

BAC Local 23 North Shore Chapter Health & Welfare Fund Supplemental Health Reimbursement Plan

A Participant must have a minimum of six months coverage "banked" to use their supplemental health reimbursement account. Only the amount in excess of this minimum level may be used for reimbursements.

Introduction

Internal Revenue Service (IRS) rules require the Health & Welfare Fund, as a third-party administrator for your Supplemental Health Reimbursement Account, to obtain the proper documentation prior to paying claims. The IRS establishes these documentation requirements. It is important that the Fund is compliant with these rules to maintain its tax-free status under the program.

What benefits will be included in the Supplemental Health Reimbursement Plan?

Generally, expenses not covered by health insurance. Typical expenses include vision, dental and medical expenses, office visit co-pays, prescription co-pays, over-the-counter (OTC) drugs and medications that are medically necessary. Please refer to enclosed lists of Common Qualified Claims and OTC items. Expenses solely for cosmetic reasons are not expenses for medical care.

The following is a list of the basic claim documentation required for reimbursement. We will accept copies; original receipts are not required.

Office Visit Co-pays

A receipt from the doctor's office that identifies the patient, provider, date of service, procedure, and co-pay amount or a copy of the insurance Explanation of Benefits (EOB) along with a completed reimbursement claim form.

Prescription Drug Co-pays

A receipt from the pharmacy is acceptable as long as it identifies the patient, the date of service, the drug, and the amount of the co-pay along with a completed reimbursement claim form.

Over-the-Counter (OTC) Drugs and Medications

A receipt dated on or after January 1, 2020 listing the medication and corresponding cost along with a completed reimbursement claim form. Cash register receipts are acceptable only if the item and cost are clearly identified. OTC drugs, medications and treatments are only covered if they are intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease or injury. Some items are considered dual purpose (a medical purpose and cosmetic/personal or general health purpose). In this case, a note is required from a licensed medical provider that states the person has a specific medical condition for which the item is purchased. The reimbursement amount of the purchased OTC item will be limited to a reasonable quantity that is expected to be consumed in a reasonable amount of time. Sales tax on OTC purchase items can be reimbursed.

Non-covered (or not fully covered) Medical, Dental and Vision Claims

For claims that are non-covered or partially covered by health insurance, a copy of the insurance Explanation of Benefits Form (EOB) should be provided along with a completed reimbursement claim form. If an EOB is not available, a statement from the provider showing the patient, services provided, dates of services, provider and the cost after the insurance payments must be provided. BALANCE FORWARD STATEMENTS ARE NOT ACCEPTABLE. For all claims, an itemized receipt or billing statement (if greater than \$500.00) showing the patient, provider, date of service, services and cost should be provided along with a completed reimbursement claim form.

COMMON QUALIFIED CLAIMS

<p><u>Most Common Expenses</u> Over the Counter Drugs Office Visit Copays Prescription Copays Insurance Plan Deductibles Insurance Plan Co-Insurance</p> <p><u>Other Services & Fees</u> Acupuncture Oral Surgery Anesthetist Orthodontist Chiropractor Osteopath Christian Science Physician Dentist Psychiatrist Exam, physical Psychiatrist Eye Exam Psychoanalyst Gynecologist Psychologist Healing Services Sex Therapist Hospital Specialists Laboratory Surgeons Nursing</p> <p>Reimbursement of over the counter drugs (OTC) may be allowed if claims are properly substantiated by the participant. See OTC listing.</p>	<p><u>Other Miscellaneous Expenses:</u> Adoption (medical expenses incurred before the adoption is finalized) Air conditioning and air filters used for alleviating illness Alcohol and drug treatment center costs Ambulance Artificial limbs and teeth Automobile modifications (hand controls, special equipment, mechanical lifts) Birth control pills Braille books & magazines Childbirth classes (prenatal only) Contact lenses Eye glasses Fertility treatments Food & beverages for specific diseases Genetic testing (to determine possible defects) Hearing aids & batteries Immunizations Infertility treatment Laser eye surgery Lead-based paint removal Learning disability (special school or specially trained educator for learning disabled children recommended by doctor) Lifetime care at medical facility Lodging (for medical care or treatment) Medical supplies and equipment Norplant insertion or removal Obstetrical expenses Operations Optometrist Organ transplants Physical therapy Prescription medications Private hospital room Retirement home fees, costs allocable to medical care</p>	<p><u>Miscellaneous Expenses (continued):</u> Seeing-eye dog Special television to receive closed captions Speech training for a child with dyslexia or other learning disability Sterilization Stop smoking programs Student health fees Support for corrective devices (including special mattress and board for arthritis) Telephone for deaf Therapy treatments Transportation expense relative to illness (subject to IRS limits) Vaccines Vasectomy Weight loss program (to treat an existing disease) Wheelchair X-rays</p>
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OVER-THE-COUNTER (OTC) MEDICATIONS

