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

April 2015 Vol. 15, No. 2

www.associated-admin.com

CVS MinuteClinics Are Open Every Day and No Appointment or Pre-authorization is Needed

CVS MinuteClinics are staffed by nurse practitioners and physician assistants and are available to provide services for the diagnosis and treatment of minor illnesses, injuries and skin conditions, administration of vaccinations, health screenings, physicals and monitoring for chronic conditions. Most services are available for those age 18 months and older, but ages for specific services may vary. ***Services are covered only at CVS MinuteClinics.***

CVS MinuteClinic experienced practitioners:

Diagnose, treat and write prescriptions for common family illnesses such as strep throat, bladder infections, pink eye, and infections of the ears, nose and throat.

- Provide common vaccinations for flu, pneumonia, pertussis and hepatitis, among others;
- Treat minor wounds, abrasions, joint sprains, and skin conditions such as poison ivy, ringworm, lice and acne;
- Provide a wide range of wellness services including TB testing, sports and camp physicals, and lifestyle programs such as smoking cessation and a medically based weight loss program;
- Offer routine lab tests, instant results and education for those with diabetes, high cholesterol or high blood pressure;
- Provide care to adults and children 18 months and older for most services; and
- Share records with primary care provider with patient permission.

Services for These Minor Illnesses

- Allergy symptoms (2 years+)
- Bronchitis / cough
- Earache / ear infection
- Flu symptoms
- Mononucleosis
- Motion sickness
- Sinus infection / congestion
- Pink eye & styes
- Sore throat / strep throat
- Upper respiratory infection
- Urinary tract / bladder infection (females 12 years+)

Services for These Minor Injuries

- Blisters
- Bug bites & stings
- Corneal abrasions
- Deer tick bites
- Jellyfish stings
- Minor burns
- Minor cuts & lacerations
- Minor wounds & abrasions
- Splinters
- Sprains / strains (ankle, knee)
- Suture & staple removal

Patients with the following should not seek care at MinuteClinic:

- Severe chest pain
- Severe shortness of breath or

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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.

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

This issue—

Continued from page 1

difficulty breathing
- Suspected poisoning
- Children with temperatures of 104+ degrees F. or more
- Adults with temperatures of 103+ degrees F. or more
- Conditions that require our practitioners to prescribe controlled substances

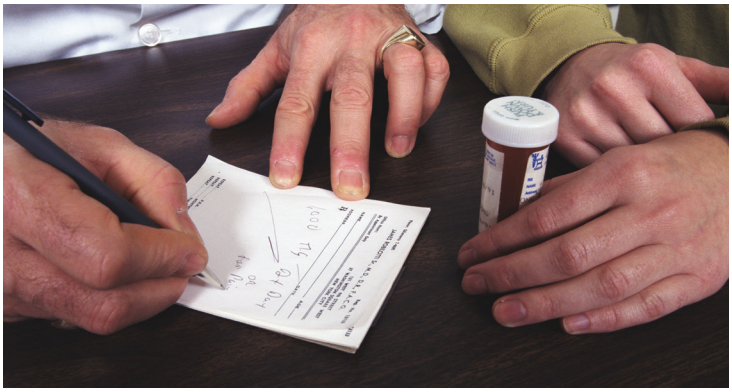
Patients with conditions or health needs outside of the clinical scope of MinuteClinic will be directed to other health care providers within the community.

Other Services Include:

- Skin Condition Exams
- Wellness & Physical Exams
- Health Condition Monitoring
- Vaccinations, Labs & Tests—go to www.minuteclinic.com to learn more.

Some additional charges may apply for certain treatments.

IMPORTANT: *Medical services provided at CVS Minute Clinics are subject to all other rules and provisions of the Welfare Plan.*



Save Money by Using a Delta Dental Dentist

The Fund has contracted with Delta Dental, a dental Preferred Provider Organization ("PPO"). While you are not required to use a Delta Dental provider, doing so can save you significant money and stretch your dental benefits. Delta Dental dentists have agreed to provide services at specific—generally lower—rates. Using a Delta Dental dentist means the amount you pay is usually lower as well.

Benefits and Covered Services		
	Using a Delta Dental Dentist	**Not Using a Delta Dental Dentist**
Diagnostic and Preventive Services • Oral exams • Routine cleanings • X-rays • Fluoride treatment • Space maintainers • Sealants	100%	80%
Basic Benefits • Fillings	80%	60%
Major Benefits • Crowns • Inlays • Onlays • Cast restorations	50%	50%
Endodontics • Root canals	80%	60%
Periodontics • Gum treatment	80%	60%
Oral Surgery • Incisions • Excisions • Surgical removal of tooth including simple extractions	80%	60%
Prosthodontics • Bridge • Dentures	50%	50%

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Retiree Information Forms Will Be Mailed Soon. *Return Promptly* To Avoid Suspension of Pension Benefits.

