Sheet Metal Workers' Retiree Health Plan

of Southern California, Arizona & Nevada

<u>If you are electing coverage under the Sheet Metal Workers' Retiree Health Plan</u>, or would like to review what is available to you, please complete both sides of this form, & return it to the Administrative Office, along with your Pension application. If, after your review, you decide to enroll in the Sheet Metal Workers' Retiree Health Plan, **y**ou must submit a completed **<u>Enrollment Form</u>** *(included in each plan's enrollment packet)* for the plan of your choice, **to the Administrative Office.** *This* form is NOT an enrollment form. It is simply a request for more information on the Plans available.

<u>If you are declining coverage at this time</u>, please sign and date the back of this form, and indicate whether or not you have other coverage available.

Please send me enrollment materials for the following Medical Plan(s): Please note that <u>not</u> all Plans are available in all areas. To enroll you must reside in your selected Plan's covered service area, as defined by your zip code. If you do not reside in a contracted service area, you are not eligible for Retiree Health coverage. If you should move outside the contracted plan's service areas, or if the contracted plans no longer provide service in your area, Retiree Health coverage will terminate.

California	❍ United HealthCare HMO / Medicare Advantage HMO	❍ Health Net HMO / Seniority Plus HMO	❍ Kaiser Permanente HMO/ Senior Advantage HMO
Nevada	❍ United HealthCare EPO / Medicare Advantage HMO*****	❍ Health Plan of Nevada HMO / Senior Dimensions HMO	❍ Hometown Health HMO***** ***(Northern NV only)***
Arizona	❍ United HealthCare EPO / Medicare Advantage HMO		

*******Medicare Advantage is not available in Northern Nevada. In addition, there is no contracted Medicare plan available in the Hometown Health HMO Plan. If you and/or your eligible dependents are eligible for or become eligible for Medicare, it may be necessary for you to change plans. If no contracted Medicare plan is available, coverage will terminate*

Returning *this* completed form does **<u>NOT</u>** enroll you in the Retiree Health Plan. You must submit a completed **Enrollment Form** for the plan of your choice **to the Administrative Office** at least 30 days prior to your Retiree Health coverage effective date.

I understand that if I and/or or my spouse are eligible for or become eligible for Medicare, I/we must: 1) notify the Administrative Office, 2) enroll in <u>both Parts A and B</u>, **and,** 3) must assign our Medicare benefits to our HMO medical plan. **Failure to do so may result in a termination of health coverage**.

<u>Check one below:</u>

☐ I am eligible for and enrolled in Medicare Parts A and B

☐ I am <u>not</u> eligible for Medicare

If you are married and have chosen "retiree + spouse" coverage, <u>please also check one below:</u>

☐ My spouse is eligible for and enrolled in Medicare Parts A and B

☐ My spouse is <u>not</u> eligible for Medicare

_____ _____

Signature ***Date***

PRINT Name:	Last 4 digits of SSN

Eligibility for Retiree Health Plan Coverage

Beginning with pension benefits effective July 1, 2016 and after, eligibility for Retiree Health Plan coverage is limited to participants with at least 15 years of Pension Credit earned in this Plan, (Reciprocal Credits will not apply). In addition, a total of two of the pension credits must be earned in the 60 months (5 years) prior to the effective date of pension benefits during which time contributions must have been made to the Health Plan.

Retiree Health coverage is limited to HMO/ EPO coverage available in contracted service areas. If you do not reside in a currently contracted service area, coverage is not available. If you should move outside a contracted service area, or should the HMO or EPO no longer provide coverage in your area, retiree health coverage will terminate.

Please check one below:

☐ ***I am ELECTING Retiree Health Coverage***

I hereby authorize the appropriate deduction from my monthly Local Pension benefit check for coverage under the Sheet Metal Workers' Retiree Health Plan. This deduction will begin following the expiration of any existing Active Hour Bank. I understand that monthly premiums and benefits are subject to change. This authorization is to remain in effect until it is revoked by me in writing. I also understand that if my pension check is not large enough to deduct the entire monthly health coverage premium, that I will be required to remit self-payments to the Administrative Office by the 20th of the month prior to the month of coverage.

I have completed the reverse side of this form, and have indicated which HMO/EPO plan(s) I would like to receive more information on. I will submit a completed Enrollment Form to the Administrative Office at least 30 days prior to my Retiree Health coverage effective date.

_____ _____

Signature *Date*

☐ ***I am WAIVING Retiree Health Coverage***

I do **not** wish to elect coverage under the Sheet Metal Workers' Retiree Health Plan. I understand that I am relinquishing coverage under the Retiree Health Plan, and that once coverage is waived or terminated, I may be allowed a one-time reenrollment. I further understand that for the first 12 months of such reenrollment coverage, I may be required to remit monthly premiums to the Administrative Office, and that such premium may be considerably higher than the premium in effect for those who have elected coverage when first eligible to do so and continuously maintained such coverage.

Are you declining Retiree Health Plan coverage because you have other current coverage available?

☐ Yes ☐ No

If Yes, what is the name of the other health plan coverage? _____

_____ _____

Signature *Date*

PRINT Name:	**Last 4 digits of SSN**