Chicago & Vicinity Laborers' District Council
Health & Welfare Fund • Retiree Health & Welfare Fund

LiUNA! Feel the Power

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Retiree Medical Plan (LIUNA Members)

Please read the following information carefully.

You must submit a copy of the Pension Award Letter you received from the Laborers' International Union of North America (LIUNA) that indicates the effective date of your pension.

In addition, the forms listed below must be completed in full and returned to the Fund Office along with the copy of your Pension Award Letter. The forms are:

- Enrollment Election form
- Premium Self-Payment Agreement Form
- Medicare Award Statement (to be completed by you)
- Medicare Award Statement (to be completed by your spouse, if married)

Coverage under the Retiree Medical Plan will only be offered to you once **– when you first apply for retirement benefits. If you choose not to enroll in this coverage at that time or discontinue coverage at any time, you may not enroll or attempt to reenroll at a later date.**

Your premium payments are due on the 1st day of every month, with a grace period of 30 days. If payment is not received by the due date, all benefits will terminate immediately. ***Once coverage under the Retiree Medical Plan is terminated, it cannot be reinstated.***

Once you, or your spouse, are eligible for Medicare, you must enroll. Once enrolled, you must submit a copy of your Medicare Card, which indicates effective dates for Medicare Parts A & B, to the Fund Office. If you fail to enroll when you, or your spouse, are eligible to do so, the Fund Office will reduce any benefits payable by the amount Medicare would have paid.

If you, or your spouse, elect Medicare Part D prescription coverage, your prescription coverage under the Plan will terminate. Once coverage is terminated, it cannot be reinstated. Also, your monthly premium will not be reduced.

Any questions regarding enrollment in the Retiree Medical Plan may be directed to the Customer Service Department, extension 510.

Chicago & Vicinity Laborers' District Council
Retiree Health & Welfare Fund

RETIREE MEDICAL COVERAGE
ENROLLMENT ELECTION FORM

Your Name:	Date of Birth	Participant's Alt. ID:
Spouse's Name:	Spouse's DOB	SSN
Dependent Child's Name:	Child's DOB	SSN
Dependent Child's Name:	Child's DOB	SSN
Dependent Child's Name:	Child's DOB	SSN

Your Address: _____

City/State/Zip code: _____

COVERAGE CHOICES

☐ **I wish to enroll in the Retiree Medical Plan.**

- The Claim Department will determine your eligibility for participation in the appropriate Retiree Medical Plan.
- When you reach age 65, or become disabled and eligible for Medicare, you must enroll in Medicare Part B. The premium of $174.70 (as of January 1, 2024) will be deducted from your Social Security check.
- If you are currently enrolled in a Medicare Risk HMO, but wish to be covered under this Plan, you must leave the Medicare Risk HMO and complete these enrollment forms.
- The monthly premium cost for retiree medical coverage is dependent on the number of years of participation in the Laborers' Welfare Fund earned at the time of retirement. The premium for the retiree only coverage is doubled for family coverage (includes the retiree, spouse and eligible dependents). To participate in this Plan, you must complete the enclosed "Premium Self- Payment Agreement Form" which will list the premium rates in effect at this time. Premium rates are reviewed annually and are subject to change.

☐ **I decline to enroll in the Retiree Medical Plan.**

- I understand that I have only one opportunity to enroll for retiree medical coverage and that once I decline enrollment, I will not be able to enroll at a later time.
- I understand that if I am over age 50, I will be covered under the Retiree Basic Medical Coverage Plan at no cost until age 65.
- I understand that if I am under age 50, I will NOT be covered under the Retiree Basic Medical Coverage Plan. (Disability Pensioners, who are NOT retirement age, do NOT receive Basic Retiree's Coverage.)
- I understand that I may also be offered coverage under COBRA instead of under the Retiree Basic Medical Coverage Plan when my bank of hours expires.

☐ I understand that if I decline coverage in the Retiree Medical Coverage Plan, I will not be allowed to enroll in the future.

☐ I understand that if I decline to elect coverage for my eligible dependents at this time, I may add eligible dependents in the future, but dependent coverage will be subject to higher premium rates.

