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

When Hospice Care Is Needed

The Fund will cover inpatient and outpatient hospice care for terminally ill participants and dependents whose life expectancy is six months or less and who are receiving palliative, not curative, care. If the terminally ill patient survives beyond the six months, care must be re-certified in order for benefits to continue.

Benefits for Hospice Care Include:

- Inpatient care at a hospice facility
- Intermittent nursing care by a registered or licensed practical nurse
- Services of a licensed medical social worker
- Home health aide visits
- Radiation for palliative purposes only
- Medical-surgical supplies
- Oxygen
- Physician home visits
- Ambulance and wheelchair transportation to and from the hospital for palliative treatment or for admission as an inpatient hospice level of care.

Coverage

Hospice treatment will be covered under Major Medical at 80% after satisfying the annual deductible, up to the out-of-pocket maximum. After you have reached the out-of-pocket maximum ($4,000 per calendar year) benefits will be paid at 100%, up to the usual, customary and reasonable (UCR), up to $200,000. Benefits will be covered at 50% after $200,000 has been paid.

Pre-Certify

Hospice care **must** be certified with American Health Holdings in order to be covered. Call American Health Holdings at (800) 641-5566 to certify hospice treatment. Failure to certify care may result in loss of benefits.

Ambulance Coverage

You, your spouse and children have coverage for ambulance services to a hospital only if it's a medical emergency. Some examples of medical emergencies include a heart attack, chest pains, cardiovascular accidents, poisonings, convulsions, loss of consciousness or respiration, and other acute conditions. Of course this is not a complete list and there could be other conditions which require immediate treatment.

The coverage is up to $100 per incident at 100% with no deductible. When it is determined that medically necessary life support services are provided while being transported, 50% 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.

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 Coordination of Benefits form on page 3.

This issue—

Coordination of Benefits Rules

Virtually every group health plan has Coordination of Benefits ("COB") rules. They are designed to protect the Fund (and all group health and welfare plans) from paying when another plan is liable. If you, your spouse, or your dependents have benefit coverage in more than one group health plan, the Fund office needs to know in order to determine which plan processes the claim first, second and even third (if you have coverage under three group plans).

When duplicate coverage exists, the "primary" plan typically pays benefits according to its Schedule of Benefits and the "secondary" plan pays a reduced amount. **The Fund will never pay, either as primary or secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed 100% of the usual, customary and reasonable (UCR) charge.** This provision applies whether or not a claim is filed under Medicare or any other group plan.

Benefit Coordination Rules

If a person is covered by two or more group plans, the order in which benefits are paid is determined as follows:

1. The plan which covers the person as an employee pays before the plan which covers the person as a dependent.
2. If you are covered under two group plans, the plan which has covered you the longest pays first. There are two exceptions to this rule: (1) a group policy that covers a person for reasons other than being laid off or retired will determine the benefits that are paid first and (2) a group policy that covers a person as a laid-off or retired employee will determine the benefits that are paid second.

Complete and Return COB Form

If you or your dependents have coverage through another plan, please complete the form on the next page and return it to the Fund office at the address shown at the bottom.

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 paid in error.

Reviewing Accident & Sickness Benefits

60 Days to File for A&S

All Weekly Accident and Sickness ("A&S") claims must be filed within 60 days from the date that the disability began as certified by a doctor.

If you are disabled for longer than 60 days, then you must file a claim **before** you return to work. You cannot file a claim for A&S benefits later than your doctor certifies that you are disabled.

In no event may a claim be filed after 60 days and after you return to work.

