JAEGER & FLYNN ASSOCIATES, INC.
BENEFITS | HUMAN RESOURCES | RISK MANAGEMENT | INSURANCE

SMWIA SHEET METAL WORKERS INTERNATIONAL ASSOCIATION

May 3,2017

Welcome to Open Enrollment July 2017!

It is **open enrollment time,** which means that you may change, add, or waive your health and/or dental coverage with changes effective **July 1st, 2017**. Any changes in insurance coverage must be received no later than **Friday**, **June 2nd** by the Fund office. **If you are currently enrolled in SMW Local 83's medical and/or dental insurance plans and you are not making any changes, you do not need to take further action as your current elections will remain in place.**

If you have children under age 18, please see enclosed materials for possible cost savings.

Your monthly premiums, dental, RX, administration fees and retiree contribution will continue to be deducted from your PAP account monthly. Please take some time to review your accounts and the insurance options because this is the time to make a change and to start to build up your PAP balances. If you would like to make any changes to your medical plan effective **July 1, 2017**, then you will need to fill out and return the enclosed SMW Health and Benefits Fund Enrollment Form to the Fund office prior to **June 2nd, 2017**. If you would like to discuss your current plan or have any questions about moving to another option please contact **Meg Kelsey at 373-0069 ext 173 or at mkelsey@jaegerflynn.com.**

2017 Triple Option Health Insurance Offerings

TRIPLE OPTION OFFERING 2017							
		Current Plan and Option 1		Option 2		Option 3	
		BSNENY PPO 815		BSNENY PPO 829 Hybrid		BSNENY HDPPO 7200	
Benefits		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Single/Family)		None	$250/$500	$500/$1,000	$1,000/$2,000	$1,500/$3,000 (Combined IN & OON)	
Plan Year or Calendar Year Accumulator		Calendar Year		Calendar Year		Calendar Year	
Aggregate or Embedded		N/A	Embedded	Embedded		Aggregate	
Coinsurance		None	80%/20%	90%/10%	70%/30%	None	70%/30%
Total OOP Max (Single/Family)		$6,350/$12,700	$5,500/$11,000	$1,000/$2,000	$2,000/$4,000	$5,000/$10,000	$10,000/$20,000
Primary Care Office Visit		$25	Ded & Coins	$25	Ded & Coins	Ded then $30	Ded & Coins
Specialist Office Visit		$25	Ded & Coins	$40	Ded & Coins	Ded then $50	Ded & Coins
Preventive Care		Covered in Full	Ded & Coins	Covered in Full	Ded & Coins	Covered in Full	Ded & Coins
Inpatient Hospital		Covered in Full	Ded & Coins	Ded & Coins	Ded & Coins	Ded then $250	Ded & Coins
Outpatient Surgery		Covered in Full	Ded & Coins	Ded & Coins	Ded & Coins	Ded then $75	Ded & Coins
Emergency Room		$100	$100	$100	$100	Ded then $50	Ded then $50
Maternity R&B & Delivery Fee		Covered in Full	Ded & Coins	Ded & Coins	Ded & Coins	Ded then $250	Ded & Coins
Out-Patient Diagnostic X-ray		Covered in Full	Ded & Coins	Ded & Coins	Ded & Coins	Ded then $30	Ded & Coins
Out-Patient Diagnostic Lab Services		Covered in Full	Ded & Coins	Ded & Coins	Ded & Coins	Ded then $30	Ded & Coins
Home Health Care		$25	Ded & Coins	$40	Ded & Coins	Ded then $50	Ded & Coins
Skilled Nursing Facility		Covered in Full	Ded & Coins	Ded & Coins	Ded & Coins	Ded then $250	Ded & Coins
Durable Medical Equipment (DME)		Covered in Full	Ded & Coins	Ded & Coins	Ded & Coins	Ded then 20%	Ded & Coins
Diabetic Supplies		$25	Ded & Coins	$25	Ded & Coins	Ded then $30	Ded & Coins
Vision Coverage							
Exam		$25 (Covered in Full Every 2 Years)		$40 (Covered in Full Every 2 Years)		Ded then $50 (Covered in Full Every 2 Years	
Lenses/frames		Not Covered, Discounts Available		Not Covered, Discounts Available		Not Covered, Discounts Available	
2017 Premiums	Counts						
Employee Only	128	$541.05		$437.26		$322.50	
Employee +1	90	$1,109.22		$896.38		$661.11	
Family	185	$1,536.59		$1,241.81		$915.89	

SMW LOCAL 83 HEALTH AND BENEFITS FUND ENROLLMENT FORM

SMW MEMBER NAME (FIRST NAME + MI + LAST NAME)	SOCIAL SECURITY #	GENDER ☐ Male ☐ Female	DATE OF BIRTH (MM/DD/YY)	
MAILING ADDRESS (STREET, APT NO.)	CITY	STATE	ZIP CODE	TELEPHONE
EMAIL ADDRESS:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED	CLASSIFICATION: ☐ MEMBER ☐ RETIREE		

WHICH PLAN TYPE(S) & COVERAGE AMOUNT(S) ARE YOU ENROLLING IN?

