Operating Engineers Local 139 Health Benefit Fund

P O Box 160, Pewaukee, WI 53072-0160, 262-549-9190 or toll free 800-242-7018, Fax 262.549.3549, hra@iuoe139.org

Health Reimbursement (HRA) Claim Form

Participant Information (IUOE 139 member)			
Print Participant's Last Name	First Name	OEF Number or SSN	
Address Street Number	City	State	Zip
Telephone Number	Email Address (a confirmation email will be sent from the Health Fund when this form is received)		

- ✓ Enter the total reimbursement amount for each family member on the lines below (do not itemize individual expenses for each person)
- ✓ Include copies of the blue Explanation of Benefit (EOB) forms from the Health Fund, prescription receipts, or receipt for services not covered by the Health Fund benefits. For copies of the EOB's go to www.iuoe139healthfund.org.
- ✓ Do **not** send the balance due types of statements from the doctor's office or hospital.
- ✓ Total HRA claim amount must be $250 or more. If under $250, the Health Fund will hold the claim until more receipts are submitted. The Fund will pay the lesser of the Total HRA Claim Amount listed or the EOBs and receipts.

HRA Expense Total Per Person (Do not itemize the claims)		
Relationship	Print Name (First and Last)	Amount Per Person
Participant		$
Spouse		$
Child (1)		$
Child (2)		$
Child (3)		$
	TOTAL HRA CLAIM AMOUNT	$

Participant Authorization (this form must be signed or it will be returned)

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 Health Benefit Fund. 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 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 fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that I 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 _____

** this form must be signed or it will be returned **

HRA Claims and Reimbursement Procedures

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

While you can submit requests for reimbursement at any time, **the Plan requires that any total requests for reimbursement be for a minimum of $250.** Therefore, you will have to hold your requests for reimbursement until you have at least $250 in eligible expenses. In addition, the amount reimbursed for any eligible expense will not exceed your HRA balance at the time reimbursement is requested. You must file a written claim for reimbursement with the Fund Office within 24 months of the date of the expense or your claim will not be accepted and will be denied.

Along with the 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 of the balance of charges for which coverage is available.
- If an expense is not covered under the Health Benefit Fund, an itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums. Post-tax premiums only.
- Any additional documentation requested by the Fund Office.
- If you, your spouse, and/or your eligible dependents are eligible for other coverage, you must include a copy of the Explanation of Benefits (EOB) from the other coverage as well as any EOB from this Plan. Only expenses that are covered, but not reimbursed, as shown on the EOB form, will be considered eligible for reimbursement.
- If the blue EOB form has an exclusion code 32 requesting accident information to determine possible third party liability, it will be returned and not reimbursed from the HRA as the claim is unresolved under the health benefits.
- If the blue EOB form has an exclusion code 29 requesting the coordination of benefits EOB from another insurance company, it will be returned and not reimbursed from the HRA as the claim is unresolved under the health benefits.

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

Copies of the EOBs can be obtained from the web site at www.iuoe139healthfund.org.

Send claims to: Operating Engineers Local 139 Health Benefit Fund
P O Box 160
Pewaukee, WI 53072
Fax: 262.549.3549
Email: hra@iuoe139.org