IBEW-NECA LOCAL 505
HEALTH PLAN

ALABAMA ADMINISTRATORS
1717 OLD SHELL ROAD
MOBILE, AL 36604

EFFECTIVE FOR 2016 AND 2017
MAXIMUM AMOUNT = $350

SUPPLEMENTAL CARE BENEFIT

The Supplemental Care Benefit will reimburse you for some medical expenses. You must pay for the expense first and then file a claim for reimbursement. The maximum reimbursement amount applies per covered employee, with single or family coverage.

CONSTRUCTION ELECTRICIAN & CONSTRUCTION WIREMEN CLASSIFICATIONS ARE NOT ELIGIBLE FOR THIS BENEFIT

SUPPLEMENTAL CARE BENEFIT

This benefit will pay up to the annual maximum benefit amount per family, per year, or if single, that amount in behalf of the employee for un-reimbursed medical expenses and some medical expenses that are not covered by the Health Plan.

This benefit provides a reimbursement of 100% of the expense up to the maximum benefit, no deductible.

Un-Reimbursed Medical Expenses: Any covered service which is not paid in full by a group health plan, this Health Plan, or another group health plan, due to a deductible or co-pay or an expense exceeding a specific limit, may be filed under the Supplemental Care Benefit for reimbursement.

All you need do is file a Supplemental Care Benefit claim form and attach a copy of the Explanation of Benefit form you received from the Health Plan (or the other group health plan) indicating the expense and the portion you had to pay. **This is a reimbursement benefit and you must pay the expense <u>first</u> and show proof of payment in order to be reimbursed.**

Other Expenses: These services may qualify for reimbursement in addition to covered medical services that are not reimbursed in full by the Health Plan:

- ✓ Dental Services
- ✓ Chiropractor
- ✓ Foot Treatment
- ✓ Newborn Care
- ✓ Co-Pays
- ✓ Physical Exams
- ✓ Artificial Teeth
- ✓ Mental Health
- ✓ COBRA premium payment
- ✓ Vision Exams
- ✓ Eye Glasses
- ✓ Contact Lenses
- ✓ Medical Supplies
- ✓ Weight-Loss (Prescribed)
- ✓ Eye Surgery
- ✓ Hearing Aids

***** This is not an all inclusive list.

You must file a claim for this benefit. Complete this form and attach a copy of the Explanation of Benefit and/or the expense receipt and file with the Plan Manager.

How do I file for this benefit?

You will use the Supplemental Care Benefit claim form and attach the receipt for the service or expense to be reimbursed. You will also need to show **proof of payment** in some form to be reimbursed under the Supplemental Care Benefit.

Example: If you have an eye exam and glasses, you would attach the receipt showing the name of the person receiving the service, the date of the service, the amount charged, and the date paid. Proof that the medical service has been paid is required. This is the same for dental services. This is true for any expense that is not paid in full by a group health plan. **Remember that you must pay for the service or expense first and the Supplemental Care Benefit will reimburse you up to the annual maximum benefit.**

What is the benefit period?

The benefit period starts on January 1st and extends through December 31st. Services rendered during this period of time qualify for reimbursement. **You must file the claim within 12 months of the date incurred**.

It is important to remember that you must file the expense first with any group health plan you or your dependent is covered under unless it is an expense that is not covered by the group health plan. In that case, you must file the receipt showing the name of the individual receiving the service, the type of service, date the service was performed, amount charged and the **date of payment**. **The Plan cannot pay for the expense first – you must pay first, and then file a claim, and then the Plan will reimburse you for the cost up to the annual maximum benefit. Additional information can be obtained from the Plan Manager –**

Alabama Administrators
1717 Old Shell Road
Mobile, AL 36604
(251) 478-5412 OR 1-800-221-7025

IBEW-NECA LOCAL 505 HEALTH PLAN

The Supplemental Care Benefit will reimburse you for some medical expenses. You must pay for the expense first and then file a claim. The annual maximum reimbursement amount applies per covered employee, with single or family coverage.

FILE CLAIM WITH THE PLAN MANAGER –

ALABAMA ADMINISTRATORS
1717 Old Shell Road
Mobile, AL 36604
PHONE (251) 478-5412 OR 1-800-221-7025

EMPLOYEE NAME PLEASE PRINT ALL INFORMATION		**BIRTHDATE**
SOCIAL SECURITY NUMBER	**CURRENT EMPLOYER**	**GROUP NO.**
		505HP
PATIENT NAME IF OTHER THAN THE EMPLOYEE		**BIRTHDATE**

STATE THE NATURE OF THE EXPENSE – ATTACH: INVOICE & PROOF OF PAYMENT – SHOW TOTAL REIMBURSEMENT EXPECTED

YOUR MAILING ADDRESS	**CITY**	**STATE**	**ZIP**	**PHONE NUMBER**

ELIGIBLE FOR REIMBURSEMENT:

Un-Reimbursed Medical Expenses: Any Covered Service that was not paid in full by the Plan (for example, if due to the calendar year deductible, employee's co-pay or share of benefit percentage or a charge exceeding the allowed amount) may be filed for reimbursement. Complete this form; attach a copy of the explanation of benefit (insurance payment) or the medical expense, and **proof of payment**.

Other Expenses: Expenses that are not covered by the Health Plan may be filed for reimbursement and include:

Dental Services	**Vision Exams**	**Eye glasses**	**Contact Lenses**	**Eye Surgery**	**Optometrist**
Physical Exam	**Chiropractor**	**Newborn Care**	**Artificial Teeth**	**Medical Supplies**	**Hearing Aids**
Foot Treatment	**Mental Health**	**Smoking Cessation**	**Weight-Loss (Prescribed)**	**Wigs (Prescribed)**	**Addiction Therapy**

To file a claim you must complete this form and attach a copy of the bill and proof of payment (receipt). Please be sure that the bill or receipt includes a description of the service, the date charges were incurred, amount of the expense, and the **name** of the individual incurring the expense, and **proof** that you have paid the balance or the expense.

I attest that the expense filed for reimbursement under the Supplemental Care Benefit has not been reimbursed by any other group health plan and I have paid for the expense as evidenced by the attached receipt. I understand that I must pay for the expense first before filing for reimbursement and that the Health Plan may not pay in advance for any service or expense – this is a reimbursement benefit.

X _____ **X** _____

SIGNATURE OF EMPLOYEE **DATE SIGNED**

ADDITIONAL INFORMATION ABOUT THIS FORM AND YOUR PRIVACY RIGHTS CAN BE OBTAINED FROM THE PLAN MANAGER.

EXPENSES MUST BE SUBMITTED WITHIN TWELVE (12) MONTHS OF THE DATE INCURRED TO BE ELIGIBLE FOR COVERAGE

FILE CLAIMS WITH THE PLAN MANAGER –

ALABAMA ADMINISTRATORS
1717 OLD SHELL RD.
MOBILE, AL 36604

PHONE 1-251-478-5412
TOLL FREE 1-800-221-7025
FAX 1-251-478-0203

PROOF OF PAYMENT MUST BE SUBMITTED FOR REIMBURSEMENT – YOU MUST PAY THE EXPENSE FIRST AND THEN BE REIMBURSED

CONSTRUCTION ELECTRICIAN & CONSTRUCTION WIREMAN ARE NOT ELIGIBLE FOR THIS BENEFIT