Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada
P.O. Box 10067, Manhattan Beach, CA 90266
Phone: 800-947-4338 Fax: 310-798-0766

Important Notice to Plan A Participants Who May Lose Eligibility for Benefits Due to a Reduction in Work Hours

If you wish to continue your coverage on a self-pay basis, you may qualify to enroll in either the Self-Pay Program or COBRA. A **summary** of these programs, for comparison purposes only, is outlined below. Please review these options very carefully. Once you have made your election to enroll in either Plan, you will not be allowed to enroll in the other. If you do not elect the Unemployed/ Disabled Self-pay Plan and make the necessary initial payment by the due date, your only option will be COBRA Continuation Coverage, at a higher monthly premium.

The specific rules regarding these programs are summarized at pages 28-37 of the Plan A Summary Plan Description, but the following recent modifications also apply.

	Unemployed & Disabled Self-pay Program	COBRA Continuation Coverage
Current Monthly Premium	**Single** **$300** **2-Party** **$450** **Family** **$550** ***See Note Below**	**Single** **$522** **2-Party** **$1,044** **Family** **$1,521**
Enrollment & Initial Payment Deadline	Completed application and initial payment must be received in the Administrative Office **no later** than the 20th day of the last month of Active coverage, prior to your termination of coverage. **If you do not submit your initial payment by the due date, your only option will be COBRA, at a higher premium**.	Completed Election Form must be received in the Administrative Office **no later** than 60 days from date of loss of Active coverage. Initial payment must be received **no later** than 45 days from election date, and must cover all months retroactive to your loss of coverage.
Monthly Payments	Due in the Administrative Office no later than the 20th of the month prior to the month of coverage. **Payments received after the due date will be returned and coverage will terminate**. Once self-pay coverage is terminated, it cannot be reinstated.	To avoid a possible delay in processing of benefits, payments are due in the Administrative Office no later than the 20th of the month prior to the month of coverage. Payments will be accepted until the 30th day of the coverage month.
Qualifications	**Unemployed** - You must be available for covered employment, as evidenced by Local Union's records. **Disabled** - Written verification of disability must accompany completed application and initial payment.	Loss of coverage due to a reduction in work hours. You are **not eligible** to enroll in COBRA if you are working in **Non-Covered Sheet Metal Service**.

	Unemployed & Disabled Self-pay Program	COBRA Continuation Coverage
Available Extension	6 consecutive months *(dependent on prior use)*	18 consecutive months
Additional Extensions ***(if you qualify)***	A 6-month extension may be approved by the Trustees, for a total not to exceed 12 consecutive months. **Please contact the Administrative Office for an extension application prior to the expiration of your initial 6 months.**	11 additional months may be available **if** you receive a Social Security Disability Award. Please contact the Administrative Office **immediately** for more information.
Death Benefit	Remains $20,000.	**None.** Self-pay conversion may be available. Please contact the Administrative Office for more information.
Termination of Coverage	Coverage will terminate on the earlier of: the last day of the month for which a timely premium has been paid, or, the last day of the month of the available extension period.	
Reinstatement of Active Coverage	Coverage may be reinstated by returning to work for a Contributing Employer and obtaining a minimum of: either a total of 120 hours within 6 months of your termination of coverage, or a total of 240 hours in 2 consecutive months. **Please keep in mind that there is a full month between work month and coverage month.**	

***Note:** A participant may, in writing, elect to "suspend" coverage of dependents who were covered previously under Actives Coverage, if doing so would result in a lower monthly self-pay premium. The participant may make such an election ONLY when he or she first enrolls on the Self-pay Plan. "Suspended" dependents will remain "suspended" until the participant's Active coverage is reinstated. At that time, all otherwise-eligible "suspended" dependents will automatically be reinstated to coverage.

IMPORTANT: If you choose to enroll in the Unemployed/Disabled Self-pay plan, your first payment must be received in the Administrative Office no later than the 20th of the month **prior** to the month of coverage. If you do not elect the Unemployed/ Disabled Self-pay plan and make the necessary timely payment, your only option will be COBRA Continuation Coverage. You will automatically receive a COBRA notification within 14 days of your loss of coverage. If you do not elect to continue your coverage on either of these self-pay plans, coverage may be reinstated as indicated on the chart above.

It is YOUR responsibility to know the number of hours in your bank, and when coverage will terminate. It is also your responsibility to remit the required premiums by the due date. The Administrative Office does *not* send monthly bills or reminder notices. Once Self-pay or COBRA coverage has been terminated, it cannot be reinstated.

If you have any questions or need additional information, please **do not hesitate to contact the Eligibility Department at 800-947-4338, option #3**.

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Aviso a los participantes que hablan español: *Si tiene alguna pregunta tocante este aviso, o requiere alguna otra información tocante a su cobertura de salud, por favor no dude en*

comunicarse con la Oficina Administrativa al 800-947-4338, donde habrá varios representantes bilingües que con gusto le ayudarán.

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Attn: Eligibility Department

Application for Unemployed or Disabled Self-Pay Coverage

Please PRINT clearly:

Name: _____ Last 4 Digits of SSN: _____

Address: _____ Phone #: _____

_____ Local Union: _____

Are you currently on the Local Union's "Out-Of-Work" List and available for covered employment? [ ] YES [ ] NO

When were you last referred to a Sheet Metal Job? _____

Did you accept it? [ ] YES [ ] NO If not, why? _____

_____

Are you currently employed? [ ] YES [ ] NO If yes, provide the name & address of your current employer and your job duties:

Employer Name: _____

Address: _____

Job Duties: _____

Are you currently unable to work due an injury or illness? [ ] YES [ ] NO
If YES, please attach proof of disability.

Please provide any other information you believe relevant: _____

_____

I understand that I have the option to continue my coverage under COBRA for a period of up to 18 months, and have chosen to instead enroll in the Self-pay coverage, which is available for up to 6 consecutive months. I also understand that all payments are due in the Administrative Office **no later than the 20th of the month PRIOR to the month of coverage**. The Administrative Office does NOT send bills or reminder notices. **Failure to remit payments by the due date will result in termination of coverage**. Once terminated, Self-pay coverage cannot be reinstated.

I certify that all the above answers are true and correct to the best of my knowledge.

_____ _____

Signature ***Date***

Unemployed /Disabled Self-Pay coverage is available for a period of 6 consecutive months, dependent on prior use. If necessary, you may apply for an additional 6-months. Please contact the Administrative Office for an application.

***** In no event will Self-pay coverage be provided for more than 12 consecutive months *****

Local Union Verification: _____ Date: _____