

# INSURANCE Q & A'S

## *When do I become eligible for benefits?*

Plan A employees hired on or after March 1, 2004 & Plan B employees hired on or after October 4, 2004 (except Clerk's Helpers/Utility Clerks) become eligible to elect coverage in the plan beginning the first day of the calendar month following their 6<sup>th</sup> month of employment. Premiums must be paid and the Required Hours worked in the 5<sup>th</sup> month for initial coverage in the 7<sup>th</sup> month.

Plan A Clerk's Helpers hired on or after March 1, 2004 & Plan B Utility Clerks hired on or after October 4, 2004 become eligible to elect employee-only coverage beginning the first day of the calendar month following their 18<sup>th</sup> month of employment. Premiums must be paid and the Required Hours worked in the 17<sup>th</sup> month for initial coverage in the 19<sup>th</sup> month. If you are promoted, credit is given for the purpose of medical plan eligibility and dependent coverage, from your original date of hire.

## *What do I need to do to establish and maintain eligibility for benefits?*

If you choose to enroll in Employee-Only coverage, your premium is \$7.00 per week. This amount will be deducted automatically from your paycheck on a weekly basis

If you are a Clerk and choose to enroll your children, the premium for you and your children is \$10.50 per week.

If you are a Clerk with at least 24 months of service and choose to enroll your legal spouse or registered domestic partner, the total premium for you and your spouse/domestic partner or your spouse/domestic partner and any dependent children is \$15.00 per week (your payment is the same whether or not you have dependent children).

**You must complete a payroll authorization form to permit your employer to withhold the amount of your premium payment from your paychecks.**

If you decline enrollment for you and/or your eligible Dependents because you and/or they have other health insurance, you and/or they may be able to enroll in the future, outside of Open Enrollment, provided that you request enrollment within 30 days after the loss of the other group coverage.

## *How many hours a month do I have to work to maintain eligibility for benefits?*

The Required Hours are:

- ❖ 64 hours: All Clerks Helpers and Utility Clerks
- ❖ 76 hours: Plan B Clerks, Plan A & B Meat Cutters, and Uniform Department Employees
- ❖ 92 hours per month for Plan A Food and Meat Clerks and General Merchandise Clerks

### *What is a month?*

The hours you work in any one week are credited to you as of each Sunday, based on the standard Industry workweek, which is Monday through Sunday. Your monthly hours are credited to you as of the last Sunday of each month.

### **Which family members are covered?**

Clerks' dependent children will become eligible to participate in the plan on the first day of the month following the employee's 6<sup>th</sup> month of employment. Your Spouse/Domestic Partner will become eligible on the first day of the month following the employee's 24<sup>th</sup> month of employment.

Clerk's Helpers/Utility Clerks do not have dependent coverage. Clerk's Helpers/Utility Clerks promoted to Clerk will become eligible to elect coverage when promoted if their promotion follows their sixth month of employment. For more information, call your local or the Trust Fund.

Eligible dependents include:

- ❖ Legal spouse or registered domestic partner
- ❖ Unmarried children and stepchildren under 19 years of age, foster children (must meet Fund's requirements), and legally adopted children who are principally supported by you.
- ❖ Unmarried children 19 through 23 years of age who are full time students with Student Certification on file who are principally supported by you.
- ❖ Totally and permanently disabled unmarried children who are age 19 and older provided they meet all of the requirements who are principally supported by you.

### **How can my child extend their coverage after reaching age 19?**

Students are covered from age 19 through their 24<sup>th</sup> birthday month as long as they are unmarried and a full time student at an accredited school. A completed "Student Certification", signed by the member and School Registrar, must be on file for each school term. To cover the summer months the member must complete and sign a "Student Certification of Intent to Return to School After Summer Recess" each year.

**The Trust Fund must be notified if the student drops below a full time course load during the semester.**

Overage dependents may elect COBRA Continuation Coverage if they are between the ages of 19 and 24 and are not full time students or after they reach the age of 24 and are no longer eligible to extend their coverage as a full time student.

### **How do I enroll my Registered Domestic Partner or Same Sex Spouse?**

If you wish to enroll your Registered Domestic Partner or Same Sex Spouse and their children, you will need to complete and return specific paperwork to the Fund Office.

You will also be required to pay taxes on the value of the coverage provided to your Registered Domestic Partner or Same Sex Spouse and their children unless they qualify as your tax dependents under the Internal Revenue Code.

Contact the Fund Office for a complete information package on Registered Domestic Partner/Same Sex Spouse coverage, which will include specific tax information and all necessary paperwork for enrolling your Registered Domestic Partner or Same Sex Spouse and/or their children in the Plan.

