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

For Your Benefit

Operating Engineers Local No. 77

January 2022 Vol. 22, No. 1

www.associated-admin.com

What is "balance-billing" (and what is "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance-billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—such as when you have an emergency or when you schedule a visit at an in-network facility but you are unexpectedly treated by an out-of-network provider.

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You are protected from balance-billing for:

Emergency services

If you have an emergency medical condition and receive emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance-billed for these emergency services. This includes services you may receive after you're in stable condition, unless you give written consent and give up your protections not to be balanced-billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance-bill you and may not ask you to give up your protections not to be balance-billed. If you receive other services at these in-network facilities, out-of-network providers can't balance-bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance-billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance-billing isn't allowed, you also have the following protections:

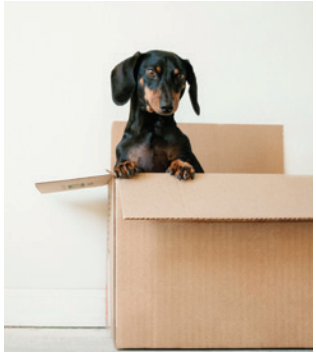
- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, please contact Participant Services at the Fund office for assistance, or you may contact the U.S. Department of Health and Human Services ("HHS") by visiting https://www.cms.gov/nosurprises/consumers or calling 1-800-985-3059.

Visit HHS.gov for more information about your rights under federal law.

Important! Keep The Fund Office Informed Of Your New Address & Phone

It is very important that you tell the Fund Office when your address and/or telephone information changes. The Fund office sends out important information about your benefits, Plan booklets, and this For Your Benefit newsletter. Without the correct information, your benefits may be affected.



If you're planning to move (even temporarily), or have recently moved, let the Fund Office know your new address and telephone number by calling toll-free (877) 850-0977. Remember, telling the Union or your employer is not the same as telling the Fund Office.

Retirees: For your protection, your change of address request must be in writing. Please send information to:

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

Street Address Required Even If You Have A Post Office Box.

We must have your current street address on file even if you're using a Post Office ("PO") Box for mail delivery. The Fund Office will continue to mail all statements or pension checks to a PO Box (unless you are having your check electronically transferred), but we must have your street address as well.

Participants Encouraged to Use Website for Valuable Benefit Information

Benefits change frequently, but you can find the most up-to-date information regarding your Plan online at www.associated-admin.com. Simply click "Your Benefits" (at top or at left) and choose *Operating Engineers Local 77.*

Checking eligibility or status of claims is provided through the MemberXG Benefit System.

Along with important notices, the website includes various forms available for download, such as an enrollment form, change of address form, change in beneficiary form (Health & Welfare and Pension), and more.

Your Summary Plan Description ("SPD") booklet is available, as well as any modifications (*Insert to SPD*) that have occurred since the book's print date.

Every *For Your Benefit* newsletter, dating back to January 2011, is archived for quick access by participants. Simply click on the month and year of the issue you'd like to access (for example, "January 2022") and a PDF of that issue will open in another tab in your browser. You may download the file for reading offline. Phone numbers for Plan Providers are listed as well.

Your January 2022 *401(k) Enrollment* Option

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 and is processed via a 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)?

Participants are able to do the following deferral for their 401(k):

- For participants that are **under age 50** they are eligible to defer .50 to $7.00 per hour, in .50 increments, each pay period for deposit to their Deferral Salary Account
- For participants that are **over age 50** they are eligible to defer .50 to $9.00 per hour, in .50 increments, each pay period for deposit to their Deferral Salary Account.

How Do I Know How Well My Investments Are Doing?

Effective January 4, 2021, Empower Retirement officially acquired the retirement business of Mass Mutual. Participants who have not been receiving their quarterly statements are encouraged to direct their inquiries/requests directly to Empower Participant Services @ 855-756-4738 or Participant_services@empower-retirement.com.

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.

Caremark OTC COVID-19 Tests
(with no prescription) under the Pharmacy Benefit Solution

CVS Caremark offers the following solution to meet the requirements - please note that the below coverage capabilities cannot be adopted separately.

	Direct Member Reimbursement (post service reimbursement)	Direct Coverage of OTC COVID-19 Tests (PBM adjudication at Pharmacy Point of Sale)
Member Experience	Reimburses members for OTC COVID-19 tests after purchase, starting January 15, 2022 until the end of the PHE. An online claims submission process through Caremark.com and the CVS Caremark mobile app (available for Android and Apple) are available in addition	Most OTC COVID-19 tests are covered through the member's pharmacy benefit. Members can obtain an OTC COVID-19 test with no upfront out of pocket cost, simply by presenting their prescription benefit ID card to any in network pharmacy that elects to offer COVID-19 test through this program. To meet the Direct Coverage safe harbor requirements, the network also must have a direct-to-consumer shipping
Member Purchasing Options	Members can purchase OTC COVID-19 tests from any pharmacy or merchant of their choice. Caremark's solution will require a receipt as proof of purchase, and members will be required to attest that the OTC test was purchased for personal use, not employment, that it has not been reimbursed by another source, and was not purchased for resale.	All pharmacies participating in the broad national CVS Caremark network will have the option of participating in this offering. **Note:** We are performing a solicitation of the broad CVS Caremark national network. Pharmacies will have the option to opt-out. Members will know which pharmacies are participating only when they attempt to utilize their pharmacy benefit at pharmacy point-of-sale.
COVID-19 OTC Test Kit Products	CVS Caremark will be able to adjudicate post-service claims for all OTC COVID-19 tests, regardless of manufacturer or merchant.	CVS Caremark will be able to adjudicate point-of-sale claims for most OTC COVID-19 tests across a broad network of pharmacies.
Plan Sponsor Cost	A $2.50 manual claim processing fee will be applied to each manual claim processed. Clients are required to reimburse members the full cost of the test, however, if the client's plan meets the safe harbor requirements (as noted in the member experience above), the reimbursement limit of $12 per test provided in the Administration guidance may be applied.	For OTC kits processed through the pharmacy benefit, CVS Caremark will process payment of OTC COVID-19 test kits at market-competitive rates that will help ensure pharmacy participation and adequate access.
Limitations in Place	• Quantity limit of eight tests per 30 consecutive days across both coverage capabilities.	

