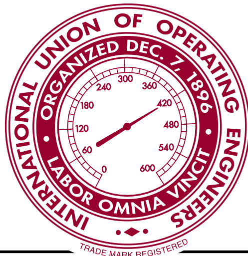
Questions about Your Benefits? Call Participant Services at the Fund Office (877) 850-0977. Press "2" for a representative or "1" to use the automated system.



For Your Benefit

Operating Engineers Local No. 77

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www.associated-admin.com

Improvements to Your Dental Benefits

The Board of Trustees is pleased to announce the following improvements to your dental benefits **effective January 1, 2016:**

- The deductible decreased from $50 per person or $150 per family to $25 per person and $75 per family.
- The annual maximum has increased from $1,000 to $1,500.
- An orthodontia benefit has been added to pay at 50% to a lifetime maximum of $1,500 per person (up to age 19).

Complete and return COB form on page 5

Improvements to Your Vision Benefits

The Board of Trustees approved **effective January 1, 2016**, the following vision benefit improvements:

- An increase in frame allowance from $130 to $150.
- An allowance of frames every 12 months instead of every 24 months.

See page 3 for a complete list of your new vision benefits starting on January 1, 2016.

Prior Authorization is Required for Compound Drugs over $300

Effective July 1, 2015, any compound drug over $300 must be pre-authorized by calling the Fund Office at (877) 850-0977 and pressing "2" to speak to a representative.

A compound drug is a medication made by combining, mixing or using alien ingredients (some of which may not be subject to approval by the FDA), in response to a prescription, to create a customized drug that is not otherwise commercially available.

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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.

American Health Holding's Case Management Program Offers Help to 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 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.

Get the Best in Eyecare and Eyewear with VSP Vision Care

You'll like what you see with VSP.

- Value and Savings. You'll enjoy more value and the lowest out-of-pocket costs.
- High Quality Vision Care. You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- Choice of Providers. The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- Great Eyewear. It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- Register at vsp.com. Once your plan is effective, review your benefit information.
- Find an eyecare provider who's right for you. To find a VSP provider, visit vsp.com or call (800) 887-7195.
- At your appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more. Visit vsp.com to find a VSP provider who carries these brands. Automatically get an extra $20 to spend when you choose one of these featured frame brands.

Revised VSP Vision Benefits Summary

Effective January 1, 2016, the chart below shows the new vision benefits summary when using a VSP Choice network.

Benefit	Description	Copay	Frequency
YOUR COVERAGE WITH A VSP PROVIDER			
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every plan year*
PRESCRIPTION GLASSES		$10	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • 20% savings on the amount over your allowance • $80 Costco allowance	Included in Prescription Glasses	Every plan year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every plan year
Lens Enhancements	• Progressive lenses • Scratch-resistant coating • Average savings of 20-25% on other lens enhancements	$0 $0	Every plan year
Contacts (instead of glasses)	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every plan year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS							
Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.							
Exam	up to $52	Single Vision Lenses	up to $34	Lined Trifocal Lenses	up to $66	Contacts	up to $105
Frame	up to $70	Lined Bifocal Lenses	up to $50	Progressive Lenses	up to $66		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.

*Plan year begins in July.

“Coordination of Benefits” Procedures

The following article applies to actively working participants who are not covered by Medicare. If you are actively working and eligible for Medicare, different rules apply.

If you have insurance coverage under two or more group plans, there are certain rules which the Fund follows to determine which plan pays first and how the coverage works.

Which Plan Pays First?

The plan that covers you as an employee pays before a plan that covers you as a dependent. For example, if you work for Clark Construction Group, Inc., the Fund is primary for you. If your spouse works for Clark Construction Group, Inc. and you are covered as his/her dependent, the Fund is secondary for you if you have other coverage through your own employer. When the Fund is primary, it will process your claim first (under the terms of your plan's coverage).

Secondary Coverage through the Fund

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.

When the Fund is secondary, it will pay covered charges that remain after the primary coverage has paid its portion, but it coordinates with the primary carrier so that both plans together pay no more than 100% of the bill. In order for the Fund to cover you as a secondary provider, you must have followed the rules of the primary plan. For example, if the other plan requires you to see a doctor or facility in their network, you must have done so. If it requires you to file your claim within a certain time frame in order to be covered, you must have done that also.

