Questions about Your Benefits? Call Participant Services at the Fund office (877) 850-0977. Press "2" for a representative or "1" to use the automated system.

For Your Benefit

Operating Engineers Local No. 77

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www.associated-admin.com

American Health Holding Is Your New Utilization Management Provider

Effective September 1, 2011, American Health Holding, Inc. ("AHH") replaced Nationwide Better Health as your new Utilization Management ("UM") provider. This is the provider which certifies your inpatient hospital stays and many outpatient procedures as well. **You must contact AHH to pre-certify ALL non-emergency or elective hospital stays and within 24 hours after an emergency admission, as well as to certify all in- or out-patient mental health or substance abuse treatment.**

The Precertification Process Is Easy

1. Call American Health Holding at (800) 641-5566 when:

- A hospital admission is necessary,
- Inpatient or outpatient elective surgery is to be performed,
- A pregnancy has been physician confirmed, or
- An emergency hospital admission has occurred within 24 hours after emergency admission.

The representative will need the following information:

- Name, address and age of the patient,
- Hospital/Physician name and address,
- Employee Social Security Number, and
- Admission date and proposed procedure.

2. AHH will review and coordinate the hospital stay with your health care provider to determine:

- The reason for admission,
- Surgical procedures to be performed,
- The appropriate length of the hospital stay, and
- Alternative options, such as preadmission testing and outpatient treatment.

3. Once you are admitted, a nurse will contact your health care provider frequently to confirm that:

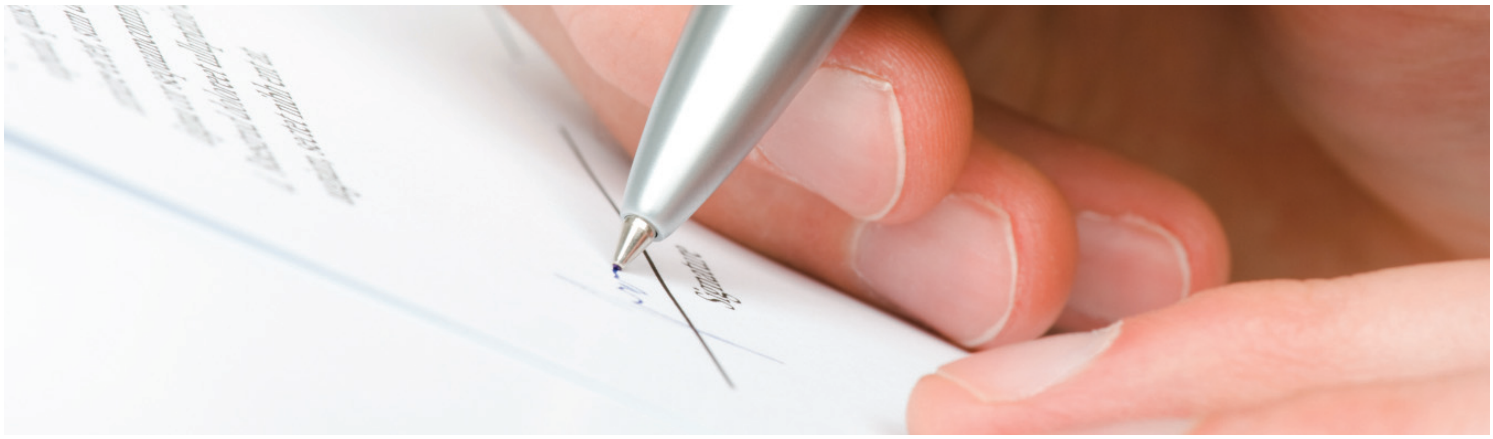
- The admission and procedures have taken place,
- The prescribed treatment is being rendered, and
- A release is scheduled as soon as inpatient hospital care is no longer necessary.

Continued on Page 2

The purpose of this newsletter is to explain your benefits in easy, uncomplicated language. It is not as specific or detailed as the formal Plan documents. Nothing in this newsletter is intended to be specific medical, financial, tax, or personal guidance for you to follow. If for any reason, the information in this newsletter conflicts with the formal Plan documents, the formal Plan documents always govern.

Complete and return COB form on page 4 and the Beneficiary Designation form on page 5.

