Instructions and Important Information Regarding Value Bank Reimbursement Requests

Eligible Medical and Drug Expenses – Members with Value Bank balances with a minimum of three months of premium banked at the coverage level and tier in which you are enrolled, may seek reimbursement from their Value Bank for previously unreimbursed deductibles, co-insurance and co-pays (that occurred within 24 months) while eligible and incurred under the Iron Workers Welfare Plan of W. PA.

Eligible expenses are:

- Deductibles
- Co-insurance
- Co-payments for medical
- Co-payments for prescription drugs

Please Note – The incurred date for the above reimbursable expenses **must be within 24 months of your request.** Expenses incurred before that date are not reimbursable.

Legal Spouse and Eligible Dependents – Only eligible medical and drug expenses incurred by you, your legal spouse or eligible dependents, and who are enrolled in the Plan, are eligible for reimbursement.

Supporting Documentation – For all medical expenses, attach all pages of your Highmark BCBS Explanation of Benefits or the Highmark "Claims Detail at a Glance".

For prescription drug co-payments, submit an itemized receipt including patient's name, date, name of drug and co-pay amount from the pharmacy (cash register receipts are not acceptable).

Submission of Reimbursement Requests – Fax or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable.

Requests for reimbursement must be made within 24 months of the incurred date.

Eligible claims submitted within the timeframe described above will be reimbursed to you within 30 days of submission of the proper documentation to the Plan Office.

The Minimum Request for Reimbursement is $50.

Other Permissible Reimbursements from the Value Bank for Claims Incurred on or After 1/1/2011

Effective for claims incurred **on or after 1/1/2011**, members may also be reimbursed from their Value Bank for:

- **Dental treatment and artificial teeth** – You can be reimbursed for the amounts you pay for the prevention and alleviation of dental disease. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as x-rays, fillings, braces, extractions, dentures and other dental ailments.

- **Vision exams, glasses, contacts** – You can be reimbursed for fees paid for eye examinations. You can also be reimbursed for the amounts you pay for eyeglasses and contact lenses needed for medical reasons.

- **Eye surgery** – You can be reimbursed for the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

- **Hearing aids** – You can be reimbursed for the cost of a hearing aid.

- **Smoking cessation programs** – You can be reimbursed for amounts you pay for a program to stop smoking. You cannot be reimbursed for amounts you pay for drugs that are designed to help stop smoking that do not require a prescription, such as nicotine gum or patches.

- **Insurance Premiums** – You can be reimbursed for insurance premiums you pay for policies that provide payment for dental and vision care, as long as the premiums have not been paid using pre-tax dollars.

Requests for these claims must include itemized statements that include patient name, date of service, detail of service, charge, and provider name and address.

Only eligible expenses incurred by you, your legal spouse or eligible dependents, and who are enrolled in the Plan, are eligible for reimbursement.

IRON WORKERS OF WESTERN PENNSYLVANIA BENEFIT PLANS
2201 Liberty Avenue, Room 203, Pittsburgh, PA 15222
Toll-Free: 1-800-927-3199, Telephone: 412-227-6740, Fax: 412-261-3816

The minimum request for reimbursement is $50

Value Bank Reimbursement Request

Member Name ______________________ SS# ______________________

Address ____

Phone ______________________ E-Mail ______________________

Please list all out-of-pocket unreimbursed eligible medical expenses (as defined in the instructions) for which you are requesting reimbursement.

Description of Expense	Date of Service	Amount*
Example: Office visit co-pay		
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

*Do not include amounts paid or eligible for payment under any other health care, dental or vision plan or program, federal, state or governmental program, Workers' Compensation, or any other policy of health, dental or vision insurance.

TOTAL EXPENSES $__________

Include with this form all "Supporting Documentation" as defined on the instructions. Retain a copy for your records. Canceled checks are not acceptable. Failure to submit Supporting Documentation will delay (or prevent) claims processing.

Member Certification

By submitting this form, I hereby certify the following:

- All expenses identified above are "Eligible Medical Expenses" as defined in the instructions.
- All expenses were incurred by me, my legal spouse, or an eligible dependent as defined in the SPD.
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I will not deduct the above listed expenses on my personal federal and/or state income tax return for any year. The Plan does not accept responsibility for direct payment to any individuals other than the member.

I have read and understand the information contained in the instructions.

MEMBER SIGNATURE ______________________ **DATE** ______________