

# Central States Joint Board Health & Welfare Trust Fund

245 Fencil Lane ~ Hillside, Illinois 60162 ~ 312-738-0822 or 1-800-258-6466

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## Tiered Rate Coverage Election Effective January 1, 2017

Dear Participant:

As the Board of Trustees for the Central States Joint Board Health & Welfare Trust Fund, we are pleased to provide you and your dependents with healthcare coverage. With the cost of healthcare continually increasing, we know how important this coverage is for you and your family.

As you may know, when you work for an employer that participates in the Fund, contributions are made to the Fund on your behalf to provide you, and any of your eligible dependents, with Health & Welfare Plan coverage.

### ***Tiered Rate System – You Must Elect a Level of Coverage***

If you are covered under a collective bargaining agreement that has Central States Joint Board Health and Welfare Fund the monthly contribution required on your behalf will be based on the level of coverage you elect. You have the option of electing:

- Employee only coverage;
- Employee plus children coverage; or
- Employee plus spouse coverage;
- Employee plus family coverage (which includes coverage for your spouse and children).

As with any change in your coverage, if you add or terminate coverage for a dependent, certain documentation must be provided. Please keep in mind that contribution rates are periodically reviewed and are subject to change at any time. Also, note that if you choose to not elect coverage during open enrollment in December that your current tiered rate will remain for the following year, barring a qualified event.

PLEASE NOTE: Contribution rates are determined based on the cost of providing coverage. Each employer, through the collective bargaining process, determines whether the entire contribution amount is paid by the employer or split between the employer and the participant. Your collectively bargained contribution rates are listed on your enrollment form.

***Coverage of Dependent Children until Age 26. Your Dependent Children are eligible for coverage until age 26 even if they do not live with you or depend upon you for their support. Individuals may request enrollment for such children during the month of December. Enrollment will be effective January 1, 2017. For more information, contact Anthony Iori, Plan Manager at (312) 738-0822 or-(800) 258-6466.***

### **Calendar Year Coverage Election**

Generally, the coverage you elect will be effective as of January 1 and that level of coverage will remain in effect through December 31 of that year (provided you remain eligible for coverage). However, under certain circumstances, you may change your coverage election. You are allowed to:

- Add coverage for your eligible dependent if you:
  - ◆ Did not enroll an eligible dependent because your dependent had other coverage and the other coverage ends (including a loss of coverage due to reaching a Plan maximum); or
  - ◆ Marry or acquire a new dependent child (through birth, adoption, or placement for adoption).

- Terminate coverage for your eligible dependent(s) if they lose eligibility for Plan coverage, such as your dependent child attaining the limiting age or, the death of your spouse, or your divorce from your spouse.
- Change your coverage election if your costs change as a result of collective bargaining negotiations

**You must request a change in coverage within 60 days** of the date of the event that qualifies you for this special enrollment (as described above). If you do not notify the Fund Office within **60 days** of the event, you will need to wait until the next enrollment period in December to request a change. Therefore, it is very important that you notify the Fund Office as soon as possible to request a special enrollment. *For example, if you elect employee plus spouse coverage and you subsequently divorce, while your ex-spouse may be eligible to elect and self-pay for COBRA continuation coverage, if you do not notify the Fund Office within 60 days, your monthly contribution rate will not be reduced to the employee only amount.*

**Please Note: Open Enrollment period is from December 1<sup>st</sup> to December 31<sup>st</sup> with change of election to be effective January 1<sup>st</sup> of the following year.**

### **What You Need to Do**

Attached you will find an enrollment form for 2017. During this initial, and subsequent, enrollment:

- Consider your options to determine the level of coverage that is best for you, and your family, if applicable.
- Complete the enrollment form.
- **Send the completed enrollment form to the Fund Office by \_\_\_\_\_.**

If you have any questions, please contact the Fund Office.

Sincerely,  
Board of Trustees

*This announcement serves as a Summary of Material Modifications (SMM) and contains highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at anytime.*

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## Enrollment Form

*Please complete, sign, and return this form to the Fund Office. Please print all information.*

### Employee Information

Employee Full Name: \_\_\_\_\_ Employee SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Shop: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Gender:  F  M Hire Date: \_\_\_\_\_

### Coverage Level Election

I elect the following coverage level under the Central States Joint Board Health & Welfare Trust Fund:

- Employee Only, with a monthly contribution rate of \$ \_\_\_\_\_
- Employee Plus Children, with a monthly contribution rate of \$ \_\_\_\_\_
- Employee Plus Spouse, with a monthly contribution rate of \$ \_\_\_\_\_
- Employee Plus Family (Spouse and Child(ren)) , with a monthly contribution rate of \$ \_\_\_\_\_

### Dependent Information

Provide all information for eligible dependents to be covered under the Plan (attach additional page, if necessary).

Full Name (First, MI, Last)	Relationship	Sex		Social Security Number	Date of birth	Check if Employed
		F	M			
		<input type="checkbox"/>	<input type="checkbox"/>		____/____/____	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		____/____/____	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		____/____/____	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		____/____/____	<input type="checkbox"/>

### Employee Authorization

I understand that if I elect not to cover a dependent at this time, I will not be able to enroll my dependent until the next enrollment period, unless a special enrollment is necessary. By selecting a coverage level, signing, and submitting this form, I understand this election will remain in effect until the end of the calendar year for which this form is signed and I authorize the applicable contribution rate for this coverage, if any, be deducted from my paycheck. I understand that by electing coverage for a dependent child, I am certifying that the dependent child is not eligible for insurance coverage through his/her employer or through his/her spouse's employer. Moreover, I certify that I will promptly advise the Central States Joint Board Health & Welfare Fund if my dependent child's employer or his/her spouse's employer offers health coverage even if my dependent child elects not to receive coverage through his/her employer or his/her spouse's employer. **I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.**

Employee Name (print): \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Completion of this enrollment form is not a guarantee of eligibility or benefits.

\_\_\_\_\_ Initials of Company Representative for approval of enrollment form due to change, addition or open enrollment.

## **Newborns' Act Disclosure**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **WHCRA Enrollment Notice**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

The Fund covers 80% of the reasonable and customary costs of procedures performed In-Network and Out of Area after an individual meets his or her \$700 calendar year deductible or after the family meets a \$2,100 calendar year deductible.

If you would like more information on WHCRA benefits, contact Anthony Iori, Plan Manager at (312) 738-0822 or-(800) 258-6466.

## **WHCRA Annual Notice**

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? contact Anthony Iori, Plan Manager at (312) 738-0822 or-(800) 258-6466 for more information.