MID CENTRAL OPERATING ENGINEERS HEALTH & WELFARE FUND

February 2017

Bookkeeping Department:

Jackie Ellinger, Supervisor

Staff:
Debbie McCowen
Pam Matherly
Brittany Karanovich

Telephone: 812-232-4384 or Toll Free: 877-299-7099

HOW DO I BECOME ELIGIBLE FOR BENEFITS

May

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Worked 150 Hours

June

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Worked 150 Hours

July

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Worked 125 Hours

August

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/ 31	25	26	27	28	29	30

Worked 175 Hours

1. **YOU MUST WORK 4 CONSECUTIVE MONTHS**
2. **YOU MUST WORK A TOTAL OF 400 HOURS DURING THE 4 CONSECUTIVE MONTHS**

- ❑ **DID I WORK 4 CONSECUTIVE MONTHS? YES!!!**
- ❑ **DID I WORK A TOTAL OF 400 HOURS? YES!!!**
  600 hours worked
- ❑ **DO I QUALIFY FOR BENEFITS? YES!!!**

YOUR BENEFITS WOULD BEGIN SEPTEMBER 1ST

HOW DO I BECOME ELIGIBLE FOR BENEFITS

May

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Worked 125 Hours

June

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Worked 125 Hours

July

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Worked 100 Hours

August

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/ 31	25	26	27	28	29	30

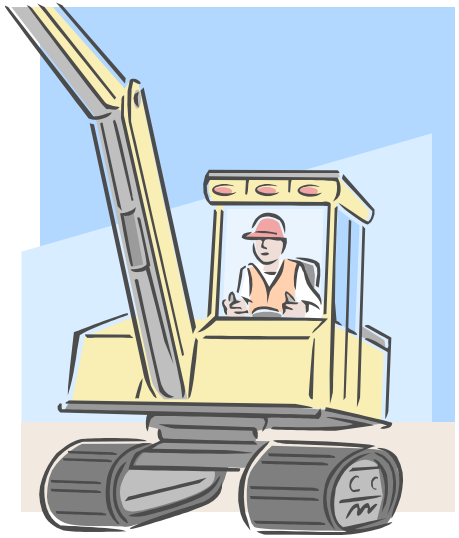
Worked 25 Hours

1. **YOU MUST WORK 4 CONSECUTIVE MONTHS**
2. **YOU MUST WORK A TOTAL OF 400 HOURS DURING THE 4 CONSECUTIVE MONTHS**

- ❑ **DID I WORK 4 CONSECUTIVE MONTHS? YES**
- ❑ **DID I WORK A TOTAL OF 400 HOURS? NO**

375 hours worked

- ❑ **DO I QUALIFY FOR BENEFITS? NO**



HOW DO I REMAIN ELIGIBLE?

Continued Eligibility

Once you are eligible, coverage continues on a period-by-period basis. The Plan looks at four-month periods, known as Contribution Periods and Eligibility Periods. You are eligible for coverage during an Eligibility Period if you have at least:

- 400 Credited Hours for the corresponding Contribution Period (as shown below); or
- 1,200 Credited Hours (known as "bank hours") in the last three Contribution Periods (a one-year period).

2014		
Eligibility Period	**400 Hours Needed OR**	**1200 Hours Needed**
4-1-2017 to 7-31-2017	**11-1-2016 to 2-28-2017**	**3-1-2016 to 2-28-2017**
8-1-2017 to 11-30-2017	**3-1-2017 to 6-30-2017**	**7-1-2016 to 6-30-2017**
12-1-2017 to 3-31-2017	**7-1-2017 to 10-31-2017**	**11-1-2016 to 10-31-2017**

ELIGIBILITY PERIOD…..I RECEIVED A BILL….WHAT SHOULD I DO???