This month, the Fund Office will 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 pension 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.

Important: If you retired on a disability pension and believe your disability to be "***permanent***," you do not have to obtain a letter from your physician every three years. You will have to request a waiver from this requirement to the Trustees in care of the Fund Office for consideration. Your request should include a written statement from your physician affirming that your disability is permanent and therefore you will not be eligible to return to work as an Operating Engineer at any time in the foreseeable future.

No one but the Retiree can sign the RIF, unless an individual holds a Power of Attorney for the Retiree. A copy of the 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 by a Notary Public.

Summary of Material Modifications

Below are Summaries 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 January 1, 2015 – Out-of-Pocket Maximum for Prescription Coverage Is Now $2,500.** The Board of Trustees approved an improvement in the Fund's prescription benefit by implementing a yearly $2,500 out-of-pocket maximum per participant effective January 1, 2015. You continue to be responsible for paying 40% for each brand-name medicine, until you reach the out-of-pocket maximum of $2,500, when purchased at a CVS Pharmacy or through CVS Caremark Mail Service Pharmacy.
- 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.

OPERATING ENGINEERS UNION LOCAL NO. 77 PENSION FUND

- **Effective January 1, 2015 – Change in Pension Calculations.** The pension calculation will be reduced to 2.1% of contributions. The previous benefit was 2.5% of contributions.

OPERATING ENGINEERS UNION LOCAL NO. 77 INDIVIDUAL ACCOUNT FUND

- **Effective January 1, 2015 – Increase in 401(k) Deferrals.** 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.

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 performed 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.

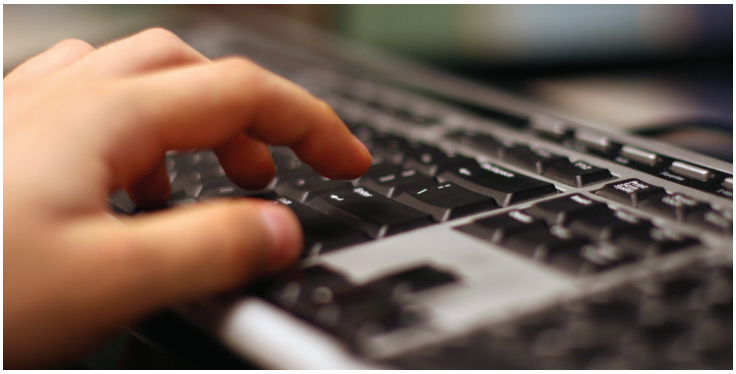
Cyber Attack Impacting Anthem, Inc.

You may recall earlier this year Anthem, Inc., the parent company of our health insurance provider, was the target of a highly-sophisticated cyber attack. Anthem has informed us that its member data was accessed, and could include that of our participants.

Thirty-seven independent companies—including CareFirst BlueCross BlueShield—operate in various locations across the United States and Puerto Rico to form the BlueCross and BlueShield network. This network enables you to receive the same health insurance benefits for any medical care you may need while living or traveling within the coverage areas of any other BlueCross BlueShield company.

All or portions of the following states were affected: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. If you received care in any of these Anthem locations within the past ten years, your claims experience may have been retained in Anthem's database.

Anthem has created a website, www.anthemfacts.com, and a hotline, 1-877-263-7995, for its members to call for more information. Anthem is offering credit monitoring services to all impacted members.



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Deductibles

The Fund will pay up to $1,000 per calendar year (per participant and dependent) for examinations, cleanings, fillings, and other dental services. There is a $50 deductible per person, per calendar year, to a maximum family deductible of $150. The deductible does not apply to preventive care such as cleanings, or to diagnostic procedures such as x-rays.

Advantages

When you use a Delta Dental provider, you will only be asked to pay your portion at the time of your visit. The participating dentist will file the claim for you and receive reimbursement directly from Delta Dental.

If you go to a non-Delta Dental provider, you may be asked to pay the cost in full and you may have to file your own claim. If you use a non-Delta Dental dentist and file your claim, payment will be made directly to you, not to the dentist. You are responsible for paying the non-Delta Dental dentist in full.

Locating A Provider

To find a Delta Dental provider, call (800) 932-0783 or go online to www.midatlanticdeltadental.com.

