Board of Governors Medical Retirement Plan
for members of
PSA, PTAA, Physicians, Maritime Professional Assn.
Non-Union Non-Classified (optional)

The Board of Governors (BOG) has established a health care insurance coverage plan for employees participating in the BOG Alternate Retirement Plan upon their retirement. This includes employees who are eligible to participate in a Board of Governors (BOG) Alternate Retirement Plan (ARP) retirement plan sponsored through TIAA-CREF, AIG Retirement or MetLife.

Summary

Effective June 21, 2009, all participating employees will be subject to a mandatory payroll deduction of .9% of their salary, as ratified by your union. Employee contributes 0.9% of salary each biweekly paycheck.

Ex: An employee earning $50,000 per year would have $17.31 per pay period withheld (or $450 annually).

Eligibility

This health benefit applies to all employees who either currently participate in or will be eligible to participate in the BOG's ARP plan as defined in RIGL 16-17.1-1 and 2. This includes employees with a primary retirement plan funded through TIAA-CREF, AIG Retirement or MetLife.

Coverage

Eligible employees retiring after June 30, 2008, who are not yet 65 will no longer be entitled to the Pre 65 Medical Coverage, but may purchase health insurance coverage at the actual retiree premium rate for themselves and their spouses.

Employees retiring after June 30, 2008, who are at least 65 years of age, shall receive the Post 65 Medicare supplemental coverage in accordance with the table below for Post 65 Medicare Supplement Coverage.

Post 65 Medicare Supplemental Coverage

Years of Service	Employer's Share	Employee's Share
10-15	50%	50%
16-19	70%	30%
20-27	90%	10%
28+	100%	0%

Board of Governors (BOG) Medical Retirement Plan Authorization

this section to be completed by Non-Union Non-Classified employees only

Institution: ☒ URI ☐ RIC ☐ CCRI ☐ OHE

☐ I hereby **authorize** the BOG to deduct from my salary each biweekly pay period in order to participate in the Board's Medical Retirement Plan.

☐ I **decline** the plan and understand that I will not be able to join the plan in the future.

Last name ***(please print)***	***First Name***	***M.I.***	***Social Security #***

Employee Signature ***Date***