# LOCAL 369 BENEFIT AND RETIREMENT FUND

Part 1 - Getting To Know Your Health Insurance Benefits

Part 2 – Vision and Dental Benefits

Part 3 – Retiree Health Insurance

# WELCOME AND INTRODUCTION

Benefit Office Staff:

Star Raines, Administrator
Debbie Reid, Senior Contribution Processor
Lisa Amshoff, Senior Claims Processor
Melanie Wendler, Enrollment Clerk
Jennifer Burgin, Asst. Administrator
Laura Miller, Contribution Processor
Lisa Carroll, Claims Processor
Linda Strange, Enrollment Clerk

- Getting to know your health insurance benefits – an overview
- Detailed review of vision and dental benefits
- Retiree Health Insurance Coverage

## Goals:

1. Members will leave with a better understanding of their insurance benefits.
2. Members will leave knowing how to submit claims for both vision and dental benefits.
3. Members will learn how to maximize the benefits they have for health, vision and dental and how they all work together.

# HEALTH AND WELFARE BENEFITS OVERVIEW

## 1. Summary Plan Description - Booklet

- Initial Eligibility – Pages 1-6
- Medical Benefits – Pages 21-27
- Prescription Drug Benefits – Pages 28-30

## 2. Summary of Benefits – Single Sheet Handout

- Deductibles and Out-of-Pocket Maximums
- In-Network vs Out-of-Network Benefits
- Co-Pays at the doctor's office
- Prescriptions
- Disability & Death Benefit

## 3. Explanation of Benefits – Road Map

- Deductibles Met – Year-to-date totals
- Out-of-Pocket Met – Year-to-date totals
- Write-Off Amount
- Member Balance

# Explanation of Benefits Road Map

## ELECTRICAL WORKERS LOCAL 369 BENEFIT FUND

906 MINOMA AVENUE
LOUISVILLE, KY 40217
(502) 635-2611

### ***EXPLANATION OF BENEFITS***

| | |
|---|---|
| DATE: | 8/01/2019 |
| MEMBER UID: | 123456789 |
| PATIENT: | PATIENT NAME |
| CLAIM #: | 768630 |
| CHECK #: | 123456 |
| PAID: | 8/01/2019 |
| BILLING#: | 123456789 |

MAIL TO:

MEMBER NAME
MEMBER ADDRESS
CITY, STATE ZIP

PAID TO:

PROVIDER NAME
PROVIDER ADDRESS
CITY, STATE ZIP

The entity that provided medical services

The date of service. The date you went to the doctor.

This is the network negotiated fee.

The co-pay amount is what you pay when you go to the doctor's office.

*NOTE: $20 for a regular physician / $40 for a specialist*

| PROCEDURE CODE | SERVICE DATES | TOTAL CHARGE | ELIGIBLE EXPENSE | MAJOR MED DEDUCTIBLE | CO-PAY | BENEFIT PAYMENT | MEMBER BALANCE | EX |
|---|---|---|---|---|---|---|---|---|
| 99213 | 5/08/2019 | 151.00 | 68.45 | 21.38 | 40.00 | 7.07 | 61.38 | 32, 12 |
| OFFICE OUTPATIENT VISIT 15 MIN | | | | | | | | |
| 81002 | 5/08/2019 | 14.00 | 2.15 | 0.00 | 0.00 | 2.15 | 0.00 | |
| URNLS DIP STICK/TABLET RGNT NO | | | | | | | | |
| | TOTALS: | 165.00 | 70.60 | 21.38 | 40.00 | 9.22 | 61.38 | |

The difference between total charges and eligible expense

**WRITEOFF AMOUNT** **94.40**

EX(S) LISTED BELOW ARE REFERENCED IN THE DETAIL ABOVE UNDER THE HEADING 'EX'
32- PATIENT'S CO-PAY TO PROVIDER
12- APPLIED TOWARD ANNUAL DEDUCTIBLE

This is the amount you owe to the provider after insurance benefits have been applied.

*NOTE: This is the amount you can claim for HRA reimbursement.*

Year-to-date total of Individual Deductible met

Year-to-date total of individual out-of-pocket maximum met

| | |
|---|---|
| IND. DEDUCTIBLE YTD | 300.00 |
| FAMILY DEDUCT YTD | 600.00 |
| IND. OOP YTD | 300.00 |
| FAMILY OOP YTD | 600.00 |

Year-to-Date total of family deductible met

Year-to-Date total of family out-of-pocket met

**SUMMARY OF BENEFITS: Active Employee Program and Disabled Employee Program**

This Summary of Benefits is not available to participants eligible for coverage under the Retired Employee Program. Unless noted otherwise, percentages listed indicate amount of Covered Charges paid by the Plan. Covered Charges are paid based on the usual, customary, and reasonable charge (UCR).

