HEAT AND FROST INSULATORS AND ALLIED WORKERS LOCAL 6

HEALTH AND WELFARE ELIGIBILITY FAQS

1) **I JUST STARTED WORKING WHEN WILL I GET BENEFITS?**
    a. To meet the initial eligibility requirements, you will need to receive a total of 350 work hours within a 6-month period.
        i. If you receive 350+ work hours during the work months of October – March, you will begin eligibility for the quarter of June, July, and August.
        ii. If you receive 350+ work hours during the work months of January- June, you will begin eligibility for the quarter of September, October, and November
        iii. If you receive 350+ work hours during the work months of April-September, you will begin eligibility for the quarter of December, January, and February.
        iv. If you received 350+ work hours during the work months of July – December, you will begin eligibility for the quarter of March, April, and May.
2) **I JUST BECAME ELIGIBLE AND GOT A BIG PACKET IN THE MAIL, WHAT IS THIS?**
    a. Once you pass the initial eligibility qualifications, you will be sent an eligibility packet in the mail. This packet includes important plan documents that you will be responsible for completing and returning to the Benefit Office, as well as a copy of your Summary Plan Description. It is very important that you read through and complete all documents provided to you in this packet. The documents include forms to add dependents to your policy, protected health information release forms, among other documents to ensure we have all the correct information on file to contact you if need be.
3) **WHAT IS THE ONE TIME SPECIAL ELIGIBILITY AND HOW DOES IT WORK?**
    a. The one-time special eligibility rule is an option offered by the fund to jump start your eligibility if you may be short on hours for the quarter. This option is available to all members but can only be used ONCE during the members lifetime. If you believe you may be short on work hours and want to check your eligibility for the one-time special rule, please reach out to the benefit office to confirm your eligibility, process your enrollment, and request the forms to enroll in the one-time special eligibility benefit.
4) **WHAT DO I NEED TO WORK EACH QUARTER FOR ELIGIBILITY?**
    a. A minimum of 350 work hours are required each quarter for continuation of coverage.
        i. Work hours received in the months of January, February, and March, will reflect eligibility coverage for the quarter of June, July, and August
        ii. Work hours received in the months of April, May, and June, will reflect eligibility coverage for the quarter of September, October, and November
        iii. Work hours received in the months of July, August, and September, will reflect eligibility coverage for the quarter of December, January, and February.
        iv. Work hours received in the months of October, November, and December, will reflect eligibility coverage for the quarter of March, April, and May.

5) **WHAT HEALTH BENEFITS DO I HAVE AS AN ACTIVE MEMBER?**

   a. Active member benefits include Medical and Dental benefits with Blue Cross Blue Shield of MA, Prescription benefits through CVS Caremark, and Vision Benefits through Davis Vision.

6) **WHAT IS AN HOUR BANK AND HOW DOES IT WORK?**

   a. The hour bank is a benefit offered by the fund to help members build up a safety net to use if they may be short on hours or need to take time off work. Any hours worked over the required 350 work hours in a quarter will be deposited into your hour bank and begin to build up until they are needed. You can have a maximum of 700 hours built up in your hour bank. Your bank will be used automatically if you happen to be short on hours for the quarter, so no action is required on your end to use this benefit.

7) **WHAT IF I DON'T HAVE ENOUGH WORK HOURS FOR ELIGIBILITY?**

   a. If you run into a situation where you are short on hours and do not have an hour bank balance to assist with the eligibility requirements, you will be responsible for a monthly contribution on your behalf to continue coverage with the Fund. To continue coverage for the upcoming quarters until you regain coverage via work hour requirements, you will be required to elect COBRA coverage and make a monthly contribution on your behalf to pay for the continuing coverage. If this situation is to arise, you will automatically be sent the COBRA election forms along with more detailed information on what COBRA continuation coverage is, how long you are eligible for COBRA, and what your monthly premium would be. If you choose to not elect the COBRA continuation coverage, your coverage with the fund will be terminated and you will be required to meet the reinstatement qualifications to regain coverage at any time.

8) **I LOST ELIGIBILITY COVERAGE, BUT HAVE GONE BACK TO WORK, WHEN WILL MY COVERAGE BE REINSTATED?**

   a. To reinstate coverage after you have been terminated, you will be required to meet the reinstatement qualifications. The reinstatement qualifications mimic the initial eligibility requirements. 350+ hours will be required to be worked within a 6-month periods to reinstate coverage for a single quarter. It is important to note that hours that have been previously used for eligibility can not be used to count towards reinstatement. However, you may be eligible to begin your coverage sooner with the one-time special eligibility rule. Please be sure to contact the Benefit Office if you find yourself in this situation to discuss your options for reinstating your coverage.

