



**IMPORTANT INFORMATION FOR PARTICIPANTS ENROLLED IN THE I.A.T.S.E.  
NATIONAL HEALTH AND WELFARE PLAN C**

Dear Plan Participant:

This notice is intended to notify you of some significant changes to Plan C and remind you of the upcoming CAPP charges that, essentially, will only increase for Plan C-1. You were recently alerted to some of this information in the Fund's summer 2009 *Behind the Scenes* newsletter. Please read this notice carefully and save it for future reference. A copy will also be posted on the Fund's Web site, [www.iatsenbf.org](http://www.iatsenbf.org), for your convenience.

**QUARTERLY ENROLLMENT PERIODS**

One important procedural change relates to *new* participants and when they may voluntarily enroll in one of the four Plan C benefit choices. A similar change applies to the earliest date for automatic enrollment (for those who do not exercise their voluntary enrollment rights).

Starting with the January–March 2010 coverage quarter, **for new participants**, initial enrollment (voluntary or automatic) will occur only at the beginning of a calendar quarter. Mid-quarter enrollment is being eliminated to allow a smoother transition to continuing enrollment, which has always been on a calendar quarter basis.

For background, please note that as employer contributions accumulate in CAPP\* accounts, new participants are offered voluntary enrollment when their balance has enough to cover the \$150 administration fee plus *one month* of Plan C-2 individual coverage. Automatic enrollment occurs when employer contributions accumulate and an individual's CAPP account balance covers the \$150 administration fee plus the current CAPP charge for *one quarter* of Plan C-2 individual coverage. (These contribution threshold levels will not change.) There will also continue to be a two-month window between the contribution threshold measurement and the start of initial enrollment.

Under the current system, the voluntary and automatic enrollment thresholds are tested at the end of every month. And for those new participants who satisfy the appropriate threshold, based on when the contribution amount is received and credited to a CAPP account, the initial enrollment starts two months later.

Accordingly, under the current system, initial enrollment often occurs in the middle of a calendar quarter, leaving only one or two months for the new enrollee to transition to his/her first ongoing enrollment quarter. With the several steps needed to renew and maintain quarterly enrollment, this can often leave too little time for Plan participants to successfully complete the first ongoing quarter's enrollment requirements. With such little time, many new participants receive their initial enrollment statement and the statement for the first ongoing quarter so close together that

\* CAPP: Contributions available for premium payments

the response to one is often thought to apply to both, and the new enrollee may soon lose ongoing coverage as a result. This change is aimed at reducing those occurrences.

Under the new Plan change, contribution thresholds will only be tested four times a year, at the end of the first month of every quarter. For those who satisfy the appropriate threshold, initial enrollment will start two months later at the beginning of the next calendar quarter. Since the qualifying threshold may have been met in an earlier month, in some cases this will result in the new participant gaining initial enrollment with a larger CAPP account balance than would have been the case under the current system, leaving him/her better positioned for enrollment maintenance.

Re-entry into the Plan after losing coverage has various requirements, depending on the reason for the loss of coverage. Please refer to the Plan for more details or call the Fund Office at 1-800-456-3863 if you would like more details.

### **COMBINING CAPP ACCOUNTS – CHANGES WILL BE EFFECTIVE ON THE START OF THE QUARTER**

Plan C participants married to each other, or who have established domestic partner status, may request the combination of their CAPP accounts. Such participants may also request the uncoupling of their CAPP account. Either change will begin at the start of the calendar quarter following notification to the Fund Office. The Plan is eliminating the ability to combine or uncombine accounts off the established quarterly cycles.

### **CHANGING TO THE MEDICAL REIMBURSEMENT PLAN – WILL BE EFFECTIVE ON START OF THE QUARTER**

Participants enrolled in Plan C-1, C-2 or C-3 who obtain medical/hospital/prescription drug coverage from another source, perhaps through a spouse's employment, may request that their enrollment be transferred to Plan C's Medical Reimbursement Program (described below). Such transition to Plan C's Medical Reimbursement Program will occur at the beginning of the calendar quarter following the Fund Office's receipt of proof of such outside health insurance coverage. The Plan is eliminating the ability to enroll in the Medical Reimbursement Program off the established quarterly cycles.

