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## Eligibility and Enrollment

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*This Eligibility and Enrollment section describes general information about the benefit plans including:*

- ◆ *Who is eligible and when coverage begins.*
- ◆ *How benefits are paid when there are two sources of health care coverage or when a third party (such as automobile insurance) is involved.*
- ◆ *How benefits are affected when coverage ends.*

*Taken together, the Summary Plan Description for each Plan, this Eligibility and Enrollment section, and the Plan Information & Rights section are considered to be your total Summary Plan Description as required (for most of the Plans) by the Employee Retirement Income Security Act (ERISA) of 1974.*

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## Eligibility and Enrollment

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## Eligibility and Enrollment



### Eligibility for Benefit Coverage

To be eligible for benefits, you must be a member in Wage Class I, II, or III. You are considered a member if your employer is making contributions to the Fund for your employment as the result of a collective bargaining agreement. You are also considered a member if you are a Disabled Member, a Pensioner, a member who is covered for certain benefits through extended coverage, or a person who is covered by direct payment under COBRA.

#### ***Wage Classes Defined***

*Wage Class I means:*

- ◆ Full-time working members
- ◆ Part-time working members whose average weekly earnings are not less than the lowest full-time weekly wage in the applicable collective bargaining agreement

*Wage Class II means:*

- ◆ Part-time working members whose average weekly earnings are at least 60%, but less than 100%, of the lowest full-time weekly wage in the applicable collective bargaining agreement

*Wage Class III means:*

- ◆ Part-time working members whose average weekly earnings are less than 60% of the lowest full-time weekly wage in the applicable collective bargaining agreement

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## **Benefits Eligibility Depends on Wage Class**

The specific benefits for which you and your dependents are eligible depend on your Wage Class, as shown in this chart:

BENEFIT	WAGE CLASS I	WAGE CLASS II	WAGE CLASS III
<b>Medical</b>	<b>Member and dependents</b>	<b>Member and dependents</b>	<b>Member only (no dependents)</b>
<b>Dental</b>	<b>Member and dependents</b>	<b>No coverage</b>	<b>No coverage</b>
<b>Prescription Drug Plan</b>	<b>Member and dependents</b>	<b>No coverage</b>	<b>No coverage</b>
<b>Camp and Scholarship</b>	<b>Member and dependents</b>	<b>No coverage</b>	<b>No coverage</b>
<b>Disability</b>	<b>Member only</b>	<b>Member only</b>	<b>Member only</b>
<b>Death and AD&amp;D</b>	<b>Member only</b>	<b>Member only</b>	<b>Member only</b>

### ***If Your Wage Class Changes***

If you no longer meet the eligibility requirements for your Wage Class, your eligibility for that Wage Class's benefits will change as of the first day of the following month.

For example, assume you are a part-time working member in Wage Class I and that you begin earning less than the full-time average wage on July 15. Provided you earn at least 60% of the average weekly wage, you will become eligible for the benefits provided to Wage Class II members as of August 1.

## **Enrolling and Effective Date**

You must fill out a Benefit Fund Enrollment Form and return it to the Fund Office **within 30 days of the date you become eligible**. For dependent coverage, you must furnish any documents required, such as a marriage certificate, birth certificate, or adoption court orders.

After you appear as eligible in the system, you will receive a Health Service Identification Card for the health care benefits for which you are eligible. The medical coverage provider also will issue an identification card to you and your eligible dependents.

*Be sure to check the information on your ID cards and keep them with you.*

## **When You Become Eligible**

Generally, the coverage for which you are eligible will take effect :

- ◆ 30 days after the Fund has received the first contribution from your employer on your behalf or
- ◆ 30 days after the date that your employer notifies the Fund that contributions will begin.

There are special situations in which the standard employer contribution requirements described above do not apply. You will become eligible as of the *first day* that your employer is required to make contributions if:

- ◆ You are a newly organized member who is actively employed, actively at work, and not on probation.
- ◆ You are covered by your employer's plan and you exercise your option, if available, to enroll in the Benefit Fund Plan instead, provided you are actively employed, actively at work, and not on probation.