9) **I HAVE TO MAKE A HEALTH CARE PREMIUM PAYMENT, WHEN WILL THIS BE DUE AND WHERE DO I NEED TO SEND IT?**

   a. All premiums are due the first day of each eligibility month, so June payment would be due by June 1st. All payments will need to be mailed to: HEAT AND FROST INSULATORS AND ALLIED WORKERS LOCAL 6 BENEFIT OFFICE, 1 BATTERYMARCH PARK, SUITE 317, QUINCY, MA 02169

10) **MY DEPENDENT CHILD IS TURNING 26, WHAT HAPPENS WITH THEIR COVERAGE?**

   a. Dependent children who have reached the age of 26 will remain on your coverage until the last day of the month in which they turn 26. Your dependent will be offered the option of COBRA if they wish to continue coverage with the fund after their termination from your plan.

11) **IM GETTING A DIVORCE, WHAT DO I NEED TO DO?**
   a. In the event of a divorce, you will be responsible for notifying the Benefit Office within 60 days of the finalization of the divorce and provide a copy of the full divorce decree for review to determine further benefits for your ex-spouse.

12) **I AM GETTING MARRIED WHAT DO I NEED TO DO?**
   a. To add your new spouse onto the policy effective the date of marriage, you will need to notify the benefit office and provide a copy of the marriage certificate within 60 days of the marriage. If you do not notify the benefit office of the marriage within the first 60 days, you can still add your spouse to the policy, however, their eligibility will begin the first day of the eligibility month when the supporting documents are received.

13) **I JUST HAD A BABY, WHAT DO I NEED TO DO?**
   a. To add your newborn onto the policy effective their date of birth, you will need to notify the benefit office and provide a copy of the legal birth certificate within 90 days of the date of birth. If you do not notify the benefit office of the birth within the first 90 days, you can still add your newborn to the policy, however, their eligibility will begin the first day of the eligibility month when the supporting documents are received.

14) **IM ON SHORT TERM DISABILITY, HOW WILL THAT EFFECT MY ELIGIBILTY?**
   a. When receiving STD benefits through Local 6, you will not receive credits towards your health and welfare. If your coverage ends due to a lack of work hours, you will either need to make self-payments to continue eligibility or wait until you go back to work and reinstate with work hours

15) **IM ON PFMLA/FMLA, WHAT DO I NEED TO DO AND HOW WILL THAT EFFECT MY ELIGBILITY?**
   a. If you begin to receive PFMLA/FMLA benefits, you will be responsible for providing the Benefit Office with a copy of the award letter advising of your benefit as well as copies of the paystubs for the payments received during the time you are receiving the benefit. During the time you are receiving the PFMLA/FMLA benefit, you will receive credits on your behalf to ensure a continuation of your health coverage. You can receive up to 30 credit hours a week for each week you are receiving the benefit, which is up to 120 hours in a month. These credits will apply just as if they were work hours received on your behalf. Please be advised that you will not receive the credits for your PFMLA/FMLA benefits until after all supporting documentation has been received.

16) **I AM READY TO RETIRE, HOW DO I KNOW IF I AM ELIGIBLE FOR CONTINUED HEALTH AND WELFARE BENEFITS WITH THE FUND?**
   a. To continue with the health and welfare benefits as a Retiree, you will be required to meet three qualification rules
      i. You will need to be eligible, with either work hours or banked hours, for the health and welfare benefits the day prior to your retirement date.
      ii. You are eligible to receive a pension immediately under the Pension Fund
      iii. You earned a minimum of three years of vesting service under the Pension Fund during the five-year period prior to the start of receiving your pension payments.
   b. It is very important to note that every member situation is different and unique to them. Once you are ready to retire, please be sure to reach out to the Benefit Office to discuss your eligibility and options for continuing coverage with the Fund.

17) <u>WHAT COVERAGE OPTIONS DO I HAVE AS A RETIREE FOR MYSELF AND DEPENDENTS?</u>

a. Early Retirees (those not yet Medicare eligible) and their dependents are offered two options for continuing coverage with the Fund once their coverage as an Active member has run out. You may either elect to continue the same coverage you had while actively employed or elect to enroll in the health allowance reimbursement plan. Please be advised that a monthly premium contribution will be required on your behalf if you choose to continue with the coverage through the Fund.

