

**HRA**  
**IBEW LOCAL 595 HEALTH CARE FUND**  
**HEALTH REIMBURSEMENT ACCOUNT (HRA)**  
**P. O. Box 3420**  
**San Ramon, CA 94583**

**Instructions:** To receive benefits from the Health Reimbursement Account (HRA), you must complete **ONE FORM** per patient, along with the following information:

**Reimbursement for:**

Medical Co-payments

**Information Required:**

Copy of your Health and Welfare Plan Explanation of Benefits (EOB).

**Balance due statements are not acceptable.**

Dental Co-payments

Copy of Health and Welfare Plan Dental Explanation of Benefits Form (EOB).

**Orthodontic services will be paid for after services are rendered.**

Vision Co-payment

Copy of your VSP Explanation of Benefits.

Prescription Co-payment

Copy of the drug label stub or a printout from your pharmacy.

**Cash register receipts are not acceptable.**

**PLEASE NOTE:** The minimum amount that can be reimbursed must total \$20.00 per submission, unless you are requesting benefits for a self payment. **You MUST allow up to 30 business days for reimbursement.** All reimbursements for claims will be made payable to the member.

Member's Name: \_\_\_\_\_ Member's SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Type of Service**

(Medical, Dental, Vision  
or Prescription)

**Providers Name**

**Date of Service**

**Amount of Claim**

Claims must total at least \$20.00

_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____

By signing this form, I understand that benefits shall be paid in accordance with the Health Reimbursement Account Plan eligibility requirements and limitations established by the Board of Trustees. (See reverse side of this form for a brief description of covered benefits).

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# EXTENDED RESERVE ACCOUNT

## **What is a H.R.A.?**

A Health Reimbursement Account is an individual account for each Active Member. The purpose of the H.R.A. is to help defray some of your out of pocket health care cost.

## **How will my H.R.A. be funded?**

Each participant will have an account based on hours worked under the Collective Bargaining Agreement multiplied by an amount determined by the Board of Trustees.

## **How will I be informed of my H.R.A. balance?**

H.R.A. information appears on your monthly status report. The monthly status report shows your current balance, any new work hour contributions to the H.R.A. and any reimbursement requests that have been processed.

## **What can I use the H.R.A. account for?**

- ◆ To pay bills for covered medical, dental, vision or prescription expenses which would otherwise not be payable under the IBEW Local 595 Health Care Plan.
- ◆ To pay any Self Payment amount which may be due.

In other words, The H.R.A. may be used for one or more of the following expenses incurred:

- ◆ All or part of any co-payments required or amounts in excess of usual, customary and reasonable limits, on covered Medical, Dental or Vision services.
- ◆ Denied Medical, Dental, and Vision services (Provided they are IRS approved medical expenses)
- ◆ Prescription drug program co-payment
- ◆ Self Payments

## **What expenses are not allowed?**

Benefits payable under the H.R.A. are subject to IRS rules and regulations regarding the IRS definition of medical expenses, which may be included in medical expense deductions. The following is a brief list of expenses not payable under the H.R.A. they include but are not limited to:

- ◆ Expenses already covered under the IBEW Local 595 Health Care Plan
- ◆ Vitamins/ Supplements (whether prescribed by a doctor or not)
- ◆ Over the counter drugs or supplies
- ◆ Life Insurance premiums, premiums for other insurance, etc.

## **What happens to my H.R.A. after I retire?**

You will still be able to use your H.R.A. as before including Retiree Self payments. Should you die, your H.R.A. will be transferred to your surviving spouse.

## **Eligibility Requirements**

You must be an eligible employee of the IBEW Health Care Plan.

## **Self Payments**

If you are required to make a self-payment to maintain your coverage, you may use your H.R.A. account to make the payment.

## **Maximum Benefit**

Your maximum benefit equals the current balance in your Health Reimbursement Account.

**MAIL TO:**  
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