

Local 315

Americans for Financial Independence

47 Nepperhan Ave., Suite #4

Elmsford, NY 10523

Phone 914-366-6868

Fax 914-366-8063

Membership Requirements

1. All members must be employed a minimum of twenty **(20)** hours per week
2. Employee occupation must be listed
3. All Social Security numbers, dates of birth, and provider names and numbers must be completed
4. All plans with a spouse and/or dependent(s) having a different last name than the member **MUST** submit a marriage and/or birth certificate for the appropriate dependent(s)

Enrollment-Complete these forms:

1. Enrollment Worksheet
2. Local 315 Application Form
3. AFI Membership Form
4. AFI ACH Form

Payment Instructions:

1. The plan requires a \$125.00 Annual Administration Fee.
2. Contributions for the medical plans are made in advance of the coverage period for which you are paying and can be made on a quarterly basis by mail or by automatic bank debit. If paying quarterly, the first payment must be **three (3)** months' premium. Future quarterly payments are due on the 15th of the month prior to the beginning of the quarter for which you are paying. If paying by automatic checking, a void check must be attached to this form. Automatic debits will occur on the 15th of the month prior to the month of coverage.
3. If your coverage is terminated for any reason, and you wish to be reinstated, you will be subject to a \$75 reinstatement fee.

NOTE: All payments received after the due date are subject to a late fee (currently \$35). Payments that are returned as a "chargeback/not authorized" will incur a \$50 fee. All other returned payments are subject to a \$35 fee.

All enrollment materials must be received by A.F.I. no later than the 20th of the month prior to the requested start date.

Americans for Financial Independence

Enrollment Worksheet

Local 315 website-www.anthem.com

Includes 315 Health & Welfare Fund, union dues and association fees

EPO:

Single	\$1,482.95
Employee + 1 Child	\$2,589.70
Employee + Spouse	\$2,965.90
Family	\$3,928.25

315 rates effective through 06/30/2027. All other fees are subject to change

**** ONE CHECK PAYABLE TO A.F.I. ****

Fage Financial

T (845) 499-2255

E info@fagefinancial.com

www.fagefinancial.com

Please circle one payment mode: Monthly Automatic Check OR Quarterly E-mail Inv.

315 Medical Plan: \$ _____ X ____ = \$ _____

Optional Dental Plan - please inquire if interested.

Annual Administration Fee: \$125.00

Total Contribution at Enrollment: \$ _____

NOTE: Completed paperwork to be received at AFI no later than the 20th of the month prior.
No cancellation requests will be honored once a month has started

Member Name _____ Rep. Name _____

Member Signature _____ Rep. Signature _____

Date _____

Please note that it will take approximately 10 to 14 **business** days, after your effective date, for you to receive your ID# and cards from the insurance carrier.

Member's Initials _____

B.A.T LOCAL UNION 315
APPLICATION AND CHECK-OFF AUTHORIZATION

I, the undersigned, hereby apply for membership in the above Local Union and I authorize said Local Union to represent me for the purpose of collective bargaining, and I voluntarily authorize and direct my Employer to deduct from my wages initiation fees, monthly dues, and assessments, to become due to it as the periodic dues, initiation fees and assessments uniformly required by said Local Union as a condition of acquiring or maintaining membership, and in compliance with the Labor-Management Relation Act of 1947.

This voluntary authorization and assignment shall be irrevocable for the period of one (1) year or until the termination of the collective bargaining agreement between my Employer and said Local Union, whichever occurs sooner, and I agree and direct that this voluntary authorization and assignment shall be automatically renewed, and shall be irrevocable for successive periods of one (1) year each or for the period of each succeeding applicable collective bargaining agreement between my Employer and said Local Union, whichever occurs sooner, unless written notice by certified mail is given by me to the Local Union and my Employer not more than twenty (20) days and not less than ten (10) days prior to the expiration of each period of one (1) year, or of each applicable collective bargaining agreement between my Employer and said Local Union, whichever occurs sooner, regardless of whether I am or remain a member of the Local Union.

You have a right to be a nonmember of the above Local Union and nonmembers have the right to (1) object to paying a fraction of the Local Union dues and fees that are not germane to Local Union's duties as bargaining agent, and to obtain a reduction of fees for such non-germane activities, (2) to obtain from Local Union sufficient information to enable you to decide whether to object to Local Union's fair share dues and fee equivalency calculation, and (3) to be told the Local Union's internal procedure for objection. Items (2) and (3) may be obtained by written request to the Local Union address provided above. You should be aware that exercising the option of becoming a nonmember means you will not have the right to vote on your contract, to participate in the development of contract proposals, or vote in Local Union elections

FOR OFFICE USE ONLY

Starting Date: _____ Initiation Date: _____

Name of Member: _____ Social Security No: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____ Date of Employment: _____ Class of Work: _____

Firm Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Beneficiary: _____ Relationship: _____

Employee's Signature: _____

UNION COPY

Personal Health Questions For Applicant and Dependents – Circle YES or NO. Must answer ALL Questions

