



January 2021 Open Enrollment Changes

The Board of Trustees for IBEW Local No. 236 Health and Benefits Fund has approved changing the medical, prescription and dental insurance carriers to Empire Blue Cross Blue Shield and is also offering a new Voluntary Vision benefit also through Empire Blue Cross Blue Shield. We want to make this transition as seamless as possible for you.

Depending on the health plan you are currently covered under please be sure to review the following information:

CDPHP PPO \$25/\$25:

If you are currently covered by CDPHP PPO \$25/\$25, your coverage will automatically be transitioned to the same tier (single/2 person/family) coverage under Empire Blue Cross Blue Shield's PPO \$25/\$25 plan.

CDPHP HDPPO:

If you are currently covered by CDPHP HDPPO, your coverage will automatically be transitioned to the same tier (single/2 person/family) coverage under Empire Blue Cross Blue Shield's HD PPO

Blue Shield of NENY EPO:

If you are currently covered by Blue Shield of NENY EPO, your coverage will automatically be transitioned to the same tier (single/2 person/family) coverage under Empire Blue Cross Blue Shield's PPO \$25/\$25 plan.

SavRX prescription plan:

If you are currently covered for prescriptions through SavRX, your coverage will automatically be transitioned to the prescription plan under your Empire Blue Cross Blue Shield's medical coverage through their vendor, IngenioRX

Blue Shield of NENY Dental:

If you are currently enrolled in Blue Shield of NENY dental plan, your coverage will automatically be transitioned to the same tier (single/2 person/family) coverage under Empire Blue Cross Blue Shield's dental plan

If you would like to change your coverage and/or elect the Voluntary Vision plan you will need to complete the enrollment form included in this packet to select the coverage.

You will receive a new Empire Blue Cross Blue Shield ID card that you will use for your medical, prescription and dental coverage. All coverage on one ID card!

We have put together a FAQ for you to help with any questions. Please visit IBEW's website at www.ibew236funds.org for assistance.

Respectfully yours,

The Board of Trustees, IBEW Local No. 236 Health and Benefits Fund
and Jaeger & Flynn Associates, Inc. your Benefit Partners



2021 FAQ

- Q. When will I receive my new ID cards?
A. You will receive one card for your Medical, Prescription, and Dental coverage prior to January 1, 2021
- Q. How do I know if my doctor, dentist, or pharmacy participates with my new Empire Blue Cross Blue Shield plan?
A. Visit Empire Blue Cross Blue Shields website at <https://www.empireblue.com/find-care/>
- Q. Is my prescription still covered under my new Empire Blue Cross Blue Shield plan?
A. Visit Empire Blue Cross Blue Shields website at <https://www.empireblue.com/ms/pharmacyinformation/home.html>
- Q. I have a prescription I need to get filled through mail order, do I need to get a new script in January in order to continue getting them filled through mail order?
A. Yes, you will need to fill out a mail order form and submit it with your prescription to Empire's prescription vendor, IngenioRX
- Q. I have a prescription that has 3 refills left, will those refills transfer over to Empire after January 1?
A. Yes, any refills left on your current prescription will transfer over to Empire's prescription vendor, IngenioRX
- Q. Will my prior authorizations for medical/prescriptions be transferred to Empire Blue Cross Blue Shield?
A. Yes, any prior authorizations will be transferred from CDPHP and Blue Shield of NENY
- Q. Who do I call if I have a question about a claim for a date of service prior to January 1, 2021
A. If you had CDPHP prior to January 1, 2021, contact them at 518-641-3100 or 877-724-2579
If you had Blue Shield of NENY prior to January 1, 2021, contact them at 518-220-4600 or 800-888-1238
If you have a question about your PAP account, contact JFA at 518-373-0069 or 800-388-8538 ext. 350
- Q. Who do I call if I have a question about a benefit/claim for a date of service after January 1, 2021
A. Contact the Member Service team at 518-539-6045



Welcome to Open Enrollment January 2021!