OTC drugs, medications and treatments are only covered when they are used in the diagnosis, cure, mitigation, treatment or prevention of disease or injury. Dual Use Items may have a medical purpose and a personal/cosmetic purpose or general health purpose. For Dual Use Items, a note from a licensed medical provider stating the person has a specific medical condition for which the item was purchased must be attached to the claim form. Excluded items are those used primarily for general health and well-being and are not covered regardless of reasons for use. The reimbursement amount of a purchased OTC item is limited to a reasonable quantity expected to be consumed in a reasonable amount of time. Two bottles of an item in any one reimbursement is the limit. Sales tax on the OTC items can be included in the reimbursement.

Covered OTC Items

<p>Antiseptics Antiseptic wash and ointments for cuts or scrapes (such as Bactine & Neosporin) Benzocaine swabs Boric acid powder First aid wipes Hydrogen peroxide Iodine tincture Rubbing Alcohol Sublimed sulfur powder</p> <p>Cold, Flu, Allergy Medications Allergy medications Cold relief liquid & tablets Cough drops & syrup Expectorant liquid & tablets Flu relief liquid & tablets Medicated chest rub Nasal decongestant inhaler Nasal decongestant spray or drops Nasal strips to improve congestion Sinus & allergy homeopathic nasal spray Sinus medications Vapor patch cough suppressant</p> <p>Diabetes Diabetic lancets Diabetic supplies Diabetic test strips Glucose meters</p>	<p>Ear/Eye Care Airplane ear protection Ear drops for swimmers Ear water-drying aid Ear wax removal drops Homeopathic earache tablets Contact lens solutions</p> <p>Health Aids Antifungal treatments Denture adhesives Diuretics and water pills Hemorrhoid relief Incontinence supplies Lice control Medicated bandages Motion sickness tablets Oral electrolyte maintenance solutions (such as Pedialyte) Respiratory stimulant ammonia Sleeping aids</p> <p>Menstrual Products Tampons Pads Liners Cups Sponges</p>	<p>Pain Relief Bunion and blister treatments Itch relief Orajel Pain relievers liquid & tablets Pain reliever ointment (such as BenGay) Throat pain medications</p> <p>Personal Test Kits Cholesterol tests Colorectal cancer screening tests Home drug tests Ovulation indicators Pregnancy tests</p> <p>Skin Care Anti-itch medications Bunion & blister treatments Cold sore & fever blister medications Corn & callus removal medications Diaper rash ointment Eczema cream Medicated bath products Wart removal medications</p> <p>Stomach Care Acid reducers Antacid gum, liquid, tablets Anti-diarrhea medications Gas prevention food enzyme dietary supplement Gas relief drops for infants & children Ipecac syrup Laxatives Pinworm treatment Upset stomach medications</p>
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Dual Use OTC Items - requires doctor letter

