California Service Employees Health and Welfare Trust Fund

828 West Washington Blvd. • Los Angeles, CA 90015
(213) 747-7551 • (877) 492-2778 • (877)HWCASRV

TO: ELIGIBLE PLAN PARTICIPANTS COVERED UNDER THE MCAA AEROSPACE AGREEMENT

RE: HEALTH & WELFARE ENROLLMENT

Our records indicate that you are eligible for **MEMBER ONLY** Health & Welfare benefits through your employer and SEIU-USWW. Your benefits are paid 100% by your employer, provided you have been employed for at least 90 days and are paid a minimum of 110 hours per month.

KAISER "C-9" MEDICAL AND PRESCRIPTION DRUG BENEFITS
MEMBER-ONLY COVERAGE

Co-pays are $30 per doctor visit, $125 per emergency room visit, $15 for each generic drug & $35 for each brand name drug. Please refer to the enclosed Plan Summary.

After 36 months of employment, you may add eligible dependents to your Health & Welfare benefits at no cost to you.

Please complete, **sign** and return the enclosed enrollment form. **Your health insurance cannot be activated without complete enrollment information.**

The Agreement also allows you to "Opt Out" of Trust Fund benefits if you have other current alternate creditable coverage that you recently acquired. To opt out of the Trust Fund plans, you must submit the enclosed Opt-Out form and attach the Creditable Coverage Certificate from your other insurance carrier. This certificate must show you, the employee, as being currently covered at the time of opting out of the Trust Fund benefits. Once you have Opted Out, you will not have any benefits under the Trust Fund.

If you have any questions regarding your Health & Welfare benefits, please contact us at (213) 747-7551 or toll free (877) 492-2778.

Receipt of this notice does not constitute a determination of your eligibility.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

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OPT-OUT FORM

Complete this form if you do not want to enroll in or wish to dis-enroll from the health and welfare benefits plan offered by the California Service Employees Health & Welfare Trust Fund ("Trust Fund"). This form can only be completed by an employee whose collective bargaining agreement ("CBA") allows for opt-out or dis-enrollment from coverage offered by the Trust Fund.

I, the undersigned, hereby certify under penalty of perjury that the following statements are true and correct:

1) I have been given the opportunity to enroll and participate in the health and welfare benefits plan offered by the Trust Fund.

2) I voluntarily elect to decline participation in that plan and to opt out of the medical, dental, and vision coverage offered by the Trust Fund.

3) I acknowledge that my voluntary decision to opt out means that the Trust Fund will **not** extend health and welfare benefits neither to me nor to my dependents.

4) I have obtained other health care coverage from another provider. Proof of other health coverage must be submitted with this form.

5) I acknowledge that if I wish to enroll in the health and welfare benefits plan offered by the Trust Fund in the future, I must notify the Trust Fund within sixty (60) days of my loss of other health care coverage, except that if I am eligible for Medicare, I will **not** be allowed to opt back into the health and welfare benefits plan offered by the Trust Fund.

Employee Name: _____
[Please print clearly.]

Social Security Number: _____

Home Address: _____

Phone Number: _____

Employer Name: _____

Employee Signature: _____ **Date:** _____

FOR FUND USE ONLY.

Opt Out: Approved_____ Denied_____ Effective Date: _____

Reason for Denying Request:

_____

_____

_____

OPT-OUT INSTRUCTIONS

You must complete the opt out form to opt out of the health care coverage offered by the California Service Employees Health & Welfare Trust Fund (the "Trust Fund").

Take note that your employer and collective bargaining agreement may have additional requirements or terms for opting-out of the Trust Fund's coverage. For that reason, you are advised to review your collective bargaining agreement prior to submitting this form.

You must submit this form to the Trust Fund Office and to your employer.

If you wish to opt back into the Trust Fund's coverage, refer to your collective bargaining agreement for eligibility information.

You may obtain this form by contacting your employer or Union office or by calling the Trust Fund Office toll-free at (877) 492-2778 or by visiting the Trust Fund Office inside the SEIU-USWW building at 828 W. Washington Blvd., Los Angeles, CA.

If you lose coverage through your other health insurance, you must contact the Trust Fund Office within 60 days from the date coverage was lost in order to enroll back into the Trust Fund's coverage. Medicare-eligible members will not be allowed to opt back into the Trust Fund's coverage.

For more information, please contact the Trust Fund Office directly at (213) 747-7551 or toll-free at (877) 492-2778 and review the terms of your collective bargaining agreement.