



# Initial Eligibility and Enrollment

The I.A.T.S.E. National Health & Welfare Fund Plan C is an individual account type plan. If an employer contributes to Plan C on your behalf, the Fund Office will set up an account in your name. You can use the amounts in your account to purchase health coverage for yourself and, if you choose, your spouse and/or dependents. You can choose single or family coverage, and you can choose from four different benefit plans. If you live in Puerto Rico, the plan has a HMO option for single or family coverage. Read on to learn about when you become eligible to elect coverage, how to enroll yourself and your dependents, what information you need to give to the Fund to enroll and where to send it, and how you can lose coverage. Remember, if you ever have any questions, you can always contact the Fund Office.

## Your CAPP account

When you work in covered employment for a contributing employer, all employer contributions received on your behalf go into a CAPP (Contributions Available for Premium Payments) account in your name. The balance of your CAPP account determines:

- when you become eligible for health care coverage, and
- how much (if anything) you must contribute (self-pay) toward the cost of your coverage each coverage quarter.

You cannot contribute to your CAPP account on a pre-tax or post-tax basis. Only employer contributions based on work performed in covered employment are credited to your CAPP account. Employer contribution rates may be stated as dollars per hour, day, week or month, or as a percentage of pay.

CAPP accounts are **notional** accounts maintained for Plan participants that have no cash value: that means they are not like bank accounts from which you can withdraw money.

CAPP accounts and CAPP account balances are not vested benefits. Your CAPP account balance can be decreased if the Fund determines that employer contributions were credited to your account by mistake. The Trustees reserve the right to change CAPP account requirements and/or balances at any time.

## When you first become eligible

You first become eligible for benefits when your employer makes contributions totaling \$150 plus one month's current premium cost (the "CAPP charge") for Plan C-2 single coverage. The first \$150 in employer contributions is used to pay for Fund administrative costs. This \$150 administrative fee will be charged every time you enter or re-enter the Plan. If you enroll solely in Plan C-MRP, there is an additional administrative fee (see page 26).

## When you can enroll and choose your coverage level

The earliest you can enroll for Plan C coverage is when you become eligible for "optional enrollment." If you do not enroll at that time, you will have another opportunity to enroll when you become eligible for "automatic enrollment."

### Optional Enrollment

You are entitled to **optional** enrollment when your CAPP account balance equals the current **monthly** CAPP charge for Plan C-2 single coverage plus the \$150 administrative fee. When you become eligible for **optional** enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form.

### Automatic Enrollment

If you do not enroll when you first become eligible for **optional** enrollment, you cannot enroll until you become eligible for **automatic** enrollment. You are entitled to automatic enrollment when your CAPP account balance equals the current **quarterly** CAPP charge for Plan C-2 single coverage plus the \$150 administrative fee. When you become eligible for **automatic** enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form.

You cannot waive coverage once you become eligible for **automatic** enrollment. If you do not elect a Plan option when you become eligible for **automatic** enrollment, you will be enrolled automatically in Plan C-2 single coverage. (Participants in Puerto Rico will be enrolled automatically in single coverage under Triple-S.)

## When your coverage begins

If you enroll and submit any required documentation, plus pay any applicable self-payment, by the deadline, your coverage will take effect as of the first day of the following coverage quarter. Coverage is based on calendar quarters, starting January 1, April 1, July 1 and October 1. Please see the chart on the next page to see when you will receive a CAPP statement, when your enrollment materials and self-payments (if any) are due, and when your coverage will begin.





IF CONTRIBUTIONS REQUIRED FOR ENROLLMENT ARE RECEIVED BY THE FUND OFFICE BY	THE FUND OFFICE WILL MAIL YOUR CAPP STATEMENT AND ENROLLMENT/ PAYMENT FORM IN	YOUR ENROLLMENT MATERIALS AND SELF-PAYMENT (IF REQUIRED) WILL BE DUE AT THE FUND OFFICE BY	YOUR COVERAGE WILL BEGIN ON THE FIRST DAY OF THE COVERAGE QUARTER THAT BEGINS IN
October 31	mid-November	December 15	January
January 31	mid-February	March 15	April
April 30	mid-May	June 15	July
July 31	mid-August	September 15	October

When you enroll in family coverage (and pay the necessary premiums), coverage for your dependents begins on the same date that your coverage starts. This happens only if you provide all of the required documents needed to enroll your dependents by the deadline.