1. Heart Attack, brain tumor, stroke, heart disease or heart problems? YES NO
2. Cancer, tumor, lymphoma or any type of transplant? YES NO
3. Any surgery or hospitalization in the last 5 years, OR currently pending, planned or recommended? YES NO
4. Emphysema or COPD? YES NO
5. Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder? YES NO
6. Seizures, epilepsy, hemophilia, Sleep Apnea or blood disorder? YES NO
7. Diabetes, endocrine, Auto Immune, Crohn's Disease or Arthritis or pituitary disorder, growth disorder, lupus, MS, AIDS or HIV+? YES NO
8. Currently pregnant, premature delivery or multiple births? YES NO
9. Is anyone listed on the application taken or are currently taking medications in the last 12 months? YES NO

If **Yes** answer to questions # 1 - 8 please provide date, type and further treatment if any.

If **Yes** answer to question # 9 list any and all **Medications** taken in the last 12 months below by anyone listed on the application.

Please list the name of medication, dosage and corresponding medical condition information. Please include diagnosis date and date of last physician visit for condition.

Applicant Signature _____ Date _____

AMERICANS FOR FINANCIAL INDEPENDENCE

MEMBERSHIP FORM

MEMBER INFORMATION						
MEMBER LAST NAME			MEMBER FIRST NAME			
MEMBER SS#			MEMBER DOB			
HOME PHONE			CELL PHONE			
MEMBER GENDER ☐ MALE ☐ FEMALE			EMAIL			
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER						
STREET ADDRESS						APT #
CITY			STATE		ZIP	
EMPLOYED 20+ HRS PER WEEK (ON AVERAGE) ☐ NO ☐ YES			OCCUPATION			
			☐ W2 ☐ K1 ☐ SCHEDULE C			
BUSINESS NAME			BUSINESS PHONE			
BUSINESS ADDRESS			BUSINESS EMAIL			
SPOUSE / DOMESTIC PARTNER INFORMATION (IF APPLICABLE)						
SPOUSE / PARTNER LAST NAME (IF DIFFERENT)			SPOUSE / PARTNER FIRST NAME			
SPOUSE / PARTNER SS#			SPOUSE / PARTNER DOB			
SPOUSE / PARTNER GENDER ☐ MALE ☐ FEMALE			SPOUSE / PARTNER EMAIL			
DEPENDENT INFORMATION (IF APPLICABLE)						
LAST NAME (IF DIFFERENT)	FIRST	MIDDLE	DOB	AGE	RELATIONSHIP TO MEMBER	SS #
PLAN SELECTION						
PLAN NAME		EFFECTIVE		PREVIOUS CARRIER		
*** All documents included in my application for benefits have been completed accurately and truthfully to the best of my knowledge.						
MEMBER SIGNATURE				DATE		

AMERICANS FOR FINANCIAL INDEPENDENCE

AUTHORIZATION AGREEMENT FOR PRE-ARRANGED WITHDRAWALS

This bank account deduction program allows you to have your premium automatically deducted from your bank account. Please complete and sign this form to authorize withdrawals.

Member's Name: _____
Last Name First Name

Payer's Name: _____
(if different from above)

Address: _____

INITIAL

WITHDRAWAL

Date: ____ / ____ / ____

Amount: \$ _____

RECURRING

WITHDRAWAL

Start Date: ____ / ____ / ____

Amount: \$ _____

☐ Monthly

☐ Quarterly

☐ Semi-Annual

☐ Annual

**Payer's
Bank Name:** _____

Routing Number: _____ **Account Number:** _____

I hereby authorize Americans for Financial Independence aka AFI, to initiate withdrawal(s) from my bank account in such amount as needed to keep my benefits active until revoked. Revocation must take the form of written notification from member and/or payer in such manner to afford AFI a reasonable opportunity to act on it and/or within 30 days. I understand AFI may cancel this payment plan at any time. I represent and warrant that I am authorized to execute this authorization agreement and I indemnify and hold AFI, bank and their agents harmless from damages, loss or claims resulting from all authorized actions hereunder.

***** Note: \$35 return fee for "non sufficient funds", \$50 return fee for "non authorized or stopped, account frozen, etc"**

**Payer's
Signature:** _____ **Date:** _____

**Print
Name:** _____ ☐ New Participant ☐ Change

ATTACH VOIDED CHECK

Acknowledgement of Late Enrollment

I acknowledge that my enrollment materials were submitted after the 20th of the month prior to the effective date of coverage.

Therefore, as a result of the delay, I understand and accept that I may not be able to verify my eligibility sooner than 30 days from the start date of enrollment.

I further understand and accept that my identification card(s) may arrive no sooner than 30 days from the requested start date of enrollment.

I also understand and accept that I may have to contact the carrier directly regarding any out-of-pocket expenses and/or claims issues.

I understand that if I need additional assistance in expediting the process mentioned above, I can contact customer service (914)-366-6868.