### **TWO ENROLLMENT EXCEPTIONS**

If a participant already enrolled in Plan C's Medical Reimbursement Program involuntarily loses the underlying other source of health insurance coverage, he or she can enroll in Plan C-1, C-2 or C-3 as of the first of the month following the appropriate notification to the Fund Office.

Furthermore, adding newly acquired dependents, as a result of marriage or birth of a child, for example, to Plan C enrollment, which may include a change from individual to family coverage, will occur on the first of the month following proper notification to the Fund Office as long as you apply for the coverage within 30 days of the applicable event. Likewise, in the event of a divorce, the elimination of the former dependent spouse's coverage occurs on the first of the month following the divorce. For more information please see the Special Enrollment rules in the Summary Plan Description.

### **ONE-TIME FREE PASS**

While Plan C is innovative and flexible in providing health insurance coverage to meet the varying needs of many, it requires intensive participant attention to complete the enrollment maintenance process, which occurs on a quarterly basis. When a participant inadvertently misses a step that causes an unintended loss of coverage or a "downgrade" to a less extensive and lower cost enrollment package at the start of the next quarter, an appeal to the Board of Trustees can be

filed. The appeal process allows the participant to provide verification that an attempt was made to provide the required information and/or self-payment before the deadline.

In some cases, an appeal on its own merits results in a reinstatement of the desired coverage. If not, you may now be eligible for a new **one-time free pass**. **This can occur** when a missed quarterly enrollment step threatens to disrupt the coverage of a participant who has maintained *at least eight calendar quarters of continuous Plan C coverage immediately preceding the loss of or change in coverage*. This free pass is only available once every five years. As such, an affected participant may still choose not to exercise it if he or she can file an appeal, which on its own merits corrects the misstep.

When there is a misstep or error leading to a loss or downgrade in coverage, the Fund Office sends the participant such notice that includes the effective date as well as his or her continuation rights under COBRA's self-pay program. To exercise the free pass, the participant who qualifies on continuity must, **within 45 days of the date coverage was lost or downgraded**, send a written request for consideration. If approved, he or she must: (1) correct the error or missed step retroactively to the date of the error, including promptly remitting any required co-payment; and (2) maintain the coverage level in effect prior to the error.

**CAPP CHARGE REMINDER EFFECTIVE OCTOBER 1, 2009**

As a reminder, the quarterly CAPP charge for Plan C-2 individual coverage will increase by only \$12, to \$1,542, effective October 1, 2009. **(CAPP charges for Plan C-2 family coverage and Plan C-3 individual and family coverage will stay the same.)**

The current and all the October 1, 2009 quarterly CAPP charges are as follows:

**I.A.T.S.E. National Health and Welfare Fund – Plan C  
Quarterly CAPP Account Charges Current and Effective October 1, 2009**

<b>PLAN C-1</b>	<b>Current</b>	<b>Effective October 1, 2009</b>
<u>COVERAGE</u>		
Individual	<b>\$2,730</b>	<b>\$3,174</b>
Family	<b>\$5,694</b>	<b>\$6,846</b>
<b>PLAN C-2</b>		
<u>COVERAGE</u>		
Individual	<b>\$1,530</b>	<b>\$1,542</b>
Family	<b>\$2,598</b>	<b>\$2,598</b>
<b>PLAN C-3</b>		
<u>COVERAGE</u>		
Individual	\$1,086	<b>\$1,086</b>
Family	\$2,058	<b>\$2,058</b>

Plan C-2 remains a cost-effective health benefits plan; it balances broad coverage with the ability to spread the risk among its large number of enrollees with varying health care needs. Plan C-3 provides more basic benefits at a lower cost. As per the earlier notice on CAPP charges, effective October 1, 2009, Plan C-1 quarterly charges are increasing considerably, to \$3,174 for individual coverage and \$6,846 for family coverage. As with all Plan C's health insurance coverage options, CAPP charges are intended to reflect the current and projected cost of benefits. Plan C-1 (with benefits only somewhat more generous than that of Plan C-2) attracts fewer and fewer enrollees, but those few enrollees tend to have a greater than average need for medical services.

