incurred before being reimbursed**. Only the following services may be paid directly to the provider by use of this form: Orthodontic care, Lasik eye surgery, hearing aids, and dental claims above the Maximum Benefit Payable Amount in the Schedule of Benefits.
3. Attach all required supporting documentation.
   Supporting Documentation: The type of documentation described under either A or B below **must** be attached to the completed form.

   A. Explanation of Benefits form (EOB): This is the form you receive each time you or a health care provider submit claims for payment of your health, dental or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental, or vision care plans, you **must** attach an EOB.

   B. All other Expenses: For expenses not covered at all by your (or your spouse's) health, dental, or vision care plans, reimbursement request **will not be processed** without acceptable evidence of your expenses. Acceptable evidence includes the following information:

      - Name of person for whom the service/supply was provided
      - Date expense was incurred (must be within 12 months of date of submission) Dates of services over 12 months old are not reimbursable.
      - Type of service (i.e. orthodontic care, Lasik eye surgery, hearing aids, or dental claim)
      - Name of provider (i.e., physician, hospital, dentist, orthodontist)
      - Amount of expense(s)

4. Please provide a copy of the invoice from the Provider for each requested reimbursement.
5. **Sign and Date the form (if submitted without employee signature claim(s) will be denied)**
6. Please make copies for your records, as these documents will not be returned.
7. Mail the completed form and attachment(s) to: **Five River Carpenters H&W Fund, 5001 J Street SW, Suite 100, Cedar Rapids, IA 52404**
8. If you have any questions regarding your reimbursement account or claims, please call the customer service number or visit the member website address at www.5rcbenefits.com.
9. Your provider will be paid only the amount you have in accumulated reimbursement amounts at the time your claim form is received. You will be responsible for paying to the provider any amount above the accumulated reimbursement amount.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this plan.
- Reimbursement will only be made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.
- Reimbursement is not available for dates of service over 12 months old.
- **YOU MUST HAVE AT LEAST THREE MONTHS OF FUTURE ELIGIBILITY IN YOUR ACCOUNT IN ORDER TO RECEIVE ANY IRS REIMBURSEMENTS.**

ADDITIONAL HRA FORMS CAN BE FOUND ON THE WEBSITE UNDER FORMS & DOCUMENTS; www.5rcbenefits.com

HRA qualified medical expenses

This is a quick reference list of expenses that can be reimbursed from your health reimbursement arrangement (HRA) account. It is not intended to be comprehensive itemization, but is only intended to provide a sample list of eligible expenses the Trustees believe are reimbursable. Remember only the IRS can determine what is or is not an allowable expense from an HRA account.

For a more comprehensive list of Medical expenses that are allowed as deductions by Section 213(d) of the Internal Revenue Code, please refer to IRS Publication 502 titled. "Medical and Dental Expenses," Catalog Number 15002Q. You can order the publication by calling (800) TAX-Form or see it online at www.irsgov/pub/irs-pdf/p502.pdf. For tax advice, please seek the services of a competent professional.

Eligible medical expenses

- Abdominal supports
- Acupuncture
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Birth control pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental amounts in excess of plan maximum
- Dental benefit deductible
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Elastic hosiery (prescription)
- Eyeglasses
- Guide dog
- Gum treatment
- Medical amounts in excess of plan maximum
- Medical benefit co-pay
- Medical benefit deductible
- Prescription amounts in excess of plan maximum
- Prescription benefit co-pay
- Prescription benefit deductible
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Therapy equipment
- Ultraviolet ray treatment
- Vaccines
- Vasectomy
- Vision Care amounts in excess of plan maximum
- Vision Care co-pay
- Vision Care deductible
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Eligible over-the counter drugs

- Insulin

Some more specific examples of what is an allowable medical reimbursement.

Eye Surgery

You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

Dental Treatment

You can include in medical expenses the amounts you pay for the prevention and alleviation of dental disease. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments. Note: Teeth Whitening Are Not Includible.

Stop-Smoking Programs
You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Weight-Loss Program
You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs,
2. The food alleviates or treats an illness, and
3. The need for the food is substantiated by a physician

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.

The following is a list of items of expenses the Trustees believe **are not** reimbursable.

Ineligible medical expenses		
• Advance payment for services to be rendered next year • Athletic club membership • Automobile insurance premium allocable to medical coverage • Boarding school fees • Bottled water • Commuting expenses of a disabled person • Cosmetic surgery and procedures • Cosmetics, hygiene products and similar items • Funeral, cremation or burial expenses	• Health programs offered by resort hotels, health clubs and gyms • Illegal operations and treatments • Illegally procured drugs • Maternity clothes • Penalties for failure to precertify according to health plan rules • Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits • Scientology counseling • Social activities	• Special foods and beverages • Specially designed car for the handicapped • Swimming pool • Travel for general health improvement • Tuition and travel expenses to send a problem child to a particular school
Ineligible over-the-counter drugs		
• Acne treatments • Allergy medications • Antacids • Antibiotic ointments • Anti-diarrhea medicine • Calamine lotion • Cold medicine • Cosmetics (including face cream and moisturizer) • Cough drops and throat lozenges • Dietary supplements	• Fiber supplements • First and creams • Herbs • Lip balm (including Chapstick® or Carmex®) • Medicated shampoos and soaps • Motion sickness pills • Nasal sprays • Nicotine medications • Pain relievers • Pedialyte®	• Sleep aids • Sinus medications and nasal sprays • Suppositories and creams for hemorrhoids • Toiletries (including toothpaste) • Vitamins (daily) • Wart removal medication • Weight-loss drugs for general wellbeing