LOCAL 25
SHEET METAL WORKERS

May 1, 2017

RE: Sheet Metal Workers - Local 25 Retirees

We completed an extensive search for a new Retiree Dental vendor and are happy to announce that Aetna will be your new provider effective July 1, 2017. We have improved your Dental plans significantly at the same cost.

Please note that dental implants are now covered under the DMO and the new plan has less "out-of-pocket costs" for most procedures. The new PPO plan has an increased plan maximum and has Preventative Procedures covered at 100% when using an In-Network Dentist.

There are two AETNA Dental plans to choose from (DMO: In-Network only and a PPO: In and Out-of-Network benefits). To locate an In-network Dentist and the Dentist's DMO Code for the Enrollment Form, go to www.aetna.com or call 877-238-6200 and **reference the Local 25**. *If you enroll in the DMO.....you must elect a Dentist as your primary Dentist by putting their Primary Dentist code on the Enrollment Form or contacting Aetna by phone to make your election.*

Locating a Dentist online.....go to www.aetna.com

- Click on "Find a Doctor"
- Under "Search without logging in"....Click on "Plans through your job"
- Click on "Dentist (Primary Care) and enter your zipcode
- Under "Select a plan".....choose one of the following:
  - ✓ Low Option (DMO) – Network Name: DMO/DNO. You MUST see an In-network Dentist
  - ✓ High Option (PPO) – Network Name: PPO/PDN with PPO II. You can see any Dentist, but the plan pays more if you see an In-network Dentist
- You will find the "Primary Dentist" code under each Dentists' name.

See attached plan information for more details on the plans being offered.

NOTE: You no longer need a Dental Member ID Card to receive care. Simply tell the Dentist your Name, Date of Birth and Social Security Number. You will receive more information on this in your welcome kit that will be mailed to your home after you enroll.

Your coverage will begin on July 1, 2017. If you are interested in enrolling, you **MUST** complete the attached Enrollment Form and return it to Extensive Benefits, Inc. no later than Monday, June 26th.

If you decide to enroll, it will be charged to your Credit Card, Debit Card or automatically withdrawn from your checking account each month. Your first payment will be on June 28, 2017 for your July coverage and on the 28th of each month thereafter. The name on your statement will be "Extensive Benefits – Union Insurance". To contact Extensive Benefits, call 888-416-4211 to update your payment information or if you receive a new credit card.

MONTHLY RATES:

	AETNA DENTAL	
	Low Option DMO	High Option PPO
Member Only	$22.80	$32.69
Member + 1	$38.44	$65.39
Family	$63.14	$98.84

Please contact Lois Riccobono with Van Valen Associates with any questions you may have regarding the plans. Her number is 516-399-0700 and email is lois@vvassoc.com.

Regards,
Joseph Demark Jr.
President and Business Manager

Sheet Metal Workers – Local 25
2017 Retiree Enrollment Form

SECTION 1: Your Information *(Please Print Clearly)*

First Name:	Last Name:
Street Address:	
City: State: Zip Code:	Gender: ☐ F ☐ M
Date of Birth (MM/DD/YY):	Social Security Number (XXX-XX-XXXX):
Email Address:	Phone #:

SECTION 2: Your Coverage Selection

	AETNA DENTAL DMO	AETNA DENTAL PPO
YOURSELF ONLY	☐ $22.80	☐ $32.69
YOU + 1	☐ $38.44	☐ $65.39
FAMILY	☐ $63.14	☐ $98.84

Aetna Primary Dentist Code for DMO: ____________

SECTION 3: Your Dependents (Dependent Children are covered to the end of the month they turn 26.)

	First Name	Last Name	Gender (M/F)	Date of Birth (MM/DD/YY)
Spouse				
Dependent				
Dependent				

SECTION 4: Your Monthly Payment Information

Payment is taken on the 28th of each month by Extensive Benefits (Union Insurance)

You must pay with VISA, MasterCard, Discover, American Express, Debit Card or Automatic Withdrawal from Checking Account.

Account Name: (First)____________ (Last)____________

☐ **Credit or Debit Card Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ - __ __
M M Y Y

☐ **Checking Account:** ***Bank Name:*** ____________

ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

____________ ____________

Routing Number (9 digits) *Account Number*

I hereby authorize Extensive Benefits to charge insurance premiums to my credit/debit card indicated in this authorization form. This payment is for Dental insurance monthly premiums, underwritten by Aetna. My signature and date on this form certifies and warrants that all dependent eligibility information is true, correct and current.

____________ ____________

Signature *Date*

RETURN THIS FORM TO:

Email: INFO@extensivebenefits.com
Fax: 404-585-3508
Mail: Extensive Benefits, Inc.
P.O. Box 813546
Smyrna, Georgia 30081

If you have any questions regarding the coverage options, please contact Aetna (Dental) - 877-238-6200 (Reference Plan Local 25)

For billing questions, contact Extensive Benefits at 888-416-4211