Signature of member

Date

____/____/____



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, see <https://ibatpa.healthspace.net/Logon/>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-878-222-4410 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$700 individual / \$1,400 family Out-Of-Network: Not Covered	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible (embedded). Deductible will reset on July 1st.
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In-Network: \$6,600 individual / \$13,200 family Out-Of-Network: Not Covered	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met (embedded). Out-of-pocket will reset on April 1st.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.Anthem.com or call 1-878-222-4410 for a list of participating providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$45 co-pay/visit	Not covered	
	Specialist visit	\$45 co-pay/visit	Not covered	
	Preventive care/screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Not covered	Diagnostic testing done during an office visit is covered at 100%.
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Not covered	Pre-authorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com	Generic Drugs (Tier 1)	Retail: \$15 co-pay /prescription Mail Order: \$30 co-pay /prescription	Not covered	Medical Out-of-pocket limit applies. Covers up to a 30-day supply (retail & specialty);31-90 day supply (mail order). Once the medical annual out-of-pocket limit is met, you pay nothing for covered prescription medication
	Preferred Brand Drugs (Tier 2)	Retail: \$30 co-pay /prescription Mail Order: \$60 co-pay /prescription	Not covered	Medical Out-of-pocket limit applies. Covers up to a 30-day supply (retail & specialty);31-90 day supply (mail order). Once the medical annual out-of-pocket limit is met, you pay nothing for covered prescription medication
	Non-Preferred Brand Drugs (Tier 3)	Retail: \$60 co-pay /prescription Mail Order: \$120 co-pay /prescription	Not covered	Medical Out-of-pocket limit applies. Covers up to a 30-day supply (retail & specialty);31-90 day supply (mail order). Once the medical annual out-of-pocket limit is met, you pay nothing for covered prescription medication
	Specialty drugs (Tier 4)	Generic: \$15 co-pay/prescription	Not covered	Specialty Drugs are covered through BioPlus.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Preferred Brand: \$30 co-pay/prescription Non-Preferred Brand: \$60 co-pay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Not covered	Pre-authorization is required for some services.
	Physician/surgeon fees	Deductible then 20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	\$150 co-pay/visit	\$150 co-pay/visit	Copay waived if admitted.
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	
	Urgent care	\$45 co-pay/visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Not covered	Pre-authorization required.
	Physician/surgeon fee	Deductible then 20% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Office services	\$45 co-pay/visit	Not covered	
	Inpatient/Outpatient services	Deductible then 20% coinsurance	Not covered	Pre-authorization required for inpatient.
If you are pregnant	Office visits	\$45 co-pay /visit	Not covered	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Copay applies to initial visit to confirm pregnancy, then all other prenatal visits are covered at 100%.
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Not covered	
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Not covered	Pre-authorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				more than a 96 hour stay in order to avoid a denial of services.
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Not covered	Pre-authorization is required. Limited to a maximum of 200 visits per year.
	Rehabilitation services	Office: \$45 co-pay/visit Outpatient/Inpatient: Deductible then 20% coinsurance	Not covered	Pre-authorization is required for initial visit. Physical therapy, occupational therapy, respiratory therapy & speech therapy have separate limit of 30 visits per year.
	Habilitation services	Office: \$45 co-pay/visit Outpatient/Inpatient: Deductible then 20% coinsurance	Not covered	Pre-authorization is required for initial visit. Physical therapy, occupational therapy, respiratory therapy & speech therapy have separate limit of 30 visits per year.
	Skilled nursing care	Deductible then 20% coinsurance	Not covered	Pre-authorization is required.
	Durable medical equipment	Deductible then 20% coinsurance	Not covered	Pre-authorization is required for items over \$2,500.
	Hospice services	Deductible then 20% coinsurance	Not covered	Pre-authorization required. Limited to a maximum of 210 visits per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
- Acupuncture - Bariatric surgery - Cosmetic Surgery	- Dental Care (Adult) - Long Term Care - Non-emergency care when traveling outside the U.S.	- Routine Eye Care (Adult) - Routine Foot Care - Weight Loss Programs	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
- Abortion - Chiropractic Care	Hearing Aids (limited to 1 per ear per lifetime)	Private-duty Nursing	

	• Infertility Treatment (limited to 3 treatments per lifetime combined with artificial insemination and invitro fertilization.)	
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the plan at 1-878-222-4410. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$400	■ The plan's overall deductible	\$400	■ The plan's overall deductible	\$400
■ Specialist [co-payment]	\$30	■ Specialist [co-payment]	\$30	■ Specialist [co-payment]	\$30
■ Hospital (facility) [coinsurance]	10%	■ Hospital (facility) [coinsurance]	10%	■ Hospital (facility) [coinsurance]	10%
■ Other [coinsurance]	10%	■ Other [coinsurance]	10%	■ Other [coinsurance]	10%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$400	Deductibles	\$400	Deductibles	\$400
Copayments	\$30	Copayments	\$30	Copayments	\$105
Coinsurance	\$1270	Coinsurance	\$560	Coinsurance	\$280
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$	Limits or exclusions	\$	Limits or exclusions	\$
The total Peg would pay is	\$3000	The total Joe would pay is	\$990	The total Mia would pay is	\$785