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

For Your Benefit

Operating Engineers Local No. 77

January 2015 Vol. 15, No. 1

www.associated-admin.com

Out-of-Pocket Maximum for Prescription Coverage Is Now $2,500

Material Modification

The Board of Trustees approved an improvement in the Fund's prescription benefit by implementing a yearly $2,500 out-of-pocket maximum limit per participant effective January 1, 2015. You continue to be responsible for paying 40% for each brand-name medicine when purchased at a CVS Pharmacy or through CVS Caremark Mail Service Pharmacy.

Increase in 401(k) Deferrals

Material Modification

Effective January 1, 2015, you can make contributions to the 401(k) Plan in $0.50 per hour increments, up to $4.00. The previous limit was $3.00.

See page 3 of this newsletter regarding enrolling in the 401(k) Option.

Change in Pension Calculations

Material Modification

Effective January 1, 2015, the pension calculation will be reduced to 2.1% of contributions. The previous benefit was 2.5% of contributions.

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—

Please Remember Your Accident and Sickness Benefits Are Taxable

It is important to remember that Weekly Accident and Sickness ("A&S") benefits are taxable and must be reported on your IRS tax return. Income tax is not automatically withheld from your A&S payments unless it is requested. A&S benefits along with any tax withheld will be included on the W-2 issued by your employer.

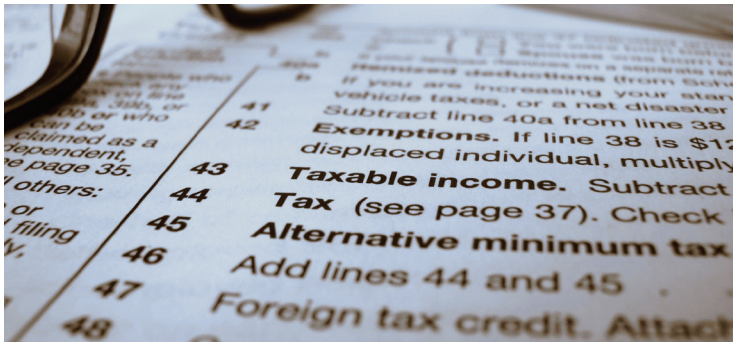
Follow IRS Rules

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 and select "Operating Engineers Local 77." Under the heading "Downloads," select and print the form entitled "Request for Federal Income Tax Withholding from Sick Pay." You can also call the Fund at (877) 850-0977 and we will be glad to mail one to you.



To Receive Accident and Sickness Benefits, You Must Meet Certain Criteria

If you are disabled due to a non-occupational accident or illness and unable to work, the Health Fund will pay you Weekly Accident and Sickness ("A&S") benefits. The benefits are paid weekly and will include payments for a portion of a week.

However, in order to receive A&S pay, the following conditions must be met:

1. The disability must be a result of a non-occupational accident or disease for which benefits are not payable under the Workers' Compensation law; and
2. The disability begins
   a. After commencement of a hospital confinement; or
   b. From an accident or illness involving a fracture procedure; or
   c. For periods certified to by a physician or surgeon following surgery, provided all other requirements are met; and
3. You are not being paid by your employer.

Weekly A&S benefits are payable for a ***maximum of 13 weeks*** for any one disability. If you cease being disabled, you are required to notify the Fund.

Special circumstances: payment of benefits for six weeks

If you are taking a prescribed medication which prevents you from operating machinery, you may be eligible for A&S benefits for a maximum of six weeks (or the length of time you take the medication, whichever is less). To be eligible for benefits under this provision, the Fund must receive a doctor's note. Contact the Fund for more information if this applies to you.

You Can Enroll In the 401(k) Option During January

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 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.

How much can I put into the 401(k)?

You can contribute up to a maximum of $4.00 per hour worked, in 50-cent increments. For example, you may choose to save $.50 an hour, $1.00, $2.50, or even $4.00 per hour worked. And, very importantly, your contribution is pre-tax.

How do I know how well my investments are doing?

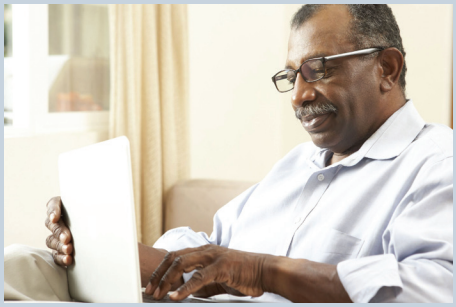
You'll receive a financial statement of your 401(k) account on a quarterly basis from MassMutual Financial Group that shows the amounts you've contributed and how all your investments have performed. You can also review your account online by going to www.massmutual.com. Make a selection at Login Access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



Appeals Must Be Filed On Time

If your claim has been denied, the Fund will send you a written denial that includes the reason for the denial and a reference to the Plan provision or rule on which it is based. If you have a claim that has been denied, in part or in full, you have the right to appeal the decision to the Board of Trustees. But be sure to file your appeal on time.

When are the deadlines?

You have ***180 days*** to file an appeal for ***Weekly Accident & Sickness Claims and Medical Claims***.

