Questions about Your Benefits? Call the Fund office at (877) 850-0977. Press "1" to reach the Automated Benefit Information System or Press "2" to speak with a representative.

For Your Benefit

Operating Engineers Local No. 77

Vol. 11, No. 2

www.associated-admin.com

Material Modification

Mental Health Parity Act Changes in Mental Health And Substance Abuse Benefits

Below is a Summary of Material Modification (change) to your Summary Plan Description booklet. Please keep this notice with your booklet so you will have it when you need to refer to it. If there is any discrepancy between the terms of the Plan and its amendments, and this document, the provision of the Plan, as amended, will control.

Effective January 1, 2011, as a result of the Mental Health Parity and Addiction Equity Act ("MHPAEA"), the Board of Trustees approved changes for mental health and substance abuse benefits.

Alcohol and Substance Abuse Benefits

Treatment of alcohol and substance abuse is covered if the participant/covered dependent meets the following conditions:

1. Prior approval is required.

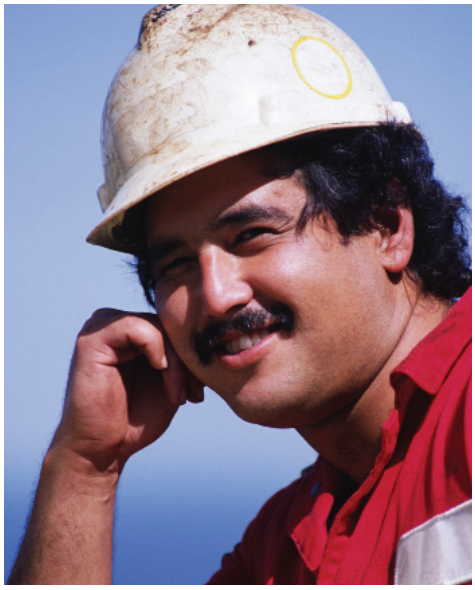
2. You must submit a letter of medical necessity from the legally qualified physician requesting treatment by a social worker and/or a drug and alcohol counselor. With approval, the Fund will pay for the treatment of drug and alcohol addiction.

3. The Fund will pay 100% for inpatient and outpatient care up to the Usual, Customary and Reasonable ("UCR") charges and subject to the other limits of the Plan. No other benefits are payable under the Plan for drug and alcohol addiction. Inpatient treatment (including at a drug and alcohol treatment facility) must be approved by the Nationwide Better Health ("Nationwide") prior to your admission.

Contact Nationwide at (800) 925-8573 to pre-authorize treatment. You must submit a request in writing prior to undergoing treatment in order to be covered for this benefit.

Mental Health Benefits

Mental health treatment is now covered under Major Medical up to the Usual, Customary, and Reasonable ("UCR") charges and subject to the other limits of the Plan. All mental health care must be certified through Nationwide in order to be covered.



Summary of Material Modifications (Changes) This Issue!

Operating Engineers Union Local No. 77 Health and Welfare Fund

Operating Engineers Union Local No. 77 Pension Fund

Operating Engineers Union Local No. 77 Individual Account Fund

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.

This issue—

No one but the Retiree can sign the RIF, unless an individual holds a Power of Attorney for the Retiree. A copy of any such Power of Attorney must be on file with the Fund office. If, for health reasons, the Retiree is unable to sign the form and there is no Power of Attorney on file, then the Retiree must sign an "X" on the RIF and have it notarized showing the Notary Public seal.

Retirees: Retiree Information Forms Are Being Sent Return Promptly to Avoid Suspension of Benefits

The Fund office will shortly send Retiree Information Forms (RIFs) to be completed and returned to the Fund office. The form asks questions about your current address, beneficiary information, and employment information (if you are employed after retirement).

Even if you completed this form last year, you still must complete and return this year's RIF. It is very important that you review all sections of this form to be certain the information is correct. If necessary, mark corrections on the form and promptly send it back to the Fund office. ***If we don't receive your RIF, your benefits may be suspended until it is received.*** To assist you, the Fund office will include a postage-paid, return envelope with the first mailing.

Send Appeals to New Address

As you know, you have the right to appeal a denial of your claim by writing to the Board of Trustees.