It is **open enrollment time**, which means that you may add, change, or waive your health and/or dental coverage effective January 1, 2021. Any changes in insurance coverage must be received no later than December 15th in the IBEW Local 236 Health & Benefit Fund Office.

New for 2021!

IBEW Local 236 is changing medical, prescription and dental carriers from CDPHP, Blue Shield of NENY, and SAVRX to Empire Blue Cross Blue Shield. You are also being offered an optional voluntary vision plan through Empire Blue Cross Blue Shield. **If you are currently enrolled in the IBEW Local 236 Health & Benefit Fund medical and/or dental insurance plans and you are not making any changes, you do not need to take further action. Jaeger & Flynn Associates will automatically transfer your enrollment from CDPHP, Blue Shield of NENY and SavRX to Empire Blue Cross Blue Shield.**

If you are enrolled in the CDPHP PPO \$25/\$25 you will automatically be transferred to the Empire Blue Cross Blue Shield Copay PPO \$25/\$25 plan.

If you are enrolled in the CDPHP HDPPPO you will automatically be transferred to the Empire Blue Cross Blue Shield HD PPO plan.

If you are enrolled in the BSNENY EPO plan you will automatically be transferred to the Empire Blue Cross Blue Shield Copay PPO \$25/\$25 plan

If you would like to enroll in the new voluntary vision plan through Empire Blue Cross Blue Shield you will need to fill out an enrollment form and send to the Fund Office by December 15, 2020.

If you would like to make any changes to your medical and dental insurance plans effective January 1, 2021, or if you want to enroll in the new optional vision plan then you will need to fill out and return the enclosed IBEW Local 236 Health and Benefit Fund Enrollment Form to the Fund Office prior to **December 15, 2020.**

If you are opting-out of coverage effective January 1, 2021 because you have other medical coverage through an employer sponsored plan, then you will need to fill out and return the enclosed IBEW 236 Health and Benefit Fund Enrollment/Opt-Out/Attestation Form, and proof of your other medical coverage to the Fund Office prior to **December 15, 2020. If you previously opted out of coverage, you will need to complete this requirement again for 2021 as this is an annual requirement.**

NEW 2021 Health Insurance Offerings

- **Health Insurance:** To review the complete benefit summaries for the 2021 health plans, logon to your HRA account at <https://jfaflex.lh1ondemand.com> and go to the "Tools & Support" tab. To verify your doctor participates with Empire Blue Cross Blue Shield, visit their website at <https://www.empireblue.com/find-care/>

➤ **Empire Blue Cross Blue Shield:** 2 Health options -

1. PPO Co-pay Option: \$25 co-pays for doctor visits and \$240 for inpatient hospital stays.

or

2. High Deductible PPO Option: Deductible; Annual maximum of \$2,500 for individuals, \$5,000 for two-person and \$7,500 for family contracts.

