



BENEFITS UPDATE

April 2013

Dear Participant:

The Trustees of the Electrical Insurance Trustees Retirement Health Reimbursement Account Plan for Communication Participants ("CHRA Plan") adopted the following changes to the CHRA Plan effective as of April 1, 2013:

Accounts for Traveling Workers

In the event that you are a traveler (i.e., a member of another I.B.E.W. Local Union temporarily working for a participating employer) who does not become eligible for medical benefits under the EIT Health & Welfare Plan for Communication Members and a contributing employer makes contributions to the CHRA Plan on your behalf, your HRA account in the CHRA Plan ("HRA account") will be available for immediate reimbursement. Such reimbursement is limited to qualified medical expenses as defined under Section 213(d) of the Internal Revenue Code of 1986, as amended ("IRC"). Examples of qualified and non-qualified medical expenses under Section 213 of the IRC are included with this Benefits Update.

You must submit a completed *"Application for Retirement Health Reimbursement Account Distribution"* and an itemized receipt for qualified medical expenses to receive a reimbursement from your HRA account. Distributions will be made directly to you upon receipt of a completed application but no reimbursement may exceed the balance of your HRA account at the time of the reimbursement. You will generally receive a reimbursement from the Fund within a month after submission; however, some reimbursement requests may require additional time to process.

The minimum amount you may submit for reimbursement from your HRA account is \$15. You may submit reimbursement requests at any time to the Fund Office; however, the Fund will not process such requests more than monthly. Additionally, all reimbursement requests must be received by the Fund Office no later than 12 months following the date on which the expense was incurred. This means if you incur an expense on February 3, 2013, you must submit your reimbursement request to the Fund Office before February 3, 2014.

If you have any questions about the benefit changes described in this Benefit Update, please contact the EIT Benefit Funds Office at 312-782-5442.

IMPORTANT INFORMATION

This Benefits Update is intended to serve as a Summary of Material Modifications for the Electrical Insurance Trustees Retirement Health Reimbursement Account Plan for Communication Participants. If any conflicts exist between the terms of this Benefits Update and the official Plan document, the terms of the official Plan document will control. The Trustees reserve the right to amend, modify or terminate the CHRA Plan at any time. Receipt of this Benefits Update does not confer any eligibility or entitlement to any benefits under the CHRA Plan.

Electrical Insurance Trustees Health Reimbursement Account Plan for Communication Participants

Employer Identification Number: 36-1033970

Plan Number: 513

IRS SECTION 213(D) QUALIFIED MEDICAL EXPENSES

The Internal Revenue Service defines qualified medical care expenses within the IRS Section 213(d). Medical care expenses are defined as "amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part of function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness."

The products and services listed below are examples of medical expenses eligible for payment under a Health Reimbursement Account. This is not all inclusive; additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations. For a complete list, please refer to Section 213(D) of the Internal Revenue Code.

ELIGIBLE EXPENSES

Dental Services

Crowns/Bridges
Dental X-Rays
Dentures
Exams/Teeth Cleaning
Extraction
Fillings
Gum Treatment
Oral Surgery
Orthodontia/Braces

Insurance Related Items

Co-Pay and Co-Insurance Amounts
COBRA Premiums
Deductibles
Healthcare Insurance premiums *(not paid by another source)*
Medical Expenses *(not covered by or in excess of benefits provided by another benefit plan, insurer or Medicare)*

Lab Exams/Tests

Blood Tests
Cardiographs
Diagnostic
Laboratory Fees
Urine/Stool Analysis
X-Rays

Prescribed Medication[†]

Allergy Medicine
Antihistamines
Analgesics
Antacids
Anti-Diarrhea Medication
Aspirin
Birth Control/Contraceptives
Calcium Supplements
Cold Medicine
First Aid Creams
Hemorrhoid Medication
Insulin
Laxatives
Motion Sickness Pills
Muscle/Joint Pain Relief
Nasal Sinus Spray
Pain Reliever
Pregnancy Tests
Sinus Medication
Sleeping Aids
Vitamins

Obstetric Services

Lactation Expenses
Mid-Wife Expenses
OB/GYN Exams
Pre/Post Natal Treatment

Practitioners

Allergist
Chiropractor
Christian Science
Osteopath
Physician
Psychiatrist
Psychologist