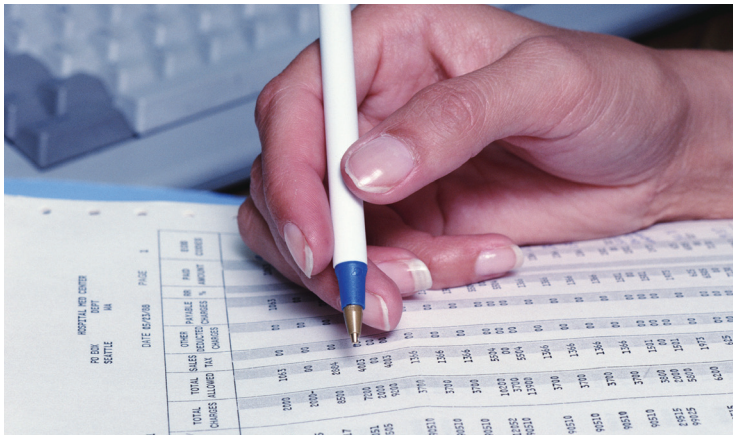
Applying For A&S

If you are eligible for benefits and become disabled to the extent that you cannot perform the usual and customary duties with your participating employer, you may apply for A&S benefits. However, the following rules apply:

- You must be seen by a physician;
- Your physician and you must complete all questions and sign the "Weekly Accident & Sickness And/Or Maintenance of Benefits Form."
- File the A&S claim form within 60 days of your disability.

Obtaining an A&S Claim Form

Weekly Accident and Sickness claim forms can be obtained by logging onto www.associated-admin.com. Click on "Your Benefits" located to the left of the screen. Select "OE Local 77" and from this site you will be able to print the "Weekly Accident and Sickness And/Or Maintenance of Benefits Form." You can also call the Fund office at (877) 850-0977 and request this form. You should be certain to complete all the information on the form and return to the Fund office at the address mentioned at the top of the form.



Operating Engineers Local No. 77
Trust Fund of Washington, D.C.
Health And Welfare Program

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (877) 850-0977
www.associated-admin.com

4301 Garden City Drive, Suite 201
Landover, Maryland 20785-6102
Telephone: (877) 850-0977
www.associated-admin.com

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** _____

Fax to (410) 683-7788 or mail to:

Fund Office
Operating Engineers Local No. 77
Health and Welfare Trust Fund
911 Ridgebrook Rd.
Sparks, MD 21152-9451

77 COB Form
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Self-Payments Allows Continuation Of Health & Welfare Benefits

The Self-Payment Option is a voluntary benefit offered by the Plan as an alternative to COBRA. If you meet the criteria for Self-Payments described in your Summary Plan Description (SPD) booklet, you may maintain your eligibility for Health and Welfare benefits by making payments yourself. Self-Payments allow you to protect your benefits if you lose eligibility due to layoff or because of reduction in hours.

Pointers

- You are eligible to maintain your coverage by making self-payments for a maximum of 18 months.
- You may self-pay when your eligibility ends if you are disabled or if you are unemployed. Unless you are disabled and unable to work, you must remain available for immediate employment in the jurisdiction of Local No. 77 ("covered employment") during the entire time you are making Self-Payments.
- If you are not disabled and not available for work in covered employment or if you decline covered employment, you are no longer eligible to make self-payments.
- When you leave work and have a period of self-payments, you will be credited with the number of employer-paid hours you have in your bank ***on the date you stopped working***. The months for which you make self-payments do not add to your "bank" of hours. Instead, the hours in your "bank" remain frozen until such time as you are no longer making self-payments (when you return to work, for example).
- During the period of self-payment, you will be credited with one month's eligibility for Health and Welfare benefits for each month that you make a self-payment.
- When you do return to work, you will be credited for the hours of service for the ***12 months immediately preceding the month in which you began making self-payments***, whatever that amount may be. You must continue to self-pay when you return to work in order to maintain your Health and Welfare benefits until you have accrued enough employer-paid hours to equal ***400 hours in the last three-month period***.

If you become eligible for the Self-Payment Option, the Fund office will send you a letter describing the program in detail and giving you the cost.

Information Regarding Your Health and Welfare Death Benefit

Your beneficiary will be entitled to receive a lump sum Death Benefit upon your death (as long as you are eligible for health coverage at the time of your death). In order to designate your beneficiary with the Fund office, you must fill out a beneficiary form. You may contact the Fund office to have one sent to you, or you can access one online by logging onto www.associated-admin.com, clicking on the "Your Benefits" tab (located on the left side of screen), and selecting the "OE Local 77" link. From there you will be able to print the "Change in Beneficiary (Health and Welfare)" form.

