



MASON TENDERS' DISTRICT COUNCIL TRUST FUNDS

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ANNA GUTSIN
FUNDS' DIRECTOR

IMPORTANT NOTICE – ACTION REQUIRED

March 2020

Dear Retiree:

As explained in a notice sent to you in February 2020, the Board of Trustees of the Mason Tenders' District Council Welfare Fund ("the Fund") has adopted new contribution requirements for your retiree health coverage effective as of July 1, 2020.

Enclosed is an Election Form that you must complete if you wish to continue receiving retiree coverage from the Fund as of July 1, 2020 (when the contribution increase goes into effect). As stated in the Election Form, your completed and signed form must be received by the Fund Office (or postmarked) by June 30, 2020. Please read the Election Form even if you do not wish to continue your coverage as of July 1. The Election Form contains information regarding payments (including credits and refunds for prior pre-payments) and deadlines.

If you do *not* wish to receive coverage from the Fund as of July 1, 2020, you do not need to return an Election Form (and you will receive a refund of any contributions you pre-paid for coverage beginning July 2020).

If you continue receiving coverage from the Fund beginning July 1, 2020, a new Election Form will be sent to you for coverage beginning January 1, 2021.

Please contact the Eligibility Department at 212-452-9700 if you have any questions or need assistance.

Sincerely,

The Eligibility Department

MASON TENDERS' DISTRICT COUNCIL WELFARE FUND
RETIREE MEDICAL COVERAGE ELECTION FORM

I, _____
(Print Name) (Social Security Number)

am currently receiving retiree coverage from the Mason Tenders' District Council Welfare Fund (the "Fund").

I understand that, in order to continue receiving retiree coverage from the Fund as of July 1, 2020, I must submit this completed Election Form to the Fund Office prior to July 1, 2020 and make the payments by the deadlines stated below. (*The completed and signed Election Form must be received by the Fund Office or postmarked no later than June 30, 2020.*) I further understand that if I do not submit this Election Form to the Fund Office by that date, I will not be permitted to re-enroll in the Fund's retiree coverage at a later date.

ELECTION

I hereby elect to continue receiving the retiree coverage provided by the Fund (which includes medical, dental, vision and death/gravesite benefit coverage). **I understand that I am required to pay \$600.00 per month for this coverage (for single or family coverage) beginning with the month of July 2020 (subject to change in the future).** I further understand that, when I attain age 65, the monthly contribution will be reduced to \$300 for single coverage but will remain at \$600 if I have family coverage.

Note: If you elect coverage, you will receive a credit for any amounts previously paid for coverage for the period July – December 2020. For example, if you already paid \$50/month for the remainder of 2020 (a total of \$300), you will receive a credit of \$300 toward the July contribution and will owe \$300 for the month of July 2020. If you do not timely elect to continue coverage, the Fund will send you a refund for the amount you previously paid for July – December 2020.

By my signature below, I hereby acknowledge that:

- (i) the above contribution amount will change in the future, in the sole and absolute discretion of the Fund's Board of Trustees;
- (ii) my eligibility status may change in the future due to new information provided to the Fund, an amendment to the Fund's eligibility rules, or upon further review by the Fund;
- (iii) as with all benefits provided by the Fund, these benefits are subject to modification and termination in the sole and absolute discretion of the Fund's Board of Trustees; and
- (iv) monthly payments must be received by the Fund Office or postmarked *before* the first day of each coverage month, beginning with the month of July 1, 2020 (i.e., by June 30, 2020 for coverage in July 2020). If I do not timely pay the required monthly contribution, my (and my family's) coverage will be terminated as of the end of the last month for which I timely paid the required contribution, and I will not be permitted to reinstate my/our coverage in the future. Payment must be made by check or money order payable to the "Mason Tenders' District Council Welfare Fund," and may be made in advance.

(Signature of Participant)

Date