1099Rs for Retirees will be mailed in late January. Look for yours!

For Your Benefit

Operating Engineers Local No. 77

January 2013 Vol. 13, No. 1

www.associated-admin.com

Material Modifications

Shingles Vaccination And Chantix Now Covered

The following are Summary 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.

The Board of Trustees is pleased to announce that **effective November 6, 2012,** the Fund will cover the Shingles vaccination for participants age 60 and older.

The Fund will also cover Chantix under the prescription plan through CVS Caremark, effective November 6, 2012.

Annual Dollar Limit on Essential Health Benefits Is Now Two Million Dollars

Material Modification

The following 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 January 1, 2013, the overall dollar limit on essential health benefits under the Plan has increased from $1,250,000 to $2,000,000 for participants and eligible dependents.

For example, if the Plan pays for $2,000,000 in Major Medical Benefits that are "essential health benefits" for claims incurred by an individual during 2013, 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 2013.

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 essential and/or 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% for benefits that are considered "essential health benefits."

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—

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When To Go To The Emergency Room

When To Go To An Emergency Room

Your Plan covers visits to an emergency room when your medical condition indicates that immediate medical treatment is required. Some examples of medical emergencies which require immediate treatment include heart attack, severe chest pains, cardiovascular accidents, poisoning, loss of consciousness or respiration, convulsions and other acute conditions. Of course, this is not a complete list and there could be other conditions which require immediate treatment.

It's important to remember that **the Fund will not cover the emergency room charge if the care was not of an emergency nature** and could have been provided by your physician or other provider in an outpatient or other alternative care setting (such as a CVS MinuteClinic or urgent care facility).

When To Use A CVS MinuteClinic or urgent care facility (such as Patient First)

If you have a condition **which is not** determined to be "urgent" as noted by the diagnosis from the physician, you may use the services at a CVS MinuteClinic or an urgent care facility. For example, if your diagnosis (again, as stated by the attending physician), is for a bad cold, an earache, back pain, or a cut or a scrape, you will have coverage if you go to a CVS MinuteClinic or an urgent care facility.

Remember, the general rule of thumb is that if your symptoms, including the degree of severity, are such that immediate medical care is required, you should go to an emergency room. The emergency room should be reserved for medical emergencies and should not be used for general illnesses/injuries that could be treated at your doctor's office during regular office hours or at a CVS MinuteClinic or urgent care facility where no appointment or pre-authorization is needed.

Material Modification

Exclusion And Limitations

The following 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 November 6, 2012, the Board of Trustees amended item numbers 20, 21, and 25, of the "Exclusion and Limitations" section of the Operating Engineers Local No. 77 Health and Welfare Summary Plan Description to read as follows:

No benefits under this Plan shall be payable for injuries, illness or death sustained in the course of, or as a result of, both misdemeanor or felonious criminal activity or any illness, injury, or death that was a result of alcohol or drug induced intoxication or the willful intent to injure himself or another. However, the injuries, illness, or death resulting from an act of domestic violence or from a medical condition (such as depression or including a mental health condition) are not solely excluded because the source of the injury was an act of domestic violence or a medical condition. In compliance with HIPAA's anti-discrimination provisions, the Plan reserves the right to exclude certain self-inflicted injuries so long as the injury did not result from a medical condition or domestic violence and such exclusion is consistent with the other provisions in the Plan.

Open Enrollment for the 401(k) Option of the Operating Engineers Local 77 Individual Account Plan 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 Justin 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. Justin'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).

Justin 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?