You have ***60 days*** to file appeals for non medical/ non-disability claims such as ***Pension Claims and Death Benefit Claims***.

How do I file an appeal?

To file an appeal, you must make a written request to the Board of Trustees at the address below:

Operating Engineers Local No. 77
911 Ridgebrook Road
Sparks, MD 21152-9451

Include the participant's name, Social Security Number, the patient's name (if different from the participant's), the dates of service and the reasons why you think your claim should be reconsidered.

Remember, your letter of appeal for either Medical Claims or Weekly Accident & Sickness Claims must be received by the Fund within ***180 days after your claim has been denied*** for the filing deadline to be met. Otherwise, the appeal will be considered late.

Your Benefits When Hospice Care Is Needed

The Fund will cover inpatient and outpatient hospice care for terminally ill participants and dependents whose life expectancy is six months or less and who are receiving palliative, not curative, care. If the terminally ill patient survives beyond the six months, care must be re-certified in order for benefits to continue.

Benefits for hospice care include:

- Inpatient care at a hospice facility
- Intermittent nursing care by a registered or licensed practical nurse
- Services of a licensed medical social worker
- Home health aide visits
- Radiation for palliative purposes only
- Medical-surgical supplies
- Oxygen
- Physician home visits
- Ambulance and wheelchair transportation to and from the hospital for palliative treatment or for admission as an inpatient hospice level of care.

Coverage

Hospice treatment will be covered under Major Medical at 80% after satisfying the annual deductible, up to the out-of-pocket maximum. After you have reached the out-of-pocket maximum ($4,000 per calendar year) benefits will be paid at 100%, up to the usual, customary and reasonable (UCR), up to $200,000. Benefits will be covered at 50% after $200,000 has been paid.

Pre-Certify

Hospice care **must** be certified with American Health Holdings in order to be covered. Call American Health Holdings at (800) 641-5566 to certify hospice treatment. Failure to certify care may result in loss of benefits.

Who Should Get The Shingles Vaccine?

Your plan of benefits covers the shingles vaccine for participants age 60 and older when administered through your doctor's office or a CVS Caremark pharmacy. But who should get the shingles vaccine? According to the Centers for Disease Control and Prevention ("CDC"), whether you've had shingles or not, adults age 60 and older should get the shingles vaccine (Zostavax). Although the vaccine is also approved for use in people ages 50 to 59 years, the CDC isn't recommending the shingles vaccine until you reach age 60.

According to James M. Steckelberg, M.D. the shingles vaccine protects your body from reactivation of a virus—the chickenpox (varicella-zoster) virus—that most people are exposed to during childhood. When you recover from chickenpox, the virus stays latent in your body. For unknown reasons, though, the latent virus sometimes gets reactivated years later, causing shingles. The shingles vaccine usually prevents this reactivation.

The shingles vaccine isn't fail-safe; some people develop shingles despite vaccination. Even when it fails to suppress the virus completely, however, the shingles vaccine may reduce the severity and duration of shingles. Although there's hope that the vaccine will reduce your risk of severe, lingering pain after shingles (postherpetic neuralgia), studies haven't yet found strong evidence of that effect.

The shingles vaccine is a live vaccine given as a single injection, usually in the upper arm. The most common side effects of the shingles vaccine are redness, pain, tenderness and swelling at the injection site, and headaches.

The shingles vaccine isn't recommended if you:

- Have ever had a life-threatening allergic reaction to gelatin, the antibiotic neomycin or any other component of the shingles vaccine
- Have a weakened immune system due to HIV/AIDS, lymphoma or leukemia
- Are receiving immune system-suppressing drugs, such as steroids, adalimumab (Humira), infliximab (Remicade), etanercept (Enbrel), radiation or chemotherapy
- Have active, untreated tuberculosis
- Are pregnant or trying to become pregnant

This article is from MayoClinic.com.

You Have 365 Days to File Medical Claims and 60 Days to File Accident and Sickness Claims

You must file all Medical claims and Death and Dismemberment claims within ***365 days*** from the date of an event, except for Weekly Accident and Sickness claims, which must be filed within ***60 days*** from your disability determination date or before you return to work, whichever is later.

An "event" is defined as the accrual of charges for medical care, the date of injury, disease or illness, the date of disability, date of accident or sickness or date of death or injury which causes dismemberment.

How to file a Medical Claim

Actively working participants and non-Medicare primary retirees should show your ID card to the provider of service. The provider will generally file your claim for you. Virtually all claims from a CareFirst provider will be filed electronically with the Fund. No claim form is necessary.

If you used a non-CareFirst provider or the provider files a paper claim, send an itemized bill directly to the Fund at the address shown below. Be sure the participant's ID number is marked clearly on the bill. The Fund may have you sign an "Assignment of Benefits" statement allowing payment to be made directly to the provider.

