1099Rs for Retirees Will Be Mailed in Late January. Look for Yours!

For Your Benefit

Operating Engineers Local No. 77 Funds

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Material Modifications

PPACA – Major Changes in Your Health Benefits

Below are Summaries of Material Modifications (changes) 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.

These Summaries of Material Modifications are being provided to advise you as to certain new developments relating to the Operating Engineers Local No. 77 Trust Fund of Washington, D.C. (the Plan), which are applicable to the Plan and its Schedule of Benefits, effective January 1, 2011. These Summaries of Material Modifications describe changes to the terms of the Plan required by the Patient Protection and Affordable Care Act (the PPACA), and related changes to the Plan adopted by the Board of Trustees.

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 their 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 their own employment, or through the employment of their spouse, that adult child under age 26 is not eligible to enroll for Plan coverage (even if they don't enroll in the other plan).

Eligible adult children that enrolled during the "special election period" offered prior to January 1, 2011 received coverage which began 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 include a provision

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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.

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providing coverage to dependents between the ages of 19 and 23 who are students. 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 age 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." 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 Million
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 (regardless of whether they are essential or non-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 non-essential 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 Benefit 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 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 (regardless of whether they are essential or non-essential health benefits) for that individual with respect to claims incurred in 2011 will be paid at the rate of 50%.

Observation #1: 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.

Observation #2: In Example 2, receiving Major Medical Benefits at a rate of 50%, in order to receive an additional $175,000 in Major Medical Benefit payments for non-essential health benefits and reach the annual maximum on non-essential health benefits of $200,000 ($25,000 + 175,000 = 200,000), the individual would need to incur an additional $350,000 in Major Medical Benefit expenses for non-essential health benefits ($350,000 x 50% = $175,000) to reach the $200,000 annual maximum on non-essential health benefits.

Notice About the Early Retiree Reinsurance Program

The following notice applies to all participants and all Plan participants who are family members.

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

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

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year, it will pay for additional non-generic prescription drugs 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.

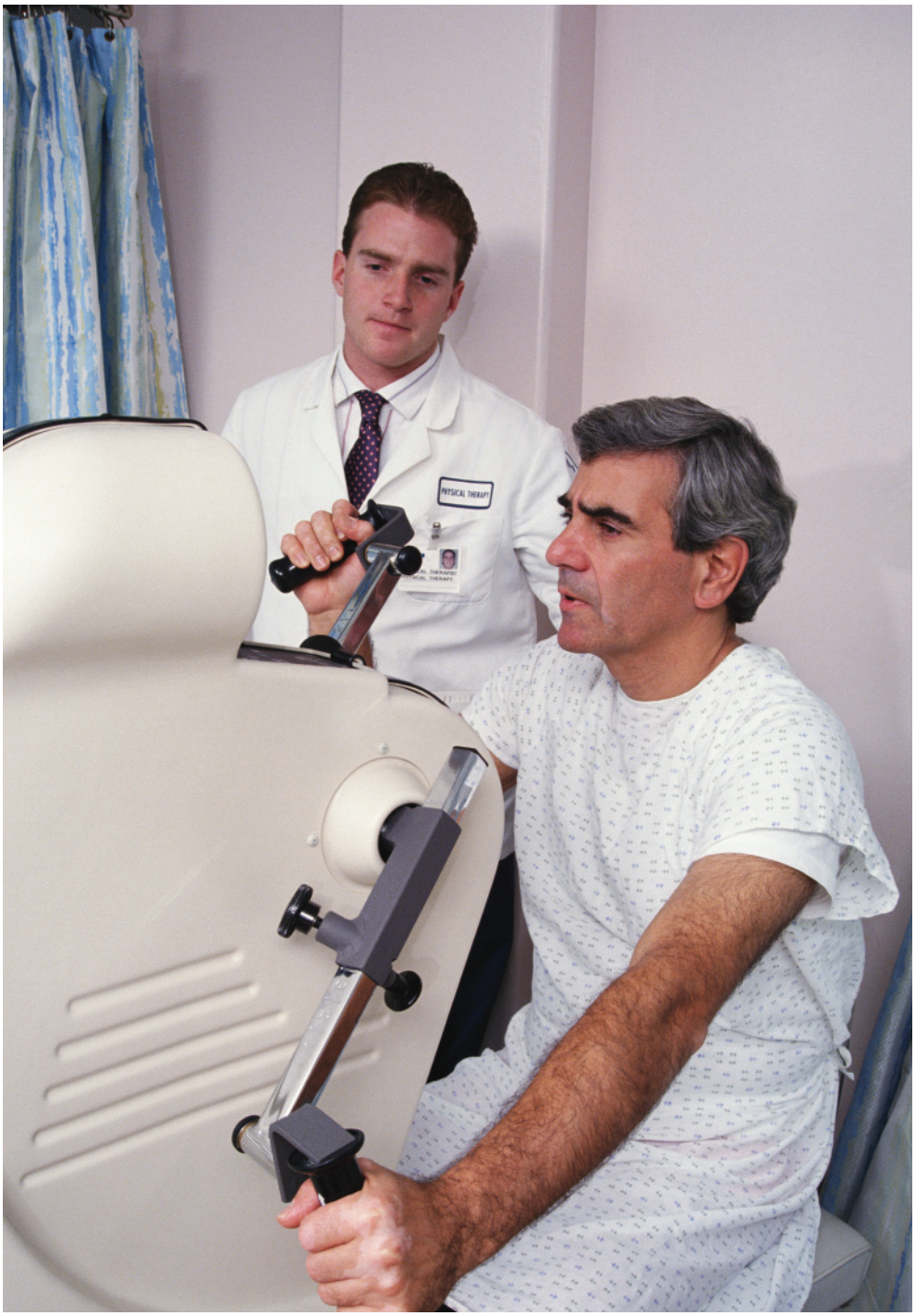
Non-generic:
Individual's coinsurance is 60%.