- **Prescription Drugs:** Please present your Empire Blue Cross Blue Shield medical card for all prescription drugs. This coverage is included and is automatic once you have chosen to enroll in any of the IBEW Local 236 Health & Benefit Fund health medical insurance options. To verify your pharmacy is participating, visit their website at <https://www.empireblue.com/ms/pharmacyinformation/rxnetworks.html> or contact the Pharmacy Member Service department at (833) 271-2371
- **HRA Medical VISA Debit Cards:** Once you have a balance in excess of your required applicable minimum balance hold-back, "available reimbursement funds", you will automatically receive a VISA debit card from Jaeger & Flynn.
- **HRA Opt-Out Form:** If you are newly opting out of medical coverage through the IBEW Local 236 Health & Benefit Fund effective 1/1/2021, you must complete an enrollment form and the waiver form (included in this mailing) and provide proof of alternate employer coverage to the Fund Office. The monthly HRA opt-out fee for 2021 will remain at \$100 per month.
- **Empire Blue Cross Blue Shield Dental Insurance:** Coverage is optional. If you are currently enrolled in Blue Shield of NENY's dental plan and you are not making any changes you do not need to do anything. Your current elections will be transitioned to Empire Blue Cross Blue Shield. To verify your dentist participates with Empire Blue Cross Blue Shield, visit their website at <https://www.empireblue.com/find-care/>
- **Empire Blue Cross Blue Shield Vision Insurance: New for 2021!** In addition to your medical plan covering 1 routine eye exam every year, you can elect additional Vision coverage. Coverage is optional and includes eye exams, lenses, frames, and contacts every 12 months. Included in the vision benefit is coverage for safety glasses. In order to elect the vision plan, you must complete the enrollment form and return it to the Fund Office no later than December 15th.
- **Beneficiary Card:** If you are currently eligible, and do not already have a beneficiary card on file or if you have a beneficiary card on file and would like to make any changes to your beneficiaries please contact the Fund Office. If you are not making changes, your beneficiary card remains in effect. The cards cover the **Annuity, Pension, and Life Insurance benefits.**
- **HIPAA Authorization Form:** If you would like to make changes to your HIPAA authorizations, please contact the Fund Office. **Please remember we cannot discuss your account with anyone you haven't authorized.**
- **State and Federal Notice packet:** This notice packet contains important information regarding your benefits and will be provided on an annual basis. This packet can be found on <https://jfaflex.lh1ondemand.com/Login>.

In the event an active participant finds coverage through their spouse or employer, has insufficient funds in their Health and Benefit account, or has dependents “aging out” of coverage, the following options are available to qualified participants:

- **Waiver of coverage:** If you are opting out of coverage through the IBEW Local 236 Health & Benefit Fund, this completed waiver and proof of alternate coverage must be provided to the Fund Office in order for reimbursements to be made from the IBEW Local 236 Health & Benefit Fund and classification under the contribution adjustment levels.
- **Note:** If you lose that alternate coverage you should immediately seek coverage under the IBEW Local 236 Health & Benefit Fund options. If you do not notify the Fund Office within **60 days** of that loss you will not be able to get coverage through the plan until the “open enrollment” period following the Fund Office’s receipt of all required documents.
- **COBRA:** is also an available option.

In addition, the following coverages apply to active participants in the Plan. These benefits are included in the monthly insurance premiums and the monthly opt out fees.

Disability Insurance: Mutual of Omaha is our NEW carrier: Please contact the IBEW Local 236 Health & Benefit Fund Office for a disability benefits claim application and/or to determine if you are eligible.

Life Insurance: Mutual of Omaha is our carrier: The benefit is \$10,000 for our active participants and \$3,000 for a covered Retiree

Questions? Contact information:

Visit us online at: www.ibew236funds.org
IBEW Local 236 Health and Benefit Fund
3000 Troy-Schenectady Road
Schenectady, NY 12309
Kim Fielding (518-782-5499 option 2)
kfielding@zenith-american.com
Benefit related questions contact the Customer
Service department at 518-539-6045

Visit us online at: www.jaegerflynn.com
Jaeger & Flynn Associates, Inc.
Group Service (518-373-0069 ext. 350)
jfagroupservice@jaegerflynn.com
Lisa Lagon, GBA, PHR, SHRM-CP ext.
121
Lisa Peretti-DiSorbo, Acct. Manager ext.
200

Thank you for your attention to these items and we wish you the very best health and continued prosperity in the coming years.

Respectfully yours,

The Board of Trustees, IBEW Local No. 236 Health and Benefits Fund
and Jaeger & Flynn Associates, Inc. your Benefit Partners

The charts below detail the minimum balances and the Health and Benefit and Annuity contribution adjustment applicable for 2021. Please note that the 1-year minimum balances show as "A" represents the minimum balance amount in your Health Reimbursement Account (HRA) necessary in order to receive reimbursements for covered out of pocket medical expenses.

Effective January 1, 2021

The following chart details the minimum balances, the Health & Benefit and the Annuity contribution adjustment applicable for 2021. Please note that the one year minimum balances shown as Level A represents the minimum balance amount in your Health Reimbursement account (HRA) necessary in order to receive reimbursements for covered out of pocket medical expenses.