## **When Coverage Begins**

Coverage begins on the date you become eligible.

## **Who Is an Eligible Dependent**

Eligible dependents include:

- ◆ Your legally married spouse.
- ◆ An unmarried child from birth to age 19 who is primarily dependent upon you for financial support.
- ◆ An unmarried child at least 19 but under age 23 who is a full-time student enrolled in and attending an accredited college, university, or some other school and who is primarily dependent on you for financial support. Coverage will terminate at age 19 unless you provide proof that the child is a full-time student. You must provide proof of student status each year until the child's 23rd birthday, at which time coverage ends.
- ◆ Other unmarried children up to age 19 (or age 23 if a full-time student) who meet the Plan's eligibility requirements and for whom you are required to provide health coverage under a qualified medical child support order (QMCSO); this is any judgment, decree, or order issued by a court of competent jurisdiction or through an administrative process established under state law which has the force and effect of law in that state that requires you to provide child support or health care coverage for a natural or adopted child. Contact the Benefit Fund Office for a copy of the plan's procedures relating to QMCSOs (there is no charge).
- ◆ An unmarried child age 19 or older who is disabled; the provisions for continuing coverage are described on the next page.
- ◆ For purposes of these requirements, special support and residency rules apply in the case of separated or divorced parents. Contact the Benefit Fund Office or consult with your tax advisor for more information.

## **How Child is Defined**

The term "child" includes:

- ◆ a natural child who is primarily dependent upon you for financial support and
- ◆ a child who has been legally adopted by you or placed with you for adoption by a court of competent jurisdiction.

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Dependents are not eligible if they are on active full-time military duty in the armed forces of any country.

## **Continuing Coverage for Disabled Children**

In certain instances, health care coverage for an eligible disabled dependent child may continue after age 19 as explained below.

### ***Continued Coverage with No Age Limit***

Coverage for a dependent child may continue *regardless of the dependent's age*, as long as the member remains eligible for coverage, and provided the following conditions are met:

- ◆ the child is unmarried and covered by the Plan *before* his or her 19th birthday, and
- ◆ the child is primarily dependent on you for financial support, and
- ◆ the child is incapable of self-sustaining employment because of a mental or physical disability that began before the child's 19th birthday and
- ◆ you provide proof of disability as required.

### ***Continued Coverage to Age 23***

Assuming you provide proof of disability as required, coverage for a disabled child may continue *up to age 23* if:

- ◆ your eligible dependent child is disabled before age 19, but he/she becomes covered as a dependent under this Plan after his or her 19th birthday or
- ◆ your eligible dependent child becomes disabled *at or after age 19* but before age 23.

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***You must submit written proof of a child's dependent status and mental or physical disability. The Benefit Fund reserves the right to require, at its expense, an independent medical, psychiatric, or psychological evaluation of the child's disabled status.***

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## Late Enrollment

If you do not enroll within 30 days of the date you are eligible, or you do not add newly eligible dependents within 30 days—and later apply for coverage—retroactive coverage is not guaranteed. If you notify the Benefit Fund more than 30 days from the date you or your dependents are eligible, coverage will be provided but it will not be retroactive for more than 30 days.

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***Medical coverage for you or your dependents will not be made retroactive for more than 30 days prior to the date the Fund receives notification.***

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## Changing Your Coverage

To keep your coverage up to date as required by Plan rules, you should notify the Benefit Fund within 30 days of the date that one of the following events occurs:

- ◆ marriage or divorce or other change in legal marital status (such as legal separation),
- ◆ birth of a child or a child is legally adopted by you or placed with you for adoption by a court of competent jurisdiction,
- ◆ death of a spouse or covered dependent,
- ◆ a change in your dependent's eligibility (for example when your child reaches age 19 or age 23 if a full time student),
- ◆ you are required to cover your dependent according to a judgment, decree or order, including a qualified medical child support order (QMCSO) resulting from your divorce, legal separation, annulment, change in legal custody or death of your spouse (if you wish, you may contact the Benefit Fund Office for a copy of the Plan's procedures relating to QMCSOs at no charge),
- ◆ a change in your, your spouse's, or your dependent's place of residence,
- ◆ entitlement to Medicare or Medicaid,
- ◆ a significant change in the cost of coverage or a significant change in the benefit coverage under your spouse's health care plan, or
- ◆ a change in employment status of you, your spouse, or dependent that results in a gain or loss of eligibility for health coverage.