## Enrollment Summary

The following chart summarizes the rules for initial participation in the Health & Welfare Fund Plan C:

IF EMPLOYER CONTRIBUTIONS ON YOUR BEHALF EQUAL	THEN	YOUR ENROLLMENT OPTIONS
Less than the \$150 plus the <b>monthly</b> charge for the Plan C-2 single coverage.	You <b>do not</b> yet meet the requirements to enroll.	You are not eligible to enroll.
At least \$150 plus the <b>monthly</b> charge for Plan C-2 single coverage.	You meet the requirements for <b>optional</b> enrollment.	You can enroll in Plan C-1, C-2, C-3, C-4, Triple S in Puerto Rico or C-MRP as a standalone option (with acceptable proof of other medical coverage that is Affordable Care Act compliant) or waive coverage entirely by not enrolling.
At least \$150 plus the <b>quarterly</b> charge for Plan C-2 single coverage.	You meet the requirements for <b>automatic</b> enrollment.	You can enroll in Plan C-1, C-2, C-3, C-4, Triple S in Puerto Rico or C-MRP as a standalone option (with acceptable proof of other medical coverage that is Affordable Care Act compliant). If you do not timely select a coverage option, you will be enrolled automatically in Plan C-2 single coverage (or Triple S single if you reside in Puerto Rico).

## What level of benefit coverage you can elect

When you become eligible for enrollment, you will have the following choices for benefit coverage:

- **Plan C-1** (single or family coverage), which provides the highest level of in-network and out-of-network coverage at the highest cost;
- **Plan C-2** (single or family coverage), which provides a lower level of in-network and out-of-network coverage at a lower cost than Plan C-1;
- **Plan C-3** (single or family coverage), which provides only in-network coverage at a lower cost than Plan C-1 or C-2; or
- **Plan C-4** (single or family coverage), which is a high deductible plan that provides only in-network coverage at a lower cost than Plan C-1, C-2, C-3.
- **Triple S** (single or family coverage), which is a PPO and is available only to residents in Puerto Rico;
- **Plan C-MRP** (Medical Reimbursement Program) as a stand-alone option, if you provide acceptable proof that you have employer- or union-sponsored group medical coverage from employment that meets the minimum value standards of the Patient Protection and Affordable Care Act (ACA). This option is described in detail later in this SPD.

You can compare the benefits offered under each Plan by looking at the “Benefits at a Glance” at the beginning of the SPD. Each of the benefit options, Plans C-1, Triple S, C-2, C-3 and C-4, have a “CAPP charge.” The CAPP charge is the quarterly amount needed to pay for the benefits provided in that Plan option. CAPP charges are reviewed and set by the Board of Trustees every six months, on April 1 and October 1. You can find the current cost of each option on the Fund’s website, [www.iatsenbf.org](http://www.iatsenbf.org), or by referring to the Fund’s latest edition of its newsletter “Behind the Scenes,” or by contacting the Fund Office.

## What forms you need to complete to enroll

When you become eligible for optional or automatic enrollment, the Fund Office will mail you an “Enrollment/Payment Form” that you must timely complete and return to the Fund Office Lockbox address. You must complete the form and elect which Plan option (Plan C-1, C-2, C-3, C-4, Triple S or C-MRP) you want, as well as select either single or family coverage. If your CAPP account balance is not sufficient to cover the CAPP charge for the Plan option you elected, you can self-pay for coverage. That is explained in the next section. Once you complete the Enrollment/Payment Form, and collect any required documentation you need to enroll, you can mail it to the Fund Office Lockbox at:

I.A.T.S.E. National Benefit Funds  
P.O. Box 11945  
Newark, NJ 07101-4945

You can also register and log in to your account online and select your coverage option by visiting the Funds’ website at [www.iatsenbf.org](http://www.iatsenbf.org).