Classification	Single		2-Person		Family	
	From	To	From	To	From	To
Level A	-	7,660.00	-	12,680.00	-	14,400.00
Level B	7,661.00	22,980.00	12,681.00	38,040.00	14,401.00	43,200.00
Level C	22,981.00	38,300.00	38,041.00	63,400.00	43,201.00	72,000.00
Level D	38,301.00	& Greater	63,401.00	& Greater	72,001.00	& Greater

The following chart details the allocation of contributions as shown below:

Classification	Annuity	H&B	Total Contribution	Admin Fee	Net to H&B
Level A	0.25	14.75	15.00	0.35	14.40
Level B	2.90	12.10	15.00	0.35	11.75
Level C	3.25	11.75	15.00	0.35	11.40
Level D	6.50	8.50	15.00	0.35	8.15

The Charts below are shown to provide an estimate of the work hours required to maintain health insurance at the specified contribution levels and balance:

Empire BlueCross BlueShield Copay Plan Without Dental

Classification	Contribution Rate	Single in hours	2-Person in hours	Family in hours
Level A	14.40	521.13	880.62	1,002.28
Level B	11.75	638.67	1,079.22	1,228.32
Level C	11.40	658.27	1,112.36	1,266.03
Level D	8.15	920.78	1,555.94	1,770.89

Empire BlueCross BlueShield High Deductible Plan Without Dental

Classification	Contribution Rate	Single in hours	2-Person in hours	Family in hours
Level A	14.40	350.49	537.09	616.93
Level B	11.75	429.54	658.22	756.07
Level C	11.40	442.73	678.43	779.28
Level D	8.15	619.27	948.97	1,090.04

**IBEW Local 236
Health and Benefit Fund
Monthly Premiums for 2021**

2021 Monthly Premium Rates	Medical and Prescription Drugs	Optional Dental Insurance	Optional Vision Insurance	Total With Optional Coverages
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Empire BlueCross BlueShield Co-Pay PPO				
Single	625.36	53.59	7.86	686.81
Two-Person	1,056.74	135.92	12.83	1,205.49
Family	1,202.73	153.23	18.42	1,374.38

Empire BlueCross BlueShield High Deductible PPO				
Single	420.59	53.59	7.86	482.04
Two-Person	644.51	135.92	12.83	793.26
Family	740.32	153.23	18.42	911.97

Monthly Opt Out Fees				
Single	100.00	53.59	7.86	161.45
Two-Person	100.00	135.92	12.83	248.75
Family	100.00	153.23	18.42	271.65

IBEW LOCAL 236 HEALTH & BENEFIT FUND ENROLLMENT / CHANGE FORM

PARTICIPANT NAME (FIRST NAME + MI + LAST NAME)	SOCIAL SECURITY #	GENDER	DATE OF BIRTH (MM/DD/YY)	
MAILING ADDRESS (STREET, APT NO.)	CITY	STATE	ZIP CODE	TELEPHONE () -
EMAIL ADDRESS:	MARITAL STATUS: ___ SINGLE ___ MARRIED	CLASSIFICATION: ___ ACTIVE ___ RETIREE		

WHICH PLAN TYPE(S) & COVERAGE AMOUNT(S) ARE YOU ENROLLING IN?		
MEDICAL COVERAGE: EMPIRE BLUECROSS BLUESHIELD ___ COPAY PLAN ___ HIGH DEDUCTIBLE PLAN ___ SINGLE ___ 2-PERSON ___ FAMILY ___ WAIVE/OPT OUT	VISION COVERAGE: EMPIRE BLUECROSS BLUESHIELD ___ SINGLE ___ 2-PERSON ___ FAMILY ___ WAIVE/OPT OUT	DENTAL COVERAGE: EMPIRE BLUECROSS BLUESHIELD ___ SINGLE ___ 2-PERSON ___ FAMILY ___ WAIVE/OPT OUT

