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 dependents' 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 <u>not</u> 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, <u>remember to keep a copy of the claim form and supporting documents for your records.</u>

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: Bricklayers & Masons' Local Union No. 5, Ohio
Health and Welfare Fund
6200 Rockside Woods Blvd. N Ste 210
Independence, OH 44131

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

BRICKLAYERS & MASONS' LOCAL UNION NO. 5 OHIO, HEALTH & WELFARE FUND
SUPPLEMENTAL HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

Member Name: _____

Social Security #: _____

Member Address _____

_____

Phone Number: _____

Supplemental Health Reimbursement/Expense Claims

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 clamed 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:

Bricklayers & Masons' Local Union No. 5, Ohio
Health and Welfare Fund
6200 Rockside Woods Blvd. N, Ste 210
Independence, OH 44131

Fax: (216) 520-1644