18) <u>WHAT IF I DON'T WANT TO CONTINUE COVERAGE WITH THE FUND WHEN I RETIREE?</u>

a. If you meet the requirements and you do not choose to continue coverage through the fund, then you will be eligible to enroll in the Retiree health allowance reimbursement plan. This benefit allows members to enroll in whatever coverage fits their lifestyle best and to be reimbursed quarterly for the Medical premiums paid for that coverage. Reimbursement allowance amounts will differ depending on the type of pension you are receiving and the number of dependents on your policy. Please be advised that only Medical premiums are eligible for reimbursement. Dental, Vision, and Prescription premiums are not eligible for any reimbursement benefits. If you are thinking of electing the health allowance reimbursement plan, please reach out to the Benefit Office to go over what documentation is required to be submitted and the amount you may be eligible for reimbursement.

19) <u>WHAT HEALTH BENEFITS DO I HAVE AS A MEDICARE RETIREE?</u>

a. If you elected to continue coverage with the Fund at Retirement and you or your dependents are Medicare eligible, you will be enrolled into the Medex II Supplement Plan. This is a Medicare Supplement Plan that covers Medical benefits only, no dental, vision or prescription benefits are offered with this Supplement Plan. If you do not wish to transition into the Medex II plan, you can always elect the Health allowance reimbursement plan in its place.

20) <u>WHAT HAPPENS WHEN MYSELF OR MY DEPENDENTS BECOME MEDICARE ELIGIBLE?</u>

a. If you or a dependent are or become Medicare eligible once you retire, you will be required to enroll in both Medicare Parts A & B and provide the Benefit Office with a copy of your Medicare Card to ensure a quick and seamless enrollment into the Medex II plan.

21) <u>I WANT TO CONTINUE WITH MY HEALTH COVERAGE AS A RETIREE, HOW DO I MAKE THE MONTHLY PAYMENTS?</u>

a. Retirees continuing their coverage with the Fund have two options on making their monthly premium payments. You may either choose to send in your payment via check or money order, or you can elect for automatic pension deduction. The pension deduction option would deduct your monthly premium from your pension check prior to it being sent to you and would require no additional monthly mailings or payments on your behalf.

22) **<u>I AM RETIRED, BUT STILL WANT TO WORK, HOW MUCH CAN I WORK AND HOW WILL THAT EFFECT MY COVERAGE OR SELF-PAYMENT?</u>**

   a. Retiree's age 62 and above are able to work a maximum of 40 work hours each month in order to continue to receive their Retiree benefits with the Fund. If you receive contributions on your behalf with your work hours, the contributions will be used to assist in reducing the monthly premium you are responsible for. If you plan to go back to work full time or plan to work over the maximum 40 hours in one month, it is very important that you contact the Benefit Office to advise of this and discuss how this change will affect your benefits.

23) **<u>CAN I COME INTO THE BENEFIT OFFICE FOR ASSISTANCE IN PERSON?</u>**

   a. Yes! If you would like to come into the Quincy office for in person assistance, please be sure to contact the Benefit Office in advance so we can be sure to have all information to best assist you together for your visit and to assure the most knowledgeable coordinator is available to assist you with all your questions.

24) **<u>I HAVE FURTHER QUESTIONS WITH REGARDS TO MY BENEFITS, WHO CAN I CONTACT?</u>**

   a. For Medical and Dental claim inquiries, please contact:
      i. Blue Cross Blue Shield of Massachusetts – 800-588-5508
   b. For Vision claim inquiries, please contact:
      i. Davis Vision – 800-999-5431
   c. For all other benefit questions, including pharmacy benefits, please contact:
      i. Sydney Thomas, Plan Liaison – 248-813-9800 (3042)
      ii. Please send all email inquiries to both Sydney.thomas@benesys.com and insulatorslocal6@benesys.com

Please be advised that this is not a replacement for the information within your Summary Plan Description. This is meant to be a tool to assist with the most frequently asked questions and as a quick reference guide for those situations. While this may provide a basic breakdown for some of the most frequently asked questions, we recognize that all member situations are unique and may require lesser or additional information to assist with their questions and specific situations. Please continue to utilize your SPD for the full Plan Guidelines and contact the benefit office with any questions you may have. Our main goal is to assist you, our members, and provide the best service possible for every situation.