Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

3001 Metro Drive, Suite 500 | Bloomington, MN 55425 | 952-851-5797 | 1-844-468-5917

COVERAGE OPT-OUT FORM

This Opt-Out Form is used by individuals who are benefits eligible under the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund ("Plan") to opt-out of Plan coverage, to the extent permitted under the applicable collective bargaining agreement. Your coverage under the Plan will terminate the sooner of exhaustion of grace weeks or the first day of the month following the date you sign the completed Opt-Out Form ("Coverage Termination Date"). Following satisfaction of employer contributions to achieve initial eligibility for coverage in the Plan, contributions, including any employee contributions, will end the first week following your election to opt-out.

DIRECTIONS

Directions for Employee: If you are eligible for benefits under the Plan and your collective bargaining agreement allows you to opt-out of coverage under the Plan, you may exercise the opt-out option by completing Section 1 of this Coverage Opt-Out Form and providing it to your employer. While you are in opt-out status your employer will not make contributions to the Plan on your behalf even though you continue to work. PLEASE NOTE: If you are opting out of Plan coverage because you are enrolled in other health coverage, you must attach a signed written statement to this effect to receive special enrollment rights if you later lose eligibility for that other coverage.

Once you opt-out of Plan coverage for yourself and your dependent(s), you will not be entitled to re-enroll in the Plan's coverage, except to the extent permitted under the following special enrollment rights.

Special Enrollment Rights: You are entitled to special enrollment rights under the Plan as required by applicable law in the following circumstances:

- If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this Plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must submit your enrollment request to the Fund Office within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Once you submit your enrollment request, your employer will again begin to make contributions to the Plan on your behalf.

- If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must submit your enrollment request to the Fund Office within 30 days after the marriage, birth, adoption, or placement for adoption.

- If coverage under a Medicaid Plan or under a state children's health insurance program for you or your dependent(s) is terminated as a result of loss of eligibility for such coverage. However, you must submit your enrollment request to the Fund Office not later than sixty (60) days after the date of termination of such coverage.

- If you or your dependent becomes eligible for a state premium assistance subsidy from a Medicaid Plan or through a state children's health insurance program with respect to coverage under the Plan. However, you must submit your enrollment request to the Fund Office not later than sixty (60) days after the date you or your dependent is determined to be eligible for the assistance.

CAUTION – In order to be able to re-enroll or enroll a dependent in the Plan after having opted-out, you must be eligible to be covered. If, during the time you were in opt-out status, you lost eligibility because your employer stopped making contributions on your behalf, you will be required to again meet the Plan's rules for eligibility (i.e., become an Eligible Employee again) before being allowed to resume coverage. For part-time Employees who have not had a break in service and full-time Employees, this means earning at least 8 weeks of contributions in 12 consecutive weeks of employment. A part-time Employee who goes 6 consecutive months with no employer contributions will suffer a break in service. When that happens, the part-time Employee must re-qualify as an Eligible Employee by working 12 months during which at least one employer contribution is made in each month. These rules are stated in Section 4.6 REINSTATEMENT OF COVERAGE of the Summary Plan Description.

To request special enrollment or obtain more information, contact the Fund Office, at (952) 851-5797 or (844) 468-5917.

If you are opting out of Plan coverage because you are enrolled in other health coverage, your out-of-pocket costs for health care services will likely increase because payment for your health care expenses will not be coordinated between the Plan and your other health coverage. You will be responsible for paying for health care services to the extent they are not covered under your other health coverage.

EXAMPLE OF COORDINATION OF BENEFITS

Josie incurred medical expenses in the amount of $100. Both health plans considered the allowable expense to be $80 payable at 80%. Deductibles have been satisfied for both plans.

	Coordination
Total charge	$100
Allowed amounts by both	$80
Primary paid	$64 (80% of $80)
Secondary paid	$16 (subtract $64 from $80)
Patient responsibility	$0

Without the benefit of coordination of benefits the patient would be responsible for $16 of the total charge.

Once your employer has completed Section 2, your employer will forward a copy of this Coverage Opt-Out Form to the Fund Office.

Directions for Employers: Upon receipt of an employee's signed and dated Coverage Opt-Out Form, please have the authorized employer representative complete Section 2 of this form and submit copies to the Fund Office and to the Local 663 Union Office.

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SECTION 1 EMPLOYEE INFORMATION

If you are eligible for benefits under the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (the "Plan") and you have the right under your collective bargaining agreement to opt-out of coverage under the Plan, you may elect to opt-out of the Plan's coverage by completing and submitting this form to your employer. If you are a Full-time employee and elect to opt-out of the Plan's coverage, none of the Plan's benefits will be available to you or, if applicable, to your spouse or your dependent(s). If you are a Modified Part-time employee and elect to opt-out of the Plan's coverage, none of the Plan's benefits will be available to you. Your coverage under the Plan will terminate the sooner of exhaustion of grace weeks or the first day of the month following the date you sign your completed Opt-Out Form. You will no longer be required to make contributions to your employer the first week following your election to opt out.

Employee's Data

Name:	Social Security Number:
Date of Birth:	Phone Number:
Address:	Marital Status: ☐ Married ☐ Single ☐ Divorced

Spouse's Data

Name:	Social Security Number:
Date of Birth:	Phone Number:
Spouse's Employer Name:	Employer's Address:
Employer's Phone Number:	
Is your spouse enrolled in other Group Medical Coverage? ☐ Yes ☐ No	If yes, is the coverage type: ☐ Single ☐ Family

Dependent Data

Name	Relationship	DOB	Soc. Sec. No.	Sex	Employer/Other Insurance

Please provide the complete names, birth dates, etc., for each of your dependents that are eligible for Plan benefits. If a dependent child is employed and/or has other insurance, please include that information. Attach additional pages if necessary to list all of your dependents.

I have read this Coverage Opt-Out Form in its entirety and understand that by signing below, I am exercising my right under the collective bargaining agreement to opt-out of coverage under the Plan. I understand that Plan benefits, including the following, will no longer be made available to me, my spouse, or my dependent(s) (if applicable):

Medical	Vision	Disability
Prescription	Dental	Life Insurance

I understand that if I opt-out of Plan coverage I will only be able to re-enroll for Plan coverage under the special enrollment rights circumstances described on page 1. I understand that my employer will no longer collect my contributions and my employer will no longer make contributions to the Plan on my behalf as of the Coverage Termination Date. All of the above statements are true to the best of my knowledge and belief.

_____ _____

Participant's Signature *Date of Signature*

SECTION 2 EMPLOYER INFORMATION

If an employee is eligible for benefits under the Plan is employed in a classification under a collective bargaining agreement with the United Food and Commercial Workers Union District Local 663 that permits the employee to opt-out of Plan coverage, and the employee elects to opt-out of Plan coverage the employer is no longer required under the applicable collective bargaining agreement to make contributions to the Plan on the behalf of that employee following satisfaction of employer contributions to achieve initial eligibility for coverage in the Plan.

Employer:	Is employee employed in a classification under a collective bargaining agreement with the United Food and Commercial Workers Union District Local 663 that permits the covered employee to opt-out of Plan coverage? ☐ Yes ☐ No
Address:	Phone Number:

_____ _____

Signing for the Employer *Date of Signature*

Its: _____

Directions for Employers: Upon receipt of an employee's signed and dated Coverage Opt-Out Form, please have the authorized employer representative complete Section 2 of this form and submit copies to the Fund Office and to the Local 663 Union Office.