

OPERATING ENGINEERS TRUST FUNDS

I.U.O.E. LOCAL 12 HEALTH & WELFARE / PENSION / VACATION / TRAINING

100 EAST CORSON STREET • PASADENA, CALIFORNIA 91103 • (626) 356-1000

P.O. BOX 7063, PASADENA, CALIFORNIA 91109

WEBSITE: www.oefunds.org



November 17, 2009

Dear Participant,

Fund Office records indicate that someone in your family (either you, your spouse or a dependent child (if any)) is not enrolled in the Health & Welfare Plan at this time. This is your opportunity to enroll other family members in the Plan for coverage beginning April 1, 2010. Please read this Open Enrollment information carefully. You must complete the enclosed form and return it to the Fund Office no later than December 10, 2009.

If you decide to enroll another family member in the plan at this time, you must pay the monthly fees for January, February and March, 2010, **but that family member's coverage will not begin until April 1, 2010.** Any medical or dental expenses that person incurs prior to April 1, 2010, will not be covered.

IMPORTANT: If you currently have a deduction from your monthly pension check and return the enrollment form before December 10, 2009, we will begin the automatic deduction from your pension check on January 1, 2010. If you cannot submit your form that quickly, please enclose your January 2010 payment with the enrollment form and your deductions will be changed effective February, 2010.

If you currently make direct payments by personal check or money order, you must remember to increase the amount of your payment according to the list on the next page effective January 1, 2010.

Please get in touch with the Information Center at (888) 512-5279 or (626) 356-1004 if you have any questions.

BOARD OF TRUSTEES

Operating Engineers Health & Welfare Fund

-OVER-

OPEN ENROLLMENT FORM - DEPENDENTS

PLEASE COMPLETE ALL OF THE REQUESTED INFORMATION
AND RETURN THE ENTIRE PAGE TO THE FUND OFFICE.

NAME: _____ SOC. SEC. #: _____

PHONE #: _____

1. Please add the following family members effective April 1, 2010:

Name	Date of Birth	Social Security Number	Have Medicare? (If yes, enclose copy of Medicare card.)	
			YES	NO

2. My new monthly fee for Health & Welfare coverage will be: \$_____.

3. If the family member you are adding is currently working at any job, please provide the following information:

Employer's Name	Employer's Phone Number

Group Insurance Name	Group Insurance Address	Group Insurance Phone Number

I understand that I may discontinue payments at any time and I will not be entitled to re-enter the Plan until the next Open Enrollment period. I understand that I can withdraw and revoke this authorization by written notice to the Fund Office.

Date

Signature

Return form to:
Operating Engineers Health & Welfare Fund, PO Box 7063, Pasadena, CA 91109

RETIREE HEALTH & WELFARE MONTHLY FEES
 (Subject to change at any time by action of Board of Trustees)

	<u>Full Fee-for-Service Plan</u>		<u>HMO Medical & Dental Plan</u>		<u>Limited Coverage Plan</u>	
	<u>Disability Pensioners</u>	<u>All Others</u>	<u>Disability Pensioners</u>	<u>All Others</u>	<u>Disability Pensioners</u>	<u>All Others</u>
	This is the CURRENT plan, which covers hospital, medical (secondary to Medicare, if applicable), Rx drugs, dental, vision, hearing aids & death benefits (all of the current Plan benefits).		You must enroll in one of the Plan's HMOs (Kaiser, Health Net, Health Plan of NV) & DeltaPMI's dental HMO plan. ALL care must be obtained through HMOs. The Fund will pay only the fees to the HMOs and death benefits.		You must obtain your medical & hospital coverage elsewhere (e.g., Medicare, your spouse's health plan, etc...) at your own cost, if any. The Fund would pay ONLY for Rx drugs, dental, vision, hearing aids & death benefits.	
Single Coverage (No dependents):						
If you have Medicare	\$ 73	\$145	Refer to Plan "M"*	Refer to Plan "M"*	\$38	\$ 76
If you DO NOT have Medicare	\$132	\$263	\$ 94	\$188	\$38	\$ 76
Two-Party Coverage (Two family members):						
If BOTH have Medicare	\$145	\$290	Refer to Plan "M"*	Refer to Plan "M"*	\$76	\$152
If ONE has Medicare	\$204	\$408	\$117	\$233	\$76	\$152
If both DO NOT have Medicare	\$263	\$526	\$188	\$376	\$76	\$152
Family Coverage (3 or more family members):						
If TWO have Medicare	\$211	\$422	\$ 92	\$184	\$95	\$190
If One has Medicare	\$270	\$540	\$164	\$327	\$95	\$190
If NO ONE has Medicare	\$329	\$658	\$235	\$470	\$95	\$190
Retirees earning over \$30,000 per year:						
Excluding Nevada residents	\$1,068		\$1,068		\$1,068	
Nevada residents only	\$1,083		\$1,083		\$1,083	

* Contact the Fund Office if you have Medicare and need Plan "M" information.