HEAT & FROST INSULATORS AND ALLIED WORKERS LOCAL 47 FRINGE BENEFIT FUNDS

Heat & Frost Insulators and Allied Workers Local 47 Welfare Fund
Heat & Frost Insulators and Allied Workers Local 47 Retirement Trust Fund

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION

September 2021

TO: ALL PARTICIPANTS IN THE HEAT AND FROST INSULATORS AND ALLIED WORKERS LOCAL 47 WELFARE FUND

RE: SUMMARY OF MATERIAL MODIFICATIONS – WORKING SPOUSE RULE

Dear Plan Participant:

The Summary Plan Description provides the following provisions with regard to Spouses that are employed:

> If the spouse of the participant regularly works thirty-two (32) or more hours per week for an Employer and if that Employee is entitled to elect at no additional cost Health/Medical coverage as a benefit of his/her employment, he/she shall not be eligible for benefits under the Fund to the extent that benefits would have been payable under the Employer's Plan if the spouse had elected Health/Medical Insurance which he/she was otherwise eligible to receive. The spouse of an Employee who is eligible and entitled to elect health/medical benefits to be provided by the Employer **will not be covered** by the Fund for dependent coverage if that spouse elects to receive monetary compensation in lieu of health/medical insurance or rejects such benefit/coverage, and **coordination of benefits will not be applicable because there is no coverage.**

Effective January 1, 2017 the Fund will enforce this rule which requires that a Working Spouse must enroll in their employers' health plans. In addition, the rule has been modified to require spouses to enroll in their employer sponsored plan whether or not there is a cost for the coverage unless they meet the Hardship provisions. Spouses that do not enroll in their employers' health plans will have **no coverage** through the Fund unless they qualify for the HARDSHIP EXEMPTION as explained below.

You must provide information regarding your marital status and your spouse's employment status (if you are married) on an annual basis. Please complete the enclosed Spouse Employment Information Form and return it to the Fund Office by no later than October 1, 2021

YOU ARE REQUIRED TO COMPLETE AND RETURN THIS FORM REGARDLESS OF YOUR MARITAL STATUS OR YOUR SPOUSE'S EMPLOYMENT STATUS

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THE BASIC "WORKING SPOUSE RULE"

If your spouse works and is eligible for coverage through his or her employer (a plan in which the employer contributes some or all of the premiums), then his or her plan is primary and the Fund will be secondary for all your spouse's medical claims. The Fund will not pay any of your spouse's health care expenses if **your spouse does not elect his or her employer's coverage**.

HARDSHIP EXEMPTION – the Working Spouse Rule will not apply if your spouse h**as gross annual wages of less than $25,000.**

You are responsible for demonstrating your spouse's entitlement to a hardship exemption by submitting a letter to the Fund office attesting to your spouse's wages from your spouse's employer on company letterhead or by submitting her annual W2 statement. The Fund office will determine whether a spouse with variable wages qualifies for the hardship exemption by looking at the spouse's average wages over the past twelve (12) months.

Dual Coverage Saves you Money – When your spouse is covered by his or her employer's plan and this Plan at the same time, the two plans together will usually pay 100% of his or her covered claims under the coordination of benefits rules. If your spouse requires hospitalization or surgery, dual coverage should save you money even after your spouse's premiums are taken into account.

Additional provisions and exceptions to the Working Spouse Rule:

1. The Working Spouse Rule only applies to your spouse's claims, not to claims incurred by your children.

2. It applies to retirees as well as active employees, but only if the retiree's spouse is still actively employed.

3. It does not apply to COBRA coverage, meaning that if your spouse terminates employment and declines COBRA, this Plan will pay its normal benefits.

4. The Working Spouse Rule only applies to medical and drug expenses.

5. The Rule applies whether or not your spouse's employer requires its employees to pay for part of the premium, whether or not the employer offers an incentive to induce employees not to enroll, and whether or not the employer offers a single-only coverage option. It also applies if the employer only offers medical coverage as an option under a cafeteria plan.

6. No reductions will apply to a particular claim if you can demonstrate that your spouse's claim would have been denied under the employer's plan (for example, if the claim was for a service that was not covered by your spouse's plan but would be covered by this Fund).

7. The provision will also be waived if the only health plan offered by your spouse's employer is an HMO plan, and your residence is more than 25 miles outside the HMO service area.