<p>Acne medications Adhesive or elastic bandages Blood pressure meter Cold or hot compresses Dietary supplements Eye drops (such as Visine) Fiber supplements Foot spa Gauze and tape</p>	<p>Gloves and masks Glucosamine/Chondrotin for arthritis Herbal medicines Hormone therapies Lactose intolerance pills Leg or arm braces Massagers Menopause treatments for hot flashes, sweats</p>	<p>Nasal sprays for snoring Orthopedic shoes & inserts Special teeth cleaning system St John's Wort Thermometers Vitamins Weight loss drugs</p>
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Excluded OTC Items

<p>Aromatherapy Baby bottles and cups Baby oil Baby wipes Breast enhancement system Cosmetics Cotton swabs Dental floss</p>	<p>Deodorants Fragrances Hair regrowth Lip moisturizers (such as Chapstick) Low "carb" and low-calorie foods Oral care (such as toothpaste, mouthwash)</p>	<p>Petroleum jelly Shampoo and conditioner Skin care (moisturizers) Soaps Spa salts Sun tanning products Toiletries Tooth brushes</p>
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SUPPLEMENTAL HEALTH REIMBURSEMENT ACCOUNT FILING PROCEDURES

What are reimbursement requirements?

- Participant must have a minimum of six months coverage “banked” to use their supplemental health reimbursement account. Only the amount in excess of this minimum level may be used for reimbursements.
- Participant must carry dependent coverage to submit claims for dependent’s expense
- Minimum total reimbursement will be \$50.00 per claim (all items added together).
- The Plan year runs March – February with the annual submission deadline of April 15th for expenses incurred with the Plan year
- Expenses less than \$50.00 incurred the last month of the plan year (February), will be reimbursed providing they are submitted no later than the annual submission deadline of April 15th and they were not submitted earlier in the year.
- Participant must submit signed claim form provided by the Fund’s Office.
- All receipts must be itemized to display items.
- Participant must submit proof of payment if amount is less than \$500.00 to a single provider.
- If the amount due to a single provider is over \$500.00, a billing statement showing the unpaid services may be submitted to the Fund’s Office. The office will generate a check directly to the provider. This check will be mailed to the participant for transmittal.

How to File A Claim

1. Complete all information on the claim form for each amount claimed for reimbursement.
2. Make sure the claim does not include items for more than one plan year (March - February). Use different claim forms for different years.
3. You must sign and date the claim form.
4. If expenses have been submitted to a health insurance plan, attach a copy of your Explanation of Benefits (EOB) and provider’s billing statement which support each reimbursement request. Please include all pages of the EOB.
5. If expenses have not been submitted to a health insurance plan, attach copy of an itemized receipt showing provider which supports each reimbursement request and shows the date the service was incurred. Cash register receipts not documenting item is not acceptable.

If you **mail** your claim with EOB’s or receipts, remember to keep a copy of the claim form and supporting documents for your records.

If you **fax** your claim with EOB’s or receipts, please remember to keep the original claim form and supporting documents for your records.

Where To Send A Claim

Mailing Address: BAC Local 23 North Shore Chapter
 Health and Welfare Fund
 9525 Sweet Valley Drive
 Valley View, OH 44125

Phone: (216) 520-1644
Fax: (216) 520-1663

**BAC Local 23 North Shore Chapter Health & Welfare Fund
SUPPLEMENTAL HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM**

Member Name: _____

Social Security #: _____

Member Address _____

Phone Number: _____

<i>Supplemental Health Reimbursement/Expense Claims</i>					
Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Description of Expense	Name of Person Who Incurred Expense	Relationship To Member	Net Amount
Total Medical Expense Claimed					\$

READ CAREFULLY: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned is solely liable for payment of all related taxes including federal, state, or city income tax and penalties on the amount paid from the Plan which relates to such expense.

Participant Signature

Date

**Note: Form must be signed in order to process the claim.

Mail or Fax Claim Form and Supporting Documents to:

BAC Local 23 North Shore Chapter
Health and Welfare Fund
9525 Sweet Valley Drive
Valley View, OH 44125

Fax: (216) 520-1663