



Sheet Metal Workers' Local No. 25

New Jersey Benefit Fund

440 Barell Avenue, Carlstadt, New Jersey 07072

Telephone 201-507-0334

WWW.SMW25.ORG



VERY IMPORTANT NOTICE TO PARTICIPANTS OF THE SHEET METAL WORKERS LOCAL 25 NEW JERSEY WELFARE FUND

Date: December 1, 2010

To: All Participants in the Sheet Metal Workers Local 25 New Jersey Welfare Fund
and their covered dependents
All retirees and their covered dependents
All COBRA participants

From: The Board of Trustees

IMPORTANT: Read this notice carefully, as it provides a special enrollment opportunity for certain children and also requires you to reenroll your children age 19 and over even if they are already enrolled.

Effective January 1, 2011, the Fund will extend coverage to participant's eligible children¹ up to the end of the month in which the child attains age 26. Coverage is available whether the child is married or unmarried, regardless of student status, employment status, financial dependency on the participant, or any other factor other than the relationship between the child and the participant. **However, through December 31, 2013, in order to receive such coverage, children who are at least 19 (but below age 26) cannot have access² to health insurance coverage through an employer (besides that of another parent's employer).** Please note that coverage will not be extended to the eligible child's spouse (if married) or children.

¹ Eligible children include natural children, legally adopted children, and children placed for adoption. Step-children are only covered if legally adopted by the Participant.

² Access – denotes that the dependent child is eligible to enroll in, or purchase health coverage through an employer (regardless of the costs of that coverage or the benefits it provides), In addition, eligibility for coverage under a group health plan of the child's spouse's employer constitutes access to "health insurance coverage through an employer."

If you remain eligible under the Fund, coverage for the eligible dependent child will generally be provided until the end of the calendar month in which the child attains age 26.

You will receive additional notifications about the Plan, including the revised definition of dependent child, in the near future.

Special Enrollment for Children Under Age 26

As a result of this change, the Patient Protection and Affordable Care Act of 2010 provides a special enrollment opportunity for certain children under age 26. Specifically, if you have a child who is under age 26 (whether married or unmarried), including a child currently receiving continuation of coverage under COBRA, that child may be eligible to enroll in the Plan as of January 1, 2011. This special enrollment opportunity applies to:

- Children between the ages of 18 and 23 who are currently enrolled in the Plan,
- Children who were not previously eligible to enroll in the Plan,
- Children who were previously denied coverage under the Plan, and
- Children whose coverage under the Plan already ended.

Special Enrollment Instructions

If you want to commence or continue coverage for a child who is at least 19 years old beginning January 1, 2011, you must complete the attached enrollment form even if your child is currently enrolled. You must request special enrollment on behalf of your child and return the attached enrollment form for each dependent child over age 19 no later than December 31, 2010. If you request special enrollment by that date, coverage will be effective on January 1, 2011.

If enrollment materials are not received by the Fund Office by December 31, 2010, you may still enroll your dependent child late. However, coverage will be effective on the first day of the month after the date the Fund Office receives your completed enrollment materials.

To request additional special enrollment forms for your dependent child or to obtain more information, please contact the Fund Office at 201-507-0334.

Elimination of Lifetime Benefit Limit

Effective January 1, 2011 the \$1-Million lifetime limit on the dollar value of benefits under the Plan no longer applies. Individuals whose coverage ended by reason of reaching this lifetime limit under the plan are eligible to re-enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact the Fund Office at 201-507-0334.

Sincerely,

Sheet Metal Workers Local 25 New Jersey Welfare Fund

BOARD OF TRUSTEES

Notice about Grandfathered Status

The Sheet Metal Workers Local 25 New Jersey Welfare Fund believes this is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator by calling 201-507-0334. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Notice about the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Instructions

Complete this form for each adult child you wish to enroll in the Plan. If you have more than one adult child, you will need to complete a separate form for each adult child. This Plan defines an adult child as an individual over age 18 and up to age 26 who is a natural child, legally adopted child, and child placed for adoption with the participant.

