I.A.T.S.E. NATIONAL HEALTH & WELFARE FUND

WAIVER OF PLAN C COVERAGE
For
MEDICARE ELIGIBLE INDIVIDUALS

Policy: Pursuant to the Medicare Secondary Payer Rules (42 CFR Section 411.172(c)), the I.A.T.S.E. National Health & Welfare Fund, Plan C ("Plan C"), will allow Medicare eligible individuals who qualify as "active" participants eligible for coverage under the Fund's rules* to refuse coverage offered by Plan C under the following rules:

1) An individual who is offered coverage or already enrolled in coverage under Plan C must elect to waive coverage by timely submitting his or her quarterly election form along with a "Refusal of Health Coverage" form to the Fund Office. Such election is due at the time all other quarterly election forms are due (i.e. the 15th of the month prior to the start of the coverage quarter).

2) An individual who timely refuses coverage shall forfeit his or her entire CAPP account balance as of the last day of the applicable employer contribution period (e.g., as of January 31 for a waiver of coverage effective for the April 1 coverage quarter). This date shall be the individual's forfeiture date.

3) An individual who timely elects to refuse coverage shall be eligible for primary coverage through Medicare, subject to Medicare's rules and regulations.

4) If such individual does not timely refuse coverage and is not enrolled in coverage, he or she will be defaulted into Plan C4 single coverage, or Triple S single if they reside in Puerto Rico, in accordance with the applicable Medicare Secondary Payer rules. If they are enrolled in coverage (and do not timely refuse coverage), they will continue in that option or be downgraded, based on their CAPP balance and Plan C rules.
5) Any employer contributions received by the Plan after an individual's forfeiture date shall be credited to the individual's CAPP account based on Plan's rules. Those individuals will be sent a quarterly statement for the following coverage quarter and will not be subject to an administrative fee or re-qualification rules.

6) If, based on contributions received after the individual's forfeiture date, an individual again becomes an "active" participant eligible for coverage,* such individual must again either elect coverage, or waive coverage by timely submitting his or her quarterly election form along with a "Refusal of Health Coverage" form to the Fund Office. Any such waiver will once again cause the forfeiture of any newly acquired CAPP account balance. If such individual does not timely refuse or elect coverage, he or she will be defaulted into Plan C-4 single coverage, or Triple S single if they reside in Puerto Rico, in accordance with the applicable Medicare Secondary Payer Rules.

**A participant is "active" and eligible for coverage if he or she received contributions during the last contribution quarter and his or her CAPP account balance equals or exceeds the cost of one quarter of Plan C-4 single coverage, or Triple S single if they reside in Puerto Rico.*

REFUSAL OF HEALTH COVERAGE
For
IATSE NATIONAL HEALTH & WELFARE FUND,
ACTIVE PLAN C PARTICIPANTS ELIGIBLE FOR MEDICARE

Instructions

You are receiving this form because the I.A.T.S.E. National Health & Welfare Fund ("Fund") has determined that you qualify as an active employee eligible for coverage,* and the Fund believes you are eligible for Medicare.

Therefore, you must either:

- **Elect** or continue coverage from the Plan, or
- **Waive your right to** coverage by completing and returning this Refusal of Health Coverage form along with your quarterly election form.

If you take no action and you are not currently enrolled in coverage, **you will be defaulted into Plan C-4 single coverage or Triple S single if you reside in Puerto Rico. If you are already enrolled, your current coverage option will continue, or your coverage will be downgraded based on your available CAPP balance and Plan C rules. The quarterly cost of the premium for such coverage will be deducted from your CAPP account**. **YOUR ELECTION OR WAIVER OF COVERAGE (INCLUDING THIS FORM IF YOU ARE WAIVING COVERAGE) MUST BE RECEIVED BY THE FUND OFFICE NO LATER THAN THE 15TH OF THE MONTH BEFORE THE COVERAGE QUARTER.** This due date is indicated on your quarterly election form, and can be found on our website, www.iatsenbf.org, in the Summary Plan Description, or by calling us at 1-800-456-FUND (3863).

If you are enrolled in Plan C coverage, such Plan C coverage will be primary, and Medicare will be your secondary coverage. If you waive your right to coverage from the Fund, your only coverage will be through Medicare. If you waive coverage ***you will forfeit your entire CAPP balance*** and not receive ***any*** benefits through Plan C or the R-MRP Plan for the coverage quarter.

** You are "active" if you received contributions to your CAPP account in the last contribution quarter and your CAPP balance equals or exceeds the cost of one quarter of Plan C-4 single coverage or Triple S single if you reside in Puerto Rico.*

REFUSAL OF HEALTH COVERAGE
For
IATSE NATIONAL HEALTH & WELFARE FUND,
ACTIVE PLAN C PARTICIPANTS ELIGIBLE FOR MEDICARE

Please read the attached instructions before completing this form.

Name: _____
(please print)
Address:_____
_____
_____
Participant ID#: _____

I, _____, hereby declare as follows:
(insert name)

- I am eligible for health coverage through Medicare and I hereby waive my right to coverage from Plan C.
- I understand that I will **forfeit my entire CAPP balance** as of the close applicable employer contribution period (e.g., as of January 31 for an election effective April 1). I understand **I will not be entitled to any benefits from Plan C or the R-MRP Plan for the applicable quarter**
- I understand that employer contributions received after such forfeiture will be credited to my CAPP account and that if my CAPP account again reaches the cost of one quarter of Plan C-4 single coverage, or Triple S single if I reside in Puerto Rico, and I am "active" at that time, I must again timely complete and submit this Refusal of Health Coverage form (which once again will cause a total forfeiture of my newly acquired CAPP account balance) or choose one of Plan C's coverage options. Otherwise, I will be defaulted into Plan C-4 single coverage, or Triple S single if I reside in Puerto Rico.
- I have carefully considered this decision and I understand that this election **MAY NOT BE REVOKED** once it is received by the Fund.

_____ _____
Signature Date

** *For more information please see the Summary Plan Description, available on the website, www.iatsenbf.org, or upon request from the Fund Office, at 1-800-456-FUND (3863) or via email at psc@iatsenbf.org.*

This form along with the quarterly statement election form must be received by the Fund Office by the due date indicated on that form. *Otherwise, unless you elect another coverage option: if you (a) are not currently enrolled, you will be defaulted into coverage (C-4, or Triple S if you reside in Puerto Rico), (b) are already enrolled in coverage, your current coverage will continue or be downgraded based on you available CAPP balance.*