This issue—



Continued from Page 1

New ID Card

A new medical identification ("ID") card was mailed to you. ***Be sure to destroy your old medical card and show the new ID card to all providers of service so that your claims are filed and processed correctly!***

Remember to pre-certify with American Health Holding by calling toll-free 1-800-641-5566.

The Board of Trustees believes this is a positive change and that American Health Holding will provide superior service to the Fund's participants. If you have any questions about this change, call the Fund office at (877) 850-0977.

New Health and Welfare Summary Plan Description Booklet

Participants were mailed a new Operating Engineers Local No. 77 Trust Fund of Washington, D.C. Health and Welfare Program Summary Plan Description ("SPD"). The booklet has been revised to contain all changes and updates made to your plan through August of 2011.

Your SPD booklet contains important information about all of your health and welfare benefits, including Accident and Sickness, Optical, Dental, and Prescription Drug benefits. Your SPD also explains the eligibility rules, how to add dependent coverage, claims filing and appeal procedures, your rights and responsibilities as a participant, and more. Telephone numbers and important addresses for the Fund office, American Health Holding, CareFirst PPO, Caremark/CVS Rx and other providers are all included in your new SPD.

It is very important that you keep your booklet handy so you can refer to it when you need. If you did not receive a new SPD, please contact the Fund office toll free at (877) 850-0977 and we will be glad to send you another. **Please be sure we have your current address on file.**

Reviewing Eligibility for Your Dependents

Under your plan of benefits, dependents include your lawful spouse residing with you and your natural children, stepchildren, adopted children or children placed for adoptions who are under the age of 26. Coverage for your spouse and children begins on the same date as your coverage.

Adult Children Age 19 to Age 26
Effective January 1, 2011 through December 31, 2013, to be eligible for plan coverage, an adult child (age 19 to age 26) must **not be** eligible for health coverage through his/her employment or the employment of his/her spouse.

Eligible adult children that enroll (or re-enroll) after 2010 will receive coverage that begins on the first of the month following the date of enrollment. Coverage terminates at the end of the month in which the dependent turns 26 years of age.

Newborns
Newborns will be covered from the date of birth until six months of age without a Social Security Number. **However, if a Social Security Number is not provided to the Fund office by the time the child is six months old, coverage will be terminated on the first day of the month following the date the child turns six months of age.**

Adding New Dependents
To add a newly eligible dependent, contact the Fund office for an enrollment form. Your spouse and eligible stepchildren can be added for coverage on the first of the month following the date of marriage. Biological children can be added effective on the date of their birth, and legally adopted children and children placed for adoption may be added effective the date of adoption or placement for adoption. In order for a new dependent to be covered, a valid Social Security Number must be provided to the Fund office.

In order for a new dependent's coverage – including a newborn's coverage – to begin on the earliest date of eligibility, you must inform the Fund office within 30 days from the date he or she first became your dependent. Otherwise, coverage will begin on the first of the month following the date the Fund office receives the required information.

Do You Have Coverage Elsewhere?

If you, your spouse, or your dependents have benefit coverage in more than one group health plan, the Fund office needs to know. Why? Because there are Coordination of Benefits (COB) rules which determine which plan processes the claim first, second and even third (if you have coverage under three group plans).

Virtually every group health plan has COB rules. They are designed to protect the Fund (and all group health and welfare plans) from paying when another plan is liable. The Fund's COB rules are described in your Summary Plan Description.

Even if you have completed a COB form before and nothing has changed, please complete the form on page 4 and return it to the Fund office at the address shown at the bottom of the form.

Remember, updating this information NOW saves time LATER (when you have a claim waiting to be processed). If you do not tell the Fund office about the other coverage and it is discovered later (after claims have been paid), you will be billed for the amount that was paid in error. Don't let this happen to you.

