aetna℠ Medical Benefits – Claim Instructions

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents: For your protection California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas and Missouri Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent **to defraud any** insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE

1. Complete items one (1) through nineteen (19) in full.
2. Complete items twenty (20) through twenty-four (24) only if other medical coverage exists.
3. Be certain to sign the authorization to release information in block twenty-five (25).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block twenty-six (26).
5. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
6. Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:
   - patient's name
   - condition being treated
   - type of service(s) rendered
   - date(s) of service(s)
   - relationship to employee

   If this information is missing, write it on the bill and sign your name.
7. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:
   - drug name
   - purchase date
   - prescription number
   - pharmacy name/address
   - dose per/day
   - nature of illness or injury
   - quantity
   - charge
   - strength
   - physician's name

   This information can be copied from the prescription bottle or box.
8. Retain copies of your bills for your record.
9. **Refer to the back of your ID card for claim mailing address.**

TO THE PHYSICIAN OR SUPPLIER

1. Complete items twenty-seven (27) through forty-six (46) in full.
2. If the employee indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

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Medical Benefits Request

Refer to the back of your ID card for claim mailing address

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name			2. Policy/Group Number
3. Employee's Aetna ID Number	4. Employee's Name		5. Employee's Birthdate *(MM/DD/YYYY)*
6. ☐ Active ☐ Retired Date of Retirement	7. Employee's Address (Include ZIP Code) ☐ Address is new		8. Employee's Daytime Telephone Number ( )
9. Patient's Name	10. Patient's Aetna ID Number	11. Patient's Birthdate *(MM/DD/YYYY)*	12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)			14. Patient's Gender ☐ Male ☐ Female
15. Patient's Marital Status ☐ Married ☐ Single	16. Is patient employed? ☐ No ☐ Yes	17. Name & Address of Employer	
18. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm			19. Is claim related to employment? ☐ No ☐ Yes
20. Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes		21. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
22. Member's ID Number	23. Member's Name		24. Member's Birthdate *(MM/DD/YYYY)*

25. To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

26. I authorize payment of medical benefits to the physician or supplier of service.

Patient's or Authorized Person's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

27. Date of illness (first symptom) or injury (accident) or pregnancy (LMP)	28. Date first consulted you for this condition	29. If patient has had similar illness or injury, give dates	30. If an emergency check here ☐ emergency
31. Date patient able to return to work	32. Date of total disability from through	33. Date of partial disability from through	
34. Name of referring physician (e.g., Public Health Agency)		35. For services related to hospitalization give hospitalization dates admitted discharged	
36. Name & address of facility where services rendered (if other than home or office)			

37. Diagnosis or nature of illness or injury (please indicate primary and secondary)
1.
2.
3.
4.

38. Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service*	Procedure Code Identify**	Description of Service	Type of Service †	Charges	Days or Units	Diagnosis Code ††	Administrative Use Only

39. Physician's Name & Address (Include ZIP Code)	40. Telephone Number ( )	41. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
	42. Patient Account Number	43. Total charge $ _____ Amount paid $ _____ Balance due $ _____
44. Physician's or Supplier's Signature	45. National Provider Identifier	46. Date

*** Place of Service Codes:**

1 - (IH)	- Inpatient Hospital	8 - (SNF)	- Skilled Nursing Facility
2 - (OH)	- Outpatient Hospital	9 -	- Ambulance
3 - (O)	- Office Visit	0 - (OL)	- Other Location
4 - (H)	- Patient Home	A - (IL)	- Independent Laboratory
5 -	- Day Care Facility (PSY)	B -	- Other Medical Surgical Facility
6 -	- Night Care Facility (PSY)	C - (RTC)	- Residential Treatment Center
7 - (NH)	- Nursing Home	D - (STF)	- Specialized Treatment Facility

** Please Use Current Procedural Terminology Codes For Surgery

†Type of Service Codes:

1 - Medical Care	8 - Assistance at Surgery
2 - Surgery	9 - Other Medical Service
3 - Consultation	0 - Blood or Packed Red Cells
4 - Diagnostic X-Ray	A - Used DME
5 - Diagnostic Laboratory	M - Alternate Payment for Maintenance Dialysis
6 - Radiation Therapy	Y - Second Opinion on Elective Surgery
7 - Anesthesia	Z - Third Opinion on Elective Surgery

††Please Use ICD•9•CM For Discharge Diagnosis

N.E.C.A. LOCAL UNION NO. 313 I.B.E.W.
HEALTH AND WELFARE FUND

Fund Office: **GEM**Group, Rockwood Office Park, 501 Carr Road, Suite 220, Wilmington, DE 19809-2800
Phone: (302) 762-2008 / (800) 223-7405 / Fax: (302) 762-3467

January 2014

Dear Participant:

Enclosed is the new Health Care/Preventative Care Spending Account (the "Annual Account") reimbursement form. This form may be used immediately. However, **after April 1, 2014 this form will be required** along with supporting documentation for any reimbursements that will be made from available Annual Account funds. After this date, failure to use the reimbursement form will result in claims being denied. You will be required to resubmit your claim(s) on the appropriate form with supporting documentation for reimbursement under the Plan provisions. Please feel free to make copies of this Form as needed.

