Questions About Your Benefits? Call Participant Services at the Fund office (877) 850-0977.
Press "2" for a representative or "1" to use the automated system.

For Your Benefit

Operating Engineers Local No. 77

July 2014 Vol. 14, No. 3

www.associated-admin.com

Retirees: Have You Returned Your Retiree Information Form?

The Fund office sent a Retiree Information Form ("RIF") to each retiree asking for information about your current address, your beneficiary, and whether you are employed. Although you may have completed this form last year, ***you still must complete and return this year's RIF. Please answer all questions*** on the form, sign and date it, and return it to the Fund office. If you don't answer all the questions, we will return the form to you for completion.

What If You Don't Have Any Changes?

You still have to complete and sign the RIF. Even if there are no changes to report, we still need to make sure the information in our files is correct.

Failure to return the form may result in suspension of your benefits.

To avoid having your benefits interrupted, ***take the time now to complete and return the RIF as soon as possible***.

Enroll This Month In The 401(k) Option

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.

MassMutual Financial Group will send you a financial statement of your 401(k) account on a quarterly basis. This statement 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)

Although your Employer may be required to make contributions to the Plan on your behalf, you may also elect to have contributions withheld from your earnings and contributed to the Plan under the 401(k) option.

Participation in this Option is ***totally voluntary***. You may stop making contributions or change the amount every six months (during January and

Continued on page 2

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.

Notice of Creditable Coverage. See page 3.

This issue—

Continued from page 1

July) by completing a Participant New Deferral form. Your 401(k) election deferrals may be made in increments of 50 cents per hour, up to a maximum deferral of $3.00 per hour. Please contact the Fund Office at 1-877-850-0977 to request a Participant 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.

Your Coverage When An Ambulance Is Needed

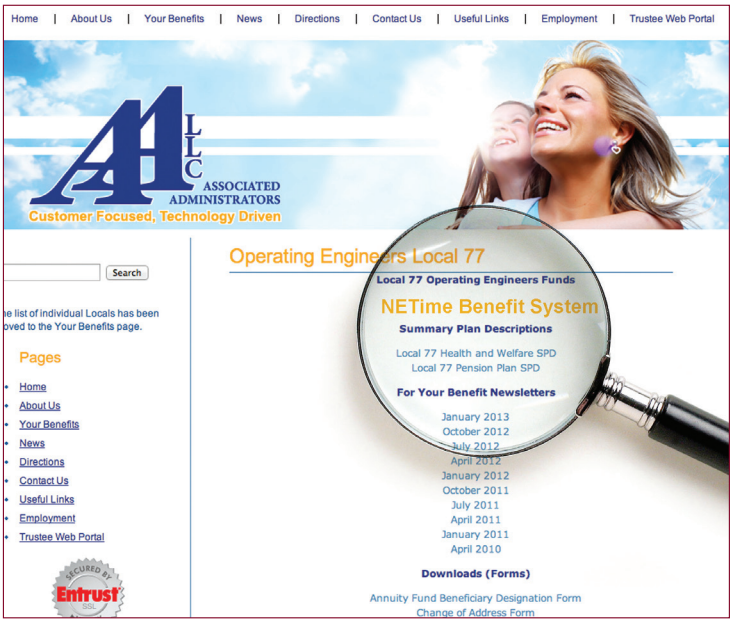
The Fund will pay for professional ambulance services, when medically necessary, to or from a hospital, up to **$100 per incident** at 100% with no deductible. When it is determined that medically necessary life support services are provided while being transported, 50% of the remaining cost of the ambulance service will be paid under Major Medical. You must satisfy the annual deductible before the additional 50% payment will apply.

Review Your Benefits Online Using NETime

The online access service called NETime (pronounced Anytime) provides real time access to benefits data in a safe, secure environment that complies with all privacy regulations. NETime provides personal benefit information via the Internet, 24 hours a day, 7 days a week, to participants and dependents.

NETime can show you:

- The date and amount of contributions your employer paid on your behalf;
- The person(s) named as your beneficiary under the Pension Fund and Health and Welfare Fund;
- Medical claims paid on your behalf for the past three years;
- Your recent eligibility;



- The date and amount of your pension payments, along with the amount withheld for taxes; and
- The dates of, and payments made to you, for Weekly Accident and Sickness benefits.