Complete & Return

COORDINATION OF BENEFITS UPDATE

Update for Yourself, Your Spouse, or Your Dependent(s)

Participant Name: _____ **Participant SSN**: _____

There is Other Group Coverage On (Choose All That Apply):

1) ___ Myself 2) ___ My Spouse 3) ___ Other Eligible Dependent(s)

If Spouse:

a) Name: _____
b) SSN: _____
c) Birth date: _____
d) Spouse's Employer:

_____ Co. Name
_____ Address
_____
(____) _____ Phone No.
_____ Benefit/HR Dept. (Contact Name)

If Other Dependent(s):

a) Name: _____
b) SSN: _____
c) Birth date: _____
d) Spouse's Employer:

_____ Co. Name
_____ Address
_____
(____) _____ Phone No.
_____ Benefit/HR Dept. (Contact Name)

Coverage is through:

___ Medicare A ___ Medicare B ___ Medicare D ___ Spouse's Employer
___ Other ___ Participant's Employer at Another Job

Insurance Co. Name: _____

Address: _____

Phone Number: _____

Group Policy #: _____ **Effective Date** _____

- If more than one family member has more than one additional coverage, or if an individual is covered by more than one other policy, attach a sheet listing the information for each.

Is it an Active or Retiree Plan? ___ Active ___ Retiree

If other group coverage is for a dependent child, are the child's natural parents legally separated or divorced? ___ Yes ____ No

Are you/your dependent eligible for Medicare coverage? ___Yes ___No

Participant's Signature _____ **Date** _____

Send to: Operating Engineers Local No. 77
Health and Welfare Trust Fund
911 Ridgebrook Rd.
Sparks, MD 21152
ATTN: IUOE Local 77 COB

L77 COB 0806sm

Complete & Return

International Union of Operating Engineers Local 77 Annuity Fund

BENEFICIARY DESIGNATION
(PLEASE PRINT)

Account Number **51753-1-1**

Participant's Name _____
FIRST MIDDLE LAST

Participant's Address _____
STREET NUMBER CITY STATE ZIP CODE

Social Security No.: _____ Marital Status: ☐Married ☐Single or Legally Separated

IMPORTANT: If no valid beneficiary designation is on file or if designation cannot otherwise be determined, beneficiary will be determined by the plan fiduciary according to plan documents and applicable law.

This designation supersedes any prior designation.

Primary Beneficiary (Check either box 1 or 2).

1. ☐ **Spouse Primary Beneficiary:** I designate my spouse to receive my entire account balance upon death.

   Spouse's Name: _____

   Spouse's Social Security No.:_____ Spouse's Date of Birth _____

2. ☐ **Non-Spouse or Multiple Primary Beneficiaries:** I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100%).

   If applicable, Spouse's Date of Birth: _____
   mm/dd/yyyy

Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent

(must total 100%)

If you are married and you have not designated your spouse as primary beneficiary, please have your spouse provide consent below.

SPOUSAL CONSENT: I understand I have a legal right to a death benefit equal to the participant's entire account balance. I consent to waive that legal right in accordance with the beneficiary designation set forth above. I acknowledge that I have a right to limit my consent only to a specific beneficiary and that I voluntarily elect to relinquish such right. I further understand and acknowledge that if I sign this form, no death benefit will be payable to me except as provided below.

_____ Date _____
Spouse's Signature

The spouse's signature must be witnessed by the Plan Administrator or a Notary Public.

Plan Administrator: _____ Date _____

-OR-

Notary Public:
Notarization of spousal consent can be signed off by a Notary Public or the Plan Administrator. A Notary Seal is not required when signed by the Plan Administrator or when participant resides in one of the following states: CT, KY, LA, ME, MI, NJ, NY, RI, VT.

Before me, the undersigned notary, personally appeared _____, and proved to me through identification documents allowed by law, which were _____, to be the person who signed the preceding document in my presence and who affirmed to me that they executed the above Consent of Spouse as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal this _____ day of _____, _____.

Witnessed: _____ State_____County_____
(official signature and seal of notary)

My Commission expires: _____.

COMPLETE BOTH PAGES

Contingent Beneficiary (optional): If no Primary Beneficiary listed above is alive upon my death, I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100%).

NOTE: MassMutual does not retain Contingent Beneficiary information nor will it be displayed on our participant website at www.massmutual.com/retire. Plan Administrator: Please retain a copy of this form in your files.

Name	Relationship	Social Security #	Percent

SIGNATURES

I understand that this beneficiary designation supersedes any previous designation.

_____ _____
Participant Date

I, the Plan Administrator, certify, to the best of my knowledge, the above information is correct. If a married participant designated a Non-Spouse Primary Beneficiary, and the spouse's signature was not witnessed by a Notary Public, I certify I witnessed the spouse's signature agreeing to the designation.