For Medical or Weekly Accident & Sickness Claims:
You must send a written request to the Board of Trustees within 180 days after you receive written notice that your claim has been denied (within 60 days for non-medical, non-disability claims).

For Pension Claims:
You must send a written request to the Board of Trustees within 60 days from the date you receive the notice denying the claim.

All appeals should now be sent to the Fund's Sparks office at:

Operating Engineers Local No. 77 Funds
Board of Trustees
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Appeals Dept.

If you have already sent an appeal to the Landover office, we will forward it. **You do not need to send it again.**

Reminder: Have Information Ready before Calling Fund Office

Before you call the Fund office to check on medical bills, please have information ready to tell the operator, such as:

- Your Social Security Number.
- The date the medical service was performed
- The amount of the bill.
- The name of the provider (hospital or doctor's name).
- The amount you have been billed.

When You Enroll in Medicare Part B, Send Copy of Medicare Card to the Fund Office

As you know, Medicare is the federal health insurance program for people age 65 and over and certain disabled persons. Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). Medicare is available at the beginning of the month in which you turn 65, whether you are retired or still working. It is also available after you have been entitled to Social Security disability benefits for two years, and generally if you have end-stage renal disease (kidney failure).

Enrolling in Medicare
If you are eligible for Retiree Health and Welfare coverage through the Fund and you – or any covered dependent -- become Medicare eligible at any age, for any reason, ***you must enroll in Medicare Part B at the earliest date you are eligible for it. Regardless of whether you or your eligible dependent enroll in the Medicare Part B program, the Health and Welfare Fund <u>will not</u> pay any benefits that are available under the Medicare program.***

Send Copy of Medicare Card
Once you (or any covered dependent) are enrolled in Medicare, send the Fund office a copy of the Medicare card. ***This is very important.*** We must update our records to adjust your monthly co-payment. In almost all cases, your co-payment is less. Sometimes participants notify us months later that they are enrolled in Medicare, resulting in a complicated process of adjustments.

Please remember to enroll in Medicare Part B as soon as you are eligible, notify the Fund office at once, and send the Fund office a copy of your Medicare card. Future retirees who become Medicare eligible should call their local Social Security Administration Office at least three months before retiring to find out how to apply for Medicare.

Material Modification

Orthotics Benefits

Below is a Summary of Material Modification (change) to your Summary Plan Description booklet. Please keep this notice with your booklet so you will have it when you need to refer to it.

Effective February 22, 2011, the Board of Trustees approved coverage of orthotics once every three years up to $500; however, if determined to be medically necessary by Nationwide Better Health ("Nationwide"), orthotics can be covered once a year up to $500 per year.

Orthotics must be pre-authorized by Nationwide. Call (800) 925-8573.

You Can Enroll in the 401(k) Option During July

During the month of July, you have the opportunity to enroll in the 401(k) Option or make changes in the amount of contributions you currently make. The 401(k) Option is a provision of the Individual Account Plan (Annuity Fund). It allows your savings to go further because the money is saved on a **pre-tax** basis.

How does a 401(k) work?
Saving in a 401(k) Option is easy through payroll deduction. Because your contribution is taken before your check is taxed, it's worth more to you in the 401(k) than it would be in your paycheck, where it would be reduced by income taxes.

How much can I put into the 401(k)?
You can contribute up to a maximum of $3.00 per hour worked, in 50-cent increments. For example, you may choose to save $.50 an hour, $1.00, $1.50, $2.00, $2.50, or even $3.00 per hour worked. And, very importantly, your contribution is pre-tax.

As an example, let's say Steve earns $50,000 a year. His total income tax rate is 31% (includes federal and any applicable state and local taxes). Steve contributes $2,500 a year to the 401(k) Plan. That reduces his taxable salary to $47,500. But it also cuts his income taxes by $775 (31% of $2,500).

Steve has saved $2,500 but his take-home pay isn't reduced by $2,500 a year. It's only reduced by $1,725.

How do I know how well my investments are doing?
You'll receive a financial statement of your 401(k) account on a quarterly basis from MassMutual Financial Group that shows the amounts you've contributed and how all your investments have performed. You may also monitor how your account is doing by using MassMutual's RetireSmart website located at www.retiresmart.com.