To file a claim directly with the Fund, send to:

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

If you used a CareFirst provider, the provider will file the claim electronically to CareFirst for you. If you do file a claim yourself, send to:

CareFirst/Network Leasing
P.O. Box 981633
El Paso, TX 79998-1633

How to file Weekly Accident and Sickness Claims

All Weekly Accident and Sickness claims must be filed within ***60 days*** from the date that the disability began as certified by a doctor. If you return to work before 60 days, then you have 60 days from the date your doctor certifies that you are disabled in which to file a claim. If, on the other hand, you are disabled for longer than 60 days, then you must file a claim BEFORE you return to work. In no event may a claim for Accident and Sickness Benefits be filed later than your doctor certifies that you are disabled. Also, in no event may a claim be filed after 60 days and after you return to work.

Weekly Accident and Sickness claims should be mailed to:

Fund Office
Operating Engineers Local No. 77
PO Box 1065
Sparks, MD 21152-9451

You must provide information to the Fund upon request.

The Fund has the right to request further information in order to properly process a claim under the Plan's provisions. If a claimant fails to provide the necessary information within a reasonable period not to exceed thirty (30) days, the Fund shall have no duty to pay the claim until such time as the documents are provided, but in no event later than 365 days.

Information Regarding Your Health and Welfare Death Benefit

Your beneficiary will be entitled to receive a lump sum Death Benefit upon your death (as long as you are eligible for health coverage at the time of your death). In order to designate your beneficiary with the Fund, you must fill out a beneficiary form. You may contact the Fund to have one sent to you, or you can access one online by logging onto www.associated-admin.com, clicking on the "Your Benefits" tab (located on the left side of screen), and selecting the "Operating Engineers Local 77" link. From there you will be able to print the "Change in Beneficiary (Health and Welfare)" form.

An "event" is defined as the accrual of charges for medical care, the date of injury, disease or illness, the date of disability, date of accident or sickness or date of death or injury which causes dismemberment.

If, at the time of your death, there is no beneficiary designation on file, or your beneficiary dies before you, the order of payment of your Death Benefit will be as follows:

1. Legal Spouse;
2. Children (Equal Shares);
3. Parents (Equal Shares);
4. Brothers and Sisters (Equal Shares); or
5. Your Estate.

The Death Benefit terminates upon termination of your eligibility.

In order for your beneficiary to receive your Death Benefit, he/she must file a written claim with the Fund within one year of the date of your death. Make sure the following documents are included with this claim (or submitted shortly after as requested by the Fund) in order for the claim to be processed and paid:

1. A certified copy of the death certificate;
2. If the estate is the beneficiary, certified letters of administration or comparable state document designating the party as executor of the estate;
3. Proof of identity;
4. Completed and signed copies of the claim form provided by the Fund; and,
5. Any other documentation requested by the Fund.

Ambulance Coverage

You, your spouse and children have coverage for ambulance services to a hospital only if it's a medical emergency. Some examples of medical emergencies include a heart attack, chest pains, cardiovascular accidents, poisonings, convulsions, loss of consciousness or respiration, and other acute conditions. Of course this is not a complete list and there could be other conditions which require immediate treatment.

The coverage is 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% 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.

Reviewing Your Vision Benefits

Your vision benefits are provided through the Vision Service Plan ("VSP"). There are over 33,000 providers available through VSP in retail and professional office locations.

Vision Coverage When Using A VSP Doctor

Your vision benefits cover an eye exam once every 12 months when done by a participating VSP provider. Coverage for eyeglass lenses is also once every 12 months, however, frames are only covered once every 24 months. You are responsible for a $10 co-payment per visit and a $10 materials co-payment when receiving either single vision, lined bifocal or lined trifocal lenses. You have an allowance of $130 towards the purchase of prescription eyeglasses **OR** contact lenses (contact lenses are in lieu of lenses and frames).

Vision Coverage When NOT Using A VSP Doctor

If you do not use a 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 frames, and $100 for contact lenses if you choose contact lenses instead of lenses and frames. You have 6 months from your date of service to submit your claim to VSP for reimbursement if you see a Non-VSP doctor.

Vision Benefits That Are Not Covered

The expenses for the following treatments or supplies are not covered by your vision plan (refer to page 70 of your Summary Plan Description booklet for more information).

- Non-prescription glasses,
- Sunglasses,
- Photosensitive, plastic, cosmetic tinted or oversized lenses (although you do have the option of paying the difference in cost between these special lenses and the cost of clear, standard lenses),
- Replacement or repair of lost or broken lenses or frames,
- Orthoptics, vision training, or vision aids for aniseikonia,
- Medical or surgical treatments, and
- Eye surgery for conditions that routinely can be corrected with corrective lenses.

Locating A VSP Doctor

You may visit the VSP website to locate the most current doctors in network by logging on to www.vsp.com. Once there, click on the member tab and register. Once you are registered, you can easily locate participating doctors close to you. Registration is not required; however it is helpful in locating doctors that participate in your specific VSP Plan.

Your Appointment

When you call to schedule your eye appointment, give the doctor your name and date of birth. Your provider will confirm your eligibility by contacting VSP.

VSP ID Card

You do not need a VSP ID card for your appointment; however if you would like one, simply go to the VSP website, www.vsp.com, where you can print one. You may also call VSP toll-free at (800) 877-7195.

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.

Operating Engineers Local No. 77 Funds

911 Ridgebrook Road
Sparks, MD 21152-9451