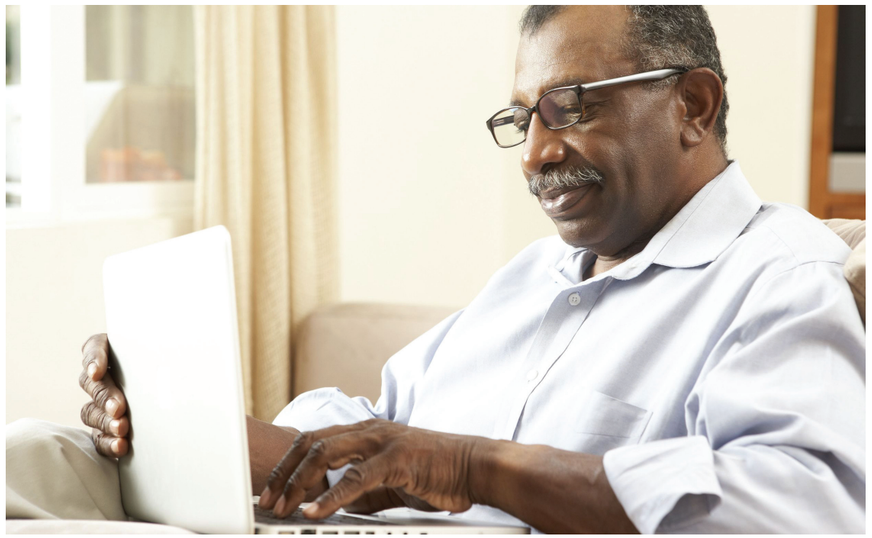
You'll receive a financial statement of your 401(k) account on a quarterly basis from MassMutual Financial Group that shows the amounts you've contributed and how all your investments have performed. You can also review your account online by going to www.massmutual.com. Make a selection at Login Access 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***. ou 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.



Eligibility for Your Dependents through December 31, 2013

Under your plan of benefits, 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. Coverage for your spouse and children begins on the same date as your coverage.

Adult Children Age 19 to Age 26

Effective through December 31, 2013, to be eligible for plan coverage, an adult child (age 19 to age 26) must **not be** eligible for health coverage through his/her employment or the employment of his/her spouse.

Eligible adult children that enroll (or re-enroll) before December 31, 2013 will receive coverage that begins on the first of the month following the date of enrollment. Coverage terminates at the end of the month in which the dependent turns 26 years of age.

Newborns

Newborns will be covered from the date of birth until six months of age without a Social Security Number. **However, if a Social Security Number is not provided to the Fund office by the time the child is six months old, coverage will be terminated on the first day of the month following the date the child turns six months of age.**

Adding New Dependents

To add a newly eligible dependent, contact the Fund office for an enrollment form. Your spouse and eligible stepchildren can be added for coverage on the first of the month following the date of marriage. Biological children can be added effective on the date of their birth, and legally adopted children and children placed for adoption may be added effective the date of adoption or placement for adoption. In order for a new dependent to be covered, a valid Social Security Number must be provided to the Fund office.

In order for a new dependent's coverage–including a newborn's coverage–to begin on the earliest date of eligibility, you must inform the Fund office within 30 days from the date he or she first became your dependent. Otherwise, coverage will begin on the first of the month following the date the Fund office receives the required information.

Q&A: Coverage for Chiropractic Visits Or Physical Therapy

Q: I hurt my back a few days ago and want to make an appointment to see a chiropractor or physical therapist. Do I receive coverage for either of these treatments?

A: Yes, your Plan does cover up to 8 visits to a chiropractor or up to 8 visits for physical therapy per calendar year. However, if you know you will need more than 8 visits in one calendar year, ***you must, before your 9th visit, get pre-authorization from American Health Holding ("AHH")*** by calling (800) 641-5566.

In order to be covered, the treatment must be medically necessary to improve your condition. Treatment to maintain a level of function is not considered medically necessary. AHH will request treatment notes from the initial consultation (as well as your other visits).

Be careful. Because of the delay in billing time, we may not know you are nearing 8 visits until you've already gone over that amount. If AHH does not certify the visits over 8 as medically necessary, you may be responsible for all charges for uncovered visits. If you ever think that you may go over 8 chiropractic or physical therapy visits, it's a good idea to call AHH, just in case.

Benefits That Are Not Subject to The Annual Deductible

There are benefits which are not subject to the annual deductible. The Fund office refers to these as "Ancillary Benefits" and these benefits are listed below:

Ambulance Benefit

When medically necessary, the Fund will pay for professional ambulance services to or from a hospital, up to $100 per incident, at 100% with no deductible. When it is determined that medically necessary life support services are provided while being transported, 50% (not 80%) of the remaining cost of the ambulance service will be paid under Major Medical. You must satisfy the annual deductible before the additional 50% payment will apply.