How to access NETime:

- Log onto www.associated-admin.com. Click on "Your Benefits," located at the left side of the screen, and select "Operating Engineers Local 77." You will be directed to Operating Engineers Local 77's link. Click on "NETime Benefits System."
- When you first access this site, you will be directed to the page where you are asked to enter a user name and password. You and your dependent(s) (if over age 18) can create your own user name and password.
- Once you have successfully logged in, you will be taken to the "Demographic" page, which displays your address, phone number, and dependent information.
- The menu selection screen appears in the left column of your screen. Here you can click on the category you wish to view (medical claims, accident and sickness benefits, etc.).

Note: The information provided on the NETime Benefits website is not a guarantee of coverage. It is possible that the information shown is inaccurate or is not fully up to date. If you believe that what is shown is inaccurate, please submit your question to the Fund office in writing. Be sure to include your name and Social Security Number in your letter.

Cut And Keep!

Important Notice About Your Prescription Drug Coverage And Medicare

The following Notice of Creditable Coverage applies to all Medicare-eligible participants, retirees, and/or spouses.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Operating Engineers Local No. 77 Health and Welfare Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Operating Engineers Local No. 77 Health and Welfare Fund has determined that the prescription drug coverage offered by the Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2)-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage under the Operating Engineers Local No. 77 Health and Welfare Fund will be affected. **If you join an outside Medicare drug plan, you will cease to be eligible for prescription benefits under the Operating Engineers Local No. 77 Health and Welfare Fund.** See below for more information about what happens to your current coverage if you join a Medicare drug plan.

You cannot have both Medicare prescription drug coverage and prescription drug coverage through the Fund at the same time. If you do decide to join a Medicare drug plan and drop your Operating Engineers Local No. 77 Health and Welfare prescription drug coverage, be aware that you and your dependents may not be able to get the same coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Operating Engineers Local No. 77 Health and Welfare Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice Or Your Current Prescription Drug Coverage

Contact the Fund office for further information at (877) 850-0977. **NOTE:** You'll get this notice each year.

Continued on page 4

Continued from page 3

You will also get it before the next period you can join a Medicare drug plan, or if this coverage through the Operating Engineers Local No. 77 Health and Welfare Fund changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 2014
Name of Entity/Sender:	Fund Office Operating Engineers Local No. 77 Health and Welfare Fund 911 Ridgebrook Road Sparks, Maryland 21152-9451
Phone Number:	(877) 850-0977

IMPORTANT!

New Claims Address For CareFirst

Claims that are not filed electronically should now be sent to:

CareFirst/Network Leasing
PO Box 981633
El Paso, TX 79998-1633

Please share this information with your provider the next time you have an appointment. Note: all claims, including secondary claims, must be filed within 365 days.

If You Enroll In Medicare Part D, You Lose Retiree Prescription Drug Coverage Under The Fund

In accordance with the Medicare Modernization Act of 2003, your retiree prescription drug coverage through the Fund is considered to be "creditable coverage." Creditable coverage means that the Plan's prescription drug benefits for Medicare-eligible participants, retirees and/or spouses has been determined to be "as good as or better" than Medicare Part D coverage.

If you are considering a Part D Medicare (Prescription) plan, ***be careful!*** Ask questions about plan maximums, required drug brands, and copays. If you do enroll in a Part D plan, your Fund retiree prescription coverage will terminate because you cannot be enrolled in both plans. It may be that a Medicare Part D plan is right for you, but be careful and make sure your questions are answered first.

Enrolling in a Part D Medicare plan does not affect your **medical** benefits through the Fund.

Eligibility For Your Dependents

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 that are under the age of 26. Coverage for your spouse and children begins on the same date as your coverage.

If You Have A New Spouse Or Child

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.

If You Have A Newborn

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.**

Adult Children Age 19 To Age 26

Eligible adult children that enroll (or re-enroll) 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.

