IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY BENEFIT TRUST

1470 Worldwide Place • Vandalia, Ohio 45377
Phone (937) 454-1744 • FAX (937) 454-5457
Address Mail:
P.O. Box 398 • Dayton, Ohio 45401 – 0398
Toll Free: (800) 331-4277

January 25, 2018

FIRST NAME LAST NAME
STREET ADDRESS
CITY, STATE ZIP

Dear FIRST NAME LAST NAME,

As you are aware, the cost of medical care continues to increase each year. In addition, the employment level for active Ironworkers covered by the Benefit Trust has increased minimally over the last several years. Accordingly, the Trustees have determined that the active participants as well as the retirees must share more of the cost of their benefits to help maintain the financial stability of the Fund. In recognition of these increased costs, the new monthly self-pay amounts for Non-Medicare Retiree Plan A and Plan B are as follows:

The new rate for Non-Medicare Retiree Plan A will be $726 per person per month as of April 1, 2018. If you or your spouse are covered by Medicare, you are not eligible for this Plan. The current retiree self-pay rate for this plan is $720 per person per month.

The new rate for Non-Medicare Retiree Plan B will be $617 per person per month as of April 1, 2018. If you or your spouse are covered by Medicare, you are not eligible for this Plan. The current retiree self-pay rate for this plan is $608 per person per month. Plan B has higher medical and prescription deductibles and coinsurances that are payable by the participant.

Dependent/Adult children of an eligible retiree will be covered under the same plan as the retiree at a **new rate of $100 per dependent/adult child per month.** The current rate is $99.

The new rates represent a 26.5% subsidy by the active Ironworkers against the projected monthly cost.

Two plans of benefits continue to be available for you to choose from at the monthly self-payment rates shown above. All members of your family will be required to be in the same plan unless a family member is on the Humana Medicare Advantage plan. All non-Medicare-eligible retirees currently covered under Plan A will have the option to select coverage under Plan B effective April 1, 2018. Once a participant has selected Plan B, they will NOT be allowed to switch back to Plan A in the future.

An election form is on the reverse side of this form if you decide to change plans. *If you do not return the form, you will continue to be enrolled in the Plan you are currently in.* **To change from Plan A to Plan B, you must select Plan B on the enclosed election form and return it to the Trust Office by March 16, 2018.** The Trustees urge you to consider this decision carefully since it cannot be changed once the election to Plan B has been made.

MEDICARE ELIGIBILITY: Once you or your dependent(s) are eligible for Medicare, coverage under this Plan must end and you may be eligible for coverage under the Plan's insured program through Humana. Due to government guidelines, you must be covered under the Humana program as of your Medicare effective date; Humana cannot retro-activate your coverage. To ensure that you have continuous coverage, **you must notify the Trust Office before your Medicare coverage begins**. To notify the Trust Office, request a Retiree Health Insurance Enrollment Form to complete and return with a copy of your Medicare card to the Trust Office at least 30 days before your Medicare effective date. It is **your** responsibility to notify the Trust Office when you are eligible for Medicare.

Should you decide to purchase your own coverage instead of coverage through the Benefit Trust, a written request that is signed and dated by the participant must be received by the Trust Office **no later than March 16, 2018.** Remember, once you terminate coverage through the Benefit Trust, except to be covered under another *group* policy, you may not purchase coverage from the Benefit Trust in the future.

Please contact the Trust Office should you have any questions.

IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY BENEFIT TRUST
RETIREE ENROLLMENT FORM

Only complete this form if you wish to <u>CHANGE</u> your Medical Plan Effective 4/1/2018

PARTICIPANT INFORMATION – Please provide all requested information.

Name (Last, First, MI)	Social Security No.
Street Address	Medicare Eligible ☐Yes ☐No
City, State Zip Code	Home Telephone No. ( )

DEPENDENT INFORMATION – Please provide all requested information for each eligible dependent (spouse and child) to be covered under the Plan.

Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐Yes ☐No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐Yes ☐No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐Yes ☐No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐Yes ☐No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐Yes ☐No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐Yes ☐No

MEDICAL PROGRAM ELECTION – Once you have decided which medical program option is right for you, indicate your choice by marking an "X" in the box by the program you are electing (choose only one). Remember that you and any eligible dependents will be covered under the same program. However, if you and/or your spouse are eligible for Medicare, you and/or your spouse will be covered under the Plan's insured program for Medicare-eligible retirees, which involves a separate election and means that you and/or your spouse will not be enrolled in this program. **You must notify the Trust Office *<u>before</u>* your Medicare coverage begins.**

☐ Plan A ($726 per adult/$100 per child per month)

☐ Plan B ($617 per adult/$100 per child per month)

AUTHORIZATION – Please read the paragraph below, sign and date.

I agree that my dependents and I will abide by the Plan provisions and understand that the Plan provisions may change. I have read the materials describing the Plan. I certify that the information on this form is correct and elect coverage as indicated.

Participant Signature	**Date**

If you changed your Plan Selection from Plan A to Plan B return completed forms to:

Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
P.O. Box 398
Dayton, Ohio 45401-0398