LOCAL UNION 903 IBEW

HEALTH PLAN

ALABAMA ADMINISTRATORS
1717 OLD SHELL ROAD
MOBILE, AL 36604

EFFECTIVE FOR BENEFIT YEARS 2017 & 2018
MAXIMUM AMOUNT = $1,000.00

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. COBRA premiums paid may also be reimbursed.

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, date of service and the portion you paid. **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
- ✓ Co-pays
- ✓ Newborn Care
- ✓ Weight-Loss (Prescribed)
- ✓ Physical Exams
- ✓ Artificial Teeth
- ✓ Hearing Aids
- ✓ COBRA premium payment
- ✓ Vision Exams
- ✓ Eye Glasses
- ✓ Contact Lenses
- ✓ Medical Supplies
- ✓ Eye Surgery
- ✓ Foot Treatment
- ✓ Mental Health

* This is not an all inclusive list.

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 annual maximum reimbursement amount applies per covered employee, single or family coverage. This benefit is for the benefit year indicated and must be renewed annually by the Trustees or it will terminate. See the reverse of this form for the application.

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 <u>first</u> 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 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

LOCAL UNION 903 IBEW HEALTH PLAN

The Supplemental Care Benefit will reimburse you for some medical expenses, see reverse for additional information. You must pay the expense first and then file a claim for reimbursement. The annual maximum benefit amount applies per employee, with single or family coverage. This benefit is annual renewable and will terminate at the end of the benefit year if not renewed by the Trustees.

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.**
		903HP

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 these include:

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

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