Medical Insurance:	OPT -OUT OPTION
☐ BSNENY–PPO Current Plan; ☐ BSNENY HYBRID PPO; ☐ BSNENY – HDPPO ☐ Single ☐ 2-Person ☐ Family	☐ $750.00/MONTH
ALL MEDICAL ENROLLMENTS INCLUDE HRA, DENTAL AND RX COVERAGE	**DELTA DENTAL COVERAGE** ☐ Single ☐ 2-Person ☐ Family ☐ OPT-OUT

INFORMATION ABOUT FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN: (For additional dependents please attach another page, Proof of Marriage or Birth Certificate is required if you are adding your spouse or dependent child(ren))

NAME (FIRST NAME + MI + LAST NAME)	ELECTING COVERAGE	WAIVING COVERAGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER
SPOUSE NAME	☐ HEALTH	☐ HEALTH			☐ M ☐ F
DEPENDENT CHILD NAME	☐ HEALTH	☐ HEALTH			☐ M ☐ F
DEPENDENT CHILD NAME	☐ HEALTH	☐ HEALTH			☐ M ☐ F
DEPENDENT CHILD NAME	☐ HEALTH	☐ HEALTH			☐ M ☐ F
DEPENDENT CHILD NAME	☐ HEALTH	☐ HEALTH			☐ M ☐ F

MEMBER CERTIFICATION:

***I hereby certify that the above information is correct. I further certify that I have read and agree to these* Terms and Conditions: I, the above named participant, hereby authorize the elected benefit premiums noted above until such time as I should provide written notice to change or discontinue these deductions/reductions. I also authorize the Plan Administrator to make any future adjustments necessary should there be a change in the premium amounts for the coverage options I have selected. I agree to notify the Plan Administrator in writing of any changes to my personal information above that may affect the administration of my reimbursement benefits. I understand that neither my employer nor the Plan Administrator will be held liable for any delays or problems in the administration of my Plan or issue of my reimbursements, in the event that I fail to provide them with this information in an accurate and timely manner. I agree to be responsible for paying any fees associated with having the Plan Administrator reissue reimbursement checks to me, in the event that initial payments issued to me are lost, stolen, misplaced, or otherwise not received by me in a timely manner. If the Plan Administrator determines that an expense I submitted for reimbursement, or that the JFA Flex Debit Card was used for was not a qualified expense under the Plan, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. By signing this enrollment form, I agree to have the amount of any over-reimbursed prescription claim deducted automatically from my HRA if my prescription coverage pays for a claim after my coverage has ended.**

_____ _____ _____

SMW LOCAL 83 MEMBER NAME **SMW LOCAL 83 MEMBER SIGNATURE** **DATE SIGNED**

For any questions, you may have regarding completing this form or additional information that may be required contact The SMW Local 83 Fund Office at 518-489-1377 or Jaeger & Flynn Associates (JFA) -1-800-388-8538. Please forward the complete form to SMW Local 83 Fund Office at 718 Third Street Albany, NY 12206. Thank you.

TO BE COMPLETED BY INSURANCE FUND OFFICE:

ELIGIBILITY DATE: _____ **INSURANCE FUND SIGNATURE:** _____ **DATE SIGNED:** _____

HEALTH PLAN AND HRA PLAN ENROLLMENT/WAIVER/OPT-OUT FORM AND HOLD HARMLESS AGREEMENT

Waiver Instructions: If you have other Affordable Care Act (ACA) Qualified Health Insurance coverage in effect through your spouse's or other family member's Employer-Sponsored Group Health Plan, you must complete and return Section One of this Waiver/Attestation Form and Hold Harmless Agreement to the SMW Local 83 Fund Office with either 1) a copy (front & back) of your insurance card that specifically identifies you as a covered dependent or 2) a letter of coverage verification (which includes your name and policy/member number) from your spouse's or other family member's insurance carrier. Please see attestation below

Section One: Please check all applicable boxes below

☐ **Option 1: Member Health Plan Opt-Out WITH HRA ENROLLMENT.** I am enrolled in a health plan offered by another employer (i.e. your spouse's employer or other family member's employer or a retiree plan) and I elect to OPT-OUT of the SMW Local 83 Health Insurance but wish to be enrolled in the SMW Local 83 Health Reimbursement Account (HRA) plan. This HRA will reimburse me (and any dependents who are also enrolled in a Qualified Health Plan) for qualified medical, dental and/or vision expenses and post-tax deductions for the employer sponsored health plan that I am enrolled in. **Example: I am opting out of insurance coverage through the SMW Local 83 Benefit Fund because I have other employer sponsored health insurance and I want myself and my dependents to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see attestation below.**

