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

For Your Benefit

Operating Engineers Local No. 77

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Material Modifications

Bariatric Surgery Covered Under Plan

At the Board of Trustees meeting on Nov. 8, 2016, a motion was approved for the Plan to cover bariatric surgery, effective June 1, 2016. The amendment provides procedural guidelines which would be deemed medically appropriate in accordance with nationally published medical guidelines at the time of the surgery.

According to the National Institute of Diabetes and Digestive and Kidney Diseases, bariatric surgery is "an option if you have severe obesity and have not been able to lose enough weight to improve your health using other methods or have serious obesity-related health problems. The surgery makes the stomach smaller and sometimes changes the small intestine."

The Plan Amendment states:

> *The Plan will cover the cost of Bariatric Surgery, subject to all other appropriate Plan provisions, provided the surgery is determined to be medically necessary, and consists of one of the following surgeries:*
>
> - *Gastric Bypass (Roux-en-Y)*
> - *Adjustable Silicone Gastric Banding*
> - *Biliopancreatic Diversion with Duodenal Switch*
> - *Vertical Gastrostomy (Sleeve Gastrectomy)*
>
> *and is subject to the following conditions and procedural guidelines along with such additional guidelines as the Board of Trustees shall deem medically appropriate in accordance with nationally published medical guidelines at the time of the surgery.*

Requirements

- *The individual should be at least 18 years old or should have reached full expected skeletal growth.*
- *Body Mass Index (BMI) of 40 or greater OR*
- ***BMI** of at least 35 or more with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease or pulmonary hypertension.*
- *Documentation of a motivated attempt of weight loss through a structured diet program, prior to bariatric surgery, which includes physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program for a minimum of six months.*

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- *Active participation in an integrated clinical program that involves guidance on diet, physical activity and behavioral and social support prior to and after the surgery.*
- *Psychological evaluation to rule out major mental health disorders which would contraindicate surgery and determine patient compliance with post-operative follow-up care and dietary guidelines.*
- *Limit to in-network benefits for contracted Carefirst providers and facilities, but limited to facilities that are certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center or are certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence*
- *Exclude any procedure that is considered experimental or investigational, in the medical community at the time the surgery is to be performed.*

The benefit is limited to a $100,000 lifetime maximum benefit under the plan.

Obesity poses several health risks including, but not limited to: strokes, heart disease, diabetes, infertility, sleep apnea, and osteoarthritis.

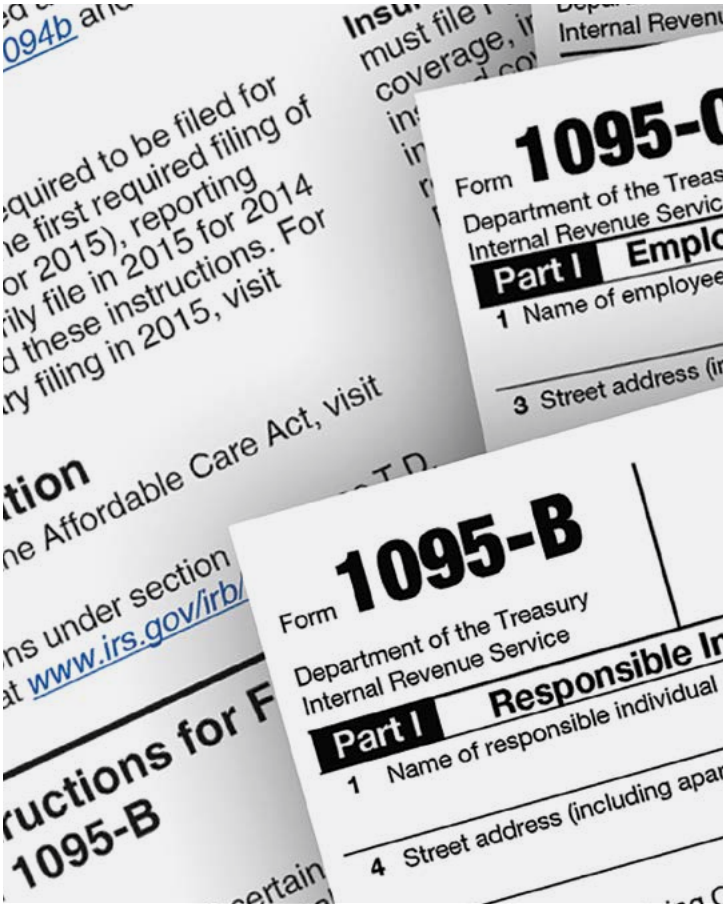
The American Society for Metabolic and Bariatric Surgery (ASMBS) has published findings showing that while some patients (approximately 5%) do regain weight following bariatric surgery, the vast majority do not. The ASMBS has a FAQ (http://asmbs.org/patients/bariatric-surgery-faqs) for those interested in learning more about this surgery.