Orthotic Benefit

The Fund office covers up to $500 every three years for orthotic appliances incurred by you or your dependents. Orthopedic shoes are covered only if it is an integral part of the brace. This benefit is available once every three years for you or your dependents up to the amount shown in the Schedule of Rates and Benefits. If approved by American Health Holding, orthotics can be covered once every year. The annual deductible does not apply to this expense.

Annual CDL Physical Exams

This benefit applies only to the participant. If you are required to have a physical for your Annual CDL Physical Exam, you will be entitled to reimbursement for the actual amount charged by the physician up to the amount shown in the Schedule of Benefits per person, per calendar year. The annual deductible does not apply.

Reminder: Weekly Disability Payments Are Taxable

Most people know that Weekly Disability benefits are paid to eligible participants who become disabled and are unable to work. What is not so well known is that the money received under this benefit is taxable income. Furthermore, income tax is not withheld automatically from your payment unless it is requested.

To have Federal income tax withheld from a weekly benefit check, you need to send the Fund office a signed IRS Form W-4S for federal income tax withholding.

Follow IRS rules

Withholding amounts must:

- be in whole dollars (for example, $35, not $34.50),
- be at least $4 per day, $20 per week, or $88 per month based on your payroll period, and
- not reduce the net amount of each sick pay payment that you receive to less than $10.

Obtaining IRS Form W-4S

You can print a copy of the W-4S form by logging on to www.associated-admin.com. Click on "Your Benefits" located at the left side of the screen. Select "OE Local 77" which will take you to the Local 77 site. Under the section entitled "Downloads (Forms)," select and print the form entitled "Request for Federal Income Tax Withholding From Sick Pay." You can also call the Fund office at (877) 850-0977 and we will be glad to mail one to you.

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 providers to obtain authorization for prescribing a length of stay within these parameters.

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 January 11, but gives birth by vaginal delivery at 6 a.m. on January 12, the 48-period begins at 6 a.m. on January 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.

Example of Expenses When Having A Baby

The Operating Engineers Local No. 77 Trust Fund of Washington, D.C. Health and Welfare Program offers financial protection for normal delivery of a baby. This coverage is available to a participant or participant's spouse; dependent daughters are not covered for child birth.

As an example, let's say a mother gave birth through a normal delivery and the hospital charged $7,540. Your Plan of benefits would pay $5,680 and the mother would be responsible for paying $1,860. The chart on the right is an example of these expenses.

Note: *This chart is only an example. Don't use these examples to estimate your actual costs under the Plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.*

Sample Care Costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
TOTAL	**$7,540**
Patient Pays:	
Deductibles	$300
Co-pays	$10
Coinsurance	$1,400
Limits or exclusions	$150
TOTAL	**$1,860**

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.

Summary of Benefits and Coverage Notice Sent

A Summary of Benefits and Coverage ("SBC") was mailed to all participants in November, 2012. Unfortunately the toll-free telephone number to call for questions was incorrect. Please call 1-877-850-0977 if you have any questions regarding your benefits. If you would like to receive the corrected SBC, call the Fund office at 1-877-850-0977 and we will send one to you. Please be sure we have your correct address on file. We apologize for the mistake.

Home Health Care

Your Plan of benefits allows coverage for home health care services ***following a hospital confinement only.*** You pay 20% of the cost when using a participating provider or 20% of the cost plus the balance over the allowed amount when using a non-participating provider. The home health care must be recommended by your doctor and must be approved by the Fund office. You must certify home health care services with American Health Holding ("AHH") in order to be covered. AHH's telephone number is (800) 641-5566.

The following services are covered (subject to Fund approval):

- Registered nurse services and licensed practical nurse services;
- Physical, respiratory and occupational therapist services;
- Rental of durable medical equipment;
- Medical and surgical supplies;
- Professional ambulance service to or from a hospital, up to the limit set forth in the Schedule of Benefits for Ambulance Services;
- Amputation Therapy; and
- Colostomy Care.