GRANDFATHERED STATUS

During the health reform debate, President Obama stated to Americans that "if you like your health plan, you can keep it." The Trustees of the Operating Engineers Local No. 77 Trust Fund of Washington, D.C. have chosen to do so, and 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/health reform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Open Enrollment for the 401(k) Option Is January 1st

If you have not enrolled in the 401(k) Option and are interested in doing so, **now is the time!** This 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 DO I ENROLL IN THE 401(K) OPTION?

Call the Fund office at (877) 850-0977 and request a Participant New Deferral form. Once you have completed the form, return it to your employer, not the Fund office.

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 Tom earns $25,000 a year. His federal income tax rate is 28%, and his state and local taxes add up to another 4% for a total 32% tax rate. Tom's contributes $1,000 a year to the 401(k) Plan. That reduces his taxable salary to $24,000. But it also cuts his income taxes by $320 (32% of $1,000).

Tom has saved $1,000 but his take-home pay isn't reduced by $1,000 a year. It's only reduced by $680.

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 can also review your account online by going to www.massmutual.com. Make a selection at Login Access by clicking on "The Journey" and entering your PIN and Social Security Number.

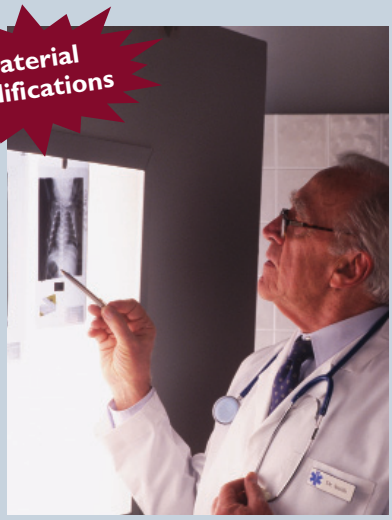
PARTICIPATION IN THE 401(K)

Participation in this Option is **totally voluntary.** You may stop making contributions or change the amount every six months (January 1st and July 1st) by completing a Participant Deferral Change form.

FOR MORE INFORMATION

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

Material Modifications



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SERVICES OF A PHYSICIAN'S ASSISTANT, SURGICAL ASSISTANT, OR CERTIFIED SURGICAL ASSISTANT ARE COVERED UNDER LIMITED CIRCUMSTANCES

Effective September 1, 2009, the Board of Trustees approved that 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. 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.

SERVICES OF A NURSE PRACTITIONER ARE COVERED WHEN SUPERVISED BY A PHYSICIAN

Effective November 9, 2010, the Board of Trustees approved services of a nurse practitioner as long as it is a service that is covered by the Plan and is supervised by a physician.

