

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



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November 17, 2009

Dear Participant,

Enclosed is OPEN ENROLLMENT information for the Retiree Health & Welfare Plan. Please read this information carefully. You must complete the enclosed form and **return it to the Fund Office no later than December 10, 2009.**

The current monthly fees are on the following page and are subject to change at any time by action of the Board of Trustees. Please note Plan "M" is available for participants with Medicare. This Plan requires you to enroll in the Medicare HMO of your choice and the Fund will provide benefits only for hearing aids, chiropractic care, dental care, and death benefits.

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

If you decide to make direct payments by personal check or money order, please return the enclosed form with your payment to cover the three-month period of January through March, 2010. Your next payment will be due by April 1, 2010.

Shortly after April 1, 2010, you will receive an identification card and a packet of Plan information. Please get in touch with the Information Center at (888) 512-5279 or (626) 356-1004 if you have any questions or need additional information.

BOARD OF TRUSTEES

Operating Engineers Health & Welfare Fund

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OPEN ENROLLMENT AUTHORIZATION FORM - RETIREE

Please complete all of the requested information
and return the entire page to the Fund Office.

NAME: _____ SS#: _____

PHONE #: _____ OEID#: _____

1. I DO NOT want to participate in the Retiree Plan at this time.
2. I want to enroll in the Retiree Plan for eligibility beginning April 1, 2010 and I want the Fund to cover the following family members. (Please include yourself if you want to be covered.):

Name	Date of Birth	Social Security Number	Have Medicare? (If yes, enclose copy of Medicare card.)		Plan Selected		
					Full Coverage	HMO Plan	Limited Plan
			YES	NO			
			YES	NO			
			YES	NO			
			YES	NO			

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

4. I prefer:

Automatic deduction from my Operating Engineers pension check	Monthly payments by personal check or money order
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5. If you or your spouse currently work at any job, please provide the following information:

Name	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: _____

THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY IN THE PLAN. YOUR ELIGIBILITY
IN THE PLAN WILL BE DETERMINED DURING PROCESSING OF YOUR APPLICATION.

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.