MEDICAL BENEFITS

| | | |
|---|---|---|
| **Annual Deductible** | $300 per person<br>$600 family maximum | |
| **Annual Out-of-Pocket Maximum** | $3,000 per person $6,000 family | |
| **Annual Maximums:** | | |
| • **Medical Benefits** | No maximum on or after January 1, 2014 | |
| • **Chiropractic Treatment** | 24 visits per person (additional visits require preauthorization) | |
| **Lifetime Maximum for Weight Loss/Reduction Benefit** | $2,500 per person | |
| **Utilization Review Penalty** | $200[1] per occurrence | |
| | **Network Provider** | **Non-Network Provider** |
| **Hospital and Inpatient Mental Health/Substance Abuse Treatment Facility** | 90% | 80% of UCR |
| **Outpatient Facility Charges** | 90%[2] | 80% of UCR |
| **Physician/Other Provider (Non-Facility Providers):** | | |
| • **Preventive Services** | 100% (not subject to deductible) | 80% of UCR after a minimum of 80% per office visit |
| • **Specialist** | 100% after $40 per office visit | 80% of UCR after a minimum of $40 per office visit |
| • **Mental Health/Substance Abuse Provider** | 100% after $20 per office visit<br>*psychiatrist is a specialist with $40 co-pay | 80% of UCR after a minimum of $20 per office visit |
| • **All Others** | 100% after $20 per office visit | 80% of UCR after a minimum of $20 per office visit |
| **Transplant Benefits (Hospital and Physician)** | 90% | 50% of UCR[2] |

PRESCRIPTION DRUG BENEFITS

| | | |
|---|---|---|
| **Annual Deductible[3]** | $50 per person[2] | |
| | **Retail Pharmacy Program Co-Payment (30-Day Supply)** | **Mail Order and CVS/Walgreens Retail Program Co-Payment (90-Day Supply)** |
| **Minimum/Maximum Co-Payment** | $5/$100 | $10/$125 |
| **Generic Medication** | 15% of prescription cost | 10% of prescription cost |
| **Brand Name Medication[4]** | 20% of prescription cost | 15% of prescription cost |

HEARING AID BENEFITS

| | |
|---|---|
| **Co-Payment** | 100% |
| **Benefit Maximum** | One exam and one device per ear every five years per person |

[1] Does not apply toward annual deductible or out-of-pocket maximum.
[2] Does not apply toward out-of-pocket maximum.
[3] Separate from the Medical Benefits Annual Deductible
[4] If a brand name medication is requested when a generic is available the difference in cost between the generic and brand name medication is added to the co-payment. This does not apply if the Physician specifies Dispense as Written (DAW) on the prescription.

DISABILITY AND DEATH BENEFITS (Employees Only)

| | |
|---|---|
| **Weekly Disability Benefit (Active Employees Only)** | $300 per week for up to 13 weeks (for non-occupational disability only) |
| **Death Benefit:** | $20,000 |
| • **Terminal Illness Benefit** | $10,000 (see your Summary Plan Description for more information) |
| **Accidental Death & Dismemberment Benefit:** | |
| • **Loss of life, both hands, both feet, sight of both eyes, or any combination of hand, foot or sight of one eye** | $20,000 |
| • **Loss of one hand, one foot, or sight of one eye** | $10,000 |
| • **Loss of thumb (each)** | $5,000 |

Walmart and Sams Club are not in-network prescription providers.

Claims for hearing aid benefits should be filed directly with the fund office.

# DEFINITIONS

**Deductible** is a specified amount of money that the insured must pay before an insurance company will pay a claim.

- Based on calendar year
- $300 Individual / $600 Family Health Insurance
- $50 Prescription

**Out-of-pocket Maximum** is the most you have to pay for covered services in a plan year. This does NOT include co-pays, deductibles or co-insurance.

- Based on calendar year
- $3000 Individual / $6000 Family Health Insurance

**Explanation of Benefits** is the paperwork you receive in the mail after we process a claim received from your provider. This will tell you what was charged by the provider, what was paid by the fund office, and what is left to pay (if any) to the provider.

**In-Network Allowable Charges** for a network Provider means the negotiated fee/rate set forth in the agreement with the participating network health Provider.

**Out-of-Network Allowable Charges** means the charges that are typically made for services and supplies in the geographic area based on the complexity of treatment received. Amounts that exceed the Allowable Charge will not apply toward the calendar year deductible or out-of-pocket maximum.

**Covered Charges** mean charges for the treatment of a non-occupational injury or sickness that have been ordered by your provider.