Long-Term Maintenance Drugs Must Be Filled through CVS Caremark Mail Service or CVS Pharmacy

You have the opportunity to have your long-term prescriptions (maintenance drugs) filled at a CVS Pharmacy or through CVS Caremark Mail Service Pharmacy. Maintenance drugs are those you take for a long period of time and/or to treat a chronic condition such as high blood pressure, diabetes, or arthritis, to name a few.

USING THE CVS PHARMACY

You can pick up your long-term medicine directly from a CVS pharmacy. You are allowed a maximum of four 30-day fills of long-term prescriptions at any retail pharmacy before you must get a 90-day supply of a prescription filled by a local CVS Pharmacy or by CVS Caremark Mail Service Pharmacy.

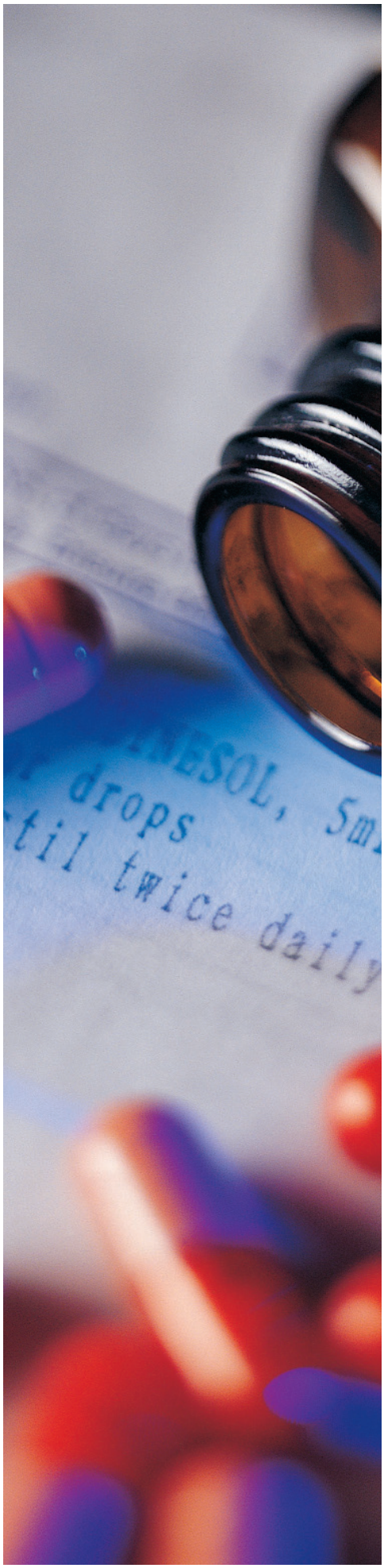
USING THE CVS CAREMARK MAIL SERVICE

There are two ways to order using the CVS Caremark Mail Service:

1. You can order on www.caremark.com. On the website, you can print a CVS Caremark Mail Service Order Form. Mail the completed form with your original prescription (not a photocopy) and your payment (check, credit card or money order) to:

CVS Caremark
P.O. Box 2110
Pittsburgh, PA 15230-2110

2. CVS Caremark also has an automated refill phone service at (866) 282-8503. Prescriptions are filled in approximately 14 days and will be delivered directly to your home.



Medical Necessity Letter Needed for Prescriptions Requiring Prior Authorization

Certain medications require prior authorization before they can be filled. But to get prior authorization, you need to ask your physician to prepare a letter of **medical necessity** and fax it to (410) 683-7778, Attention: Local 77 Prior Authorization, or mail it to the Fund office at:

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

The medical necessity letter must include the following information:

1. name, address and Social Security number of participant;

2. patient's condition

3. diagnosis (why this medication is necessary)

4. name of drug requested

5. dosage of drug requested

When the Fund office receives the letter of medical necessity from your physician, we contact CVS Caremark to initiate the prior authorization process. Based on the information your doctor provides, a determination will be made as to whether or not it has met certain FDA standards, and then both the pharmacy and your physician will be notified.