Grandfathered Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, 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 your plan may not include certain consumer protections of the Affordable Care Act 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 Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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 plan administrator at 1-877-850-0977. 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. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Cost Of Prescription Drugs Through CVS Caremark

Shown below are the co-pay rates you pay if purchasing **generic** drugs and the percentage of the cost you are responsible to pay if purchasing **brand-name** drugs at a CVS Pharmacy or through CVS Caremark Mail Service Pharmacy.

	Network Retail Pharmacy	CVS/Pharmacy	Mail Service Pharmacy
	For immediate and long-term* medicine needs	**For immediate and long-term* medicine needs**	**For long-term* medicine needs**
Up to a 30-Day Supply:	**Participant Pays:** **$5** for each generic medicine **40%** for each brand-name medicine on the drug list	**Participant Pays:** **$5** for each generic medicine **40%** for each brand-name medicine on the drug list	Up to a **90-day** supply
Maximum Allowable Benefit:	**$10,000** per year	**$10,000** per year	**Participant Pays:** **$10** for each generic medicine **40%** for each brand-name medicine on the drug list
Refill Limit:	One initial fill plus three refills for long-term* medicines.	One initial fill plus three refills for long-term* medicines per rolling year	
90-Day Supply:	**Not Available**	**Participant Pays:** **$10** for each generic medicine **40%** for each brand-name medicine on the drug list	

**A long-term medicine is taken regularly for chronic conditions or long-term therapy. A few examples include medicines for managing high blood pressure, asthma, diabetes, or high cholesterol.*

Four Easy Ways To Contact CVS Caremark:

1. **Caremark.com** Caremark.com is an easy, round-the-clock way to order refill prescriptions, check order status and get important medication information.
2. **Automated Phone System** Call toll-free 1-866-282-8503 for the CVS Caremark fully automated refill phone service.
3. **Customer Care** If you need assistance you can contact Customer Care 24 hours a day, 7 days a week. You have two easy ways to reach them: by email at customerservice@caremark.com or call toll-free at 1-866-282-8503.
4. **Telecommunications Device (TDD)** If you have a hearing impairment and need TDD assistance, please call toll-free 1-800-231-4403.

When You Call Or Log In, Be Ready To Provide:

- Your Employee ID number
- Your date of birth
- Your VISA, Discover, MasterCard or American Express number with expiration date or your Bill Me Later and electronic check processing information (registration is required), if you are paying the prescription co-payment.

Do You Need Another Prescription Card?

Additional prescription cards can be obtained by calling Customer Care toll-free at 1-866-282-8503.

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. You may also call VSP toll-free at (800) 877-7195.

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. You do not need a VSP ID card for your appointment; however if you would like one, simply go to the VSP website where you can print one.

Availability Of Pension Statement

This Notice informs you of the Plan's legal obligations under the Employee Retirement Income Security Act ("ERISA"), Section 105. Participants must receive notice that they have the right to request a pension benefit statement annually and be informed about how to get one. ***You are entitled to one (1) benefit statement per year.***

Call the Fund office at (877) 850-0977 and request a Benefit Service Request form. Complete all the information on the form and return it to the Fund office. It will take approximately 4 – 6 weeks for us to prepare your statement.

The Case Management Program Is Available To Help You And Your Family

Your benefits under American Health Holding offer you the advantages of the Case Management Program. Case Management is a program that helps you and your family if a serious illness or injury should occur. Specially-trained nurses can help you and your family to understand your treatment and offer some options for your care. They will work with your providers to help determine the right plan of care for you.

How Does The Program Work?

Case Management begins when your doctor tells you that your illness or injury may be difficult, long-term, and costly. You, a family member, or a provider then calls the Case Management Department **(toll free (800) 641-3224)**. A case manager will answer any questions you may have regarding medical care, home care needs, treatments, and services. Your case manager works to help ensure that you get high quality, cost-effective care.

How Can A Case Manager Help?

- By consulting with your doctor, hospital, and insurance company to obtain discounts for care and services when possible.
- By providing a link between you and your doctor and hospital.
- By becoming a support system for you and your family during a serious injury or illness.
- By educating you and your family on your health care, home care needs, treatments, lifestyle changes, etc.

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