HEALTH & WELFARE RECIPROCITY AGREEMENT

Request and Authorization for Transfer of Contributions

_____ _____

Participant Name (Please print) Social Security Number

I request and authorize that the Board of Trustees of the Local _____ Health and Welfare Fund to transfer to my Home Health and Welfare Fund all contributions made on my behalf to its Fund hereafter and within six months prior to the date this authorization request is received by the Fund, unless and until this authorization is revoked in writing. In support of this request, I state as follows:

1. I am a member of IUOE Local No ___ and my Union Registration No. is_____.

2.. My Home Health and Welfare Fund is _____.

3. I understand that, upon approval of my request to transfer, I cannot later request that any contributions which may be transferred to my Home Fund be transferred back to the transferring Fund.

4. I understand that, upon approval of my request to transfer contributions, me and my dependents' eligibility for benefits and all other participant rights shall be determined exclusively by the terms of my Home Fund's plan and rules, and not by the terms of the transferring Fund's plan and rules.

5. By making this request, I waive and release, on behalf of myself and my dependents, any and all claims against both Funds and their fiduciaries relating to whether the transfer of contributions is in my or their best interests.

Telephone

_____ _____

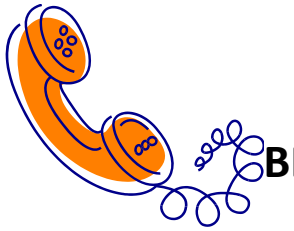
Signature Date

_____ _____

Address City, State, Zip

_____

Telephone



BENEFIT PERIOD…….I RECEIVED A BILL…..WHAT SHOULD I DO???

CHECK STUBS

1. Company Name

XYZ Excavating

JOHN DOE

123-45-6789

2. Work Dates

8/01/2016 – 8/07/2016

1234

Total Hours Worked: 40	723.20
Regular Overtime: 0	.00
Federal Withholding:	209.00
Social Security:	63.75
Medicare	14.91
IN Withholding:	34.96
IN County Tax:	9.25

3a. Employee name

4. Number of hours worked

3b. Employee SS#

*The above must be included for the Fund to process your paystubs.

Claims Department:

Dawn Kasemeyer, Assistant Administrator & Claims Supervisor
Staff:
Katricia Helton
Jenny Vauters
Jamie Bunch
Ashley Lee
Kathy McCowen

Telephone: 812-232-4384 or Toll Free: 877-299-3699

NEW MEMBER INFORMATION CARD

- Members to complete and sign front and back
- Designate a beneficiary in the event of your death
- List legal spouse and legal dependents.
- Include birthdate and social security number

Mid Central Operating Engineers Health and Welfare Fund, P.O. Box 9605, Terre Haute, IN 47808

MEMBER: Local Union (please circle one) 841 318 103 649

Last Name _____ First Name _____ M.I. _____ Telephone Number (_____)_____

Address: _____
Street /Box Number City State Zip

Social Security Number: _____ Date of Birth: ____/____/____
Mo. Day Year

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Seperated

Work Status: ☐ Active ☐ Retired ☐ Retired/Disability

Death Benefits to be paid to:

Name: _____ DOB _____ Telephone _____

Relationship: _____

Address: _____
Street /Box Number City State Zip

_____ _____
Member's Signature Date

PLEASE COMPLETE REVERSE SIDE OF CARD

DEPENDENTS: List below name of spouse and all children under age 26
List under relationship: (W) wife (H) husband (S) son (D) daughter (SS) step-son (SD) step-daughter

Last Name	First Name	M.I.	Relation-ship	Social Security Number	Date of Birth Mo/Day/Yr

If you have more dependent children, please attach a separate page.