## How you can enroll your spouse and/or dependents

If you are eligible for coverage under Plan C, your dependents may also be eligible if you elect a family plan and pay the CAPP charge for that Plan option. When you enroll a spouse and/or dependent, you will be asked to provide proof of dependent status, such as a marriage certificate, birth or adoption certificate (as described below). Failure to timely provide documents for your dependents will delay enrollment and may result in denial of benefits. **If you are enrolling in Plan C-MRP, dependent documents are also required in order to submit claims for reimbursement on their behalf.** Your spouse and/or dependents must be enrolled in the same Plan Option as you, except that if you are enrolled in Plan C-1, C-2, C-3, C-4 or Triple S single coverage, and have **excess funds**, you may enroll your dependents in Plan C-MRP only, provided they have other minimum value group health coverage. (“**Excess funds**” are described on page 28.)

Eligible dependents include:

- the spouse to whom you are legally married
- your children, regardless of marital, financial dependency or student status, through the end of the calendar year in which they turn age 26. Children are your natural children, stepchildren, children required to be recognized under a Qualified Medical Child Support Order (QMCSO) and adopted children (including a proposed adopted child during a waiting period before finalization of the child's adoption.) Foster children, grandchildren, nieces and nephews are not eligible regardless of the guardianship.
- unmarried dependent children over age 26 who are unable to do any work to support themselves because of a physical handicap or mental illness, developmental disability or mental retardation, as supported by a Social Security disability award. The incapacity must have started before the child reached age 26, and proof that the dependent continues to be eligible for Social Security disability benefits may have to be provided periodically. Initial written proof of the child's disability must be submitted to the Fund Office within 31 days after the child's 26th birthday. Coverage under this extension ends if the dependent child is no longer considered disabled, marries or is no longer dependent on you for support/becomes able to earn a living.

The Plan requires that you submit the following documents as proof of your eligible dependents status:

- **Marriage:** To cover your spouse, you must submit a copy of the certified marriage certificate and provide your spouse's social security number.
- **Birth:** To cover a child, you must submit a copy of the certified birth certificate showing biological relationship of the child to you, the participant.

The Fund automatically covers a newborn child of any covered participant for the first 30 days of his or her life. To enroll the newborn onto your coverage, you must inform the Fund Office of the birth and submit the newborn's certified birth certificate within 60 days of the child's birth. If you cannot obtain the certified birth certificate within 60 days of birth, the Fund Office will accept hospital discharge papers, or, for a home birth, the Fund Office will accept a letter noting the date of birth from the provider who assisted the home birth. You must then submit a copy of the certified birth certificate within six months of your child's date of birth to continue coverage for that child. If you want to continue coverage for a child beyond the first 30 days, you must enroll in a family plan option.

If the newborn's parent is your unmarried covered dependent, coverage cannot be extended beyond 30 days, since the child is not an eligible dependent under the Plan.

- **Stepchild:** To cover a stepchild, you must submit a copy of his/her certified birth certificate and the marriage certificate showing that you are married to the biological parent.
- **Adoption or placement for adoption:** To cover a child you adopt, you must submit a court order signed by a judge showing that you have adopted or intend to adopt the child, along with a copy of the certified birth certificate of the adopted child.
- **Disabled Dependent Child:** To continue coverage for a disabled dependent child past his/her attainment of age 26, you must submit a copy of his/her Social Security Disability award showing that the child was determined to be disabled prior to reaching age 26. You will be required to submit this each year.

If you elect family coverage and want to enroll your spouse and/or dependents, you must provide the information when you enroll.

If you are enrolled in family coverage and wish to add a dependent after you enroll, that dependent will be covered as of the first of the month following the date the Fund receives both the request to enroll that dependent and proof of dependent status (e.g., marriage or birth certificate). However, if the new dependent is a newborn child and the Fund Office receives both a request to enroll the newborn and proof of birth (birth certificate, or if that is unavailable, hospital discharge papers or other proof from a medical provider) within 60 days of the birth, the newborn will be covered from the date of birth.



If you are enrolled in single coverage, you must enroll in family coverage to add a dependent. If you acquire a new dependent, and provided that the Fund receives the request to enroll in family coverage with proof of the new dependent (e.g., marriage or birth certificate) and any required payment for family coverage within 60 days of you acquiring such new dependent, you may enroll your dependents as of the first of the month after the Fund receives such request, proof and payment (or as of the date of birth for a newborn). If you are enrolled in single coverage, and you do not enroll your dependent (and convert to and pay for family coverage and provide the required proof of dependent status) within 60 days of acquiring a new dependent, you must wait until the next Annual Open Enrollment period to change to family coverage and enroll your dependent. Note that special circumstances (described on pages 36-37) may allow you to enroll earlier.



## Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. Orders must be submitted to the Fund Office, so that the Fund Office, in consultation with Fund Counsel can determine whether the order is a QMCSO as required under federal law. You or your beneficiary can receive a copy of the Plan's procedures for handling QMCSOs at no cost by contacting the Fund Office.

The Plan provides benefits according to the requirements of a QMCSO as long as any required payment is made. The Fund Office will notify affected participants and alternate recipients if a QMCSO is received.

## What happens if you elect a Plan option and don't have enough in your CAPP account to purchase that option

The Fund will reduce the balance of your CAPP account prior to each coverage quarter to pay for your coverage based on the Plan option you elect and the CAPP charge currently in effect for that Plan option. You can elect a Plan option that has a quarterly CAPP charge that exceeds the amount in your CAPP account. If you do, you must pay the difference by making a self-payment. Please note that you can only elect a higher Plan option (such as switching from Plan C-3 to Plan C-2) at the Annual Open Enrollment. Please note that the self-payment must come from you, and not your employer or a payroll house. Employer payments are credited to your CAPP account based on different timing rules.

**You are responsible for ensuring that payment is received by the deadline in order for you to maintain coverage, regardless of whether or not you received a quarterly statement.** If you mail a check, be sure to retain proof of mailing (for example, a receipt from UPS or a return receipt requested from the U.S. Postal Service). If you pay online, keep the confirmation number that you receive from the Fund's website. If you want to pay by providing your credit card number to the Fund Office over the telephone, a credit card authorization form must be on file with the Fund Office.

Regardless of how you make the payment, you should check your account online or by telephone to ensure that payment was received. Allow adequate time for mail and/or processing. If your account has not been credited with your payment, contact the Fund Office immediately. You will be expected to provide



proof of mailing for a check or the confirmation number for an online payment. Remember, if your payment is delayed or lost, you may lose vital coverage for yourself and your family.

If you make a self-payment, and you pay more than is needed, the excess payment will be refunded to you. It cannot be held in your account for future use.

Each quarter, the Fund Office will mail you a statement indicating your CAPP account balance, your current coverage choice, your coverage options (if applicable) and any self-payment that may be required. You can view your statement online (at [www.iatsenbf.org](http://www.iatsenbf.org)) if you are away from home. **Please note that you are responsible to make your self-payment whether or not you actually receive your statement.** That's why the Fund provides a number of resources for you to track your balance, know what payment may be due, and understand your payment options.

## How you can keep track of your CAPP account balance

Participants currently enrolled in any of Plan C's coverage options receive a quarterly CAPP statement that shows a current balance. Be sure to review your statements carefully. It is very important for you to pay attention to your CAPP account balance and any due dates for submitting documents or making payments. Managing your account is vital to ensure that health coverage continues for you and your family.

If you are a Plan C participant, you have 24/7 access to personalized information about your employment history and contributions received on your behalf - both online and by telephone. We encourage you to check your work history often so that your account is up to date when the quarterly enrollment process begins. The Fund Office does not know when and where you work, so monitoring your own account will help you get the most out of Plan C. In addition, please note that your CAPP balance may change after your statement is mailed (for example, if an MRP reimbursement claim is processed). Therefore, the best way to check your CAPP balance is online or by telephone. Remember that the Fund does not send revised statements. Please review your balance, either online or by telephone, before you make a copayment in case there has been a change in your account.

You can view your CAPP account balance and employer contribution history online. Simply follow these steps to set up a personal and confidential account:

- Log on to [www.iatsenbf.org](http://www.iatsenbf.org) and click "Participant."
- Under "Participant Access" on the left side of the page, click "Create New Account."
- Enter the requested information. After you complete your registration, you can log on at any time by clicking "Log In" under "Participant Access" and entering your username and password.

If you do not have access to a computer with internet access, you can use our toll-free interactive voice response (IVR) phone system, which is also available 24 hours a day. Simply call (800) 456-FUND (3863). The IVR phone system uses key questions to give you confidential access to personal information about your benefits—including your current CAPP account balance.