



**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**

**Value Bank  
Medical Care Reimbursement Request**

The minimum request for reimbursement is \$50

Member Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

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

Description of Expense	Date of Service	Amount*
<i>Example: Office visit co-pay</i>		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

**TOTAL EXPENSES \$ \_\_\_\_\_**

**Include with this form all "Supporting Documentation" as defined on the reverse side of this form.** 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 important information on the reverse side.
- 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 employee.

I have read and understand the information on the reverse side of this form.

**MEMBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

## IMPORTANT INFORMATION

**Eligible Medical and Drug Expenses** - Members with Value Bank balances may seek reimbursement from their Value Bank for previously unreimbursed deductibles, co-insurance and co-pays (that occurred after January 1, 2010) while eligible under the Iron Workers Welfare Plan of W. PA.

Eligible expenses are:

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

**Legal Spouse and Eligible Dependents** - Only eligible medical expenses incurred by you, your legal spouse or eligible dependents (as defined in the SPD), and who are enrolled in the Plan, are eligible for reimbursement.

**Supporting Documentation** - For all medical expenses, attach your Highmark BCBS Explanation of Benefits.

For prescription drug co-payments, submit an itemized receipt 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.

**Please Note** - The incurred date for reimbursable expenses **must be January 1, 2010 and after**. Expenses incurred before that date are not reimbursable. Requests for reimbursement must be made within 24 months of the incurred date.

**The Minimum Request for Reimbursement is \$50.**