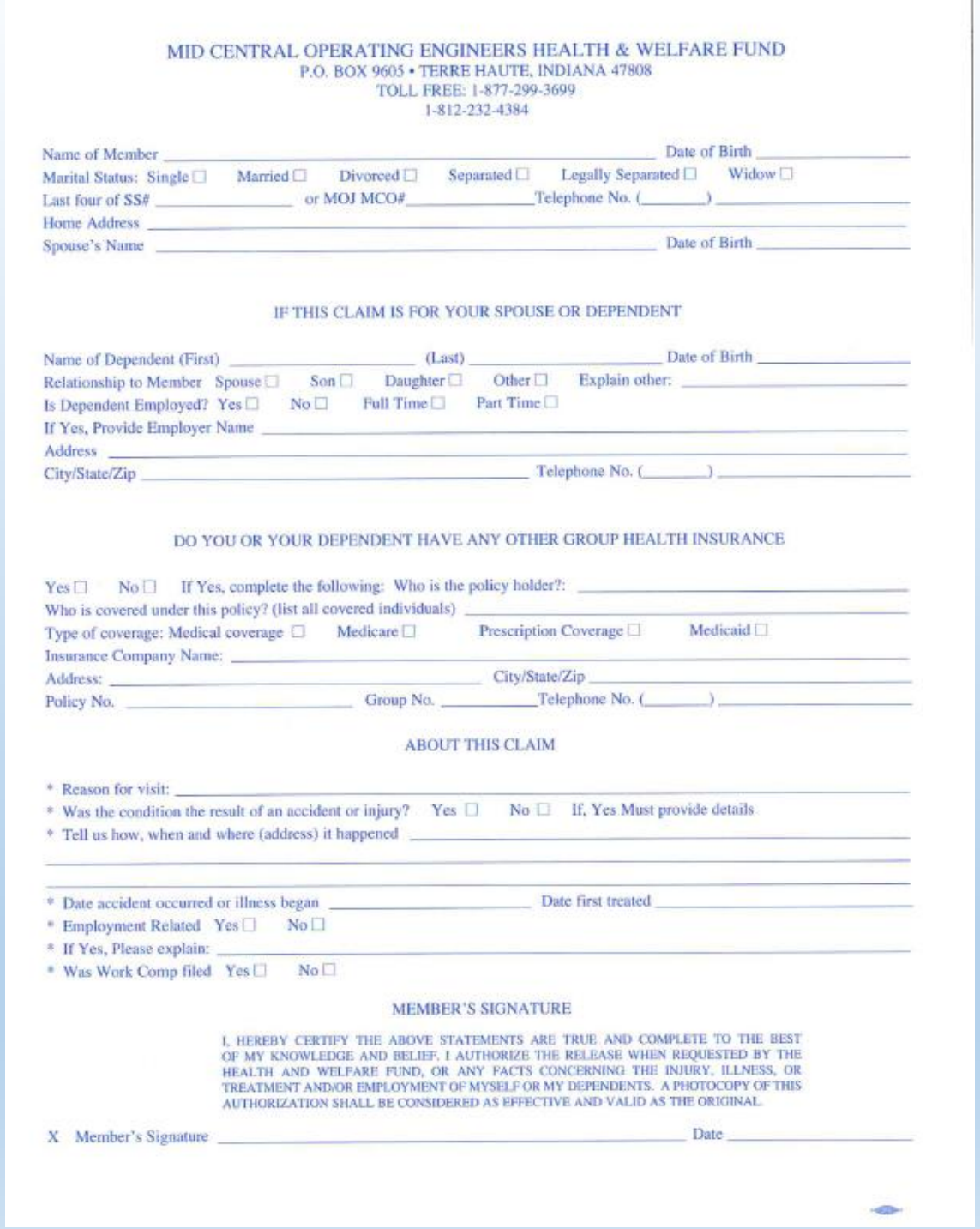
IMPORTANT CHANGES

- MARRIAGE: Marriage Certificate
- DIVORCE: Divorce Decree
- BENEFICIARY CHANGES: Updated Information Card
- ADDRESS CHANGES: Complete Change of Address Form available online at www.midcentral.org or mail change of address in writing signed by the member to the Fund office.
- NEW DEPENDENTS: Please provide a copy of the birth certificate.
  - Step Children generally require additional documentation such as divorce decree for determining eligibility and coordination of benefits, etc.
- OTHER INSURANCE COVERAGE: Provide HIPAA Certificate and/Copy of other Benefit Card, Prescription Card, Dental Card or any other applicable coverage.
- MEDICARE: Provide a copy of Medicare Card for you and any dependents who receive Medicare, regardless of age. If you have been awarded Social Security Disability, please provide a copy of the Award Letter stating the date of entitlement.

