Please be advised that the Union Hall and Fund Office are closed in order to protect our staff and membership. We continue to operate remotely. All activities have been cancelled or postponed, including all training classes, April and May union meetings, the health fair, and retiree luncheons.

FOR UP-TO-DATE INFORMATION AND COVID-19 RESOURCES, CLICK HERE.

To reach the Fund Office, email Fundoffice@ualocal33.org
To pay dues, email Kbarbour@ualocal33.org
For apprenticeship or JATC questions, email Jlindquist@ualocal33.org
For all other matters, call 515-558-0482 or email Aroberts@ualocal33.org or jshanks@ualocal33.org

The health and safety of you and your family is our #1 priority at this time.

#pullingtogether

To continue on to the website, click close on the top right corner of this box.
From the home page, you will need to scroll down to access the HRA form.
Plumbers and Steamfitters Local Union 33 has proudly served the plumbing and mechanical construction and service industry for over 125 years.

With the expertise necessary to complete projects safely and on schedule, the highly skilled members of Local 33 provide quality craftsmanship throughout central and western Iowa. Our productive workforce of 1,500 plumbers, steamfitters and welders is highly-trained and ready to work on multi-family housing, commercial and industrial facilities, as well as process piping.

If you’re a contractor in our jurisdiction, we can supply the manpower to meet your needs in plumbing, heating, air conditioning, controls, medical gas, high purity piping, valve repair, water treatment and other specialties.

If you’re looking for a career, our trade is one of the most promising and lucrative possibilities!
Start by adding the member’s name in the fields above.

Expense Information
Please complete the form below for each item you wish to have paid from your HRA.

The following expenses cannot be reimbursed from your HRA:

-- Prescription co-pays
-- Items that are not covered by the Plan (i.e. LASIK surgery, charges over Usual & Customary, claims received after 1 year from date of service, etc.)

Qualified Health Care Expenses

Claims
Hit the "Add Claim" button to start adding your claims for review.

There are no claims.

Add Claim

Total Reimbursement from HRA
Minimum reimbursement is $25.00

$0.00
After adding the member’s name, click on Add Claim to start the process.
**STEP 1**
Date must be entered as MM/DD/YYYY.

**STEP 2**
Enter Provider Name

**STEP 3**
Click the drop down arrow and select which expense type you would like processed out of the HRA.

- Major medical deductible
- Major medical co-insurance
- Dental & Hearing (expenses in excess of the annual benefit)
- Vision (expenses in excess of the annual benefit up to $1,000 per person/per year)
- COBRA premium payment
- Retiree premium payment
- Chiropractic care up to $1,000 per person/per year
- Fitness club memberships (must have a prescription from your physician)
- Orthodontia treatment $1,500 (one time per dependent under age 19)
Add info, if available. This step is optional.

Please document any payments already made by you, reference claim numbers from your EOB (found in the right corner), if available.

*STEP 4*

Patient *
Jane Doe (Dependent)

Pay Member or Provider *
Provider

Amount to Pay from HRA *
100.00

Claim Documentation Upload
Choose File
no file selected
**STEP 5**
Enter Patient Name

Jane Doe (Dependent)

**STEP 6**
Enter “Provider” or “Member” to be paid.
Enter amount of bill.

Date Expenses Incurred *
01/01/2020

Name of Service Provider
UnityPoint Clinic

Expense Type *
Major medical deductible

Details you want the fund office to know
Please document any payments already made by you, reference claim numbers from your EOB (found in the right corner), if available.

Patient *
Jane Doe (Dependent)

Pay Member or Provider *
Provider

Amount to Pay from HRA *
100.00

Claim Documentation Upload

Submit

*STEP 8*
Click here to attach picture or pdf of provider bill, if available.

*STEP 7*
Enter amount of bill.
Date Expenses Incurred *
01/01/2020

Name of Service Provider     Expense Type *
UnityPoint Clinic     Major medical deductible

Details you want the fund office to know
Please document any payments already made by you, reference claim numbers from your EOB (found in the right corner), if available.

Patient *     Pay Member or Provider *
Jane Doe (Dependent)     Provider

**All payments will be sent to the Provider unless proper proof of payment is submitted

Amount to Pay from HRA *
100.00

Claim Documentation Upload
Choose File no file selected

*STEP 9*
Click submit after all of the fields have been completed.
**Name**

<table>
<thead>
<tr>
<th>First</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>Doe</td>
</tr>
</tbody>
</table>

**Expense Information**

Please complete the form below for each item you wish to have paid from your HRA.

The following expenses cannot be reimbursed from your HRA:

- Prescription co-pays
- Items that are not covered by the Plan (i.e. LASIK surgery, charges over Usual & Customary, claims received after 1 year from date of service, etc.)

**Qualified Health Care Expenses**

**Claims**

Hit the "Add Claim" button to start adding your claims for review.

<table>
<thead>
<tr>
<th>Date Expenses Incurred</th>
<th>01/01/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Service Provider</td>
<td>UnityPoint Clinic</td>
</tr>
<tr>
<td>Expense Type</td>
<td>Major medical deductible</td>
</tr>
<tr>
<td>Details you want the fund office to know</td>
<td>Please reference any previous payments to the provider (we will need proof of payment to reimburse the member), split payments (if you only want part of the claim paid), or reference numbers from the explanation of benefits that we mail out (located in the top right corner of the EOB).</td>
</tr>
<tr>
<td>Patient</td>
<td>Jane Doe (Dependent)</td>
</tr>
<tr>
<td>Pay Member or Provider</td>
<td>Provider</td>
</tr>
<tr>
<td>Amount to Pay from HRA</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Review the claim information before submitting.
Review the amount being paid to the provider or being reimbursed to the member.

**Do you have other insurance that is secondary to this plan?**
- **Yes**
  - If yes, please include a copy of that EOB.
- **No**

**Other Documentation Upload**
If you feel there are any other relevant documents to attach, please do so here.

Click here to upload your bill or proof of payment.

This is to certify that my statements on this Claim Form are complete and true. I understand that payments will be made directly to the provider if I fail to provide sufficient proof of payment. Further, I certify that any expenses reimbursed are for eligible medical expenses for myself, my spouse, or eligible dependents and such expenses have not and will not be reimbursed under any other Health Reimbursement Account, insurance plan, nor be claimed as an income tax deduction.

**Signature**

Sign your name in this box with either your finger or mouse pointer.

**Submit**

Click Submit