Reminder one form one patient per patient

Solano-Napa Counties Electrical Workers Health & Welfare Plan VEBA Supplemental Accumulated Share Account (SAS) and Kaiser Deductible & Coinsurance Reimbursement Form PO Box 1306 San Ramon, CA 94583

☐ Check Here for VEBA Reimbursement

<u>Instructions for the VEBA SAS:</u> To receive benefits from the Reimbursement Medical Account, you must complete <u>ONE FORM</u> per patient, along with the following information. Please be sure that all documents reflect the patient's name, description of service, date of service and the amount:

Reimbursement for: Information Required: Medical Co-payments Once your Kaiser deductible has been met, a copy of your Kaiser Co-payment receipt. Balance due statements are not acceptable. **Dental Co-payments** Copy of your dental Explanation of Benefits Form (EOB). Orthodontic services will be paid for after services are rendered. Copy of your itemized vision claim. Vision payment Copy of the drug label stub or ask your Kaiser pharmacy for a Reimbursement Receipt. Prescription Co-payment Cash register receipts are not acceptable. কৈকক OR প্রকর্ ☐ Check Here for Deductible & Coinsurance Reimbursement Instructions for Kaiser Deductible & Coinsurance Reimbursement: To receive benefits from the Plan, you must first accumulate \$250 in Kaiser charges which were applied to your deductible or are for coinsurance you were required to pay and then complete this form and submit it along with a copy your Kaiser bill or Summary of Account (SOA) and proof of payment. Please be sure that all documents reflect the patient's name, description of service, dates of service and the amounts. NOTE: REIMBURSEMENT REQUESTS FOR COPAYMENTS, OPTICAL BENEFITS AND OTHER CHARGES THAT ARE REIMBURSABLE UNDER THE SUPPLEMENTAL ACCUMULATED SHARE ACCOUNT (SAS) VEBA\ HRA ARE NOT REIMBURSABLE UNDER THE KAISER DEDUCTIBLE AND COINSURANCE REIMBURSEMENT PROVISION. Participant's Name: Participant's SS#: _____ Phone Number: (Home) _____ (Work) _____ _____ Relationship: ____ to participant **Providers Name** Type of Service Date of Service **Amount of Claim** (Medical, Dental, Vision, (Dr. Name/Office Name) (The Date Patient Seeked Services) (Reimbursement you are requesting) Prescription, Deductible or Co-insurance) By signing this form, I understand that benefits shall be paid in accordance with the Reimbursement Medical

Phone: 925-208-9980 ● Toll Free: 866-544-9880 ● Fax: **925-246-5118**Email: <u>staff@ibew180benefitfunds.org</u>

Member's Signature: Date: _____

Account Plan eligibility requirements and limitations established by the Board of Trustees.

Explanations and Additional Information – please do not print this page

Completed forms and supporting documents and be mailed or faxed to:

Solano-Napa Co. Ele. Workers H&W Fax: 925-246-5188

Reimbursements

P.O. Box 1306

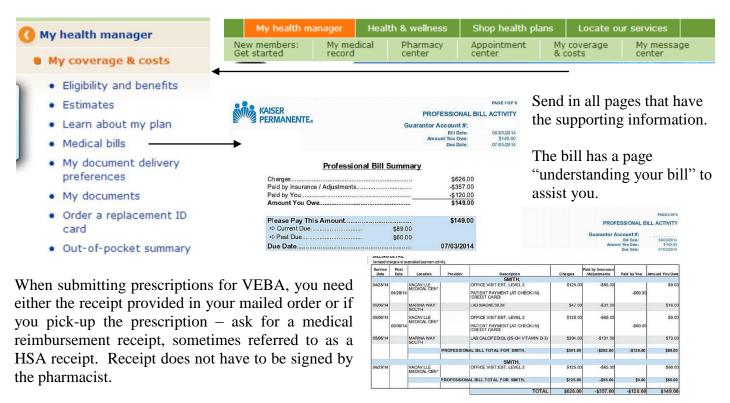
Do not email submissions; email for questions or follow-up.

San Ramon, CA 94583

Detailed information on how and which items are covered can be found at: http://www.ibewlu180.org/hw

VEBA is funded while working in Napa or Solano under the Inside Agreement. \$1.00 to retirement H&W (A.S.) and \$.30 to reimbursement (S.A.S.)

For Deductible & Coinsurance Reimbursement Kaiser services, you can submit the receipt provided at check-in or the bill received from Kaiser (below); also found at kp.org:



Separate Forms for each Patient and for VEBA or Deductible/Coinsurance submission; example:

	VEBA	Deductible/Coinsurance
Mom	\$90	\$55
Dad	\$30	\$35
Son	\$0	\$110
Daughter	\$30	\$55

VEBA would be submitted on three forms and supporting documents for \$150 (no minimum level) Deductible would be submitted on four forms and supporting documents since all four, totaled, exceed the \$250 minimum. *The entire example, seven forms and supporting docs, can be mailed or faxed together.*

For dental, submit the EOB you received from Solano-Napa Electrical Workers Health & Welfare Plan with VEBA checked. VEBA reimbursements can only be paid when your account has funds to do so.

Please submit items within one year of service.

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