Participation in the 401(k)
Participation in this Option is ***totally voluntary.*** You may stop making contributions or change the amount every six months (during January and July) by completing a Participant New Deferral form.

For more information
You can receive answers to questions about the 401(k) Plan, investment options, or account information by calling MassMutual at (800) 743-5274 or logging onto www.massmutual.com.

Summary of Material Modifications

Below are Summary of Material Modifications (changes) made to your Plans during the past year. Please read over them and clip them where indicated so you can keep them with your Summary Plan Description ("SPD") booklets and your other benefits information.

OPERATING ENGINEERS UNION LOCAL NO. 77 HEALTH AND WELFARE FUND

• Effective February 22, 2011. The Board of Trustees approved coverage of orthotics once every three years up to $500; however, if determined to be medically necessary by Nationwide Better Health ("Nationwide"), orthotics can be covered once a year up to $500 per year.

Orthotics must be pre-authorized by Nationwide. Call (800) 925-8573.

• Effective January 1, 2011. Pursuant to the Patient Protection and Affordable Health Care Act (PPACA), the Board of Trustees of the Operating Engineers Local No. 77 Health and Welfare Fund ("Fund") has made several changes to the Fund's Plan of benefits.

DEPENDENT COVERAGE

• Effective January 1, 2011, the Plan will offer dependent eligibility for a child up to age 26, and will eliminate the eligibility requirements that a child be unmarried and financially dependent on the participant.

A. Coverage to Age 26

Effective January 1, 2011, the Plan will cover an eligible dependent child up to age 26 (meaning through the end of the month of his or her 26th birthday). Individuals whose coverage ended, or who were denied coverage (or who were not eligible for coverage) under the Plan because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan.

Because it is considered "grandfathered" (see the discussion below) under the PPACA rules, prior to 2014, the Plan will exclude coverage to an adult child under age 26 if the child is eligible to enroll in an employer-sponsored plan that is not a parent's plan. Therefore, prior to 2014, if an adult child under age 26 is eligible for an employer-sponsored plan through his or her own employment, or through the employment of the spouse, that adult child under age 26 is not eligible to enroll for Plan coverage (even if he or she doesn't enroll in the other plan).

Eligible adult children that enroll during the "special election period" offered prior to January 1, 2011 will receive coverage beginning on January 1, 2011. Eligible adult children that enroll after the special election period will receive coverage that begins on the first of the month following the date of enrollment.

B. Elimination of Certain Dependent Eligibility Requirements

Effective January 1, 2011, the Plan is eliminating the requirement that a dependent child be unmarried, and is eliminating the requirement that a dependent child be at least 50% dependent on the participant for support.

C. Coverage for Dependent Students Under Age 23

Effective January 1, 2011, the Plan will no longer require dependents between the ages of 19 and 23 to be students in order to be covered. These dependents will now be eligible for coverage because the Plan offers dependent coverage up to age 26.

D. Revised Definition of Dependent Eligibility

Based upon the changes discussed in sections A – C above, effective January 1, 2011, the Plan's general definition of a "dependent" will provide as follows:

Dependents include your lawful spouse residing with you and your natural children, stepchildren, adopted children or children placed for adoption who are under the age of 26. It is a further requirement for dependent eligibles that a valid Social Security number be provided to the Fund Office for each dependent.

E. Disabled Children

The Plan provides that if a dependent child is incapable of self-support due to a mental or physical disability, the age limit for dependents does not apply. The terms of the Plan regarding disabled children will not change. Effective January 1, 2011, the Plan's age limit will become 26. However, for coverage for disabled children beyond age 26, this does not alter the Plan requirements that: (1) the child be unmarried; (2) the child be financially dependent on the participant for support; (3) the child was the participant's dependent before the child turned age 19; (4) the disability began before age 19; (5) the disability be certified by a physician and found by the Board of Trustees to be a qualifying disability; and, (6) the child continue to be eligible for dependent coverage under the Plan (the Fund Office may require evidence of the dependent's continuing disability).

LIFETIME LIMIT

Effective January 1, 2011, the Plan's $1 million lifetime limit on the dollar value of Major Medical Benefits from the Plan is eliminated with respect to "essential health benefits."

