

# UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 152 HEALTH AND WELFARE FUND

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## HIGHLIGHTS OF HEALTH REIMBURSEMENT ARRANGEMENT

November 20, 2023

TO: All Full Time and Part Time Active Participants of Acme Markets and Shop Rite with 18 or more months of Active Service in the UFCW Local 152 Health and Welfare Fund

This notice describes certain changes to the information contained in your Summary Plan Description ("SPD") and summary of benefits and coverage ("SBC"). Please do three things with this notice:

1. Read it, and if you have any questions, contact the Fund Office
2. Keep this notice with your SPD and SBC; and
3. Mark the sections of the SPD that have been changed so that when you refer to that section of the SPD you will be reminded that the changes described in the notice have occurred.

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**January 1, 2024**, the following change will apply to your plan of benefits under the UFCW Local 152 Health & Welfare Fund ("Fund").

### **What is a Health Reimbursement Arrangement?**

A Health Reimbursement Arrangement ("HRA") is available for eligible Participants and their eligible dependents. This HRA allows for reimbursement of out-of-pocket expenses such as copayments, coinsurance, deductibles, and other services not generally covered by other plans.

### **Who is eligible for the HRA benefit?**

Participants are eligible to participate in an HRA if their employer is required to make an HRA contribution on the Participant's behalf.

### **How much is available for use through the HRA?**

The HRA is funded through employer contributions subject to change and/or elimination. Funds attributed to an eligible Participant's HRA are notional and as a result are available only for eligible expenses. Participants cannot directly access their HRA balance, and these funds are subject to forfeiture to the Fund if unused.



### **How do eligible Participants use the HRA?**

Participants eligible to use the HRA on behalf of themselves and their eligible dependents must submit receipts to the Fund Office no later than June 30 of the year following the calendar year in which the expense was incurred. For example, reimbursable expenses incurred anytime between January 1, 2023 and December 31, 2023 are eligible for reimbursement if submitted by June 30, 2024.

### **What is an eligible expense for the HRA?**

HRA funds can be used for reimbursement of out-of-pocket expenses such as copayments, coinsurance, deductibles, and other services not generally covered by other plans. These services are identified in the Internal Revenue Service's Publication 502 that is amended from time to time. In addition, the Fund Office has a list of qualified medical expenses that is available upon request.

### **What happens to unused funds attributed to an eligible Participant's HRA?**

If there are unused funds attributed to the HRA after the time period to submit reimbursements for eligible expenses expires, these funds are transferred to the Fund. Under no circumstances will funds attributed to an HRA ever be transferred to a Participant or an employer.

Please be reminded that reimbursements described herein are dependent upon the Fund's receipt of contributions made on your behalf as an employee retention incentive as noted in your Collective Bargaining Agreement ("CBA").

If you have any questions regarding the changes, please contact the Fund office at 856-793-1598 or 1-800-555-4959.

## HRA – IRS Section 213(D) Qualified Medical Expenses

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance service
- Annual physical exam
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan (electronic)
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery (following mastectomy for cancer)
- Car equipment to accommodate medical needs
- Capital expenses (special equipment or home modifications to accommodate disability)
- Chiropractor
- Christian Science practitioner
- Contact lenses
- COVID-19 related expenses
- Crutches
- Dental treatments
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction treatment
- Drugs (see Medicines)
- Eye exam
- Eyeglasses
- Fertility enhancement (in vitro fertilization, etc.)
- Founder's fee (see Lifetime care – advance payments)
- Guide dog (or other service animal)
- Health Institute (when prescribed)
- HMO premiums
- Hearing aids
- Home care
- Home improvements (see Capital expenses)
- Hospital services
- Insurance premiums that cover medical care, including employer-sponsored health insurance plan, Medicare Part A, Part B and/or Part D, and prepaid insurance premiums
- Unused sick leave used to pay premiums
- Intellectually and developmentally disabled special housing
- Laboratory fees
- Lactation expenses
- Lead-based paint removal
- Learning disability (see Special education)gal fees that authorize treatment for mental illness
- Lifetime care – advance payments
- Lodging for treatment at a nearby hospital or medical facility
- Long-term care
- Meals at a hospital or similar institution
- Medical conferences (if it concerns a current illness or condition of the participant, participant's spouse or dependent)
- Medical information plan
- Medicines (prescription medicines and drugs)
- Nursing services
- Operations
- Optometrist
- Organ donors (see Transplants)
- Osteopath
- Oxygen
- Physical examination
- Pregnancy test kit
- Prosthesis (see Artificial limb, Breast reconstruction surgery)
- Psychiatric care
- Psychoanalysis
- Psychologist
- Special education for learning disabilities caused by mental or physical impairments, including nervous system disorders
- Sterilization
- Stop-smoking programs
- Surgery
- Telephone equipment for those hard of hearing or with a speech disability
- Television equipment for those hard of hearing or with a speech disability
- Therapy
- Transplants
- Transportation to and from medical care
- Trips (transportation and lodging for a trip to another city to receive medical services)
- Tuition (see Special education)
- Vaccines
- Vasectomy
- Vision correction surgery
- Weight-loss program
- Wheelchair
- Wig (due to hair loss from disease)
- X-ray

# UFCW Local 152 HEALTH AND WELFARE FUND

27 Roland Avenue, Suite 100, Mount Laurel, NJ 08054 • 1-800-555-4959 or 1-856-793-1598

## Health Reimbursement Account (HRA) Claim Form

Mail, fax or email completed form and documentation to: 27 Roland Avenue, Suite 100, Mt. Laurel, NJ 08054

**MEAT SIDE FAX 856-793-3102 / RETAIL CLERKS FAX 856-793-3100 OR EMAIL ANA RAMIREZ AT [ARAMIREZ@TSONLINE.COM](mailto:ARAMIREZ@TSONLINE.COM)**

1. Please print clearly. All information in each section must be completed.
2. Attach required documents. Refer to eligible expenses on the reverse side of this form.
3. The participant must sign each Claim Form that is submitted. Reimbursement will not be processed without a signed form.

PARTICIPANT INFORMATION	
Participant's ID (Social Security Number)	Participant's Date of Birth (MM/DD/YYYY) / /
Participant's Name (Last, First, Middle Initial)	
Address	Daytime Phone
City	State Zip
Employer	Local Union Number
I certify that the expenses for which I am seeking reimbursement have been incurred by me, my eligible spouse or other eligible dependent. The patient named below is eligible for benefits and did, in fact, receive the services listed. I certify that these expenses have not been reimbursed, nor will they be reimbursed, under any other benefit plan. I agree to submit and retain sufficient documentation for any expenses for which I seek reimbursement.	
Participant Signature _____	Date _____

The below section must be completed only for eligible expenses (as listed on the back of this form) and only for expenses incurred during your plan year. You must have been a participant in the plan at the time the expense was incurred. The incurred date of the expense is the date of service.

An itemized receipt/statement for each amount requested and an Explanation of Benefits (EOB) from your insurance company must be attached in order for your claim to be processed.

EXPENSE INFORMATION			
Patient's Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /	
Provider	Type of Service	Date of Service (MM/DD/YYYY) / /	Total Amount Submitted \$
Patient's Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /	
Provider	Type of Service	Date of Service (MM/DD/YYYY) / /	Total Amount Submitted \$
Patient's Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /	
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