Upstate New York Engineers Benefit Funds

International Union of Operating Engineers
Local Unions 17, 158

101 Intrepid Lane, P.O. Box 100 –Colvin Station
Syracuse, New York 13205-0100

Phone: 315.492.1796 *Deborah M. Spaulding - Administrator* *Fax: 315.492.6618*

MEDICARE SUPPLEMENT PLAN

Dear Participant:

On the first day of the month in which you attain the age of 65 you become eligible for Medicare. You're Normal coverage with the Engineers Joint Welfare Fund ceases, including the use of the prescription drug benefit. As a participant of the Medicare Supplement Plan you will be provided with a Medicare Supplement I.D. card. You must present your I.D. card to your service provider in order for the service provider to submit the Explanation of Medicare Benefits statement to the Fund Office for payment.

The cost to enroll in the Medicare Supplement Plan is $185.00 per month per participant. It is required that the monthly premium be deducted from your monthly pension benefit if applicable.

BENEFITS COVERED UNDER THE MEDICARE SUPPLEMENT PLAN

- **Medicare Part A Deductible - $1,556.00 for 2022**
- **Medicare Part B Deductible - $233.00 for 2022**
- **20% of Medicare Approved Charges**
- **61st -90th Medicare Inpatient Co-Insurance Days - $389.00 per day for 2022**
- **21st -100th Medicare Co-Insurance Days for Skilled Nursing Facilities $194.50 per day for 2022**
- **60 Life Time Reserve Days - $778.00 per day for 2022**
- **Lifetime maximum of $50,000 coverage outside the USA**

Please contact the Medicare Supplement Claims Department by calling 315-492-1796. Dial Option #3 on the Fund Office Phone Directory, if you have any questions related to the Medicare Supplement Plan.

Sincerely,

ENGINEERS JOINT WELFARE FUND

ENGINEERS JOINT WELFARE FUND
MEDICARE SUPPLEMENT DEPT.

UPSTATE NY ENGINEERS HEALTH FUND
MEDICARE SUPPLEMENT PLAN

MEMBER APPLICATION
&
PENSION BENEFIT DEDUCTION AUTHORIZATION

I, _____Date of Birth_____hereby elect coverage in the Upstate NY Engineers Health Fund Medicare Supplement Plan and authorize the designated monthly premium to be deducted from my monthly pension benefit that I am currently receiving from the Upstate NY Engineers Pension Fund.

( ) Member Only Medicare Supplement Plan $185.00 per month

_____	_____	_____
Member Signature	Member SS #	Date

Rejection of Coverage

I, _____, hereby elect not to participate in the Upstate NY Engineers Health Fund Medicare Supplement Plan. I fully understand that by rejecting this coverage I am prohibited from participation in this Plan permanently.

_____	_____	_____
Member Signature	Member SS #	Date

THIS FORM MUST BE RETURNED WITHIN 30 DAYS

UPSTATE NY ENGINEERS HEALTH FUND
MEDICARE SUPPLEMENT PLAN

SPOUSE APPLICATION
&
PENSION BENEFIT DEDUCTION AUTHORIZATION

I, _____Date of Birth_____hereby elect coverage in the Upstate NY Engineers Health Fund Medicare Supplement Plan and authorize the designated monthly premium to be deducted from my monthly pension benefit that I am currently receiving from the Upstate NY Engineers Pension Fund.

( ) (Widowed) Spouse Medicare Supplement Plan $185.00 per month

_____	_____	_____
Member Signature	Member SS #	Date

Rejection of Coverage

I, _____, hereby elect not to participate in the Upstate NY Engineers Health Medicare Supplement Plan. I fully understand that by rejecting this coverage I am prohibited from participation in this Plan permanently.

_____	_____	_____
Member Signature	Member SS #	Date

THIS FORM MUST BE RETURNED WITHIN 30 DAYS

UPSTATE NY ENGINEERS HEALTH FUND
MEDICARE SUPPLEMENT PLAN

(WIDOWED) SPOUSE APPLICATION
&
PENSION BENEFIT DEDUCTION AUTHORIZATION

I, _____Date of Birth_____hereby elect coverage in the Upstate NY Engineers Health Fund Medicare Supplement Plan and authorize the designated monthly premium to be deducted from my monthly pension benefit that I am currently receiving from the Upstate NY Engineers Pension Fund.

( ) (Widowed) Spouse Medicare Supplement Plan $185.00 per month

_____	_____	_____
Spouse Signature	Member SS #	Date

Rejection of Coverage

I, _____, hereby elect not to participate in the Upstate NY Engineers Health Fund Medicare Supplement Plan. I fully understand that by rejecting this coverage I am prohibited from participation in this Plan permanently.

_____	_____	_____
Spouse Signature	Member SS #	Date

THIS FORM MUST BE RETURNED WITHIN 30 DAYS