**An Eligible Dependent** is a Spouse Or child under the age of 26. (Child can be natural, legally adopted, foster, step, or any child for whom you have legal guardianship)

# VISION AND DENTAL BENEFITS OVERVIEW

**Vision** - $150.00 annually for member and each dependent over the age of 18

**If under the age of 18 one exam and one pair of contacts or glasses is covered at 100% per calendar year.*

**Dental** - $250.00 annually for member and each dependent (only exclusion of services is orthodontia).

***Vision and Dental Benefits apply to active members only, they do not apply to those covered under the retiree or surviving spouse program.*

****Surgical removal of impacted wisdom teeth are covered under the health insurance*

# VISION - SUBMITTING A CLAIM

1. Submit a detailed, itemized statement, along with proof of payment, directly to the Benefit Fund office via regular US mail, fax, or email.

2. The Fund Office will reimburse you for the claim up to the $150 annual limit. ***If under the age of 18 one exam and one pair of contacts or glasses is covered at 100% per calendar year.***

3. You will have to pay for the services up front and we will reimburse you directly.

4. Remember to include your name and Anthem ID # on all documents submitted to the Benefit Fund office.

# DENTAL - SUBMITTING A CLAIM

1. Your dentist can submit the claim to the Fund office and we will make payment directly to your dentist.

OR

2. You pay for the services up front and then submit a detailed, itemized statement along with proof of payment to our office and we will reimburse you up to $250.00.

3. Remember to include your name and Anthem ID # on all documents submitted to the Benefit Fund office.

# RETIREE HEALTH INSURANCE

- Eligibility
- Cost
- When to notify the  Fund Office

ELECTRICAL WORKERS LOCAL 369
BENEFIT AND RETIREMENT FUND
906 MINOMA AVENUE
LOUISVILLE, KY 40217

PHONE:502-635-2611
FAX:502-637-3444
TOLL FREE: 800-427-2495

**RETIREE, SURVIVING SPOUSE & DISABLED**
**Effective January 1, 2019**

If you wish to continue coverage under the Electrical Workers Local 369 Benefit Program, please check one of the following:

**A. Non – Medicare – Per Adult** _____ **Number of Adults**_____
**B. Age Eligible Medicare – Per Adult** _____ **Number of Adults**_____
**C. Disabled Medicare – Per Adult** _____ **Number of Adults**_____

| | |
|---|---|
| Non-Medicare Coverage – Per Adult | $ 423 per month |
| Medicare Coverage – Per Adult | $ 272 per month |
| Disability Coverage – Per Adult | $ 248 per month |

For rules governing eligibility, please refer to your summary plan description booklet.

Please list the following information about yourself:

Full Name _____ Social Security Number _____

Address _____ City, State, Zip _____

Birth date _____ Phone Number _____

**Do you have Medicare? Yes_____ No_____ If yes, effective date _____**
**If yes, please submit a copy of your Medicare card with this form.**
**If you have Medicare due to disability, please submit a copy of your Social Service Award.**

Please list the following information about your eligible dependent:

Full Name _____ Social Security Number _____

Birth date _____

**Does your eligible dependent have Medicare? Yes_____ No_____ Effective Date_____**
**If yes, please submit a copy of your dependent's Medicare card with this form.**
**If your dependent has Medicare due to disability, please submit a copy of their Social Security Award.**

If you have eligible dependent children, please list their name, social security number and birth date on the back of this form.

**If you wish to cancel your coverage under the Plan, please list an effective date, sign and date and return the form to the address above.**

**Effective date of cancellation**_____

Member's Signature _____ Date _____

# Retiree Health Insurance

## Initial Eligibility Requirements

- Age 55
- 30 months of eligibility in the last 5 years
- Must be retired and not working

## Things to Remember

- Once you go on retiree health insurance you can't go back to active coverage.
- Contractor contributions will not count toward health insurance. You will continue to be billed as a retiree even if you go back to work.
- After age 65 and Medicare eligible, the member will change from active with Anthem coverage to having Medicare coverage with Hartford being supplemental to Medicare. The member will keep SavRX for their prescription coverage. ***The member MUST sign up for Medicare parts A & B in order to participate in the retiree program after age 65.*

## Notify The Fund Office

- As soon as you are eligible for Medicare
- A couple of months before you plan to retire to enroll in retiree insurance

# SUMMARY

## Topics Covered Today

- Basic overview of your health insurance benefits
- How to submit a vision and dental claim
- When and how to enroll in retiree health insurance program
- Maximizing your benefits!
  1. Remember that you have$150 Vision and $250 Dental Benefit per calendar year
  2. Submit co-pays and deductibles for HRA reimbursement
  3. Utilize in-network providers
  4. Use your SavRX card for all prescriptions

     **Remember that Walmart and Sams Club are NOT in-network for prescriptions**

# THANK YOU ALL FOR COMING!

## Upcoming training sessions:

- Retirement
- HRA
- Enrollment
- Contributions and Reciprocity

Thank you for coming and please give us a call if you have any questions about the materials presented or provided today! ☺

Phone: 502-635-2611

Website: www.369benefitfunds.com

General Email: 369memberhelp@369benefits.com