Reminder one form 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

Instructions for the VEBA SAS: To receive benefits from the Reimbursement Medical Account, you must complete **ONE FORM** 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.**
Vision payment	Copy of your itemized vision claim.
Prescription Co-payment	Copy of the drug label stub or ask your Kaiser pharmacy for a Reimbursement Receipt. **Cash register receipts are not acceptable.**

OR

☐ 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#: _____

Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Name: _____ Relationship: _____
one patient per form to participant

Type of Service (Medical, Dental, Vision, Prescription, Deductible or Co-insurance)	**Providers Name** (Dr. Name/Office Name)	**Date of Service** (The Date Patient Seeked Services)	**Amount of Claim** (Reimbursement you are requesting)
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

By signing this form, I understand that benefits shall be paid in accordance with the Reimbursement Medical Account Plan eligibility requirements and limitations established by the Board of Trustees.

Member's Signature: _____ Date: _____

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

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 Reimbursements
P.O. Box 1306
San Ramon, CA 94583

Fax: 925-246-5188

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

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

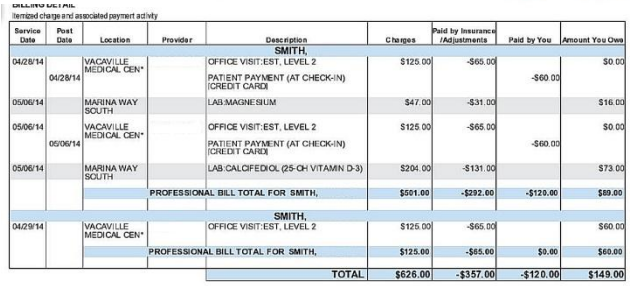
VEBA is funded while working in Napa or Solano under the Inside Agreement. $1.00 to retirement H&W (A.S.) and $.30 to reimbursement (S.A.S.)

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:

Send in all pages that have the supporting information.

The bill has a page "understanding your bill" to assist you.

When submitting prescriptions for VEBA, you need either the receipt provided in your mailed order or if you pick-up the prescription – ask for a medical reimbursement receipt, sometimes referred to as a HSA receipt. Receipt does not have to be signed by the pharmacist.



Service Date	Post Date	Location	Provider	Description	Charges	Paid by Insurance /Adjustments	Paid by You	Amount You Owe
SMITH,								
04/28/14	04/28/14	VACAVILLE MEDICAL CEN*		OFFICE VISIT,EST, LEVEL 2 PATIENT PAYMENT (AT CHECK-IN) (CREDIT CARD)	$125.00	-$65.00	-$60.00	$0.00
05/06/14		MARINA WAY SOUTH		LAB,MAGNESIUM	$47.00	-$31.00		$16.00
05/06/14	05/06/14	VACAVILLE MEDICAL CEN*		OFFICE VISIT,EST, LEVEL 2 PATIENT PAYMENT (AT CHECK-IN) (CREDIT CARD)	$125.00	-$65.00	-$60.00	$0.00
05/06/14		MARINA WAY SOUTH		LAB,CALCIFEDIOL (25-OH VITAMIN D-3)	$204.00	-$131.00		$73.00
				PROFESSIONAL BILL TOTAL FOR SMITH,	$501.00	-$292.00	-$120.00	$89.00
SMITH,								
04/29/14		VACAVILLE MEDICAL CEN*		OFFICE VISIT,EST, LEVEL 2	$125.00	-$65.00		$60.00
				PROFESSIONAL BILL TOTAL FOR SMITH,	$125.00	-$65.00	$0.00	$60.00
				TOTAL	$626.00	-$357.00	-$120.00	$149.00

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.