SHEET METAL WORKERS LOCAL NO. 33 YOUNGSTOWN DISTRICT HEALTH & WELFARE FUND

Telephone (330) 270-0453
Toll Free 1-800-589-8041

Office Location
33 Fitch Boulevard
Austintown, Ohio 44515

TO: **PARTICIPANTS AND ELIGIBLE DEPENDENTS**

RE: **MEDICAL REIMBURSEMENT PLAN**

DATE: **December 1, 2008**

A. INTRODUCTION

Enclosed you will find a statement reflecting contributions to a Medical Reimbursement Account (MRA). This account was established based upon your work under the jurisdiction of a collective bargaining agreement which requires contributions be made to an individual MRA. The MRA shall be an individual sub-account of the Plan for each Participant for whom such contributions are made. These contributions shall not create or constitute a vested benefit.

When you or your Eligible Dependent has unreimbursed covered medical expenses and an existing balance in your individual MRA, you may submit, on a form provided by the Fund office, proof of such expenses for reimbursement from their individual MRA. Copies of these forms have been included for your use. Reimbursement checks shall only be issued to Participants on a quarterly basis.

Medical expenses will be reimbursed only to the extent that reimbursement for such medical expenses is not available to the Participant under the Sheet Metal Workers Local No. 33 Youngstown District Health & Welfare Plan (hereinafter referred to as "Plan"), any health insurance policy or plan provided through any employer of the Participant.

B. COVERED EXPENSES

Reimbursement, to the extent the Participant has funds in his/her individual MRA, shall be made for expenses incurred by a Participant or his/her Eligible Dependent. Listed below are the more common covered expenses. A complete listing of all eligible expenses can be obtained from the Fund Office or by reviewing Code Section 213 of the Internal Revenue Code at http://www.trustadmin.com/pages/healthcarelist2.htm.

- Deductibles, co-payments and expenses in excess of benefit maximums applied to covered medical expenses under the Plan or other qualified plan for which you or your Dependent spouse receive medical benefits;

- Self-payments to maintain eligibility under the Plan or other qualified plan or arrangement or premium or other payments required to maintain coverage under any medical or dental insurance plan of your Spouse;
- Unreimbursed (for purposes of the MRA, unreimbursed means not already paid for by this Plan, another Plan or other source) prescription medicines (prescribed by a doctor) and insulin, including co-pays;
- Over the counter medicine bought without a prescription;
- Unreimbursed dental or vision expenses;
- Any other medical expenses identified in Internal Revenue Code Section 213, or regulations promulgated thereunder.

C. ITEMS NOT COVERED

The following is a partial list of items which shall not be subject to reimbursement. For a complete listing, please contact the Fund Office or review the listing of the ineligible expenses of the Internal Revenue Code Section 213 at http://www.trustadmin.com/pages/healthcarelist2.htm.

- Expenses for which the Participant or Eligible Dependent claimed or will claim a medical expense deduction on the Participant's tax returns;
- Expenses incurred before the Participant became initially eligible for medical benefits under the Plan, unless permitted by Code Section 213;
- Except as otherwise provided herein, expenses incurred after termination of employment and eligibility, unless permitted by Code Section 213;
- Medical expenses for which reimbursement is available under another plan or program.

D. TIME PERIOD FOR FILING CLAIM

Claims for Medical Expense Reimbursements shall be filed no later than one (1) year following the date the services were rendered.

E. CANCELLATION OF ACCOUNT

Any individual, who engages in covered employment (bargaining unit work) for a non-contributing employer, shall have his/her account cancelled and the account balance will revert to the Plan's subtrust for medical reimbursement.

F. DISPOSITION OF INDIVIDUAL MRA IN THE EVENT OF DEATH OF THE PARTICIPANT

In the event of your death, your individual MRA balance shall be placed in an individual MRA for your Spouse, or if unmarried or widowed, for your Eligible Dependent(s) as allowed by applicable provisions of the Internal Revenue Code or regulations promulgated thereunder.

G. OTHER GENERAL PROVISIONS

This individual MRA may only be used for reimbursement purposes and shall not be paid directly to your surviving Spouse or your other Eligible Dependent(s) other than for reimbursement for eligible expenses. The Health and Welfare Fund may assess an administrative fee against your MRA for the administrative costs of processing such reimbursement claims.

If you have any questions, please feel free to contact the Plan's Administrative Manager at 1-800-435-2388.

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AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME _____

ADDRESS _____

_____ PHONE NO. _____

SOCIAL SECURITY NUMBER _____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming a federal income tax deduction:

AMOUNT OF DEDUCTIBLE $_____

AMOUNT OF CO-INSURANCE $_____

VISION CARE **(attach receipts)** $_____

DENTAL CARE **(attach receipts)** $_____

OTHER MEDICAL EXPENSES **(attach receipts)** $_____
(not covered by the Health & Welfare Fund)

SELF PAYMENT BILLING **(attach copy of billing)** $_____

☐ Check here if you elect to have your self-payment remitted directly to your health fund

Please complete the above, attach a copy of your EOB (Explanation of Benefits) from the Health & Welfare Plan where applicable, and receipts showing payments were made for expenses not covered by the Health & Welfare Plan, sign and return this form to:

SHEET METAL WORKERS LOCAL 33 YOUNGSTOWN DISTRICT
HEALTH AND WELFARE FUND
33 Fitch Boulevard
Austintown, Ohio 44515

All expenses submitted for a quarter will be reimbursed in the months of March, June, September and December. For example, claims received during the months of December, January and February will be reimbursed in March. Please call first to check the status of your account before filing large dollar claims and **PLEASE MAKE A COPY FOR YOURSELF OF ALL CHARGES SUBMITTED IN THE EVENT OF LOSS.**

EMPLOYEE SIGNATURE _____ DATE _____

Not valid unless signed and dated by Employee