You will need to make changes on the Enrollment Change Form and return it to the Fund Office as soon as possible. Enrollment in the Plan will be effective as of the date of the event, provided you notify the Fund within 30 days. If you notify the Fund more than 30 days from the date of the event, coverage will be provided but retroactive coverage is not guaranteed.

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***If you do not enroll newly acquired dependents within 30 days, retroactive coverage is not guaranteed. Enrollment Change Forms can be obtained from the Fund Office.***

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## **Special Enrollment Rules**

If you do not enroll your dependents when they become eligible, you may enroll them if you meet each of these requirements:

- ◆ you are eligible for coverage through the Fund and you are currently enrolled and
- ◆ you declined dependent coverage through the Fund when it was offered because your dependents had alternative coverage and
- ◆ alternative coverage for your dependents has ended.

If you submit an Enrollment Change Form to the Fund Office within 30 days after the other coverage ends, Benefit Fund coverage for your dependents will begin as of the date the other coverage ends. If you notify the Benefit Fund more than 30 days from the date their other coverage ends, coverage will be provided but it will not be retroactive.

## **Coordination of Health Care Benefits**

The purpose of the Benefit Fund's health care plans is to help you pay for those costs that you and your dependents incur for necessary medical services and supplies. Sometimes individuals are covered by more than one group plan (for example, as a District 1199C member and as your spouse's dependent).

If each plan paid its full benefit, the total benefits paid for one claim could exceed the actual expense—and that would increase the cost of medical care for everyone. That is why the Plan has a Coordination of Benefits (COB) provision that coordinates benefits from other group plans to guard against health care overpayments.

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***To obtain all the benefits for which you are eligible, claims should be filed with each of your sources of coverage.***

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## **Dual Coverage**

For certain benefits, as described in the following appropriate sections, you may be covered as both a member and as a dependent (for example, if you and your spouse are both members of District 1199C, you could be covered as a member and as your spouse's dependent).

## **What Group Plan Means**

"Group Plan" means medical, dental, prescription, or vision coverage under a plan made available by an employer, or coverage provided under a governmental program or provided by statute (other than Medicare or Medicaid).

These plans may include pre-payment plans such as a Health Maintenance Organization (HMO) or group association coverage for an employee or dependent made available by an employer. Coverage required by statutes such as Automobile No-Fault laws (in states where coordination is permitted) is also included.

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***A group plan does not include any personal policy you may have, and COB does not apply to any such policy.***

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## **How Coordination of Benefits Works**

When there are two sources of coverage, one plan is considered “primary” and pays benefits first—the other plan is “secondary” and pays the remaining charges that are considered eligible.

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***Coverage you have as an active employee is always primary. Plans that cover you as a dependent or as a retired employee are secondary to any coverage you have as an active employee.***

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The COB feature ensures that the total benefits paid for one claim will not be more than 100% of the “allowable expenses” (this means any necessary, usual and prevailing expense that is covered, at least in part, by one of the plans). The maximum amount payable by the Benefit Fund’s Plan is the amount that would be paid if there were no other plan involved, even if the total benefit paid by all plans does not equal 100% of the allowable expense.