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The term "essential health benefits" was created by the PPACA, and is discussed below.

Effective January 1, 2011, the fact that the Plan has provided $1 million in total Major Medical Benefits on behalf of an individual will no longer prevent it from paying for Major Medical Benefit expenses that are considered "essential health benefits." However, with respect to Major Medical Benefit expenses that are not considered "essential health benefits," the Plan's $1 million lifetime limit is being maintained. Therefore, once the Plan has provided $1 million in total Major Medical Benefits on behalf of an individual, it will not pay for Major Medical Benefit expenses that are not considered "essential health benefits."

In addition, once the Plan has provided $1 million in Major Medical Benefits on behalf of an individual, it will pay for additional Major Medical Benefit expenses that are considered "essential health benefits" at a rate of 50%.

The term "essential health benefits" will have the meaning found in section 1302 of the PPACA and implementing regulations issued by the federal government. Until the federal government issues regulations further defining the term "essential health benefits," the term includes items and services covered within the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

ANNUAL LIMITS

With respect to essential health benefits, the Plan will phase out its current $200,000 annual Major Medical Benefit Maximum **over the next three years. It will also eliminate the current $10,000 per family per year benefit limit on prescription drugs. In conjunction with these changes, the Plan is adopting related benefit design changes.**

A. Overall Annual Limit

In 2011, 2012, and 2013, the Plan will contain an annual Major Medical Benefit Maximum with respect to "essential health benefits." Effective January 1, 2014, the Plan will no longer have an annual Major Medical Benefit Maximum with respect to essential health benefits. The Plan's Major Medical Benefit annual maximums on essential health benefits over the next three years are as follows:

PLAN YEAR	ANNUAL MAXIMUM
2011	$750,000
2012	$1.25 Mlillion
2013	$2 Million

For example, if the Plan pays for $750,000 in Major Medical Benefits that are "essential health benefits" for claims incurred by an individual during 2011, it will not pay for any additional Major Medical Benefit expenses that are essential health benefits for that individual with respect to claims incurred in 2011.

With respect to Major Medical Benefit expenses that are not considered "essential health benefits," the Plan's $200,000 annual limit is being maintained. Therefore, once the Plan has provided $200,000 in Major Medical Benefits for claims incurred by an individual during a calendar year, it will not pay for additional Major Medical Benefit claims incurred by that individual during that calendar year that are not considered "essential health benefits."

In addition, once the Plan has provided $200,000 in total Major Medical Benefits for claims incurred by an individual during a calendar year, it will pay for additional Major Medical Benefits that are "essential health benefits" for claims incurred by that individual during that calendar year at a rate of 50%.

Example 1: During 2011, the Major Medical Benefit costs incurred by an individual are all "essential health benefits," and the Plan pays $750,000 in essential health benefits.

Conclusion: Because the $750,000 annual Major Medical Benefit Maximum on essential health benefits has been reached, the Plan will not pay for any additional Major Medical Benefit expenses (regardless of whether they are essential or non-essential health benefits) for that individual with respect to claims incurred in 2011.

Observation: The Plan pays Major Medical Benefits for "essential health benefits" at a rate of 50% after it has provided $200,000 in Major Medical Benefits for claims incurred by an individual during a calendar year. Therefore, after receiving $200,000 in Major Medical Benefit claims payments, to receive an additional $550,000 in Major Medical Benefit payments for essential health benefits and reach the annual maximum on essential health benefits of $750,000 ($200,000 + $550,000 = $750,000), the individual would need to incur an additional $1,100,000 in Major Medical Benefit expenses for essential health benefits ($1,100,000 x 50% = $550,000) to reach the $750,000 annual maximum on essential health benefits.

Example 2: By May 2011, the Plan has paid $175,000 in Major Medical Benefits that are essential health benefits on behalf of an individual, and $25,000 in Major Medical Benefits that are non-essential health benefits on behalf of that individual.

Conclusion: All additional Major Medical Benefit expenses that are essential health benefits for that

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individual with respect to claims incurred in 2011 will be paid at the rate of 50%.