_____ _____

Participant's Signature: Date:

FUND OFFICE USE ONLY:

RETIREE MEETS THE ELIGIBILITY REQUIREMENTS UNDER RETIREE MEDICAL PLAN # _____ INITIALS _____

DEPENDENTS MEET THE ELIGIBILITY REQUIREMENTS FOR BENEFIT COVERAGE ☐ Yes ☐ No 02/2012 form

Chicago & Vicinity Laborers' District Council
Retiree Health & Welfare Fund

RETIREE MEDICAL COVERAGE
PREMIUM SELF-PAYMENT AGREEMENT FORM

Name:	Participant's Alt. ID:

Address: _____

City/State/Zip code:_____

Retiree Medical Plan premium rates are reviewed every year and are subject to change as approved by the Board of Trustees. The following premiums are for retirees with pension effective dates after **January 1, 2005** (and from March 1, 2003 through December 31, 2004 if ineligible under rules in effect during that time):

Number of Years of Participation*	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	*number of years of participation in the Laborers' Welfare Fund is measured as 800 hours reported to the Laborers' Welfare Fund in a fiscal year (from June 1st through May 31st).
Premium: Retiree Only	200	180	160	140	120	100	90	80	70	60	
Premium: Retiree & Dependents	400	360	320	280	240	200	180	160	140	120	

Number of Years of Participation*	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35 or More**	**BASIC Coverage**
Premium: Retiree Only	50	45	40	35	30	25	20	15	10	5	0	0
Premium: Retiree & Dependents	100	90	80	70	60	50	40	30	20	10	0	0

I agree with the following statements:

- ☐ I understand that the premium amount quoted is an estimate based on my currently available record of hours with the Laborers' Welfare Fund.
- ☐ I understand that I must make monthly premium payments to the Laborers' Welfare Fund. My premium is due on the first day of the month of the coverage period.
- ☐ I understand that these premiums are an eligible healthcare expense for reimbursement under the Laborers' Welfare Fund Healthcare Reimbursement Account (HRA).
- ☐ I understand that the premiums above are subject to increase by the Board of Trustees at any time.
- ☐ I understand that all questions regarding the retiree medical coverage should be directed to the Customer Service Department of the Laborers' Welfare Fund.

I elect: ☐ **Retiree Only Coverage** (for Retiree only)

☐ **Family Coverage** (for Retiree, Spouse and Eligible Dependents)

☐ **Dependent Only Coverage** (for Surviving Spouse and Eligible Dependents Only)

I agree to make timely self-payment contributions to the Chicago Laborers' Welfare Fund. **I understand if I do not make the required monthly payment within 30 days of the due date, my retiree medical plan coverage will be permanently terminated and cannot be reinstated.**

_____ _____

Participant's Signature: Date:

FUND USE OFFICE ONLY:

RETIREE MEETS THE ELIGIBILITY REQUIREMENTS UNDER RETIREE MEDICAL PLAN # _____ INITIALS _____

Chicago & Vicinity Laborers' District Council
Retiree Health & Welfare Fund

RETIREE MEDICAL COVERAGE
PARTICIPANT'S MEDICARE AWARD STATEMENT

Name:	Participant's Alt. ID:
Address: _____	
City/State/Zip code:_____	

Retiree medical coverage through the Laborers' Welfare Fund must be coordinated with any payment of healthcare benefits under Medicare from the Social Security Administration or other insurance provider.

I hereby advise the Laborers' Pension and Welfare Funds of my eligibility for Medicare with the Social Security Administration (Please check ONE of the following boxes.)

☐ I am covered under Medicare. Enclosed, please find a copy of my Medicare card showing enrollment in Medicare Part B or C.

☐ I have been approved for disability benefits from the Social Security Administration, but I am not yet covered under Medicare. Enclosed, please find a copy of my Social Security Award letter. I will send a copy of my Medicare card, showing enrollment in Medicare Part B or C. Medicare will begin on _____.

☐ I will <u>not</u> be covered under Medicare until age 65. I either have not applied or I applied and was denied for disability benefits from the Social Security Administration. Attached is a copy of my denial letter.