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***For information about how each plan pays benefits when there are two sources of coverage, see the specific sections for your Medical Plan, Dental Plan, and the Prescription Drug Plan.***

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### *Important Information About Allowable Expenses*

Generally, an allowable expense is a reasonable charge for a medically necessary expense. However, when the Benefit Fund’s health care plan is secondary, it will not pay benefits for charges the primary plan did not pay because you did not follow any cost containment provisions of that plan, such as getting a second surgical opinion, calling for pre-certification, or using certain providers.

For example, assume your spouse’s plan pays \$100 for physical exams received from a Primary Care Physician. If your spouse receives a physical from a non-network doctor and the charge is \$300, the primary plan would pay \$0. In this case, the Benefit Fund Plan would not pay any benefit because you could have received full payment from the primary plan if your spouse’s PCP had provided this service.

### **Determining Which Plan Pays First**

The following rules are used to determine whether the Benefit Fund health care plan or another group plan is the primary payer:

- ◆ If the other plan does not have a coordination of benefits provision, it will pay benefits in full before this Plan pays benefits.
- ◆ The plan that covers the person as an employee will pay benefits in full before the plan that covers the person as a dependent.
- ◆ For children’s expenses, the plan of the parent whose birthday (month and day) occurs earlier in the calendar year will pay first; when parents have the same birthday (month and day), the plan of the parent who has been covered longer under the plan will pay first.
- ◆ When parents are separated/divorced, the plan covering the dependent children of the parent with custody will pay benefits first, unless there is a court decree directing otherwise.
- ◆ When parents have joint custody, the plan covering the parent who has financial responsibility for the children’s health care expenses will pay first.

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- ◆ The plan that covers a person as an employee, or as that employee's dependent, will determine its benefits before those of a plan covering a person as a laid off or retired employee, or as that employee's dependent.

If these rules do not decide which plan's benefits are payable first, the plan that has covered the person for the longest time will be primary.

The Plan has the right to obtain from and release to any insurance company, claims administrator, organization, or person, any benefit information necessary to determine whether the coordination provision applies.

## **When a Third Party Is Liable**

The Plan will not pay any health or disability benefits for expenses for which a third party is liable and for which the member (or a dependent, if applicable) has not signed a reimbursement/subrogation agreement (except as may be otherwise provided under New Jersey law with respect to disability benefits for employees of New Jersey employers). For example, this exclusion covers benefits for injuries you received in an accident caused by someone else or benefits for work-related injuries which are payable under Workers' Compensation.

The Plan may pay benefits for this type of expense if you (or your dependent) sign a reimbursement/subrogation agreement in which you agree to reimburse the Plan out of any payment you receive from a third party and acknowledge that the Plan can initiate legal action on its own to recover payments it has made.

The following provisions will be used to determine and implement the Plan's right to reimbursement from payments received from third parties or to be subrogated:

- ◆ When you (or your dependent) submit a claim for health or disability benefits, or at any later time, the Fund may require you to sign a reimbursement agreement, except as otherwise provided under the New Jersey Temporary Disability Benefits Law. This agreement will:
  - acknowledge the Plan's right to be reimbursed for expenses for which you are entitled to be paid by a third party and
  - obligate you (or your dependent) to cooperate in pursuit of any recovery.
- ◆ If you (or your dependent) fail or refuse to execute the required reimbursement agreement, the Plan may deny payment of any benefits until the agreement is signed. Also, failure to sign a reimbursement agreement does not relieve you (or your dependent) of the obligation to reimburse the Plan for any recovery from a third party.
- ◆ The Plan is entitled to full reimbursement from any payment which you (or a dependent) receive, or may be entitled to receive, from a third party if the Plan has paid benefits for expenses arising out of the same injury or illness or with respect to the claimed loss of income. The Plan shall have first priority in any recovery regardless of the manner in which the recovery is structured or worded (for example, if the recovery seeks to limit the Plan's reimbursement by stating that amounts paid do not represent wage loss, medical, dental or vision expenses) and regardless of whether you (or your dependent) have been "made whole" by the settlement.
- ◆ You (or your dependent) must notify the Plan if you have received, or will receive, a payment from a third party relating to an injury or illness for which the Plan has paid benefits and agree to hold any recovery in constructive trust for the Plan.
- ◆ If you (or your dependent) receive a third party payment and do not report that payment to the Plan, the Plan has the right to stop making benefit payments of any type until the portion of the payment owed to the Plan is returned or offset against amounts that would otherwise be paid to you or your dependents.