INFORMATION ABOUT FAMILY PARTICIPANTS YOU WANT ENROLLED UNDER YOUR PLAN: (for additional dependents please attach another page, Proof of Marriage and Birth Certificates are required if adding spouse or dependent child(ren))

NAME (First Name + MI + Last Name)	ELECTING COVERAGE	WAIVING COVERAGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER
SPOUSE NAME:	___ HEALTH ___ DENTAL ___ VISION ___ HRA	___ HEALTH ___ DENTAL ___ VISION ___ HRA			
DEPENDENT NAME:	___ HEALTH ___ DENTAL ___ VISION ___ HRA	___ HEALTH ___ DENTAL ___ VISION ___ HRA			
DEPENDENT NAME:	___ HEALTH ___ DENTAL ___ VISION ___ HRA	___ HEALTH ___ DENTAL ___ VISION ___ HRA			
DEPENDENT NAME:	___ HEALTH ___ DENTAL ___ VISION ___ HRA	___ HEALTH ___ DENTAL ___ VISION ___ HRA			
DEPENDENT NAME:	___ HEALTH ___ DENTAL ___ VISION ___ HRA	___ HEALTH ___ DENTAL ___ VISION ___ HRA			
DEPENDENT NAME:	___ HEALTH ___ DENTAL ___ VISION ___ HRA	___ HEALTH ___ DENTAL ___ VISION ___ HRA			
DEPENDENT NAME:	___ HEALTH ___ DENTAL ___ VISION ___ HRA	___ HEALTH ___ DENTAL ___ VISION ___ HRA			

I hereby certify that the above information is correct. I further certify that I have read and agree to these Terms and Conditions: I, the above named participant, hereby authorize the elected benefit premiums noted above until such time as I should provide written notice to change or discontinue these deductions/reductions. I also authorize the Plan Administrator to make any future adjustments necessary should there be a change in the premium amounts for the coverage options I have selected. I agree to notify the Plan Administrator in writing of any changes to my personal information above that may affect the administration of my reimbursement benefits. I understand that neither my employer nor the Plan Administrator will be held liable for any delays or problems in the administration of my Plan or issue of my reimbursements, in the event that I fail to provide them with this information in an accurate and timely manner. I agree to be responsible for paying any fees associated with having the Plan Administrator reissue reimbursement checks to me, in the event that initial payments issued to me are lost, stolen, misplaced, or otherwise not received by me in a timely manner. If the Plan administrator determines that an expense submitted for reimbursement, or that the JFA Flex Debit Card was used for a non-qualifying expense under the Plan, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. By signing this enrollment form, I agree to have the amount of any over-reimbursed prescription claim deducted automatically from my HRA if my prescription coverage pays for a claim after my coverage has ended.

IBEW LOCAL 236 PARTICIPANT NAME	IBEW LOCAL 236 PARTICIPANT SIGNATURE	DATE SIGNED
For any questions you may have regarding completing this form or additional information that may be required contact the IBEW Local 236 Health & Benefit Fund (518) 782-5499 or Jaeger & Flynn Associates (JFA) (800) 388-8538. Please forward the completed form to the IBEW Local 236 Health & Benefit Fund at 3000 Troy Schenectady Rd., Schenectady, NY 12309-1614. Thank you.		

TO BE COMPLETED BY IBEW LOCAL 236 HEALTH & BENEFIT FUND OFFICE:			
Eligibility Date: _____	Benefit Effective Date: _____	Classification: _____	Insurance Code _____
Fund Office Signature _____	Date Signed _____	HRA Account: ___ Individual ___ 2-Person ___ Family ___ Waived	

HEALTH PLAN AND HRA PLAN ENROLLMENT/WAIVER/OPT-OUT FORM AND HOLD HARMLESS AGREEMENT

Waiver Instructions: If you have other Affordable Care Act (ACA) Qualified Health Insurance coverage in effect through your spouse's or other family member's Employer-Sponsored Group Health Plan, you must complete and return Section One of this Form to the IBEW Local 236 Benefit Fund Office with either 1.) a copy of your insurance card that specifically identifies you as a covered dependent or 2.) a letter of coverage verification (which includes your name and policy/participant number) from your spouse's or other family member's insurance carrier.

