Appendix A

Eligible Medical Expenses for Reimbursement from your HRA

Please remember that just because an expense is included on this list, does not mean that it is automatically reimbursable from the HRA. All the applicable requirements described in the SPD must be met in order for your claim to be eligible for reimbursement. In addition, the Fund reserves the right to request additional information that is not included in this Appendix to determine whether a particular expense is reimbursable.

Healthcare Expense Type	Substantiation Requirements
Co-Payments, Co-insurance, Deductibles and expenses that exceed the Usual or Customary Charges paid to out-of-network providers for expenses. This includes, but is not limited to, doctors, hospitals, urgent care facilities, laboratory services, radiology services, ambulance transport, mental health services, substance abuse treatment, orthotics and prosthetics.	• Explanation of Benefits (EOB) is preferable • Proof of Payment • If an EOB is not available, you may submit an itemized bill which must include the following: 1. Date of service 2. Patient Name 3. Description of services rendered (procedure code) and diagnosis code if available 4. Cost of Services rendered and proof of payment 5. Name and address of provider.
Medical Premiums • Post-tax medical, dental or vision premiums that are paid to a qualified individual or group health plan • Medicare • COBRA premiums that are paid to a qualified individual or group health plan • Premiums that are self-paid to the Fund with after-tax dollars during a period in which your Employer is delinquent	• Acceptable Proof: 1. Proof that premiums are paid with "after tax dollars," such as a letter from Human Resources or Payroll department. 2. Paycheck stub showing the amount of premiums paid. Pay stub must also include: date the check was issued, name of person the check is issued to and the amount of premium deducted. 3. Proof that the plan is a qualified individual or group health plan. 4. Copies of Medicare statements or invoices are acceptable. 5. For COBRA premiums, proof must include a letter from the Plan Administrator certifying the COBRA rate and proof that you have paid the full premium.

Dental and Orthodontic Services	• Explanation of Benefits (EOB) • Proof of payment • Orthodontics also require the following: 1. Signed and dated Orthodontic contract with provider information, patient name, payment plan selected and what the insurance company is estimated to pay 2. If the Participant does not have dental insurance, the Participant must submit a signed orthodontic contract and an itemized bill which includes the date services began, patient name, services rendered, and cost for the services
Drugs/Medicines – Prescriptions **FDA legend drugs only.** **Over-the-counter drugs or medicines <u>will be considered</u> only when submitted with a doctor's Prescription. RX must include the patient's name and have a current date. <u>Medicine for general wellbeing or cosmetic purposes are not covered!</u>**	• Documentation from the Pharmacy that must include all of the following: 1. Name and Address of Pharmacy 2. Name of patient 3. Name of Drug 4. Cost of Drug and any amounts covered by insurance 5. Prescribing doctor • Proof of Payment
Vision Care • Contact lenses • Laser surgery • Eye examinations by a licensed ophthalmologist, optometrist or optician • Prescription Eyeglass Lens	• Explanation of Benefits (EOB) is preferable • Proof of payment. • If an EOB is not available, you may submit an itemized bill which must include the following; 1. Date of service 2. Patient name 3. Description of services rendered (procedure code) and diagnosis code if available 4. Cost of services rendered and proof of payment

Hearing • Purchase price and maintenance cost for hearing aids • Batteries needed to operate the hearing aid • Hearing exams	• Explanation of Benefits (EOB) • Letter of Medical Necessity • Proof of payment • If an EOB is not available, you may submit an itemized bill which must include the following; 1. Date of service 2. Patient name 3. Description of services rendered (procedure code) and diagnosis code if available 4. Cost of services rendered and proof of payment
Durable Medical Equipment **(Equipment must be an Eligible Medical Expense as per current Internal Revenue Service guidelines.)**	• Copy of the prescription or proof that the equipment was prescribed • Letter of Medical Necessity • Proof of payment • Documentation that includes the following: 1. Name and Address of Company providing the equipment 2. Name of patient 3. Type of Equipment 4. Cost of Equipment and any amounts covered by insurance 5. Prescribing doctor

Please see IRS Publication 502, IRS Code Section 213 (d) for a complete list of Eligible and Ineligible Medical Expenses. **However, be advised that at this time the Board of Trustees is limiting reimbursements to the Medical Expenses listed in the above appendix.**

The following list provides examples of items that are **NOT** eligible for reimbursement from your HRA. This list is provided as an example and is not exhaustive.

Foods and Beverages
Cancellation Fees
Missed Appointment Fees
Late Payments
Shipping Fees
Athletic Club membership
Swimming Pool, Hot Tubs
Weight loss programs
Massage Therapy
Cosmetic Surgery and procedures
Non-prescription medicine
Acne Treatments
Suntan Lotion
Vitamins
Dietary Supplements
Exercise Equipment