If, at the time of your death, there is no beneficiary designation on file, or your beneficiary dies before you, the order of payment of your Death Benefit will be as follows:

1. Legal Spouse;
2. Children (Equal Shares);
3. Parents (Equal Shares);
4. Brothers and Sisters (Equal Shares); or
5. Your Estate.

The Death Benefit terminates upon termination of your eligibility.

In order for your beneficiary to receive your Death Benefit, he/she must file a written claim with the Fund office within one year of the date of your death. Make sure the following documents are included with this claim (or submitted shortly after as requested by the Fund office) in order for the claim to be processed and paid:

1. A certified copy of the death certificate;
2. If the estate is the beneficiary, certified letters of administration or comparable state document designating the party as executor of the estate;
3. Proof of identity;
4. Completed and signed copies of the claim form provided by the Fund office; and,
5. Any other documentation requested by the Fund office.

When Are Prosthetic Appliances Covered?

Expenses for prosthetic appliances are covered for you and your dependents when the loss of a body part occurs and it is medically necessary to purchase a replacement for a natural body part. If the replacement was not medically necessary (e.g., the recent replacement was purchased simply because it had superior enhancement over the old model), then the prosthetic appliance will not be covered.

A replacement may be given consideration when:

1. Major growth of the user is a factor (e.g., a 15 year old child who was fitted for a prosthetic leg at age 10);
2. Major pathological change has occurred at the affected site (e.g., amputee who has had further amputation of the affected limb);
3. Reimbursement for replacement breast prostheses will be made when a new prostheses is necessary due to additional disease.

Remember the Deadline When Filing An Appeal

If you have a claim denied, the Fund office will send you a written denial that includes the reason for the denial and a reference to the Plan provision or rule on which it is based. If you have a claim that has been denied, in part or in full, you have the right to appeal the decision to the Board of Trustees. But be sure to file your appeal on time.

When are the deadlines?

You have ***180 days*** to file an appeal for ***Weekly Accident & Sickness Claims*** and ***Medical Claims***.

You have ***60 days*** to file appeals for non medical/ non-disability claims such as ***Pension Claims*** and ***Death Benefit Claims***.

How do I file an appeal?

To file an appeal, you must make a written request to the Board of Trustees at the address below:

Operating Engineers Local No. 77
911 Ridgebrook Road
Sparks, MD 21152-9451

Include the participant's name, Social Security Number, the patient's name (if different from the participant's), the dates of service and the reasons why you think your claim should be reconsidered.

Remember, your letter of appeal for either Medical Claims or Weekly Accident & Sickness Claims must be received by the Fund office ***within 180 days after your claim has been denied*** for the filing deadline to be met. Otherwise, the appeal will be considered late.

Why Is Vision Health So Important?

Your eyes not only affect how you see, but how you feel. Caring for your vision can lead to a better quality of life. Your eyesight impacts your performance at work, school, and home. When your vision health is at its best, you perform better in all aspects of your life. Not to mention, eye strain leads to headaches, fatigue, and other discomforts that keep you from feeling your best.

A Window to the Rest of Your Body

Did you know that a number of health conditions can be detected early by your eye doctor? An eye exam can detect conditions like diabetes, years before you show signs of the disease, allowing you to better manage health issues before they become a problem.

In addition to diabetes, annual eye exams can identify eye and general health conditions, such as:

Macular degeneration	High cholesterol
Glaucoma	Multiple sclerosis
Diabetes	Risk of stroke
High blood pressure	Risk of heart disease

You're in Charge

The eye is controlled by muscles, just like many other parts of the body. So just like the rest of your body, your eye health is impacted by your lifestyle, including eating habits, regular exercise, and routine physical exams. Getting an annual eye exam is a very important part of maintaining your overall health.

Make An Appointment for An Eye Exam Today

The Fund uses Vision Service Plan ("VSP") to provide vision care services at discounted rates. To locate the most current doctors in the VSP network, log on to www.vsp.com or call (800) 877-7195, VSP's Interactive Voice Response, available 24 hours a day, seven days a week.

The above information was provided by Vision Service Plan.

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