## PLAN C'S MEDICAL REIMBURSEMENT PROGRAM (PREVIOUSLY CALLED "OTHER COVERAGE")

Please recall that the Medical Reimbursement Program allows enrollees to obtain reimbursement for a wide variety of medical and dental services that are not otherwise (fully) covered by the basic health insurance plan you are required to have. Depending on how you use the required underlying health insurance plan, your out-of-pocket payments available for medical reimbursement include co-payments, deductibles, co-insurance, and other incurred charges over the coverage limits. The Plan's SPD (which can be found on our Web site, [www.iatsenbf.org](http://www.iatsenbf.org)) lists the items available for reimbursement.

If your underlying insurance coverage is through Plan C-1, C-2 or C-3, you can use the medical reimbursement program for supplemental coverage provided your CAPP account balance exceeds the CAPP charge for your enrollment choice for the current and the next quarter.

If you already have health insurance coverage through another source, perhaps through a spouse's employment, you may choose the Medical Reimbursement Program as your Plan C enrollment. If you make such choice and submit proof that you have basic medical/hospital/prescription drug coverage through another source, your entire CAPP account balance can be applied to the Medical Reimbursement Program. The election of the Medical Reimbursement Program for Plan C enrollment can be made by a new participant (initial enrollment), or through the annual open-enrollment period that takes effect each January 1. Exclusive enrollment in the medical reimbursement program can also occur at the beginning of any calendar quarter following the quarter in which a Plan C-1, C-2 or C-3 enrollee obtains and provides proof of health insurance coverage through another source.

Henceforth, when you enroll in Plan C's Medical Reimbursement Program, you must specify either individual or family coverage. If you are filing Medical Reimbursement claims on behalf of a dependent, it is important that you enroll in family coverage and provide proof of dependent status, such as a marriage or birth certificate, the same as you would if you were enrolling in one of the other Plan C health insurance offerings. Please keep this requirement in mind during the next open enrollment period. Otherwise, as previously noted, newly acquired dependents can be added as of the first of the month following your notification to the Fund Office.

When you file a claim for medical reimbursement, please allow 90 days for the receipt of your check.

**Please recall that enrollees in the Medical Reimbursement Program must submit proof of basic health insurance coverage through another source by December 15 of every year. Otherwise, the open-enrollment process will result in enrollment or default to Plan C-2 or C-3 at the start of the new year, if you have at least the cost of one quarter of coverage in your CAPP account. If your CAPP balance is less than the cost of one quarter of C-3 coverage, you will cease to be enrolled in the Plan and have to meet the initial enrollment requirements to requalify. Please also recall that the \$150 annual administrative fee for Plan C participants enrolled exclusively in the Medical Reimbursement Program is applied each November 15<sup>th</sup> for the current enrollment year.**

## OTHER PLAN C COVERAGE CHANGES

Please note that the open enrollment materials you will later receive for the quarter beginning January 1, 2010 will **no longer include** (in certain areas of California and New England) enrollment in the **Kaiser Permanente or the Harvard Pilgrim HMOs** as an alternative to the standard Plan C-1, C-2 or C-3 health insurance coverage. The Kaiser and Harvard Plans have

been serving an ever decreasing number of participants and their CAPP charges, at the Plan C-1 level, have also lost their cost-effectiveness. Another change applies to the consolidation to one provider of network optical coverage, which most participants obtain through Davis Vision. The alternative providers General Vision Services (GVS) and Comprehensive Professional Services (CPS) serve a limited number of participants in specific areas of the country, and those providers will be discontinued on October 1, 2009.

We think the coming changes underscore the evolution of Plan C to a more effective model of health care access.

If you have any questions, please do not hesitate to contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES