

# LIVERMORE VALLEY JOINT UNIFIED RETIRED EMPLOYEE HEALTH BENEFIT FUND

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DATE: August 2010

TO: The Members of the Livermore Valley Joint Unified Retired Employee Health Fund

FROM: Board of Directors  
Livermore Valley Joint Unified Retired Employee Health Fund

RE: New Health Care Reimbursement Procedures

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In an effort to economically maintain the Fund, the Board of Directors of the Livermore Valley Joint Unified Retired Employee Health Benefit Fund has adopted a new procedure for health care reimbursements. This new reimbursement procedure will take effect **October 1, 2010** and was adopted to economically maintain and prolong the life of the Fund. **Please be aware that your \$135 per month health care premium reimbursement will NOT be changed, just the procedures have.**

- **MEMBERS WITH CALIFORNIA VALUED TRUST (CVT) AND CALPERS INSURANCE- YOUR BENEFITS REMAIN UNCHANGED.**
- **NON-CVT, DELTA DENTAL, VSP, OR OTHER INSURED MEMBERS, PLEASE READ BELOW.**

A summary of the new reimbursement procedure is outlined below. In short, the Administrative Office will continue to pay upfront for group health care premiums such as: California Valued Trust (CVT), CalPers and Delta Dental. All other individual health care premiums will now be paid by the members themselves initially and then reimbursed by the Administrative Office afterwards. Although we will be reimbursing your health care premium directly to you, please know that you will **NOT** be taxed on your premium reimbursement.

Specifically the new procedures are as follows:

- **If you have group health care insurance through California Valued Trust (CVT) and/or CalPers and your insurance premium is \$135 per month or**

**more, your reimbursement procedure will NOT change. There is NO action required on your part.**

- **If you *ONLY* carry dental and/or vision through California Valued Trust (CVT) and/ or Delta Dental you will need to follow the procedures listed below for your *other* (non-CVT and Delta Dental) insurance premiums, including Medicare Part B, in order to receive your reimbursement.**

- **Effective October 1, 2010 you will now pay your *other* health care insurance premiums directly to your insurance provider. Please contact your *other* (non-CVT and Delta Dental) health care insurance carriers and notify them that you are now the primary responsible party for these premiums and have the premium notices sent to your address.**

- **You will need to send in Proof of Insurance to the Administrative Office (BeneSys Administrators) on an annual basis for your *other* health care insurance. You are NOT required to send in proof for your CVT dental/vision or Delta Dental, only your *other* health care premiums, including Medicare Part B. This requirement is necessary to comply with IRS regulations. Your proof of insurance can be a copy of your current billing or Medicare statement, or some other form of documentation from your *other* insurance carriers that indicates your premium. Just as before, you will be reimbursed up to a maximum of \$135 per month for your health care premiums.**

- **The Administrative Office will credit your bank account via Direct Deposit. Please complete the Authorization Form for Direct Deposit (ACH) enclosed and mail to the Administrative Office by September 1, 2010. A self addressed envelope is included for your convenience.**

- **If you do NOT have group health care insurance through California Valued Trust (CVT) or CalPers and you do NOT have Delta Dental Insurance then:**

- **Effective October 1, 2010 you will now pay your own health care insurance coverage directly to your insurance provider. Please contact your insurance carriers and notify them that you are now the primary responsible party for your health care premiums and the premium notices should now be sent to your address.**

- **You will need to send in Proof of Insurance to the Administrative Office (BeneSys Administrators) on an annual basis. This includes your health, vision, dental and Medicare Part B premiums. Just as before, you will be reimbursed up to a maximum of \$135 per month for your health care premiums. Once again, this requirement is necessary to comply with IRS regulations.**

**- The Administrative Office will credit your bank account via direct deposit.** Therefore, it is essential that you complete the enclosed Authorization Form to allow for Direct Deposits to be made directly into your bank account. Please return such form with a copy of your voided check to the Administrative Office by September 1, 2010.

**Once again, your health care premium reimbursement will NOT change, just the procedures have.**

Please know that BeneSys Administrators, as your selected benefits administrator, will be here to assist you during this transition. Please do not hesitate to call Lisa Ng at (925) 208-9984 x 8636 should you have any questions or concerns.

Thank you for your continued cooperation and support.

# Livermore Valley Joint Unified Retired Employee Health Benefit Fund

## DIRECT DEPOSIT REQUEST

Name of Payee \_\_\_\_\_ Payee SS# \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I, the undersigned, hereby authorize the Livermore Valley Joint Unified Retired Employee Health Benefit Fund, herein called the Fund to deposit all amounts due to me at the Financial Institution named below. This authorization shall remain in force until I revoke it in writing or are no longer eligible for reimbursement, whichever occurs first. If, due to lack of knowledge of non-eligibility, the Trust Fund distributes a reimbursement payment in my account, I authorize and direct the Financial Institution to refund the Fund any amounts paid for which I was not eligible.

\_\_\_\_\_  
**Signature of Payee**

\_\_\_\_\_  
**Date**

**The following is to be completed by the Financial Institution**

### AGREEMENT OF FINANCIAL INSTITUTION

The Financial Institution named below agrees to accept for deposit in the account specified below, benefits payable by the Livermore Valley Joint Unified Retired Employee Health Benefit Fund ("the Fund"). The Financial Institution agrees to refund to the Fund, the amount of any benefit deposited in the Payee's account which represents benefits paid after non-eligibility, provided that the amount of the deposits remain in the account at the time the request for a refund is received from the Fund.

Name of Financial Institution \_\_\_\_\_

Can you accept "Automated Clearing House" transactions? Yes  No

Bank ABA No. \_\_\_\_\_ Account No. \_\_\_\_\_

Type of Account:  Checking/Share Draft  Savings

Branch \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

Please return completed form properly signed to:  
Livermore Valley Joint Unified Retired Employee Health Benefit Fund  
PO BOX 2305  
SAN RAMON, CA 94583  
(925) 208-9984