8. If your spouse is covered under his or her employer's plan, then your spouse must receive his or her medical care in accordance with that plan's rules. This Fund will not cover the amount of the other plan's noncompliance penalties, or any charges incurred because of failure to follow the other plan's rules, including failure to use HMO providers or follow the HMO's referral procedures. (This is not a new rule, and it also applies to claims for your children when your spouse's plan is primary).

9. You are required to provide accurate and timely information to the Fund about your spouse's employment status and benefit entitlement, and the Fund Office may require verification of this information from your spouse's employer.

2022 SPOUSE EMPLOYMENT INFORMATION FORM

Complete and return to Fund Office. You are required to keep the Fund Office advised if any of the following information changes. Be sure that you and your spouse sign the form on the back.

Participant's Name_____

Member ID or Social Security Number_____

Are you currently married? ☐ Yes ☐ No If you are not married, no further information is required. Please sign and date this Form below and return the Form to the Fund Office.

If married, please answer the following questions about your spouse's employment

1. Name of Spouse _____
2. Spouse's employment status: ☐ Not employed ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired
3. Name and address of spouse's employer: _____

   _____ Hire Date: _____
4. Telephone number of spouse's employer: _____
5. Does your spouse's employer offer a health plan? ☐ Yes ☐ No

Answer the remaining questions only if you answered "yes" to No. 4

6. Is your spouse eligible to enroll in the employer's health plan? ☐ Yes ☐ No
7. Is your spouse enrolled in the employer's plan? ☐ No ☐ Yes, single coverage ☐ Yes, family coverage

If your spouse's employer offers health coverage but your spouse is not eligible to participate, you must submit a letter from the employer on company letterhead. The letter should be addressed to the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund and should state that your spouse is not eligible for the employer's health plan and the reason for his or her ineligibility (for example, because your spouse works part-time).

8. Give name and address of insurance company: _____

   _____

   Group No._____ Individual ID No._____ Effective Date _____

   Type of coverage (check all that apply): ☐ Medical ☐ Rx ☐ Dental ☐ Vision

   Please include a copy of the front and back of your spouse's insurance identification card.
9. If spouse is NOT enrolled, when will your spouse be eligible to enroll in that plan? _____

If your spouse declines to elect available coverage, the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund will NOT pay any benefits for your spouse. This rule may be waived for a newly eligible participant whose spouse was offered but declined the employer's plan. You must submit a letter from the employer on company letterhead verifying this information. The letter should be addressed to the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund and should state when and under what circumstances your spouse will have another opportunity to enroll. The Fund will suspend enforcement of the non-payment rule only until the other plan's next available enrollment date, at which time the spouse must enroll in the employer's plan.

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HARDSHIP EXEMPTION

The Fund's reduced coverage will not apply if your spouse has annual gross earnings less than $25,000. You are responsible for demonstrating your spouse's entitlement to a hardship exemption by submitting a letter from the employer on company letterhead attesting to your spouse's wages. The Fund Office will determine whether a spouse with variable wages qualifies for the hardship exemption by looking at the spouse's average wages over the past twelve (12) months.

IMPORTANT

YOU MUST SIGN THE FORM WHERE INDICATED BELOW

I affirm that the information given above is true and correct to the best of my knowledge and I understand that if I have given false information or made any material misrepresentations in response to the questions in this Form, it could result in a loss of coverage to my spouse and myself and could also result in penalties and fines and possibly prosecution. ***I also understand that it is my responsibility to notify the Fund Office if any of the above information changes.***

Signature of PARTICIPANT/RETIREE **Member ID or Social Security #** **Date**

IMPORTANT

YOUR SPOUSE MUST SIGN THE AUTHORIZATION BELOW

THIS ENTIRE FORM AND THE SIGNED AUTHORIZATION MUST BE RETURNED TO THE HEAT AND FROST INSULATORS AND ALLIED WORKERS LOCAL 47 WELFARE FUND OFFICE

I hereby authorize my employer to release information regarding my employer's health plan, and my eligibility for coverage under that plan to the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund. I understand that this authorization shall remain in effect as long as I am eligible for benefits under the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund. I understand that the purpose and scope of this authorization is to allow the Heat and Frost Workers Local 47 Welfare Fund to verify with my employer whether I am eligible to obtain coverage under my employer's plan. I further affirm that the information given above is true and correct to the best of my knowledge and I understand that if I have given false information or made any material misrepresentations in response to the questions in this form, it could result in a loss of coverage to my spouse and myself, and could also result in penalties and fines and possibly prosecution. ***I also understand that it is my spouse's responsibility to notify the Fund Office if any of the information on this Form changes.***

Signature of Spouse **Social Security #** **Date**