Observation: In Example 2, receiving Major Medical Benefits at a rate of 50%, in order to receive an additional $575,000 in Major Medical Benefit payments for essential health benefits and reach the annual maximum on essential health benefits of $750,000 ($175,000 + $575,000 = $750,000), the individual would need to incur an additional $1,150,000 in Major Medical Benefit expenses for essential health benefits ($1,150,000 x 50% = $575,000) to reach the $750,000 annual maximum on essential health benefits.

B. Annual Limit on Prescription Drugs

Effective January 1, 2011, the Plan is eliminating the $10,000 per family per year benefit limit on prescription drugs.

In addition, once the Plan has provided $10,000 for prescription drug claims incurred by an individual during a calendar year, it will pay for additional non-generic prescription drug claims incurred by that individual during that calendar year at a rate of 40% (individual pays 60% coinsurance).

Therefore, once the Plan has provided $10,000 for prescription drug claims incurred by an individual during a calendar year, it will cover generic and non-generic prescription drugs as follows:

• Generic: $10 co-payment if purchased using mail order program; $5 co-payment if purchased at a pharmacy; individual pays no coinsurance.

• Non-generic: Individual's coinsurance is 60%.

GRANDFATHERED STATUS

The Trustees of the Operating Engineers Local No. 77 Trust Fund of Washington, D.C. believe that the Operating Engineers Local No. 77 Trust Fund of Washington, D.C. is a "grandfathered health plan" under the PPACA.

The Operating Engineers Local No. 77 Trust Fund of Washington, D.C. uses collectively bargained employer contributions to the Plan, and income from the investment of Plan assets, to provide the most generous health plan that is prudently possible given the assets of the Plan. To avoid the financial and other burdens on the Plan that would be associated with full implementation of the PPACA, the Trustees have decided to operate the Plan as a "grandfathered health plan" under the PPACA.

A health plan that was in existence on March 23, 2010, the enactment date of the PPACA, is referred to under the PPACA as a "grandfathered health plan." As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, coverage of dependents up to age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager at: Operating Engineers Union Local No. 77, Health and Welfare Fund, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, (877) 850-0977. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

• Effective January 1, 2011, as a result of the Mental Health Parity and Addiction Equity Act ("MHPAEA"), the Board of Trustees approved changes for mental health and substance abuse benefits.

ALCOHOL AND SUBSTANCE ABUSE BENEFITS

Treatment of alcohol and substance abuse is covered if the participant/covered dependent meets the following conditions:

1. Prior approval is required.

2. You must submit a letter of medical necessity from the legally qualified physician requesting treatment by a social worker and/or a drug and alcohol counselor. With approval, the Fund will pay for the treatment of drug and alcohol addiction.

3. The Fund will pay 100% for inpatient and outpatient care up to the Usual, Customary and Reasonable ("UCR") charges and subject to the other limits of the Plan. No other benefits are payable under the Plan for drug and alcohol addiction. Inpatient treatment (including at a drug and alcohol treatment facility) must be approved by Nationwide Better Health ("Nationwide") prior to your admission.

Contact Nationwide at (800) 925-8573 to pre-authorize treatment. You must submit a request in writing prior to undergoing treatment in order to be covered for this benefit.

MENTAL HEALTH BENEFITS

Mental health treatment is now covered under Major Medical up to the Usual, Customary, and Reasonable ("UCR") charges and subject to the other limits of the Plan. All mental health care must be certified through Nationwide in order to be covered.

• Effective November 9, 2010, services of a nurse practitioner are covered when supervised by a physician.

• Effective September 1, 2009, the services of a physician's assistant, acting under the supervision of a physician, are covered in lieu of the services of the attending physician.

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Services of a surgical assistant or certified surgical assistant are covered subject to the plan rules applicable to a second surgeon, but only if the assistant was used in lieu of the services of a second surgeon or physician.

• Effective July 1, 2010, your vision benefits are now provided through VSP Choice Plan. Your vision benefits are no longer covered under your Basic Benefit.

Improved Network – One-Stop Shopping

VSP has an extended network of 33,000 providers located in retail and professional office locations. The average driving distance to a VSP provider is just 4.2 miles, and you have the convenience of scheduling an office visit during evening and weekend hours.

