NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS
HEALTH FUND
P.O. BOX 4002, EAU CLAIRE, WI 54702 ~ PHONE: 800-424-3405

Health Reimbursement Account (HRA) Request for Reimbursement Form

Participant Information

_____

Participant's Name - Please Print *ID Number*

_____

Address *City* *State* *Zip Code*

HRA Expense Claims Attach appropriate receipt(s) for each expense listed below when submitting form; please see the attached Claim and Reimbursement Procedures for more details on what to provide. Credit card receipts, canceled checks, estimated expenses, etc. are not valid documentation. Please note that the Plan *also* requires an Explanation of Benefits (EOB) from another health plan for any expense listed below that is for an individual who has other health care coverage, regardless of whether the other coverage is primary or secondary.

Date Expense Incurred	Service Provider	Expense Description (attach documentation)	Person for Whom Expense Incurred (include full name and relationship)	Expense Amount
				$
				$
				$
				$
				$
				$
				$
Total HRA Claim				$ 0.00

Participant Authorization By signing below, I certify that all services for which reimbursement is requested on this form were provided while I was eligible for coverage under the HRA and were for me or my eligible dependents, as defined by the Plan. No expenses incurred before coverage begins are covered under the HRA. Further, 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 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. I further certify that I have not and will not seek reimbursement for the identified qualifying medical expenses under an HSA (Health Savings Account). I understand that the Internal Revenue Code permits reimbursement only for eligible health care expenses. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that, if an expense is not eligible for reimbursement under the Plan'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*

REQUEST FOR REIMBURSEMENT MUST BE RECEIVED IN THE FUND OFFICE BY THE 10TH DAY OF THE ENDING QUARTER (MARCH 10, JUNE 10, SEPTEMBER 10 AND DECEMBER 10).

REIMBURSEMENT CHECKS WILL BE ISSUED BY THE LAST BUSINESS DAY OF THE QUARTER.

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Claim Submission

Mail completed form and any required documentation to:

North Central States Regional Council of Carpenters Benefit Funds
P.O. Box 4002
Eau Claire, WI 54702

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Claim and Reimbursement Procedures

To receive reimbursement for eligible expenses, you must submit this written form, with the required supporting documentation, to the Plan in accordance with the Plan's claim procedures as described in your SPD. Reimbursement is paid directly to you; you are responsible for paying any providers.

The amount reimbursed for any eligible expense will not exceed your HRA balance at the time reimbursement is requested. It is your responsibility to resubmit the balance when the Account has sufficient funds. You must file a written claim for reimbursement with the Plan within 36 months of the date of the expense or your claim may not be accepted and will be denied.

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

- An itemized bill from the service provider that includes the name of the person incurring the charges, date the service was provided, description of services, name of provider, and amount of charge. Orthodontia expenses can be based on the date of payment or date of service. Please contact the Plan Office.
- An Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment. If coverage is available through multiple plans (either primary or secondary), an EOB must be submitted for each plan.
- Proof of the amount (premium notice), date paid, and coverage period when requesting reimbursement for other insurance premiums, such as COBRA, Medicare, self-payments or 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.** Reimbursement of insurance premiums is very limited under the HRA Plan and must satisfy certain requirements under the Affordable Care Act. Please contact the Plan Office if you are seeking reimbursement for an insurance premium. Additional documentation is also required for reimbursement of premiums under a qualified long-term care contract.
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
- Over-the-counter medications other than insulin will not be reimbursed without a doctor's prescription. You must include an itemized receipt indicating the item purchased. For prescription drugs, you must provide a pharmacy statement including the name of the pharmacy, patient's name, date the prescription was filled, patient's cost, the prescription number and the name of the drug.
- Any additional documentation requested by the Plan.

It's a good idea to make a copy of all materials you submit for your records. Materials you submit will not be returned to you.

Reimbursements for long-term care expenses, reimbursements for premiums for fixed indemnity, cancer and hospital indemnity insurance and reimbursements for expenses that could be reimbursed through a section 125 cafeteria plan are not allowed.