As always, if you have any questions regarding your Annual Account benefits, please contact GEMGroup at (302) 762-2008 or at (800) 223-7405.

Sincerely,

GEMGroup

Enclosure

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL 313 WELFARE FUND
MEDICAL REIMBURSEMENT ACCOUNT Request for Reimbursement

☐ NO ☐ YES (Claim Resubmission)

EMPLOYEE INFORMATION (*Indicates Required Information)

SOCIAL SECURITY NUMBER*	LAST NAME*	FIRST NAME*	M.I.*

HOME ADDRESS*	CITY*	☐ Check if address is new

STATE*	ZIP CODE*	HOME PHONE*	WORK OR CELL PHONE

CLAIM FOR UNREIMBURSED HEALTH EXPENSES (ATTACH SUPPORTING DOCUMENTATION)

DATE EXPENSE INCURRED	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	PERSON FOR WHOM EXPENSE INCURRED	$ AMOUNT OF REIMBURSEMENT REQUESTED

CLAIM FOR MEDICARE PART B PREMIUMS

PLEASE ATTACH STATEMENT(S) FROM MEDICARE (CMS500 NOTICE)	DATE FROM	DATE TO	AMOUNT OF REIMBURSEMENT REQUESTED

EMPLOYEE SIGNATURE REQUIRED - READ CAREFULLY

The undersigned participant in the Medical Reimbursement Account (MRA) certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the MRA with respect to such expenses. The undersigned fully understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim. The undersigned also acknowledges that the reimbursements hereby requested have not been and are not reimbursable under any other coverage. I have read and understand the important information on the reverse side of this form. I understand that any amounts reimbursed may not be claimed on my or my spouse's tax returns.

EMPLOYEE SIGNATURE *(Required)*	DATE

Remember: Claim must be submitted with itemized receipts and EOBs. Please send completed form along with all required documentation to:

International Brotherhood of Electrical Workers Local 313 Welfare Fund
3 Gateway Center, 401 Liberty Avenue, Suite 1200
Pittsburgh, PA 15222-1024

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

Please fill out the form completely using a separate line for each individual covered expense. Do not lump expenses together. Sign and date the bottom of the form and keep a copy of the completed form and all attached documentation for your records. An incomplete form or missing documentation may result in a delay or denial of reimbursement. **All information must be complete prior to the reimbursement filing deadline in order to be considered.**

PARTIAL REIMBURSEMENT: In the event that a claim is only partially reimbursed, unpaid balances from the partially reimbursed claims will not be eligible for future reimbursement.

TYPE OF SUPPORTING DOCUMENTATION

- **EOBs** - For expenses covered by the International Brotherhood of Electrical Workers Local 313 Welfare Fund or other health care plan you must submit those expenses under the health care plan first. A copy of the Explanation of Benefits (EOB) Statement which explains the amounts paid and not paid by the health care plan must be attached to this form. For copies of EOBs from Aetna for the Health and Welfare Fund you can contact GEMGroup at 1-800-242-8923. If the expenses are covered through secondary coverage by another health care plan, you must attach EOBs from all health care plans.

- **Itemized Statements or Receipts** - Expenses for services covered by the Health and Welfare Fund for other health coverage (such as hearing aids, Lasik vision surgery and other vision expenses) you must provide an itemized statement or receipt from the provider which contains all of the following:

  ☐ Name of person receiving the service
  ☐ Nature of service or supplies
  ☐ Name and address of service provider
  ☐ Amount charged
  ☐ Indication that payment was made
  ☐ Date service was rendered

- **Medicare Part B Premiums** - Documentation is required to be included with requests for reimbursement of premiums paid to the Medicare for Part B Coverage. Acceptable documentation will be the CMS 500 notice that shows premiums that have been paid.

Note: Balance forward statements, cancelled checks or credit card receipts are not acceptable as documentation of a covered expense. However, cancelled checks and credit card receipts can be submitted along with an itemized statement to show proof of payment.

COVERED EXPENSES INCLUDE:

- Expenses for services or supplies which are covered under the Health and Welfare Fund, but are the financial liability of the participant as a result of the application of deductibles, coinsurance or maximum benefit limitations.
- Premiums paid for Medicare Part B coverage.

NON-COVERED EXPENSES INCLUDE:

- Office Visit Co-Pays.

IMPORTANT LIMITATIONS ON COVERED EXPENSES:

- As required by Federal law, to be eligible for reimbursement under this benefit, all expenses must not have been reimbursed or be eligible for reimbursement under any other health plan coverage or a Flexible Spending Account; and
- The Covered Expense must have been incurred while the person receiving the service or supply was eligible for benefits under the
- International Brotherhood of Electrical Workers Local 313 Welfare Fund; and
- Proper documentation of the expense and payment must be provided.
- Your Medical Reimbursement Claims may be submitted in the year in which they are incurred and up to one additional year.