Vision Coverage with a VSP Doctor

- An exam is covered once every 12 months when rendered by a participating VSP provider.
- Lenses and frames are covered once every 24 months.
- You are responsible for a $10 co-payment per visit and a $10 materials co-payment when you receive either single vision, lined bifocal, or lined trifocal lenses. ***Note: if you go to a Non-VSP provider, VSP will pay up to $52 for an eye exam, $34 for single vision lenses, $50 for lined bifocal lenses, $66 for lined trifocal lenses, $50 for frame, and $100 for contact lenses if you choose contacts instead of lenses and frame.*** If you see a doctor other than a VSP doctor, you have 6 months to submit a claim to VSP for reimbursement.
- You have a $130 allowance for the purchase of eyeglass frame or towards the purchase of contact lenses. Contact lenses are in lieu of lenses and frame.

Find A VSP Doctor

To locate the most current doctors in the VSP network, log on to www.vsp.com. Just click on the member tab and register. Once registered, you can locate doctors that are convenient for you. Although registration is not required, it is helpful in finding a doctor who participates in your specific VSP plan. You can also call VSP's Interactive Voice Response ("IVR") toll-free at (800) 877-7195. The IVR is available 24 hours a day, seven days a week.

When You Schedule Your Appointment

When you schedule your eye appointment, simply tell your eye doctor your name and date of birth. Your provider will contact VSP for authorization of your eligibility.

When You Go To Your Appointment

You do not need an ID card; however, if you would like one, you may print it by going to the VSP website at www.vsp.com. Your VSP provider will have your authorization waiting for your arrival.

OPERATING ENGINEERS UNION LOCAL NO. 77 PENSION FUND

• Effective January 1, 2011, the Board of Trustees of Operating Engineers Local 77 Pension Plan announces a change in the pension benefit for all actively working participants as required by Section 204(h) of the Employee Retirement Income Security Act.

Under the Plan's current benefit formula, for all hours worked after January 1, 2008, you accrue monthly pension benefits upon your retirement equal to 3% of the total contributions made on your behalf to the Pension Fund. This formula is being changed by a plan amendment.

Effective January 1, 2011, for all hours worked after December 31, 2010, you will accrue monthly pension benefits upon your retirement equal to 2.5% of the total contributions made on your behalf to the Pension Fund.

Here is an example of how this change would affect a participant's pension. Assume that Ted has earned 18 years of benefit credit prior to January 1, 2008, with no breaks in service, and worked 2080 hours during each calendar year from 2008-2011, for which his employer made contributions to the fund of $1.90 per hour in 2008, $2.10 per hour in 2009, $2.30 per hour in 2010 and 2011. Assume further that Ted is unmarried. If Ted retires on January 1, 2012 (his normal retirement date), his pension would be calculated as follows:

YEARS OF SERVICE	BENEFIT CALCULATION	AMOUNT
Before 2008	18 (years) x $88.15 (pre 2008 benefit rate)	$1,586.70
2008	2080 (total hours) x $1.90 (hourly contribution) x 3% (benefit rate)	$118.56
2009	2080 (total hours) x $2.10 (hourly contribution) x 3% (benefit rate)	$131.04
2010	2080 (total hours) x $2.30 (hourly contribution) x 3% (benefit rate)	$143.52
2011	2080 (total hours) x $2.30 (hourly contribution) x 2.5% (benefit rate)	$119.60
	Total	**$2,099.42**

Upon retirement, Ted would receive a monthly pension of $2,099.42.

OPERATING ENGINEERS UNION LOCAL NO. 77 INDIVIDUAL ACCOUNT FUND

No changes.

Privacy Statement Available Upon Request

In accordance with federal law, the Fund has established Privacy Practices, which are the rules on how personally identifiable health information ("PHI") about you or your dependents may be used and disclosed by the Fund and other parties, and how you or your dependents can get access to this information.

This statement was given to you when you first became eligible for benefits. If you would like another copy of the "Notice of Privacy Practices," call the Fund office toll free at (877) 850-0977 or write to:

HIPAA Privacy Officer
Operating Engineers Local No. 77
4301 Garden City Drive, Suite 201
Landover, Maryland 20785-2210

OPERATING ENGINEERS LOCAL NO. 77 FUNDS
911 Ridgebrook Road
Sparks, MD 21152-9451