☐ I have either applied for disability benefits or appealed a denial for benefits from the Social Security Administration but have not received a decision from the Social Security Administration. I will notify you when a decision is made and send a copy of my approval or denial letter.

I agree with the following statements:

- ☐ I understand that I am required to advise the Fund Office of my coverage under Medicare or other insurance plans.
- ☐ If enrolled under the Retiree Medical Plan, I understand that I must enroll in Medicare Part B (or, alternatively Part C) in the three-month period prior to the month that I become eligible for Medicare coverage.
- ☐ If enrolled under the Retiree Medical Plan, I understand that failure to apply for Medicare Part B (or, alternatively Part C) before the month I am first eligible (before my 65th birthday) will result in a delay of my Medicare Part B benefits and a reduction in my benefits through the Laborers' Welfare Fund. In which case, I will be responsible for the payment of medical expenses incurred and the Fund will reduce my benefits by the amount Medicare would have paid, even if my Medicare Part B benefit effective date is delayed because of late enrollment.
- ☐ If enrolled under the Retiree Medical Plan, I understand that if I elect Medicare Part D Prescription Drug Plan coverage, my prescription drug coverage under the Retiree Medical Plan will terminate and cannot be reinstated and my monthly premium will not change.

_____ _____

Participant's Signature: Date:

FUND OFFICE USE ONLY:

SUBMITTED MEDICARE CARD SHOWING ENROLLMENT IN MEDICARE PART B or C ☐ Yes ☐ No 02/2012 form

Chicago & Vicinity Laborers' District Council
Retiree Health & Welfare Fund

RETIREE MEDICAL COVERAGE
SPOUSE'S MEDICARE AWARD STATEMENT

Name:	Spouse's Social Security Number:

Address: _____

City/State/Zip code:_____

Retiree medical coverage through the Laborers' Welfare Fund must be coordinated with any payment of healthcare benefits under Medicare from the Social Security Administration or other insurance provider.

I hereby advise the Laborers' Pension and Welfare Funds of my eligibility for Medicare with the Social Security Administration (Please check ONE of the following boxes.)

☐ I am covered under Medicare. Enclosed, please find a copy of my Medicare card showing enrollment in Medicare Part B or C.

☐ I have been approved for disability benefits from the Social Security Administration, but I am not yet covered under Medicare. Enclosed, please find a copy of my Social Security Award letter. I will send a copy of my Medicare card, showing enrollment in Medicare Part B or C. Medicare will begin on _____.

☐ I will <u>not</u> be covered under Medicare until age 65. I either have not applied or I applied and was denied for disability benefits from the Social Security Administration. Attached is a copy of my denial letter.

☐ I have either applied for disability benefits or appealed a denial for benefits from the Social Security Administration but have not received a decision from the Social Security Administration. I will notify you when a decision is made and send a copy of my approval or denial letter.

I agree with the following statements:

- I understand that I am required to advise the Fund Office of my coverage under Medicare or other insurance plans.
- If enrolled under the Retiree Medical Plan, I understand that I must enroll in Medicare Part B (or, alternatively Part C) in the three-month period prior to the month that I become eligible for Medicare coverage.
- If enrolled under the Retiree Medical Plan, I understand that failure to apply for Medicare Part B (or, alternatively Part C) before the month I am first eligible (before my 65th birthday) will result in a delay of my Medicare Part B benefits and a reduction in my benefits through the Laborers' Welfare Fund. In which case, I will be responsible for the payment of medical expenses incurred and the Fund will reduce my benefits by the amount Medicare would have paid, even if my Medicare Part B benefit effective date is delayed because of late enrollment.
- If enrolled under the Retiree Medical Plan, I understand that if I elect Medicare Part D Prescription Drug Plan coverage, my prescription drug coverage under the Retiree Medical Plan will terminate and cannot be reinstated and my monthly premium will not change.

_____ _____

Spouse's Signature: Date:

FUND OFFICE USE ONLY:

SUBMITTED MEDICARE CARD SHOWING ENROLLMENT IN MEDICARE PART B or C _____☐_____Yes _____☐_____No 02/2012 form