Form 1095-B Will Be Sent To You in January

The Affordable Care Act is a federal law that requires almost everyone in the United States to have medical coverage. Starting in tax year 2015, people who don't have at least a minimal level of coverage could have to pay a fine to the Internal Revenue Service (IRS). The Form 1095-B is proof that you and your covered dependents had medical coverage, so you can report it on your 2016 tax filing and avoid paying the fine.

Form 1095-B is a tax form (like a W-2 or 1099-R) you will get from the Operating Engineers Local No. 77 Trust Fund of Washington DC as proof that you and your tax dependents had the required medical coverage. The form will be mailed to you no later than January 31, 2017. You should keep your Form 1095-B with all your tax records as supporting documentation.

If you had medical coverage through the Operating Engineers Local No. 77 Trust Fund of Washington DC in 2016 and don't receive a Form 1095-B by the end of February, please contact the Fund Office at 1-877-850-0977.



What You Should Know about Accident and Sickness Benefits

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. Benefits may include payments for a portion of a week.

To receive A&S, 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 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 Office for more information if this applies to you.

If Returning to Work, Call the Fund Office

If you have been receiving Weekly Accident and Sickness benefits, be sure to call the Fund Office once you return to work— especially if you return to work before the date your physician stated on your Accident and Sickness Claim form. The Fund Office needs this information in order to update your claim and to ensure payments are not processed beyond the date you return to work. If this happens, your claim will go into an "overpaid" status until the money is refunded to the Fund Office.

A phone call to the Fund Office letting us know when you have returned to work can ensure this does not happen to you.

How to File Weekly Accident and Sickness Claims

All Weekly Accident and Sickness claims must be filed within ***60 days*** from the date 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 you as 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 the date your doctor certifies you as disabled. Also, in no event is a claim payable if 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
P.O. Box 1064
Sparks, MD 21152-1064

Accident and Sickness Benefits Are Taxable

Weekly Accident and Sickness benefits are taxable and must be reported on your IRS tax return. Income tax is not automatically withheld from your A&S payments unless 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.

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.

Use the Emergency Room Only if Urgent

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 an emergency** 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 an 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 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.

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

The above article is from MayoClinic.com.

If You're Involved in an Accident, Contact the Fund Office

If you are involved in an accident, you are asked to complete a claim form for either Accident and Sickness Benefits or Medical Benefits. The term "accident" is used to refer to any type of accident, not just car accidents. For example, a cut, bruise, break, sprain, strain, or tear are all injuries sustained as a result of an accident.

To process your claim, we must know how, when, and where all accidents occurred. If we ask for accident information, we need details about any kind of accident, not just car accidents. This is because if the accident is determined to be the fault of a third party, the Fund is not liable for those claims. A "third party" is not just another driver in a car accident – it could be that a manufacturer is at fault, another property owner, or any other party. We must ask for this information in order to process your claim correctly.

Remember, however, that work-related claims are not covered benefits under the Plan. Medical expenses due to a work-related injury should be presented through the workers' compensation insurance carrier. Work-related claims can be submitted with verification of Workers' Compensation carrier payment. This allows us to keep you "eligible" for other benefits under the Plan rules even though you are not working.

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.

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 medical 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
P.O. Box 1064
Sparks, MD 21152-1064

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.

Operating Engineers Local No. 77 Funds

911 Ridgebrook Road
Sparks, MD 21152-9451