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- ◆ Any so-called “fund doctrine” or “common fund doctrine” or “attorney’s fund doctrine” shall not defeat the right of the Plan to recover under this section without paying attorney’s fees or costs.
  - ◆ The Plan has the right to seek recovery directly from the third party on behalf of the Plan.
  - ◆ The Plan’s recovery will not be reduced by attorney’s fees.
  - ◆ The Plan also may use other self-help measures, including, but not limited to, recoupment of payments made to providers leaving you responsible for paying the providers’ actual charges and termination of coverage under the Plan for you and your dependents.

## Your Rights Under Federal Law

### ***Right to Receive Certificate of Health Coverage***

The Benefit Fund health care plan does not have any pre-existing condition limits. However, some health care plans limit benefits for health care problems (called pre-existing conditions) that you or your dependents have before coverage begins.

To bridge the gap in coverage that pre-existing condition limits can create, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that:

- ◆ a pre-existing condition exclusion may not be imposed for more than 12 months (18 months for a late enrollee) and
- ◆ prior health care coverage be counted toward the pre-existing condition limit of another employer’s plan.

In short, these provisions make your health coverage “portable” because your period of other coverage is credited toward any pre-existing condition exclusion.

Your coverage in one plan will be credited toward a pre-existing condition limit of another plan provided you do not have a break in coverage between the old plan and the new plan of 63 or more days. The 63-day period is defined by Federal law. (Under some state laws, this 63-day period may be extended for insured plans.) A waiting period under a new employer’s plan does not count toward this 63-day period.

HIPAA provides that you and your covered dependents are entitled to a certificate from your prior health plan to show evidence of prior health coverage.

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***The Benefit Fund will automatically provide a certificate of your coverage when you or a dependent loses coverage under the Plan.***

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If your coverage as an 1199C member or eligible dependent ends and you become covered by another plan, ask the plan administrator if the new plan excludes pre-existing conditions and if you need to provide a certificate of previous coverage.

## Coverage During FMLA Leave of Absence

Under the Family and Medical Leave Act of 1993 (FMLA), you may be entitled to take a leave of absence with continued benefits coverage in certain situations. In order for the Benefit Fund to continue benefits for you and your dependents during an FMLA absence, your employer must continue to make contributions on your behalf, unless you are receiving Disability benefits. (See the next paragraph for extension of coverage if receiving Disability benefits.) If the Fund does not receive these contributions, benefits will end.

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If you are receiving Short-term Disability benefits during the FMLA leave, the benefits coverage you had immediately prior to becoming disabled will continue as long as you are entitled to receive Short-term Disability benefits.

## When Coverage Will End

Eligibility for all benefit coverage, except disability, for you and/or your dependents will end on the **earliest** of these dates:

- ◆ 30 days after the Member's last day of employment, **unless** one of the exceptions described under "Extended Eligibility for Benefit Coverage" applies,
- ◆ 30 days after the date benefits are terminated because of your employer's failure to make the required contributions,
- ◆ the date you become divorced or legally separated (coverage ends for dependent spouse only),
- ◆ the date your dependent child reaches the limiting age or no longer qualifies as an eligible dependent (see "Who is an Eligible Dependent" earlier in this section),
- ◆ the last day for which you receive a disability payment from the Fund **unless** you provide proof of your return to work by submitting the appropriate form to the Fund Office or
- ◆ the day your employer is no longer obligated to make contributions to the Fund.
- ◆ Disability benefits will end as of your last day of work, unless "Extended Disability Benefit Coverage for Members Working for New Jersey Employers" applies.