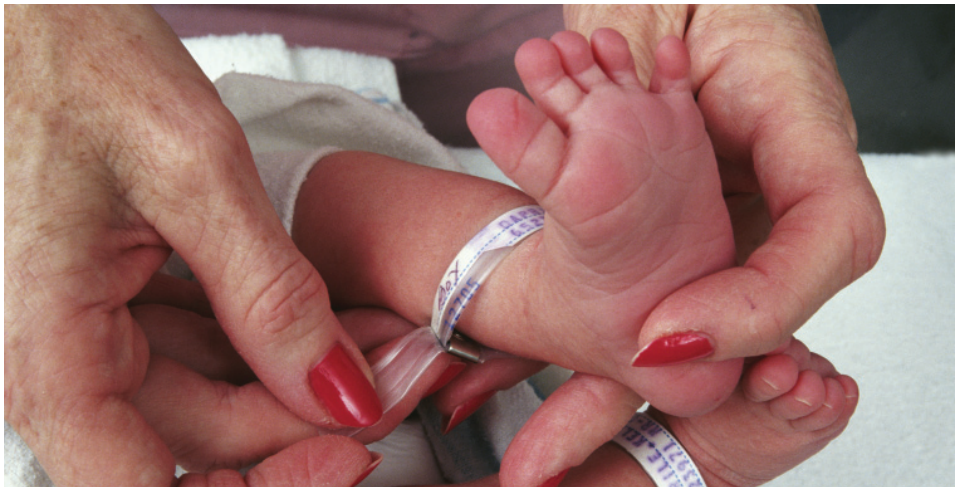
Newborns' & Mothers' Health Protection Act Provides Minimum Hospital Stay

In accordance with the Mothers' and Newborns' Health Protection Act of 1998 (the "Newborns' Act"), the Fund provides coverage for mothers and newborns to remain in the hospital after birth for a minimum of 48 hours for a normal, vaginal delivery, and a minimum of 96 hours for a cesarean delivery. The Fund cannot and does not require that providers obtain authorization for prescribing a length of stay not in excess of the above period of time.

When does the 48-hour (or 96-hour) period start?

If a woman delivers her baby in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. As an example, if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-period begins at 6 a.m. on June 12.

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. For example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.



Reconstructive Surgery Covered Following Mastectomy

The following article applies to you if your medical benefits are provided through the Fund, and not through an HMO. If you have coverage through an HMO, you should receive a notice directly from the HMO.

The Women's Health and Cancer Rights Act ("WHCRA") provides protections for individuals who elect breast reconstruction after a mastectomy. Under federal law related to mastectomy benefits, the Plan is required to provide coverage for the following:

1. Reconstruction of the breast on which a mastectomy is performed;

2. Surgery on the other breast to produce a symmetrical appearance;

3. Prostheses; and

4. Physical complications of all stages of mastectomy including lymphedemas.

Such benefits are subject to the Plan's annual deductibles and co-insurance provisions. Federal law requires that all participants be notified of this coverage annually.

HEALTH CORNER

Healthy Snacking

When hunger hits, it hits hard. It's 3 p.m., a few hours after lunch but too early to gorge on something that might ruin dinner.
The following snacks will help you with your afternoon cravings in a healthy way.

To help with snack selections, we've put together a list of tasty snack options whose nutritional rewards are just as sweet:

• CARROTS
We bet your mother told you that eating carrots would keep your eyesight, but did you know they're also great for the skin and helping the body fight infection?

•GRAPES
Grapes' flavonoid-rich interiors help protect cells from oxygen damage. They're also filled with antioxidants that fight heart disease and the development of cancer cells.

•APPLES
Apples are the snack world's most perfectly portable must-haves. Eat them with the peel on for additional quercetine, a powerful antioxidant that helps reduce the growth and spread of cancer cells; the tasty teachers' treats also are packed with vitamin C and dietary fiber.

•BANANAS
Bananas help maintain healthy heart function and blood pressure levels.

•ALMONDS
Unsalted almonds are high in the right kind of fat: monounsaturated that helps reduce cholesterol levels. They're also loaded with protein, fiber, and folic acid.

•POPCORN
Select the 94% fat-free popcorn packets for a salty snack that offers fiber and is a high-quality carbohydrate.

The above article is from VSP, GetFIT (A VSP Wellness Program). This information is general and is not intended to be a substitute for professional advice.

OPERATING ENGINEERS LOCAL NO. 77 FUNDS

911 Ridgebrook Road
Sparks, MD 21152-9451