IBEW

LOCAL UNION No. 124 I.B.E.W.
BENEFIT TRUST OFFICE
305 East 103rd Terrace
Kansas City, Missouri 64114
Log onto Website @ www.ibew124benefits.org

NECA

Fax (816) 943-0487
Telephone (816) 943-0277

July 15, 2016

Dear Participants:

The IBEW Local Union No. 124 Health and Welfare Fund Board of Trustees wishes to announce a new benefit being added to the plan. Please read this letter carefully and keep it with your Summary Plan Description (SPD).

Spouse Employment Insurance Premium Reimbursement

Effective August 1, 2016:
The plan will begin reimbursing members whose spouses elect to take the spouse's employee health insurance. This plan will reimburse you the actual amount of the spouse's premium, but only up to $175.00. All active IBEW Local Union No.124 members currently eligible for benefits through the plan are eligible for this program. Retirees are not eligible. In order to receive a premium reimbursement you must provide documentation of coverage and payment as detailed below.

Premiums will be reimbursed based on the following guidelines:

- The member must be eligible for IBEW Local 124 Health and Welfare plan during the entire period the premium reimbursement is being requested.
- Premiums will be reimbursed for up to $175 per month.
- Premiums will be reimbursed for the spouse's employee only coverage amount for medical and prescription coverage only.
- The spouse's health plan must have a deductible less than $1,300 per year and must meet the minimum value (as defined by the Affordable Care Act);
- If the spouse's deductible is more than $1,300, premium reimbursement will only be made if the spouse also waives the coverage under the IBEW Local 124 Health and Welfare.
- Documentation of enrollment, benefits, and premiums charged must be provided with each reimbursement request.
- The reimbursement must be requested no later than 13 months after the beginning of the reimbursement period.
- A 1099 will be issued for funds received each year

The attached form describes the necessary documentation in further detail.

This is a voluntary program being offered to all active members of the Plan to help provide members and their families with the best coverage options available to them. Please let the Fund Office know if you have any questions.

Sincerely,
FOR THE BOARD OF TRUSTEES

Bill Barbieri
Administrative Manager

IBEW

LOCAL UNION No. 124 I.B.E.W.
BENEFIT TRUST OFFICE
305 East 103rd Terrace
Kansas City, Missouri 64114
Log onto Website @ www.ibew124benefits.org

NECA

Fax (816) 943-0487
Telephone (816) 943-0277

2016 Spouse Employment Insurance Premium Reimbursement Form

Member Name:_____

Member SS#: _____

Spouse Name: _____

Reimbursement Policy – The Fund will reimburse 100% of your contribution up to a monthly maximum of $175.00 for eligible medical and prescription **employee only coverage for your spouse's employment based coverage.** Dental and vision coverage is not reimbursable. Retirees are not eligible.

This proof of Payment Form is for the month(s) of: (Please check the appropriate boxes)

☐ August 2016	☐ September 2016	☐ October 2016
☐ November 2016	☐ December 2016	

*The Spouse Employment Insurance Premium Reimbursement Program begins 8/1/2016

We have attached the necessary proof of payment in the form of:

☐ Copies of my paycheck stubs for each month being requested, showing a payroll deduction in the amount of $_____for **employee only coverage** for the eligibility months indicated above.

Or

☐ Verification from my employer on their letterhead verifying that I paid $_____ for **employee only coverage** for the eligibility months indicated above.

The following additional documentation that must be submitted with this form:

- The summary of benefits and coverage (SBC) for the plan in which your spouse is enrolled
- Enrollment form documenting the coverage elected by your spouse
- Enrollment materials or other documentation on employer letterhead showing the employee portion of the premium for the your spouse's health plan
- A 1099 will be issued for funds received each year.

If your spouse wishes to waive medical and prescription coverage under the 124 Welfare Plan, initial here _____. This is required for reimbursement if your spouse's health plan either has a deductible equal to or greater than $1,300 or does not meet the minimum value according to the Affordable Care Act. **By law, your spouse must waive coverage if he/she is making contributions to a Health Savings Account.** Note that even if your spouse waives medical and prescription coverage, he/she will still be eligible for dental and vision benefits.

We hereby certify that the information given in this form is true, correct, and complete to the best of our knowledge.

Member's Signature:_____ **Date:**_____

Spouse's Signature:_____ **Date:**_____