Coverage for Your Disabled Dependent

If your dependent child is incapable of self-support due to a mental or physical disability, the age limit for dependents does not apply. Coverage for disabled children beyond age 26 will continue if:

- The child is unmarried;
- The child is financially dependent on the participant for support;
- The child was the participant's dependent before the child turned age 19;
- The disability began before age 19;
- The disability is certified by a physician and found by the Board of Trustees to be a qualifying disability; and
- The child continues to be eligible for dependent coverage under the Plan.

Coverage for Prosthetic Appliances Must Be Medically Necessary

Expenses for prosthetic appliances are covered for you and your dependents when the loss of a body part occurs and it is medically necessary to purchase a replacement for a natural body part. If the replacement was not medically necessary (e.g., the recent replacement was purchased simply because it had superior enhancement over the old model), then the prosthetic appliance will not be covered.

A replacement may be given consideration when:

1. Major growth of the user is a factor (e.g., a 15 year old child who was fitted for a prosthetic leg at age 10);
2. Major pathological change has occurred at the affected site (e.g., amputee who has had further amputation of the affected limb);
3. Reimbursement for replacement breast prostheses will be made when a new prostheses is necessary due to additional disease.

Enrolling Your Dependents for Coverage

Under your Plan 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.

The 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 Office, you must fill out a beneficiary form. You may contact the Fund Office 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 "OE Local 77" link. From there you will be able to print the "Change in Beneficiary (Health and Welfare)" form.

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 office 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 Office) 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 or personal representative of the estate;
3. Proof of identity;
4. Completed and signed copies of the claim form provided by the Fund Office; and,
5. Any other documentation requested by the Fund Office.

Continuing Health and Welfare Benefits Through Self-Payments

The Self-Payment Option is a voluntary benefit offered by the Plan as an alternative to COBRA. If you meet the criteria for Self-Payments described in your Summary Plan Description (SPD) booklet, you may maintain your eligibility for Health and Welfare benefits by making payments yourself. Self-Payments allow you to protect your benefits if you lose eligibility due to layoff or because of reduction in hours.

Pointers

- You are eligible to maintain your coverage by making self-payments for a maximum of 18 months.
- You may self-pay when your eligibility ends if you are disabled or if you are unemployed. Unless you are disabled and unable to work, you must remain available for immediate employment in the jurisdiction of Local No. 77 ("covered employment") during the entire time you are making Self-Payments.

- If you are not disabled and not available for work in covered employment or if you decline covered employment, you are no longer eligible to make self-payments.
- When you leave work and have a period of self-payments, you will be credited with the number of employer-paid hours you have in your bank ***on the date you stopped working***. The months for which you make self-payments do not add to your "bank" of hours. Instead, the hours in your "bank" remain frozen until such time as you are no longer making self-payments (when you return to work, for example).
- During the period of self-payment, you will be credited with one month's eligibility for Health and Welfare benefits for each month that you make a self-payment.
- When you do return to work, you will be credited for the hours of service for the ***12 months immediately proceeding the month in which you began making self-payments***, whatever that amount may be. You must continue to self-pay when you return to work in order to maintain your Health and Welfare benefits until you have accrued enough employer-paid hours to equal ***400 hours in the last three-month period***.

If you become eligible for the Self-Payment Option, the Fund Office will send you a letter describing the program in detail and giving you the cost.

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.

HEALTH CORNER

Why Is Vision Health So Important?

Your eyes not only affect how you see, but how you feel. Caring for your vision can lead to a better quality of life. Your eyesight impacts your performance at work, school, and home. When your vision health is at its best, you perform better in all aspects of your life. Not to mention, eye strain leads to headaches, fatigue, and other discomforts that keep you from feeling your best.

A Window to the Rest of Your Body

Did you know that a number of health conditions can be detected early by your eye doctor? An eye exam can detect conditions like diabetes, years before you show signs of the disease, allowing you to better manage health issues before they become a problem.

In addition to diabetes, annual eye exams can identify eye and general health conditions, such as:

- Macular degeneration
- Glaucoma
- Diabetes
- High blood pressure
- High cholesterol
- Multiple sclerosis
- Risk of stroke
- Risk of heart disease

You're in Charge

The eye is controlled by muscles, just like many other parts of the body. So just like the rest of your body, your eye health is impacted by your lifestyle, including eating habits, regular exercise, and routine physical exams. Getting an annual eye exam is a very important part of maintaining your overall health.

Make an Appointment for an Eye Exam Today

The Fund uses Vision Service Plan ("VSP") to provide vision care services at discounted rates. To locate the most current doctors in the VSP network, log on to www.vsp.com or call (800) 877-7195, VSP's Interactive Voice Response, available 24 hours a day, seven days a week.

The above information was provided by Vision Service Plan.

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Sparks, MD 21152-9451

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