_____ _____
Plan Administrator Date

-OR-

Notary Public:
Notarization of consent can be signed off by a Notary Public or the Plan Administrator. A Notary Seal is not required when signed by the Plan Administrator or when participant resides in one of the following states: CT, KY, LA, ME, MI, NJ, NY, RI, VT.

Before me, the undersigned notary, personally appeared _____, and proved to me through identification documents allowed by law, which were _____, to be the person who signed the preceding document in my presence and who affirmed to me that they executed the above as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal this _____ day of

_____, _____.

Witnessed: _____ State_____County_____
(official signature and seal of notary)

My Commission expires: _____.

Sample wording for use in completing this form:

	To Designate	*Use This Wording*
1.	Your estate	Executors or Administrators of my estate
2.	The trustee of the Trust Established under your Will	(Name of trustee) as trustee, or the then acting trustee, of the Trust established under (your name) Will dated (date of Will)
3.	The trustee of your Revocable or Irrevocable Trust	(Name of trustee) as trustee, or the then acting trustee, of the (name of Trust) established on (date of Trust)

The Case Management Program Is Available to Help You and Your Family

Your benefits under American Health Holding offer you the advantages of the Case Management Program. Case Management is a program that helps you and your family if a serious illness or injury should occur. Specially-trained nurses can help you and your family to understand your treatment and offer some options for your care. They will work with your providers to help determine the right plan of care for you.

How Does the Program Work?

Case Management begins when your doctor tells you that your illness or injury may be difficult, long-term, and costly. You, a family member, or a provider then calls the Case Management Department **(toll free (800) 641-3224)**. A case manager will answer any questions you may have regarding medical care, home care needs, treatments, and services. Your case manager works to help ensure that you get high quality, cost-effective care.

How Can A Case Manager Help?

- By consulting with your doctor, hospital, and insurance company to obtain discounts for care and services when possible.
- By providing a link between you and your doctor and hospital.
- By becoming a support system for you and your family during a serious injury or illness.
- By educating you and your family on your health care, home care needs, treatments, lifestyle changes, etc.

Benefits That Are Not Subject to The Annual Deductible

There are benefits which are not subject to the annual deductible. The Fund office refers to these as "Ancillary Benefits" and these benefits are listed below:

Ambulance Benefit

When medically necessary, the Fund will pay for professional ambulance services to or from a hospital, up to $100 per incident, paid at 100% with no deductible. When it is determined that medically necessary life support services are provided while being transported, 50% (not 80%) of the remaining cost of the ambulance service will be paid under Major Medical. You must satisfy the annual deductible before the additional 50% payment will apply.

Orthotic Benefit

The Fund office covers expenses incurred by you or your dependents for orthotic appliances. Orthopedic shoes are covered only if it is an integral part of the brace. This benefit is available once every three years for you or your dependents up to the amount shown in the Schedule of Rates and Benefits. If approved by American Health Holding, orthotics can be covered once every year. The annual deductible does not apply to this expense.

Annual CDL Physical Exams

This benefit applies only to the participant. If you are required to have a physical for your Annual CDL Physical Exam, you will be entitled to reimbursement for the actual amount charged by the physician up to the amount shown in the Schedule of Benefits per person, per calendar year. The annual deductible does not apply.

Medical Necessity Letter Needed for Prescriptions Requiring Prior Authorization

Certain medications require prior authorization before they can be filled. But to get prior authorization, you need to ask your physician to prepare a letter of ***medical necessity*** and fax it to (410) 683-7778, Attention: Local 77 Prior Authorization, or mail it to the Fund office at:

Operating Engineers Local No. 77
Health and Welfare Program
911 Ridgebrook Road
Sparks, MD 21152-9451

The medical necessity letter must include the following information:

1. name, address and Social Security Number of participant,
2. patient's condition,
3. diagnosis (why this medication is necessary),
4. name of drug requested, and
5. dosage of drug requested.

When the Fund office receives the letter of medical necessity from your physician, we contact Caremark/CVS to initiate the prior authorization process. Based on the information your doctor provides, a determination will be made as to whether or not it has met certain FDA standards, and then both the pharmacy and your physician will be notified.

OPERATING ENGINEERS LOCAL NO. 77 FUNDS
911 Ridgebrook Road
Sparks, MD 21152-9451

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