Iron Workers' Locals 15 and 424

Pension, Extended Benefit, Annuity and Apprentice Training Funds

321 RESEARCH PARKWAY • SUITE 210 • MERIDEN, CT 06450 • TEL 203-238-1204 • FAX 203-639-0815

EXECUTIVE DIRECTOR, SUSAN A. HENDERSON TOLL FREE 1-800-982-3709

IMPORTANT – Action Required for Continued Health Coverage

RE: **Retiree Benefit Coverage Effective January 1, 2016 and later.**

Dear Prospective Retiree:

Congratulations and best wishes on your retirement.

Our records indicate that you may be eligible for the program of health and related benefits provided to eligible Retirees by the Iron Workers' Locals No. 15 and 424 Extended Benefit Fund (Retirees Ages 58-65 Plan or the Medicare Advantage Retirees Plan). In order to determine whether you **are** eligible for these benefits, you must complete the enclosed Application for Retiree Benefits and file it with the Fund Office.

New Retirees wishing to elect coverage must complete the application and return it to the Fund Office. If you do not file an Application for Retirees Coverage in a timely manner, all of your benefits under the Retirees Plans can be lost.

If you **DO NOT** wish to elect Retiree Benefits, please complete and return the enclosed "Election to Decline Retiree Coverage" form only.

In order to obtain or continue coverage from the Retirees Plans, you are required to make a monthly co-payment. The co-payment in 2016 for the Ages 58-65 Plan is **$1,100.00** deducted monthly from your monthly Pension Benefit from the Iron Workers Pension Fund. The co-payment in 2016 for the Medicare Advantage Plan is **$650.00** deducted monthly from your monthly Pension Benefit. Each of these co-payments is 50% of the projected composite cost of that benefit program and will be adjusted every year on January 1st.

If you are on Medicare but your spouse is not on Medicare or your spouse is on Medicare and you are not yet Medicare Eligible, the monthly deduction from your Pension Benefit will be **$875.00**. Once you both are Medicare-Eligible, your co-payment will be reduced to the Medicare-Eligible amount (currently **$650.00**).

These co-payments must be made by an automatic deduction from the Pension Fund. To do this, the rules require that you sign and return the attached Authorization & Assignment form, authorizing the Pension Fund to transfer your monthly co-payment directly to the Extended Benefit Fund. This monthly co-payment will be automatically transferred for each month for which you are eligible for Retiree coverage and the amount will adjust automatically on January 1st.

The amount of your co-payment is listed in Section 2 of the application. A description of Retiree Benefits available under both Plans can be found in the Summary Plan Description (SPD). If you do not have an SPD, please contact the Fund Office and one will be sent to you.

You may convert your life insurance to an individual policy if you act within 31 days after your Active Member coverage ends. If you would like more information about converting, call the Fund Office and we will put you in touch with the insurance company that issues our group policy. You may convert your life insurance even if you don't purchase one of our Retiree Plans or COBRA but you must meet the 31-day deadline.

For new Retirees, remember that, by law, when your active eligibility terminates, the Fund is required to send you a notice regarding COBRA Continuation Coverage. If you have not already received a COBRA notice, you will receive one shortly. Please do not confuse the COBRA information with the option to purchase Retiree Benefits. The COBRA Continuation Coverage is a separate benefit, and if elected, is only available for a limited time.

REMEMBER: If you want Retirees Coverage, you MUST return a properly completed application and the Authorization and Assignment.

If you have any questions, please contact the Fund Office.

Happy retirement,

Susan Henderson
Executive Director

Enclosures

APPLICATION FOR RETIREE BENEFITS
IRON WORKERS' LOCALS NO. 15 AND 424 EXTENDED BENEFIT FUND

INSTRUCTIONS: IF YOU WISH TO ELECT RETIREE COVERAGE, YOU MUST READ SECTION 1, COMPLETE SECTION 2, THEN SIGN AND RETURN THE FORM TO THE FUND OFFICE. THE FUND OFFICE HAS CALCULATED THE MONTHLY CO-PAYMENT AND HAS INSERTED THAT AMOUNT ON YOUR APPLICATION.

FOR THOSE IN THE RETIREES AGE 58-65 PLAN, THE FUND WILL AUTOMATICALLY TRANSFER YOUR COVERAGE TO THE MEDICARE ADVANTAGE RETIREES PLAN AND ADJUST YOUR CO-PAYMENT WHEN YOU BECOME ELIGIBLE FOR THAT PLAN.

1. Application: I hereby apply for Retiree Benefits coverage under the Iron Workers Locals No. 15 and 424 Extended Benefit Fund. I have received the Fund's Summary Plan Description, which describes the terms and conditions of this coverage.

   I understand that if I am eligible, such coverage will be conditioned on my making monthly payments to the Fund in such amounts as the Trustees shall determine from time to time, and that I must do that by an automatic deduction from my monthly Pension benefit from the Iron Workers' Locals No. 15 and 424 Pension Fund. I understand that I may revoke the automatic deduction authorization at any time, but that such revocation will result in the termination of Retiree coverage for me and my dependents as of the first day of the month for which no automatic Pension deduction is authorized.

2. Coverage Information/Co-Pay Determination:

CO-PAYMENT AMOUNT

(The monthly co-payment listed below provides coverage for you and your eligible dependents)

$ 1,100.00 Age 58-65 Plan (Deducted monthly from your Pension Benefit)

$ 650.00 Medicare Advantage Plan (Deducted monthly from your Pension Benefit)

$ 875.00 One spouse 58-65 Plan and other spouse Medicare Advantage Plan (Deducted monthly from your Pension Benefit)

ELIGIBLE DEPENDENTS APPLYING FOR COVERAGE

SPOUSE'S NAME _____
Date of Birth _____ Social Security # _____
Eligible for Medicare? YES ____ NO _____

DEPENDENT'S NAME _____
Relationship _____ Date of Birth _____
Social Security # _____
Eligible for Medicare? YES ____ NO _____

DEPENDENT'S NAME _____
Relationship _____ Date of Birth _____
Social Security # _____
Eligible for Medicare? YES ____ NO _____

DEPENDENT'S NAME _____
Relationship _____ Date of Birth _____
Social Security # _____
Eligible for Medicare? YES ____ NO ____

DEPENDENT'S NAME _____
Relationship _____ Date of Birth _____
Social Security # _____
Eligible for Medicare? YES ____ NO _____

I have authorized a deduction from my monthly Pension check from the Iron Workers' Locals No. 15 and 424 Pension Plan in the amount stated above, and understand that this authorization will continue in effect, with adjustments as appropriate, until I notify the Iron Workers' Locals No. 15 and 424 Pension Fund at the Fund Office in writing by registered or certified mail that I wish to terminate this authorization. I also understand that a revocation of this authorization will result in a termination of Retiree Benefit coverage for myself and my dependents as of the first day of the first month for which the authorization is no longer effective.

Member's Signature _____

Print Name _____

Date Signed _____

ELECTION TO DECLINE COVERAGE

I DO NOT wish to elect Retiree Benefit coverage for me or my dependents provided through the Iron Workers' Locals No. 15 and 424 Extended Benefit Fund.

I plan to be eligible for this coverage after my Active Coverage from the Iron Workers' Locals No. 15 and 424 Extended Benefit Fund ends: _____

_____

(describe other coverage you have through a working spouse or individual policy)

I have been provided with information on the scope of coverage provided and the cost of that coverage. I understand that if I do not apply for coverage at this time, I may not be able to purchase coverage at a later date.

Member's Signature _____

Print Name _____

Date Signed _____