☐ **Option 2: Member and/or Spouse enrolled in the SMW Local 83 or other sponsored health plan and Dependent Waiver:** I and/or my spouse and I am/are enrolled in a health plan offered by SMW Local 83 Health & Benefit Fund or another employer Sponsored health plan and my dependents are NOT enrolled in a health plan offered by SMW Local 83 Health & Benefits Fund or a Health Insurance Plan offered by another employer and I choose to waive my dependents from my Health Reimbursement Account (HRA) plan. **Example: my children are enrolled in Child Health Plus, or Medicaid and not eligible for reimbursement under my plan. I want myself (if single) and/or myself and my spouse to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see attestation below.**

☐ **Option 3: Permanent HRA Waiver:** (This option is required to be offered however it is highly unlikely that you would choose this option, unless you are in the instance of where you wish to only use the exchanges and be eligible for the federal subsidies associated and available on the marketplace.) I am not enrolled in a health plan offered by SMW Local 83 or a health insurance plan offered by another employer (i.e. your spouse's employer or another family member's employer plan) and I elect to waive myself and my dependents from the SMW Local 83 Health Reimbursement Account (HRA) plan permanently. **Proof of other health plan enrollment is required. Please see attestation below.**

I *CERTIFY BY LISTING MY NAME (AND COVERED DEPENDENTS NAMES) BELOW THAT EACH NAME LISTED HAS QUALIFIED HEALTH INSURANCE COVERAGE THROUGH (CHECK ALL THAT APPLY):*
□ SMW LOCAL 83 HEALTH & BENEFIT FUND OR □ ANOTHER EMPLOYER OR □ MY SPOUSE'S (OR OTHER FAMILY MEMBER) EMPLOYER OR □ OTHER GOVERNMENT SPONSORED PLAN THAT MEETS THE ACA DEFINITION OF MINIMUM ESSENTIAL COVERAGE (MEC).*

SMW LOCAL 83 MEMBER'S NAME: _____ **SPOUSE'S NAME:** _____

DEPENDENT_____ DEPENDENT_____

DEPENDENT_____ DEPENDENT_____

DEPENDENT_____ DEPENDENT_____

NAME OF OTHER INSURANCE CARRIER (IF NOT ENROLLED IN SMW LOCAL 83): _____

POLICY# OR MEMBER IDENTIFICATION #: _____ **EFFECTIVE DATE OF COVERAGE:** _____

SMW LOCAL 83 MEMBER'S SOCIAL SECURITY NUMBER: _____-_____-_____ **BIRTH DATE:** _____/_____/_____

I hereby elect not to have ☐ **my own** ☐ **my spouse's and/or** ☐ **my child(ren)'s** (please check all boxes that apply) health insurance premiums withdrawn from my personal HRA account. I understand that by making this Election, my own and/or my spouse's and/or my child(ren)'s health coverage under the SMW Local 83 Health and Benefit Fund (the "Fund") will terminate on the effective date of other coverage. I was given the opportunity to enroll myself and/or my spouse, and/or my child(ren) in the SMW Local 83 Health & Benefit Fund's Group Health Benefits. By waiving my own and/or my spouse's and/or my child(ren)'s Health Insurance Benefit, I am not waiving any other Benefit offered by the SMW Local 83 Health & Benefit Fund. I understand that if I later wish to enroll myself and/or my spouse and/or my child(ren) for any coverage(s) waived, I can do so only during Open Enrollment or upon involuntary loss of coverage. I further understand that I must complete the proper enrollment forms at such time.

I have attached the following "Proof of Current Coverage":

___ Employer/Insurer letter of coverage ___ Insurance ID card___ Other (please describe _____)

In consideration of my being allowed to make this Election, I hereby agree, for myself and/or my eligible dependents, to indemnify the Fund, the Trustees of the Fund and their Members, agents and representatives, and hold them harmless, against any damages, costs or expenses which they may suffer or incur, including reasonable attorneys' fees, arising out of any actions, causes of action or claims for or relating to benefits to which I or any of my eligible dependents would have been entitled had I not made this Election. This Agreement shall be binding upon my heirs, executors, administrators and assigns, and shall inure to the benefit of the Fund, its Trustees, Members, agents and representatives, and their successors and assigns.

SMW Local 83 Member's Signature: _____ **Print Name:** _____ **Date:** _____

Spouse's Signature & Acknowledgement: (Only required if waving coverage for spouse) **I** certify that I am the spouse of _____ and I hereby consent to the foregoing Election and Hold Harmless Agreement.

Spouse's Signature: _____ **Print Name:** _____ **Date:** _____