When considering RETIREMENT, please keep these Health Benefits Fund rules in mind:

The basic rules for eligibility in the Retiree Programs (Pre-Medicare and Medicare Programs) are that you must: (1) be at least age 60, (2) be receiving a pension benefit from the Pension Fund, and (3) have had Active Program eligibility (including COBRA) for at least one month during the 12 months immediately preceding your retirement date. If you are retiring on a "Disability Pension" from the Pension Fund, you may be younger than age 60, and you will be eligible if you had Active Program eligibility (including COBRA) for at least one month during the 24 months immediately preceding your retirement date. There are many other special rules which are too detailed to list here, so you should always call the Fund Office if you have questions about Retiree Program eligibility.

Significant Benefit Changes/Requirements -
When Going From the Active Program to the Retiree Program:

Annual Benefit Maximum of $1.25 million per Eligible Individual for the 2012 Plan Year, and $2.0 million per Eligible Individual for the 2013 Plan Year. The Annual Maximum Benefit or "AMB" will be eliminated as of January 1, 2014.

The **Death Benefit** drops down to **$5,000** (eligible retired members only), and there are no Accidental Death or Dismemberment benefits.

The **Dental Benefit** becomes a **$1000 family maximum** for each Plan Year (Jan – Dec) (Limit not applied to eligible dependent children effective 1/1/11.)

You no longer qualify for Weekly Disability Benefits.

You must remit a monthly contribution payment for yourself and any eligible dependents **($200 per individual in the Pre-Medicare Program, $125 per individual in the Medicare Program**, which is normally deducted from your Pension Fund benefit check).

Other important items to keep in mind:

Retiree Health Plan participants (both Pre-Medicare and Medicare Programs) are **not** required to obtain pre-authorization through MHN (Managed Health Network) for Behavioral Health services (Psych & Substance Abuse). A Pre-Medicare Retiree participant may choose any licensed psychiatric or substance abuse provider using your Anthem ID card for claim submission.

The Fund pays 90% after Medicare pays on most health services. Co-payments and deductibles will not be applied to secondary claims (when the Fund is the secondary carrier).

Becoming eligible for MEDICARE BENEFITS
When you are eligible for benefits under Medicare, you will be automatically enrolled in Medicare Part **A** (Hospitalization) and will be given the option to elect Part **B** (Doctor's Services). In order to

participate in Part **B** you must pay a premium to Medicare which is usually deducted from your monthly Social Security check.

The decision whether or not to elect Medicare Part B is yours. However, Retiree participants should be aware that if they do not choose to participate in Part B, Local 478 Health Benefits Plan, consistent with its past practice, will pay benefits as if you had chosen Part B. Therefore, our Plan will pay benefits on only 20% of those expenses which would have been covered under Part **B**. You will be responsible for the remaining 80% of these charges. Also, you do not have to elect Medicare Part D (drug program) as the Fund's drug plan is at least as good as what Medicare offers.

Once on Medicare, you will receive our "Retiree Health Identification Card" that **replaces** your Anthem ID Card.

Retiree Medicare Claims are submitted directly to the Fund Office except for Pre-Medicare participants who will still use the Anthem ID cards where providers submit the claims to Anthem.

You will still be entitled to Medical, Dental, Hospital, Surgical, Davis Vision (CT, NY, MA, RI only)/Indemnity Vision Benefits, and CVS Caremark Prescription Drug Benefits under the Retiree Plan of Benefits.

If you are scheduled for any type of medical procedure in the future and you will be transitioning from the Active Program to a Retiree Program *prior to the time your procedure occurs*, we strongly suggest that you contact the Fund Office to be sure that coverage associated with your procedure will not be affected.

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This document is intended to be a short and simple listing of the eligibility rules of the Fund's Retiree Programs and some of the significant differences between the Fund's Active Program and its Retiree Program. In all instances, the terms of the actual Plan document will control. If you have any questions regarding your Fund coverage, you should contact the Fund Office by calling (203) 288-9261 or (866) 288-9261 (toll free).