If the Fund is secondary, benefits will be paid only if you followed the rules of the primary carrier.

Complete and Return the COB Form

If you or your dependent(s) 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 of the form.

Call American Health Holding to Pre-Certify Hospital Stays

American Health Holding, Inc. (“AHH”) 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.

OPERATING ENGINEERS LOCAL NO. 77 HEALTH AND WELFARE TRUST FUND

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 <u>more</u> 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
7/2012 bns

Be Aware of the Deadline When Filing A Claim or An Appeal

FILING A CLAIM

- **One Year (365 Days) To File Medical Claims**
  You must file all Medical claims and Death and Dismemberment claims within ***365 days*** from the date of an event. An "event" is defined as the accrual of charges for medical care, the date of injury, disease or illness, the date of disability, date of accident or sickness or date of death or injury which causes dismemberment.

  Actively working participants and non-Medicare primary retirees should show their ID card to the provider of service. The provider will generally file their claim for the participant and retiree. Virtually all claims from a CareFirst provider will be filed electronically with the Fund. No claim form is necessary.

  If you used a non-CareFirst provider, send an itemized bill directly to the Fund at the address shown below. Be sure the participant's ID number is marked clearly on the bill. The Fund may have you sign an "Assignment of Benefits" statement allowing payment to be made directly to the provider.

To file a claim directly with the Fund, send to:

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

If you used a CareFirst provider, the provider will file the claim electronically to CareFirst for you. If you or the provider files a paper claim send to:

CareFirst/Network Leasing
P.O. Box 981633
El Paso, TX 79998-1633

- **Sixty (60) Days To File Weekly Accident and Sickness Claims**
  Weekly Accident and Sickness claims must be filed within ***60 days*** from the date that the disability began as certified by a doctor. If you return to work before 60 days, then you have 60 days from the date your doctor certifies that you are disabled in which to file a claim. If, on the other hand, you are disabled for longer than 60 days, then you must file a claim BEFORE you return to work. In no event may a claim for Accident and Sickness Benefits be filed later than your doctor certifies that you are disabled. Also, in no event may a claim be filed after 60 days and after you return to work.

Weekly Accident and Sickness claims should be mailed to:

Fund Office
Operating Engineers Local No. 77
PO Box 1065
Sparks, MD 21152-9451

You Must Provide Information to the Fund upon Request
The Fund has the right to request further information in order to properly process a claim under the Plan's provisions. If a claimant fails to provide the necessary information within a reasonable period not to exceed thirty (30) days, the Fund shall have no duty to pay the claim until such time as the documents are provided, but in no event later than 365 days.

FILING AN APPEAL

If your claim has been denied, the Fund 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. Be sure to file your appeal on time.

- **180 Days to File Appeals for Weekly Accident and Sickness or Medical Claims, and**

- **60 Days to File Appeal for Pension Claims and Death Benefit Claims**

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 within ***180 days after your claim has been denied*** for the filing deadline to be met. Otherwise, the appeal will be considered late.

Enrolling Your Dependents for Coverage

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

If You Have a New Spouse or Child

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.

If You Have a Newborn

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.**

Adult Children Age 19 to Age 26

Eligible adult children that enroll (or re-enroll) 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.

Pre-Authorization Is Required for Over 8 Chiropractic Visits

Your Plan covers up to 8 visits per calendar year to a chiropractor without pre-authorization. However, if you know you will need more than 8 visits in one calendar year, you must, before your 9th visit, get pre-authorization from American Health Holding ("AHH") by calling (800) 641-5566.

In order to be covered, the treatment must be medically necessary to improve your condition. Treatment to maintain a level of function is not considered medically necessary.

The Fund Office will request treatment notes from the initial consultation (as well as your other visits) and forward them to AHH. AHH will then review the notes and advise the Fund if further treatment is approved.

Be Careful. Because of the delay in billing time, we may not know you are nearing 8 visits until you've already gone over that amount. If AHH does not certify the visits over 8 as medically necessary, you may be responsible for all charges for uncovered visits. If you even think that you may go over 8 chiropractic visits, it's a good idea to call AHH, just in case.

OPERATING ENGINEERS LOCAL NO. 77 FUNDS

911 Ridgebrook Road
Sparks, MD 21152-9451

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