Section One: Please check all applicable boxes below.

- Option 1: Participant ONLY Health Plan and HRA.** I am enrolled in a health plan offered by IBEW Local 236 Health & Benefit Fund. I elect to be enrolled in our Health Reimbursement Account (HRA) Plan. This HRA will reimburse me for my personal qualified medical, dental and/or vision Expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. Example: I have single insurance coverage through the IBEW Local 236 Health & Benefit Fund and I want to be eligible for reimbursement.
- Option 2: Participant and Family Health Plan and HRA.** My family and I are enrolled in a health plan offered by the IBEW Local 236 Health and Benefit Fund and I elect myself and my family to be enrolled in my Health Reimbursement Account (HRA) Plan. This HRA will reimburse myself and my covered dependents' for our personal qualified medical, dental, and/or vision expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. Example: I have 2-Person or family insurance coverage through the IBEW Local 236 Health & Benefit Fund and I want myself and my dependents to be eligible for reimbursement.
- Option 3: Participant Health Plan Opt-Out with HRA Enrollment.** I am enrolled in a health plan offered by another employer (i.e. your spouse's employer or other family member's employer or a retiree plan) and I elect to Opt-Out of the IBEW Local 236 Health Insurance but wish to be enrolled in the IBEW Health Reimbursement Account (HRA) Plan. This HRA will reimburse me (and any dependents who are also enrolled in a Qualified Health Plan) for qualified medical, dental and/or vision expenses and post-tax deductions for the employer sponsored health plan that I am enrolled in. Example: I am opting out of insurance coverage through the IBEW Local 236 Health & Benefit Fund because I have other employer sponsored health insurance and I want myself and my dependents to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.
- Option 4: Participant ONLY enrolled in the IBEW Local 236 Health Plan with a Spouse and/or other dependents enrolled in the HRA:** I am enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund and my spouse and/or my dependents are not enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund, but are enrolled in a health insurance plan offered by another employer (i.e. your spouse's employer or other family member's employer or a retiree plan). I elect myself, my spouse, and my other dependents to be enrolled in my Health Reimbursement Account (HRA) Plan. This HRA will reimburse myself, my spouse and my other dependents for our personal qualified medical, dental and/or vision expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. Example: I have single coverage through the IBEW Local 236 Health & Benefit Fund, my spouse and children have health insurance through another employer sponsored plan and I want myself, my spouse and my dependents to be eligible for reimbursements. Proof of other health plan enrollment is required. Please see the attestation form.
- Option 5: Participant and/or Spouse enrolled in the IBEW Local 236 Health Plan or other sponsored health plan and dependent waiver:** I and my spouse are enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or another employer sponsored health plan and my dependents are NOT enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a health insurance plan offered by another employer and I choose to waive my dependents from my Health Reimbursement Account (HRA) Plan. Example: my children are enrolled in Child Health Plus, or Medicaid and not eligible for reimbursement under my plan. I want myself and/or my spouse to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.
- Option 6: Dependent Waiver:** My dependents are enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a Health Insurance Plan offered by another employer and I choose to waive my dependents from my Health Reimbursement Account (HRA) Plan. This HRA will not reimburse me for my dependents' qualified medical, dental and/or vision expenses. Example: My children are on my insurance plan or my spouse's plan but I DO NOT want them to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.
- Option 7: Permanent HRA Waiver:** (This option is required to be offered however it is highly unlikely that you would choose this option, unless you are in the instance of where you wish to only use the exchanged and be eligible for the federal subsidies associated and available on the marketplace.) I am not enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a health insurance plan offered by another employer (i.e. your spouse's employer or another family participant's employer plan) and I elect to waive myself and my dependents from the IBEW Local 236 Health Reimbursement Account (HRA) Plan permanently. Proof of other health plan enrollment is required. Please see the attestation form.

