IRON WORKERS OF WESTERN PENNSYLVANIA BENEFIT PLANS
2201 Liberty Avenue, Room 203, Pittsburgh, PA 15222
Toll-Free: 1-800-927-3199, Telephone: 412-227-6740, Fax: 412-261-3816

Value Bank Reimbursement Request

Member Name _____ **SSN** _____

Address _____

Phone _____

Member Certification

By submitting this form, I hereby certify and agree to the following:

- The Plan Office will reimburse the maximum amount of eligible expenses submitted, unless a specific amount is indicated by the member below, with an explanation on the reverse side. I understand that anything that is not eligible for reimbursement will be returned to me.
- I have enclosed with this form the appropriate "Supporting Documentation" as defined in the instructions.
- The minimum amount for request is $50.00.
- I understand that claims may take up to 30 days to be processed.
- I understand that if I do not sign and date this request form my request will be returned to me.
- All expenses submitted are "Eligible Medical Expenses" as defined in the instructions that were incurred by me, my legal spouse, or an eligible dependent as defined in the SPD.
- I have not been reimbursed nor will I seek reimbursement of the expenses I have submitted from any other source (e.g. under a spouse's employer's plan, Workers' Compensation, dental or vision programs, federal, state or governmental programs, or any other policy of health, dental or vision insurance.)
- I will not deduct the above listed expenses on my personal federal and/or state income tax return for any year. The Plan does not accept responsibility for direct payment to any individuals other than the member.
- I understand that the Plan Office will diligently review the documents I submit to substantiate my claim. I authorize the Plan Office to contact the healthcare provider listed on my claim to verify any information relating to my claim; and I authorize the healthcare provider to provide the information requested by the Plan Office. If the Plan Office determines that the information I submitted is fraudulent (including submitting a reimbursement request for healthcare services that were not provided to me or my eligible dependents, or submitting a request for which I have already been reimbursed, though the Plan or otherwise), I understand that I will not be reimbursed for such claim and instead will have the amount of the fraudulent claim deducted from my Value Bank and returned to the general assets of the Plan. I realize that submitting false information, including forged documentation, to the Plan may also result in civil or criminal action against me, and, should the Plan Office determine that the claim was fraudulent after I have already received the reimbursement, that I will be required to repay the Plan for any payments made based on such false information. I understand that my Value Bank balance and future employer contributions may be used to offset any amounts I do not repay. I also understand that benefits I receive, or will receive, under the Iron Workers of Western PA Pension Plan and the Iron Workers of Western PA Profit Sharing Plan may, in certain cases, be used to repay the Plan for fraudulent payments made to me.

I have read and understand the information contained in the instructions.

MEMBER SIGNATURE _____ **DATE** _____

☐ I would like the Plan Office to reimburse me an amount less than what is submitted. I have outlined the details on the back of this page.

Please list all out-of-pocket unreimbursed eligible medical expenses (as defined in the instructions) for which you are requesting reimbursement.

Description of Expense	**Date of Service**	**Amount**
Example: Office visit co-pay		
______________________	______________	__________
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TOTAL REQUESTED $__________

Instructions and Important Information Regarding Value Bank Reimbursement Requests

The Plan Office will diligently review the documentation you submit to substantiate your claim, including contacting your healthcare provider, if necessary. If the Plan Office determines that your claim is fraudulent (e.g., you submit a claim for healthcare services you or your eligible dependents did not receive or for which you have already been reimbursed, through the Welfare Plan or otherwise), you will not receive reimbursement for the claim and the full amount of the claim will be deducted from your Value Bank balance and transferred to the general assets of the Welfare Plan. This action will be considered a denial of healthcare benefits for which you may submit an appeal according to the Claims and Appeals Procedures described in the Summary Plan Description.

Members with Value Bank balances with a minimum of three months of premium banked at the coverage level and tier, in which you are enrolled, may seek reimbursement from their Value Bank for previously unreimbursed eligible expenses that occurred within **24 months**, while eligible and incurred under the Iron Workers Welfare Plan of W. PA. Eligible expenses are listed below.

Please Note - Only eligible expenses incurred by you, your legal spouse or eligible dependents, and who are enrolled in the Plan, are eligible for reimbursement.

Eligible expenses include:

- **Deductibles**
- **Co-insurance**
- **Co-payments for medical**
- **Co-payments for prescription drugs**

- **Dental treatment and artificial teeth** – You can be reimbursed for 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.

- **Vision exams, glasses, contacts** – You can be reimbursed for fees paid for eye examinations. You can also be reimbursed for the amounts you pay for eyeglasses and contact lenses needed for medical reasons.

- **Eye surgery** – You can be reimbursed for the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

- **Hearing screenings and hearing aids** – You can be reimbursed for the cost of hearing screenings not covered by medical insurance. You can also be reimbursed for the cost of hearing aids, batteries to operate, repairs and maintenance needed to operate as well as wax guards.

- **Smoking cessation programs** – You can be reimbursed for amounts you pay for a program to stop smoking. You cannot be reimbursed for amounts you pay for drugs that are designed to help stop smoking that do not require a prescription, such as nicotine gum or patches.

- **Insurance Premiums** – You can be reimbursed for insurance premiums you pay for policies that provide payment for dental and vision care, as long as the premiums have not been paid using pre-tax dollars.

- **Breast Pump and supplies for lactation** - Expenses for a breast pump and supplies for lactation incurred by you, your legal spouse or eligible dependents that are enrolled in the Plan.

- **Medicare Part B premiums** – The Value Bank may be used for reimbursement of Medicare Part B premiums for a member and/or his or her spouse for Medicare Part B coverage received due to a disability or attainment of age 65. Reimbursement will only be made upon the request of the member. The current plan requirement of having a minimum of three months of premium banked at the coverage level and tier for which the member is enrolled before the Value Bank will reimburse medical expenses, does not apply for reimbursement of Medicare Part B premiums.

Supporting Documentation

For eligible **medical expenses (co-pays, co-insurance and deductibles)**, attach **all** pages of your Highmark BCBS Explanation of Benefits (EOB) or the Highmark "Claims Details" which can be printed from Highmark's website.

For **prescription drug co-payments**, submit an itemized receipt from the pharmacy showing the patient's name, drug name or Rx number, date filled and co-pay amount. You can also print your prescriptions from Highmark's website. Cash register receipts are not acceptable.

For **dental, vision, eye surgery, hearing aids and smoking cessation programs** you must submit an itemized statement from the provider that indicates the patient name, date of service, detail of service, charge, and provider name, address and phone number.

For **insurance premiums**, submit a statement or pay stub showing the premium being paid using pre-tax dollars.

For **breast pumps and supplies** submit itemized receipts for purchased items or a rental agreement and cancelled checks for rented breast pumps.

For **Medicare Part B premiums** submit an itemized statement showing the payment.

PLEASE NOTE - Requests for reimbursement must be received at the Plan Office within 24 months of the incurred date. Eligible claims submitted within the timeframe described above will be reimbursed to you within 30 days of submission of the proper documentation to the Plan Office.

Submission of Reimbursement Requests – Fax, email or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable.

The Minimum Request for Reimbursement is $50.