Claim Form:

- The Fund requests a claim form at the beginning of each calendar year.
- Based on diagnosis, such as indication of an accident
- A claim for a new dependent
- A claim for a spouse.

Please make sure the claim form is completed in full. Don't forget to sign and date.



MID CENTRAL OPERATING ENGINEERS HEALTH & WELFARE FUND
P.O. BOX 9605 • TERRE HAUTE, INDIANA 47808
TOLL FREE: 1-877-299-3699
1-812-232-4384

Name of Member _____ Date of Birth _____
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Legally Separated ☐ Widow ☐
Last four of SS# _____ or MOJ MCO# _____ Telephone No. (_____) _____
Home Address _____
Spouse's Name _____ Date of Birth _____

IF THIS CLAIM IS FOR YOUR SPOUSE OR DEPENDENT

Name of Dependent (First) _____ (Last) _____ Date of Birth _____
Relationship to Member Spouse ☐ Son ☐ Daughter ☐ Other ☐ Explain other: _____
Is Dependent Employed? Yes ☐ No ☐ Full Time ☐ Part Time ☐
If Yes, Provide Employer Name _____
Address _____
City/State/Zip _____ Telephone No. (_____) _____

DO YOU OR YOUR DEPENDENT HAVE ANY OTHER GROUP HEALTH INSURANCE

Yes ☐ No ☐ If Yes, complete the following: Who is the policy holder?: _____
Who is covered under this policy? (list all covered individuals) _____
Type of coverage: Medical coverage ☐ Medicare ☐ Prescription Coverage ☐ Medicaid ☐
Insurance Company Name: _____
Address: _____ City/State/Zip _____
Policy No. _____ Group No. _____ Telephone No. (_____) _____

ABOUT THIS CLAIM

* Reason for visit: _____
* Was the condition the result of an accident or injury? Yes ☐ No ☐ If, Yes Must provide details
* Tell us how, when and where (address) it happened _____
* Date accident occurred or illness began _____ Date first treated _____
* Employment Related Yes ☐ No ☐
* If Yes, Please explain: _____
* Was Work Comp filed Yes ☐ No ☐

MEMBER'S SIGNATURE

I, HEREBY CERTIFY THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE THE RELEASE WHEN REQUESTED BY THE HEALTH AND WELFARE FUND, OR ANY FACTS CONCERNING THE INJURY, ILLNESS, OR TREATMENT AND/OR EMPLOYMENT OF MYSELF OR MY DEPENDENTS. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

X Member's Signature _____ Date _____

Mid Central Operating Engineers Health & Welfare Fund

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- Fund Contact
- Important Announcements
- Forms
- Summary Plan Description
- Initial Eligibility
- Benefit Schedules
- Retiree Rates
- FAQs
- Employers
- Delinquent Contributors
- Links

Members Log In

Welcome to the Mid Central Operating Engineers Health and Welfare Fund

This website was developed to provide our members with access to work history, eligibility, claims history and other valuable information. In order to access your information, you must register under Member Log In. Please have your Identification Number ready, which is located on your Anthem Blue Cross/Blue Shield or Eligibility Card (for retired members).

You also have the ability to view the Summary Plan Description, Benefit Schedules, Retiree Rates and much more. You may also download forms such as claim forms, change of address form, disability statements, and ACH bank forms (for Retirees only).

If you have any questions, please contact us at 1-812-232-4384 or click Fund Contact for toll-free numbers.

We also have included valuable links to other websites for your use.