### **What are my choices for Medical Coverage?**

Plan A employees hired prior to March 1, 2004 & Plan B employees hired prior to October 4, 2004 (Platinum Plus) may enroll in the **New Indemnity Medical Plan PPO with a Health Reimbursement Account (HRA), Kaiser HMO or PacifiCare HMO.**

Plan A employees hired on or after March 1, 2004 & Plan B employees hired on or after October 4, 2004 (Silver/Gold/Platinum) are enrolled in the New Indemnity Medical Plan with a Health Reimbursement Account (HRA) and cannot enroll in an HMO.

**What is an HRA?**

A **Health Reimbursement Account** is an arrangement where the Fund reimburses you for health expenses not covered by the health plan, such as deductibles, coinsurance or reimbursing you for prescription drug co-pays. The HRA with the New Indemnity Medical Plan provides you and your family members with additional funding at the beginning of each year to pay for your medical expenses. The Fund administers the HRA on your behalf. You may contact our office for additional information.

**When can I change my medical coverage?**

Plan A & B Platinum Plus participants may change their medical coverage yearly at Open Enrollment. A plan change can also be made once in a 5 year period outside Open Enrollment.

**How do I contact my HMO?**

The best way to contact your HMO is their toll free customer service lines or on their website.

- ❖ Kaiser 1-800-464-4000      [www.kaiserpermanente.org](http://www.kaiserpermanente.org)
- ❖ PacifiCare 1-800-624-8822      [www.pacificare.com](http://www.pacificare.com)

**I am enrolled in the New Indemnity Medical Plan; how can I find a doctor in the PPO network?**

You should look on the PPO website: [www.anthem.com/ca](http://www.anthem.com/ca)

You can also request a directory from our office. Make sure you verify your doctor is still part of the Blue Cross Prudent Buyer network when you make your appointment.

**What if I do not work the Required Hours for medical coverage?**

***Reinstatement of Eligibility***

You will receive a COBRA/Loss of Eligibility Notice. If you were on vacation, complete the applicable portion of the form and return to it to the Fund. If you are on approved family leave, complete the applicable portion of the form and attach a copy of the approval letter from your employer.

Platinum Plus participants (Plan A employees hired prior to March 1, 2004 & Plan B employees hired prior to October 4, 2004) may use state disability check stubs to extend their eligibility for benefits for six months or Workers Compensation check stubs to extend eligibility for 12 months. If you were on: state disability or worker's compensation, complete the applicable part of the form and submit with proof of payment from the state or the insurance carrier.

Plan A employees hired on or after March 1, 2004 & Plan B employees hired on or after October 4, 2004 cannot extend their benefits, but should submit proof of payment for state disability or Workers Compensation to preserve their months of employment to maintain skip month eligibility when they return.

### ***COBRA Continuation Coverage***

If you are unable to extend your benefits through disability, vacation or family leave and wish to elect COBRA Continuation Coverage, you should complete and return the election form within 60 days of loss of coverage.

COBRA Continuation coverage requires a monthly premium. COBRA premium rates are based on the type of coverage elected and the number of persons enrolled. The first payment must be received within 45 days from your election date. Subsequent payments are due on or prior to the first of the coverage month and will not be accepted after the last day of the month.

Current COBRA rates can be obtained from our office.

### **Failure to make a payment timely terminates eligibility for COBRA Continuation Coverage.**

### **How long will my benefits be in effect after my employment terminates?**

Coverage terminates on the last day of the month in which your employment ends. You will be sent a COBRA notice and a Loss of Coverage letter. Please keep the Loss of Coverage letter for your records.

### **If a claim is denied, how do I appeal the denial?**

You may request a free copy of the claims and appeals procedures from our office or the Fund Office.

Within 180 days after you receive the explanation of benefit, you, or your authorized representative, may file a written appeal with the Fund Office if you dispute the determination. You may request, free of charge, relevant documents records or other information from the Plan and the identity of medical experts, if any, who advised the Plan about the claim. You may submit written comments documents, records and other information to support you appeal.

The Appeals Committee will review your appeal at its first meeting that is at least 30 days after your appeal is filed. You will be notified if an extension is necessary and the date by which a decision will be made. A decision may be delayed to allow you to submit additional information. You will be notified of the decision within 5 days after it is made. If your appeal is denied, in whole or part, you may file a civil action under ERISA Section 502(a).

### **Disclaimer:**

This information has been written as clearly and accurately as possible. You should be aware, however, that benefits are governed by master policies, contracts and Plan documents. In all cases of benefit determination or differences of opinion, the legal policies, contracts of Plan documents will prevail.

You can examine the master policies, contracts and Plan documents by contacting the Fund Office. If you prefer, you can request, in writing, copies of these documents for a reasonable fee. The Fund Office will send you the documents within 30 days of receiving your request.