This special enrollment opportunity applies to:

- Children between the ages of 19 and 23 who are **currently** enrolled in the Plan,
- Children below age 26 who were not previously eligible to enroll in the Plan,
- Children below age 26 who were previously denied coverage under the Plan, and
- Children below age 26 whose coverage under the Plan already ended.

Please note: These children will not be eligible for coverage if they are eligible for any employment-based coverage other than the plan of a parent. This limitation will be in effect until December 31, 2013.

This form must be completed in its entirety and be signed by both the participant and the adult child. You must return the form to the Fund Office December 31, 2010. If you mail the form, it must be postmarked by the deadline. If you do so, coverage for your adult child will be effective January 1, 2011. If enrollment materials are not received by the Fund Office by the deadline, you may still enroll your dependent child late. However, coverage will be effective on the first day of the month after the date the Fund Office receives your completed enrollment materials.

If your child is not currently enrolled in the Plan, you must provide the Fund Office with proof of family status. Please bring in or mail the original documents and the Fund Office will make a copy and return the original to you. To enroll a dependent child, you must provide the child's original birth certificate. For adopted children or those placed for adoption with you, you must provide the court order paper signed by the judge.

Additional Information:

Mail Completed Form(s) to:

Sheet Metal Workers Local 25 New Jersey Welfare Fund
440 Barell Avenue
Carlstadt, New Jersey 07072

If you have any questions in completing this Form, please call the Fund Office at 201-507-0334.

SPECIAL ENROLLMENT FORM FOR ELIGIBLE ADULT CHILDREN UNDER AGE 26

A. Participant (Journeyman/Retiree) Information:			
Last Name		First Name	Middle Initial (MI)
Mailing Address		Social Security Number	
City		State	Zip Code
Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth: (Month/Day/Year)	Home Phone Number	Cell Phone Number
B. Adult Child Enrollment: Child's relationship to you: <input type="checkbox"/> Natural Son/Daughter <input type="checkbox"/> Adopted Child <input type="checkbox"/> Child placed with you for adoption with the participant			
Last Name		First Name	Middle Initial (MI)
Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth: (Month/Day/Year)	Social Security Number	
Is your adult child: • Currently enrolled in the Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No • Married? <input type="checkbox"/> Yes <input type="checkbox"/> No • Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Is child's spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your adult child have access* to other employer-sponsored coverage (if yes to either, complete Section D): • Through his/her own employer? <input type="checkbox"/> Yes <input type="checkbox"/> N • Through his/her spouse's employer? <input type="checkbox"/> Yes <input type="checkbox"/> N	
C. Employer Name/Address and Phone number: If your child is employed, provide employer name, address and phone number. If the child is married and the spouse is employed, provide information about the spouse's employer.			
Adult Child's Employer Name:			
Employer Address and Phone number:			
Adult Child's Spouse's Employer Name			
Employer Address and Phone number:			
D. Eligibility for Other Health Care Coverage: Complete the following section if your adult child is currently eligible for health coverage either through his/her own employment or his/her spouse's employment.			
Policyholder's Name:		Policyholder relationship to Child <input type="checkbox"/> Self <input type="checkbox"/> Child's spouse	Policyholder Date of Birth: Group and Policy #:
Insurance Company/Claims Administrator Name:		Address:	Phone #:
E. Affidavits: Sign and date the affidavits on the following page.			

**access – denotes that the dependent has the ability to enroll in, or purchase health insurance through their employer regardless of cost or benefits available.*

Please sign the affidavit on the reverse side

Affidavits

Participant (Journeyman/Retiree) Affidavit:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that the Fund is relying on this information and that if I conceal information, provide false information, or otherwise mislead the Fund, my child's eligibility for Fund coverage may be terminated retroactively and I and my child will be liable, jointly and severally, for any claims that were paid erroneously based on the false or misleading information in addition to legal fees incurred and administrative expenses.

Signature _____ Date _____

Adult Child Affidavit:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that the Fund is relying on this information and that if I conceal information, provide false information, or otherwise mislead the Fund, my eligibility for Fund coverage will be terminated retroactively and I and my parent will be liable, jointly and severally, for any claims that were paid erroneously based on the false or misleading information in addition to legal fees incurred and administrative expenses.

Signature _____ Date _____