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 WORKING AT KAISER PERMANENTE - MORENO VALLEY COMMUNITY HEALTH CENTER**

RE: **HEALTH & WELFARE BENEFITS**

Our records indicate that you are eligible for Health & Welfare benefits through your employer and SEIU-USWW. The Trust Fund coverage is offered to all eligible employees who have been employed for at least 90 days and have worked and/or been paid the minimum of 130 hours a month.

You may enroll your eligible dependents to this coverage, which the Trust Fund defines as a lawful spouse or enrolled Domestic Partner (please contact the Trust Fund for special enrollment information), your children up to the age of 26, your disabled children for whom written evidence of the incapacity is provided to the Trust Fund. If you are enrolling your spouse, a copy of your marriage certificate must be provided, if you are enrolling your children, a copy of each child's birth certificate must be provided. Social Security numbers must be provided for each dependent, however, if your dependent(s) does not have a social security number, please contact the Trust Fund office for special enrollment information.

BENEFIT TYPE	DESCRIPTION	Employee's Monthly Portion
Medical and Prescription Drug plan	**Kaiser Bronze "5808" medical and prescription drug** $4,500 annual Deductible. 40% coinsurance after plan deductible for primary and specialty care office visits and treatment - 40% coinsurance after plan deductible for each emergency room/outpatient surgery visit and ambulance services. 30% coinsurance (not to exceed $50) for up to a 100-day supply for each Generic Rx (deductible doesn't apply), 40% coinsurance (not to exceed $100) after a $250 deductible for each Brand Rx. *-or-* **Kaiser "C-8" medical and prescription drug** Co-pays are $10 per doctor visit, $50 per emergency room visit, $10 for each generic drug & $20 for each brand name drug.	*Please contact your employer for your monthly portion of the benefits listed.* *To opt out of these benefits, please turn to page 2 of this letter for more information.*
Dental Plan	**DeltaCare USA #CAC31 (HMO)** is a prepaid dental plan that offers $0 co-pays for most services and you will be required to select a panel dentist from their participating list of providers in order to receive covered benefits.	
Vision Insurance	**Vision Service Plan (VSP) #C** is a vision plan that is widely accepted by most eye care providers and offers routine eye exams, prescription glasses OR contacts, in addition to laser vision correction discounts.	
Life Insurance	You are eligible for **$10,000** life insurance and your covered dependents are eligible for $2,500 life insurance as part of your Health & Welfare benefits through the Trust Fund. For each covered month that you are eligible, your life insurance benefit will remain in effect. To qualify for the life insurance benefit, you must be eligible in the month of passing.	

Please complete, **sign** and return the enclosed enrollment form with the required documents and beneficiary designation card. **Be advised that 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 and your dependents 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.

California Service Employees Health and Welfare Trust Fund

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

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:

____

____

____

<u>OPT-OUT INSTRUCTIONS</u>

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 <u>additional requirements or terms</u> 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 <u>and</u> 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.