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***When health care coverage ends, you and your dependents may be eligible to elect COBRA continuation coverage in specific circumstances. See the Plan Information and Rights section in this handbook.***

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## Extended Eligibility for Benefit Coverage

*Your hospital, medical, dental, prescription drug, death, camp and scholarship benefits (as applicable) will be extended as described below:*

- ◆ **If you are injured or ill and receive disability payments from the Fund**, benefit coverage will continue for the length of such payments up to 180 days in a 12-month period.
- ◆ **If you are injured at work and qualify for Workers' Compensation**, benefit coverage (except disability) will continue for up to 180 days, provided you supply proof of receipt of Workers' Compensation on a monthly basis.
- ◆ **If you are injured in an auto accident**, and are receiving benefits for lost wages from your auto insurance, benefit coverage (except disability) will continue for up to 180 days, provided you supply proof of payment for lost wages from auto insurance.
- ◆ **If you become unemployed**, and immediately qualify for and receive state unemployment compensation, benefit coverage (excluding disability benefits unless you are employed by a New Jersey employer, in which case you will be covered for disabilities incurred within 14 days of your termination, unless you begin work for another New Jersey employer before that time) will continue according to the following schedule based on the member's years of continuous coverage under the Fund—up to a maximum of 26 weeks of extended coverage. To continue coverage, you must provide proof of your status to the Fund Office.

CONTINUOUS COVERAGE PERIOD		EXTENDED BENEFITS COVERAGE PERIOD
<i>More than...</i>	<i>But less than...</i>	
One year	Two years	60 days
Two years	Three years	90 days
Three years	Four years	120 days
Four years	Five years	150 days
Five years	Not applicable	180 days

***Benefits will not be extended for more than 180 days in any 12-month period for all extended coverage periods combined.***

### ***Extended Disability Benefits Coverage for Members Working For New Jersey Employers***

If you work for a New Jersey employer, you will be eligible for Private Plan disability benefits if you become disabled within the first 14 days after your employment ends, unless you begin work for another New Jersey employer at the time you become disabled. In this case, the Benefit Fund will pay Private Plan disability benefits in accordance with the Disability Benefits Law of New Jersey. Additionally, medical treatment for the disability must begin within 30 days of the last day of active employment.

#### ***If Your Employer Does Not Make Contributions***

If your employer fails to make required contributions for two consecutive months, coverage for you and your dependents will be terminated after 30 days of extended coverage; provided, however, that disability benefits will end immediately unless you work for a New Jersey contributing employer, in which case benefits will continue for 15 days. Coverage can begin again when the outstanding contributions have been made by your employer.

***An employer's failure to make contributions does not entitle you to COBRA continuation coverage.***

#### ***If You Die***

If you die while you are eligible for benefits coverage, your eligible dependents will remain eligible for health care coverage for 30 days after your death. If your dependent is hospitalized when you die, your dependent's coverage will continue until he or she is released from the hospital, even if that hospital stay exceeds the 30-day limit.

#### ***If You Retire***

If you retire with a pension from the Pension Fund for Hospital & Health Care Employees, or retire at age 65 or older with 15 or more years of coverage by the Benefit Fund, you will

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continue to be covered under certain provisions of the Plan. If this applies to you, you may contact the Fund Office for a benefit description.

### ***Continuing Death/AD&D Benefits***

When your eligibility for benefits coverage ends, you may be eligible to continue your death and accidental death and dismemberment (AD&D) coverage. Coverage amount will equal 50% of the coverage amount in effect when your coverage ends—to a maximum coverage amount of \$5,000. You must pay for this coverage; your cost is determined by the Trustees based on the cost of coverage.

To continue coverage, the Benefit Fund must receive your payments in advance by the first day of the quarter (January 1, April 1, July 1, and October 1), or coverage will be terminated.

### ***Continuing Your Coverage Through COBRA***

If your coverage ends, you may be entitled to continue it (at your expense) for a limited time under COBRA (which stands for the Consolidated Omnibus Budget Reconciliation Act). See the *Plan Information and Rights* section of this handbook for details.