UTILITY WORKERS UNION OF AMERICA
NATIONAL HEALTH & WELFARE FUND
DTE ENTERGY
HEALTH REIMBURSEMENT ARRANGEMENT
MAY 2016

WHEN YOU RETIRE:

1. **Notify the Fund Office** (UWUA National Health & Welfare Fund). You must provide the date you retire and proof that you are actually retired such as a copy of your first retirement check

2. **Complete the Health Care Enrollment** form for the Health & Welfare Fund. You must provide marriage certificate and dependent birth certificates.

3. **Claims Submission**: Provide an itemized bill, receipt or explanation of benefits (EOB). The date of service, a description of what it represents, the amount of reimbursement being requested, and the individual for whom reimbursement is being requested must also be provided.

4. You may **request reimbursement** for covered expenses for any employee covered by the Collective Bargaining Agreement and their eligible dependents as defined in the IRS Code § 152.

5. **Covered Medical Expenses** in general include, but are not limited to, amounts for such things as hospitalization, doctors and dentists bills, and prescription drugs. Such expenses also include amounts you pay for deductibles, co-payments, coinsurance, as well as premiums for group health plan coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars), COBRA continuation coverage, and Medicare Parts B, C, and D coverage. However, not all medical care expenses will be considered "eligible health care expenses" that qualify for reimbursement under the Plan. Generally, only medical care expenses within the meaning of Section 213 of the Internal Revenue Code are eligible. Some Section 213 medical expenses are excluded from coverage (see "Excludable Expenses" below.) If you have any questions as to whether an expense is reimbursable, call the Plan Administrator.

6. **Limits**. Benefits will cease when the employees account balance is zero.

7. **Forfeiture**: Participants will forfeit their account balance if they have no activity in their account for a period of three (3) years. If you are retired and have had a period of three (3) years of inactivity, you can request an extension to prevent the forfeiture of your account balance.

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HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIM FORM

Name: _____ **Member ID or SS#** _____
PLEASE PRINT

Address: _____ **Telephone Number:** _____
PLEASE PRINT PLEASE INCLUDE AREA CODE

City, State, Zip _____ ☐ Please check here if this is a new address

Instructions for claims submission:
For each itemized bill, receipt or explanation of benefits (EOB), please provide the date of service, a description of what it represents, the amount of reimbursement being requested, and the individual for whom reimbursement is being requested.

For whom may I request reimbursement?
The Health Reimbursement Account limits expenses to the employee covered by the collective bargaining agreement (or participation agreement) and their eligible dependents as defined in the IRS Code § 152.

One reimbursement request is permitted per WEEK. Total reimbursement requested must exceed $50.00. Please attach itemized bills/receipts/EOB's for each family member you are seeking reimbursement for allowable medical expenses. Please itemize your expenses below and attach receipts in order. **NOTE: Bills/receipts must clearly indicate the patient name, physician name, date of service, etc. In addition, if your bill/receipt is for a co-payment, this must be clearly indicated on your bill/receipt.**

-Missing information may cause a delay in the processing of your claim(s)-

Service	Description of Charges	Provider Name	Amount	Patient Name	Relationship
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					
	Total				

I certify that the claims itemized above have not otherwise been reimbursed and are not reimbursable through any other source. Further, I certify that Health FSA (flexible spending account established through payroll deduction) coverage, if any, for such expenses has been exhausted. I also certify that the expenses itemized are being submitted for myself and/or my eligible dependents and represent allowable expenses as defined within the Summary Plan Description **(please read the reverse side of this form).**

_____ _____
Signature of Participant Date

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION
6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • (800) 920-8116 Toll Free
FAX (517) 321-7508
www.uwuabenefits.org

Medical Care Expenses: In general, medical care expenses include, but are not limited to, amounts for such things as hospitalization, doctors and dentists bills, and prescription drugs. Such expenses also include amounts you pay for deductibles, co-payments, coinsurance, as well as premiums for group health plan coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars), COBRA continuation coverage, and Medicare Parts B, C, and D coverage. However, not all medical care expenses will be considered "eligible health care expenses" that qualify for reimbursement under the Plan. Generally, only medical care expenses within the meaning of Section 213 of the Internal Revenue Code are eligible. Some Section 213 medical expenses are excluded from coverage (see "Excludable Expenses" below.) If you have any questions as to whether an expense is reimbursable, call the Plan Administrator.

Excludable Expenses

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs:

> Long-term care services.

> Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

> Over-the-counter medications without a prescription.

> The salary or expense of a nurse to care for a healthy newborn at home.

> Funeral and burial expenses.

> Household and domestic help (even though recommended by a qualified physician due to a participant's or dependent's inability to perform physical housework).

> Massage therapy.

> Home or automobile improvements.

> Custodial care.

> Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

> Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.

> Social activities, such as dance lessons (even though recommended by a physician for general health improvement).

> Bottled water.

> Diaper service or diapers.

> Cosmetics, toiletries, toothpaste, etc.

> Vitamins and food supplements, even if prescribed by a physician.

> Uniforms or special clothing, such as maternity clothing.

> Automobile insurance premiums.

> Transportation expenses of any sort, including transportation expenses to receive medical care.

> Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

> Any item that does not constitute "medical care" as defined under Internal Revenue Code § 213.

> Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars.

Claims Submission: A claim for reimbursement of an eligible health expense must be submitted to the Plan Administrator within 12 months of the date the expense was incurred. After 12 months, the expense will no longer be eligible for reimbursement.

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RE: RETIREE CERTIFICATION

As an employee of DTE Entergy, in order to be reimbursed from your Health Reimbursement Account (HRA) you must be retired. (Please refer to pages 2 and 3 of the Summary Plan Description for further clarification. You can access this information via the web site listed below.)

In order for us to update your HRA coverage, and before claim(s) can be processed for reimbursement, it is necessary for you to complete and return the bottom portion of this letter.

If you are retired or have received a Social Security Disability Award, it is necessary that you **also complete the enclosed Health Care Enrollment Form and return it with a copy of your Marriage Certificate and Birth Certificates for any covered dependents** if you have not already done so.

If you have any questions, please do not hesitate to contact the undersigned.

Sincerely,

Health Care Department

Member ID # Member Name:

_____ Yes I am retired. I retired on _____.

_____ Yes I have a Social Security Disability Award effective _____. (Please include a copy of the award with this form if applicable)

_____ No, I am not retired.

Member Signature:_____ Date Signed:_____

Please return to address listed below

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UTILITY WORKERS' UNION OF AMERICA NATIONAL HEALTH & WELFARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

HEALTH CARE ENROLLMENT FORM

(Please Type or Print Clearly)

Participant's Name | Birth date | Member ID or SSN

Street Address

City | State | Zip Code | Telephone Number (including area code)

MARITAL STATUS (Circle One): **Married** **Single** **Divorced** **Widow** **Separated**

Spouse's Name | Birth date | Social Security No.

Dependent's Name | Relationship | Birth date | Social Security No.

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

Return this form to: UWUA NATIONAL HEALTH & WELFARE FUND
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