FREQUENTLY ASKED QUESTIONS

How are my benefits funded?

The primary source of financing for the benefits provided under the Health Care Fund and for the expenses of Fund operations is employer contributions.

What are the Fund's eligibility requirements?

Initial eligibility requires 300 hours of contributions within three (3) months OR 130 hours of contributions in one (1) month. There is a one (1) month bookkeeping period in which you are not eligible.

Effective June 1, 2019 work month, continuing eligibility requires at least $777.00 of employer contributions within one (1) month. There is a two (2) month bookkeeping period in which you are not eligible.

After initial eligibility has been met, any contributions in excess of $777.00 per month, is applied to a dollar bank which can be utilized when you do not have sufficient contributions to maintain eligibility.

What do I do if my employer does not remit my fringes?

First, call your employer. There may be a very good reason that the fringes have not been remitted. If your employer cannot explain the reason to your satisfaction, you should contact the Local Union.

How can I add my dependents to the Plan?

Complete a "Yearly Coordination of Benefits Form" and submit copies of marriage or birth certificates along with social security card numbers.

What do I do when I get divorced?

You must send a copy of your complete divorce decree to the Fund Office within 30 days otherwise coverage will be maintained for your ex-spouse. If the Fund pays for benefits that should not be paid because your spouse no longer meets the definition of a dependent, you will be held responsible.

When does coverage stop for my dependent children?

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend Adult child coverage up to age 26 effective June 1, 2011. Therefore, if you are eligible for benefits and you have a child that was previously covered in the Plan, and their coverage was terminated, you should complete a "Request for Extension of Dependent Coverage" and return it to the Fund Office. Coverage may continue until the last day of the month in which that adult child turns 26 years old or earlier if you do not maintain your eligibility under the Plan. This requires annual verification.

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What type of healthcare coverage does the plan offer?

There are two types of healthcare coverage offered by the Fund:

Standard Plan and the Enhanced Plan

The Standard Plan's deductibles, copayments, and coinsurance are higher than the Enhanced Plan. Initial eligibility gives you the Enhanced Plan for the first year of service, after that you will be required to have an annual physical to stay on the Enhanced Plan. Annual physicals are due by December 15 of the current year along with proof of the physical examination. Proof of the physical would require the form, from the Fund Office, to be filled out by an MD or DO and submitted timely.

Can I continue coverage when I retire?

Yes, provided you meet the retiree requirements for maintaining coverage.

What are the self-payment rates?

Active participant and family	$777 per month
Retiree not eligible for Medicare	$930 per month
Retiree & Spouse not eligible for Medicare	$930 per month
Retiree eligible for Medicare	$378 per month
Retiree & Spouse both eligible for Medicare	$492 per month

What is COBRA?

COBRA is the Consolidate Omnibus Budget Reconciliation Act of 1986. COBRA requires that the Fund provide coverage for participants and their dependents that may not otherwise be offered. COBRA is available for dependents who no longer meet the definition of a dependent as defined by the Plan. The rates are:

Participant (Single or Family) $804.00

What is Coordination of Benefits?

Coordination of Benefits or COB coordinates benefits with other health benefits you may have such as coverage through your spouses' employer.