

IBEW Industrial Benefits Survey

1. _____
 L.U. Company (and Division)

2. _____
 IVP District City State

3. Agreement Eff. Date _____ Exp. Date _____ Name/Title _____

4. Please provide **name(s)** of health plan carrier(s)/administrator(s) and the estimated percentage of utilization.

	Name Of The Most Utilized Plan In Each Category	Est. Percentage of Bargaining Unit Participation (%)
Health Maintenance Organization (HMO)		
Point-of-Service Plan (POS)		
Preferred Provider Organization (PPO)		
Traditional Indemnity Plan		
Vision Plan		
Dental Plan		

5. For the plan with the greatest percentage of participation in Question 4, check the appropriate boxes:

- | | |
|---|--|
| a) Wellness exams <input type="checkbox"/> Yes <input type="checkbox"/> No | d) Homeopathic treatments <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Hearing aid benefits <input type="checkbox"/> Yes <input type="checkbox"/> No | e) Psychiatric coverage <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Chiropractic benefits <input type="checkbox"/> Yes <input type="checkbox"/> No | f) Home care <input type="checkbox"/> Yes <input type="checkbox"/> No |

6. How does the company finance its health care programs? Self-insured/Self-funded Fully insured

7. Does the employer offer a flexible benefit/cafeteria plan? Yes No
 If yes, are spending accounts available based on a before-tax basis? Yes No

8. Does the employer provide "domestic partner" benefits? (Check all that apply.) Same sex Opposite sex

9. Does the employer offer a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)? Yes No
 If yes, who contributes to the HSA? Employer only Employee only Employer and Employee

10. Does the employer contribute to a Health Reimbursement Account (HRA)? Yes No
 If yes, what is the amount contributed? _____
 Please indicate if the amount is based on a formula (e.g., increases in the stock price, bonus, or profit sharing).

11. Costs: provide the **monthly dollar amount** paid by employees and employers in each category.

	HMO		POS		PPO		Traditional Indemnity	
	Employees	Employer	Employees	Employer	Employees	Employer	Employees	Employer
Member								
Member Plus Family								

12. Plan Design: provide the **dollar amount** for the most utilized plan in each category.

	HMO	POS	PPO		Traditional Indemnity
			In-Network	Out-of-Network	
Deductibles (Member)					

12. Continued (dollar amount)	HMO	POS	PPO		Traditional Indemnity
			In-Network	Out-of-Network	
Deductibles (Family)					
Out-Of-Pocket Maximum					
Co-pay (Dollar or Percentage)					
Coinsurance (Dollar or Percentage)					

PRESCRIPTION DRUGS

13. Do you have a prescription drug plan? Yes No

14. Please provide the **dollar or percentage amount** concerning your prescription drug plan.

	Generic	Preferred Brand (Formulary)	Brand Name (Not Formulary)
Retail Co-pay			
Mail Order Co-pay			

15. Are mail order prescriptions mandatory? Yes No

16. What is the maximum number of days supplied through mail order? _____ days

VISION

17. Do you have a vision care plan? Yes No 18. Is the vision plan contributory? Yes No

19. If the vision care plan is contributory, what is the employee's total monthly contribution?

Member: \$ _____ Member Plus Family: \$ _____

20. Is there coverage for laser eye surgery (LASIK)? Yes No

DENTAL

21. Do you have a dental care plan? Yes No 22. Is the dental plan contributory? Yes No

23. If the dental care plan is contributory, what is the employee's total monthly contribution?

Member: \$ _____ Member Plus Family: \$ _____

24. Is there an annual maximum coverage amount? Yes No If yes, amount? \$ _____

25. Does the dental care plan cover the following? (Check all that apply.)

- Preventive and diagnostic (cleaning and exam)
- Restorative Procedures (Endodontics: root canal and denture repair; Peridontics: root planning and gum surgery; and Prosthetics: crowns, dentures, implants)
- Orthodontics (braces)

OTHER

26. Does the collective bargaining agreement contain language that restricts the employer from making changes that would diminish the benefits? Yes No

27. What other benefits are available?

- a) Life Insurance Plan Yes No
- b) Legal Plan Yes No
- c) Long-term Disability Plan Yes No
- d) Short-term Disability Plan Yes No
- e) Long-term-care Insurance Plan Yes No
- f) Retiree Health Insurance Plan Yes No
If yes, does company contribute? Yes No
- g) Voluntary Employees' Beneficiary Associations (VEBAs) Yes No

28. Are the health benefits part of a Taft-Hartley Fund? Yes No

29. Does your local union participate in a labor-management benefits committee on health insurance? Yes No

ENTERTAINMENT INDUSTRY FLEX PLAN

30. What percentage of wages or dollar amount does the employer contribute?

31. Can the employee use these funds to pay for other benefit? Yes No

Only if you are unable to use Agreement Submission Management (ASM), please mail to the international office: IBEW® Agreement Approval Department, 900 Seventh Street, N.W., Washington, DC 20001