Boilermakers Lodge No. 154 Benefit Funds

Park West One • 1000 Cliff Mine Road, Suite 101 • Pittsburgh, PA 15275
(412) 545-5888

PATH Administrators
Contract Administrator

Dear Participant,

Enclosed for your use is the Medical Reimbursement Benefit Program Major Coverage Attestation Form along with the Medical Reimbursement Account Health Care Reimbursement Account Health Care Reimbursement Form. Please feel free to make copies of this form.

Please keep in mind, the Attestation Form **must** accompany the Medical Reimbursement Account Health Care Reimbursement Form with **every** claim submission. Claims submitted without the attestation Form may cause delay in the processing of your claim.

Feel free to contact the office at the number listed above with any questions.

Sincerely,

PATH Administrators

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MEDICAL REIMBURSEMENT ACCOUNT

HEALTH CARE REIMBURSEMENT REQUEST FORM

INSTRUCTIONS:

Type or print all information in the Employee Section below. Please complete a separate Reimbursement Request Form for each provider for which you are filing a claim.

1. Complete the Health Care Expenses section with the date of service. List the reimbursement amount next to the type of reimbursement being requested (deductible, co-insurance, etc.) and then enter the total claim amount.
2. Attach supporting documentation to the request form. This documentation should include the following:
    - Explanation of Benefits indicating deductibles, co-insurance, and amounts in excess of reasonable and customary for you or your eligible dependents.
    - Itemized bills from your doctor, dentist, or other provider for expenses not covered by your Medical, Dental, or Vision Plan.
    - Itemized statements for Qualified Dependent Care Expenses or Medical Part B Premiums.
    - Itemized bill for Boilermaker's continuation coverage under the COBRA or self-payment provisions.
3. Send completed claim form to the address listed at the top of this form.

Participant Section:

Name: _____ Social Security Number: _____
Address: _____ State: _____ Zip Code: _____
Name of Patient: _____ Relationship: _____
Provider: _____ Service type: _____

Health Care Expenses (Expenses not covered or not paid by your plan or any other plan**)**
Date (s) of Service From: ____/____/____ To: ____/____/____
Claim Reimbursement Amounts:

Deductible	$_____	For office use only
Co-insurance	$_____	Request Number:
Excess Reasonable & Customary	$_____	Date: _____
Not covered by the Plan	$_____	Amount: _____
Health Coverage COBRA/Self Pay	$_____	
Medicare Plan B Premium	$_____	
Qualified Dependent Care	$_____	

REIMBURSEMENT TOTAL: **$_____**

I certify that I am enrolled in major medical coverage in a group health plan that meets the minimum value standard under the Patient Protection and Affordable Care Act and that either I and/or my eligible dependent(s)have incurred the expense for which reimbursement is claimed from the Medical Reimbursement Account.

Participant's Signature: _____ Date: _____

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BOILERMAKERS LODGE NO. 154 WELFARE FUND
MEDICAL REIMBURSEMENT BENEFIT PROGRAM
MAJOR MEDICAL COVERAGE ATTESTATION FORM

* PLEASE RETURN TO THE FUND OFFICE *

* YOUR CLAIMS CANNOT BE PROCESSED WITHOUT THIS FORM *

Due to restrictions placed on health reimbursement arrangements ("HRAs") by the Patient Protection and Affordable Care Act ("PPACA"), the Boilermakers Lodge No. 154 Welfare Fund ("Fund") must confirm that all participants for whom employer contributions are being made to the Fund on their behalf are enrolled in major medical coverage that meets certain standards under PPACA.

If you receive major medical coverage through another plan provided by your employer, you should have been provided with a notice and a Summary of Benefits and Coverage that contains an explanation as to whether that coverage meets the minimum value standard under PPACA. If you receive major medical coverage through your spouse's employer or another source, the plan sponsor of that health plan should have provided you with this information. If you do not know whether the primary health plan in which you are enrolled meets the minimum value standard under PPACA, please contact that plan for more information. If you are not enrolled in major medical coverage at all, please indicate that as well.

Name: _____

Address: _____

Telephone: _____

Email: _____

Date of Birth: _____

Employer: _____

Please select the statement below that applies to you:

_____ 1. I am enrolled in a health plan through the Boilermakers National Health & Welfare Fund based on contributions made by my employer.

_____ 2. I am enrolled in health plan provided by my employer other than the Boilermakers National Health & Welfare Fund.

_____ 3. I am enrolled in a health plan that is not provided by my employer.

_____ 4. I am not enrolled in any other health plan except the Boilermakers Lodge No. 154 Welfare Fund Medical Reimbursement Benefit Program.

* CONTINUE ON TO PAGE 2 *

If you selected 1, please sign the Attestation below:

I have read the statements above and I attest to the following:

- I am enrolled in the Boilermakers National Health & Welfare Fund based on contributions made by my employer.

Participant Signature: _____

Date: _____

If you selected 2 or 3 please select the statement below that applies to you:

_____ A. The health plan I am enrolled in meets the minimum value standard.

_____ B. The health plan I am enrolled in does not meet the minimum value standard.

If you selected A, please sign the Attestation below:

I have read the statements above and I attest to the following:

- I am enrolled in a group health plan that meets the minimum value standard of the Patient Protection and Affordable Care Act.

- I understand that I must promptly inform the Fund if and when I am no longer enrolled in a group health plan that meets the minimum value standard of the Patient Protection and Affordable Care Act.

Participant Signature: _____

Date: _____

If you selected B, please provide the date that you began being enrolled in the health plan that does not meet the minimum value standard and sign below.

I am a participant in the Boilermakers Lodge No. 154 Welfare Fund. I am enrolled in a health plan that does not meet the minimum value standard from the date of _____.

Participant Signature: _____

Date: _____

Please contact the Fund Office at (412) 545-5888 with any questions.

PLEASE RETURN THIS FORM TO THE FUND OFFICE:

Boilermakers Lodge No. 154 Welfare Fund
c/o PATH Administrators
Park West One, Suite 101
1000 Cliff Mine Road
Pittsburgh, PA 15275