Other Medical Treatment/Procedures

Acupuncture
Alcoholism *(inpatient treatment)*
Reconstructive Surgery *(medical necessity)*
Drug Addiction
Hearing Exams
Hospital Services
Infertility
In-vitro Fertilization
Norplant Insertion or Removal
Physical Exams
Physical Therapy
Smoking Cessation Program*
Sterilization
Transplants *(including organ donor)*
Vaccinations/Immunizations
Vasectomy & Vasectomy Reversal
Weight Loss Program*

Other Medical Equipment, Supplies & Services

Ambulance Services
Breast Pumps/Lactation Supplies
Convalescent Home
Crutches
Funeral Expenses
Guide Dog
Hearing Aid & Batteries
Home/Vehicle Modifications**
Hospital Bed
Lead-Based Paint Removal
Nursing Services
Orthopedic Shoes
Special Education *(for mentally impaired or physically disabled)*
Telephone or Television equipment *(for hearing-impaired)*
Transportation Expenses *(essential to medical care)*
Wheelchair
Wigs *(hair loss due to disease)*

Vision Services

Artificial Eyes
Contact Lenses/Care Products
Eye Exams
Eyeglasses
Ophthalmologist
Optometrist
Prescription Sunglasses
Radial Keratotomy/LASIK

INELIGIBLE EXPENSES

The IRS does not allow the following expenses to be reimbursed under the HRA. Expenses relating to promoting general health are not qualified medical expenses unless prescribed by a physician for a specific medical ailment. This list is not meant to be all inclusive.

General

Athletic Club Membership
Baby-Sitting & Child Care
Canceled Appointment Fees
Contact Lens Insurance
Cosmetic Surgery/Procedures/Supplies
Dancing/Exercise Programs
Diaper Service
Discount/Write-offs
Electrolysis
Exercise Equipment
Eyeglass Insurance
Fitness Programs
Hair Loss Medication
Hair Transplant
Household Help *(other than qualified long-term care)*
Illegal Operation/Treatment
Insurance Premium Interest Charge
Life Insurance Premiums
Marriage Counseling
Maternity Clothes
Moisturizers
Nutritional Supplements
Personal Use Items
Prescription Drug Discount Program Premiums
Student Health Fee
Swimming Lessons
Teeth Whitening/Bleaching
Toothbrush/Toothpaste
Topical Creams
Vision Discount Program Premiums
Vitamins *(for general health)*
Weight Loss Foods

[†]All listed medications, including over-the-counter medicines, must have a prescription to be eligible for reimbursement.

^{*}Eligible only with Physician's certification identifying the physical nature of the medical condition and length of treatment program.

^{**}Certain costs of modifying a home or vehicle to accommodate a disabled Dependent.

APPLICATION FOR RETIREMENT HEALTH REIMBURSEMENT ACCOUNT DISTRIBUTION

SECTION I: PARTICIPANT INFORMATION - Complete this section with the Participant's information (please print).

Name:	SSN:	
Street Address:		Apt #:
City:	State:	Zip Code:
Home Phone: ()	Cell Phone: ()	E-mail:
<input type="checkbox"/> Please check box if the address indicated above is a new address		

SECTION II: MEDICAL EXPENSES - Please itemize each medical expense for which you are requesting reimbursement.

You **MUST** include a copy of your receipts for qualified Medical Expenses, as defined under Section 213(d) of the Internal Revenue Code, along with a completed Application for Retirement Health Reimbursement Distribution.

Your receipt must include the following information to be acceptable:

- Provider's Name
- Provider's Address
- Medical Expense
- Date(s) of Expense (*must be actual date expense incurred; date of payment is will not be accepted*)
- Amount of Expense

Reimbursement will not be made on any receipts that do not meet the above-mentioned requirements or for any medical expenses not covered under Section 213 (d) of the Internal Revenue Code.

PATIENT NAME	PROVIDER NAME	MEDICAL EXPENSE	DATE OF EXPENSE	AMOUNT OF EXPENSE

SECTION III: SIGNATURE - Read carefully. Sign and date below.

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Plan. Supporting documentation from my service provider(s) for all expenses is attached to this application. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the provisions of the Plan.

Participant Signature: _____ Date: _____

RETURN THIS COMPLETED FORM TO
EIT BENEFIT FUNDS, 221 N. LA SALLE STREET, SUITE 200, CHICAGO ILLINOIS 60601-1214
PHONE (312) 782-5442 • FAX (312) 782-4431