PLUMBERS LOCAL UNION No.1 WELFARE FUND
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ACCOUNT
REIMBURSEMENT GUIDE

www.ualocal1funds.org

1/2024

718-223-4313 / 718-835-2700

How to file a claim for your Health Care reimbursement arrangement account.

Account Information

1. For a list of Health Care Eligible Expenses which may be submitted, visit HRAbenefits.nypl1f.org or see the Summary Plan Description.
2. You must have itemized bills for each expense. An itemized bill contains the name of the patient, provider and shows the date(s) of services or supply and the type of service or supply. **Cancelled checks and balance forward statements cannot be used for claim purposes**.
3. A separate claim form must be used for Employee and each Eligible Dependent.
4. Disbursements are made only when at least $25.00 in reimbursement has been submitted and when at least $25.00 is available in the Health Reimbursement Arrangement Account.
5. Claims submitted or awaiting payment that are below the $25.00 minimum will be reimbursed quarterly.
6. All reimbursements will be made payable to the Employee. However, for claim expenses greater than $500.00, you can submit a balance forward statement and designate the HRA claim as "pay to Provider". Please contact the Fund Office for this option.
7. Employees will receive an Explanation of Benefits for each claim that is denied.
8. Account balance statements will be mailed to participants at the end of each Plan Year.

Expense Type Category

MD - Medical	RX - Prescription	OTC – Over the Counter
VS - Vision	DN - Dental	HR – All Other eligible out-of-pocket expenses

Filing Your Paper Claim

1. Complete the personal information requested on the Reimbursement Form.
2. List each out-of-pocket expense and attach the itemized bill within 36 months from date of service (12 months effective 1/1/2025).
3. If an expense is covered in part by a health plan, the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan Explanation of Benefits must be submitted with the claim.
4. Calculate the total amount of reimbursement due (net out-of-pocket expense) by adding the actual charges incurred.
5. Sign and date the reimbursement request.
6. **With possible disruptions with the US Postal Services, and limited access to the Fund Office, all applications and related documents should be sent by e-mail or text to info@nypl1f.org or by fax to 718-641-8155. Any questions regarding this benefit can also be submitted by email or fax.**
7. For questions or request for Direct Deposit Form: Please e-mail or text to info@nypl1f.org or by fax to 718-641-8155. You can also call the Fund Office HRA Department at (718) 223-4313 or visit our web site at www.ualocal1funds.org.

Remember: You may not claim any health care expenses for which you have been reimbursed on your Federal Income Tax. For more information regarding medical expenses, please refer to IRS Code Section 213(d).

Plumbers Local Union No.1 Health Reimbursement Arrangement (HRA) Claim Request Form

www.ualocal1funds.org

INSTRUCTIONS: You can file an electronic claim for out-of-pocket medical expenses by using your account at HRAbenefits.nypl1f.org. To file paper claims for reimbursement from your HRA account, fill out this form and sign it. The minimum reimbursement from your account is $25. Reimbursement checks will only be made payable to the Participant or Provider. Please see the SPD for information on eligible reimbursable expenses. Also, include the proper documentation. **Deadline:** Expenses incurred must be submitted within 36 months from date of service (12 months effective 1/1/2025).

(A) MEMBER INFORMATION

7/2023

(1) SOCIAL SECURITY NO. ■■■-■■-☐☐☐☐ | (2) LAST NAME | (3) FIRST NAME | (4) INITIAL

(5) STREET | (6) CITY | (7) STATE | (8) ZIP CODE

(9) BIRTH DATE ☐☐/☐☐/☐☐☐☐ | ☐ (10) MALE ☐ (11) FEMALE | (12) DAYTIME TELEPHONE NUMBER: ☐☐☐/☐☐☐/☐☐☐☐ | (13) OTHER TELEPHONE NUMBER: ☐☐☐/☐☐☐/☐☐☐☐

(14) E-MAIL ADDRESS

(15) RELATIONSHIP TO MEMBER
(M) MEMBER (S)SPOUSE
(D) CHILD (Q) QUALIFIED RELATIVE

Direct Deposit Election

☐ Check this box for Direct Deposit. You will need to manage your banking information by accessing the new Wex Member Portal

(B) CLAIM INFORMATION: Remember to list each expense and attach the itemized bills. Attach another form if you need additional space I

	DATE OF SERVICE	MEMBER/SPOUSE or DEPENDENT NAME	NET OUT-OF-POCKET EXPENSES	RELATIONSHIP TO MEMBER	PROVIDER NAME	EXPENSE TYPE / CATEGORY (See back of form)
1.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
2.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
3.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
4.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
5.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
6.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
7.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
8.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
9.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
10.	☐☐/☐☐/☐☐☐☐		$			MD☐ RX☐ OTC☐ VS☐ DN☐ HR☐
(C) MEMBER SIGNATURE/CERTIFICATION: **Reimbursements are payable to the Participant or Provider only**					**TOTAL**	$

By signing this form you certify that: (1) You or your eligible dependents have incurred the listed expenses. (2) All applicable insurance and/or other health plan benefits have been exhausted. (3) You will not deduct or take a tax credit on your Federal Income Tax Return for the listed expenses. (4) You assume all responsibility for taxes or penalties arising out of disallowed deductions. (5) You authorize any insurance company, prepayment organization, employer, hospital, or provider to release all information with respect to yourself or any of your dependents that may have bearing on the Benefits payable under this or any other plan providing benefits or services. I hereby certify that the information I have provided in support of this claim is complete, true and that all charges claimed was the amount billed.

MEMBER SIGNATURE _____ **DATE** ☐☐/☐☐/☐☐☐☐

Date Received	Date Entered	Control No.	Check Date	Amt Paid

Please Fax completed form to (718) 641-8155 or mail to Plumbers Local Union No. 1 Welfare Fund, 50-02 5th Street, Long Island City, NY 11101. Visit HRAbenefits.nypl1f.org for access to your account.