* **Note:** This is independent of your existing PBM contract. Since OTC COVID-19 tests are not considered prescription drugs, the claims will be excluded from all client rebate, pricing calculations and performance guarantees under your PBM contract.

Dependents: What You Need To Know

Dependents may include your lawful spouse residing with you and your natural children, your stepchildren, adopted children or children placed for adoption who are under the age of 26.

Newly Eligible Dependents

Your spouse and eligible stepchildren may be added on the first of the month following the date of marriage. Biological children can be added effective the date of their birth.

Newborns

Newborns are covered from the date of birth until 6 months of age without a Social Security Number. **A Social Security Number not provided by the time the child is 6 months old will result in termination of coverage by the Fund on the first day of the month following the date the child turns 6 months of age.**

Children Adopted or Placed for Adoption

The Fund provides dependent coverage for a child who is adopted or placed in adoption with a participant regardless of whether the adoption is finalized. A participant must assume legal obligation for total or partial support of the child pending the adoption of that child. Legally adopted children and children placed for adoption may be added effective the date of or placement for adoption.

Disabled Dependents

Age limits for dependents does not apply if a dependent child is incapable of self-support due to a mental or physical disability. For disabled children, dependent coverage will only continue if:

1. The child is unmarried;
2. Is financially dependent on the participant for support;
3. Was the participant's dependent before the child turned age 26;
4. The disability began before the age of 26;
5. The disability is certified by a physician and the Board of Trustees to be a qualifying disability;
6. The child continues to be eligible for dependent coverage under the Plan (Evidence of the dependent's continued disability may be required by the Fund Office).

You must inform the Fund Office within 30 days from the date he or she first became your dependent in order for a new dependent's coverage – including newborn's – to begin on the earliest date of eligibility. Otherwise, coverage will begin on the first of the month following the date the Fund Office receives the required information. The completed enrollment form and birth certificate are required. A phone call is not sufficient.

A new Dependent can be added by contacting the Fund Office at (877) 850-0977 and requesting an enrollment form.

(Note: Eligible Dependents must be listed on your most recent enrollment form and have a valid Social Security Number in order to receive dependent coverage.)

Privacy Statement Available Upon Request

In accordance with federal law, the Fund has established Privacy Practices, which are the rules concerning how personally identifiable health information ("PHI") about you or your dependents may be used and disclosed by the Fund and other parties, and how you or your dependents can get access to this information.

This statement was given to you when you first became eligible for benefits. If you would like another copy of the "Notice of Privacy Practices," call the Fund office toll free at (877) 850-0977 or write to:

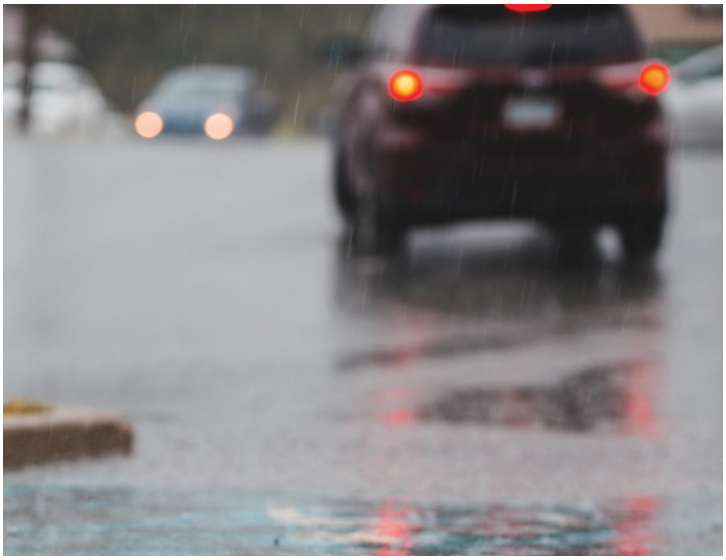
HIPAA Privacy Officer
Operating Engineers Local No. 77
8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361

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.

Emergency Room Visits

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. 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 may 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).

If you want to confirm your issue is an emergency and thus covered, please contact SwiftMD (www.SwiftMD.com). The charge will be approved if SwiftMD refers you to the emergency room.

Consider a CVS MinuteClinic or Urgent Care Facility (such as Patient First)

If you have a condition **which is not** determined to be "an emergency medical condition," 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.

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.

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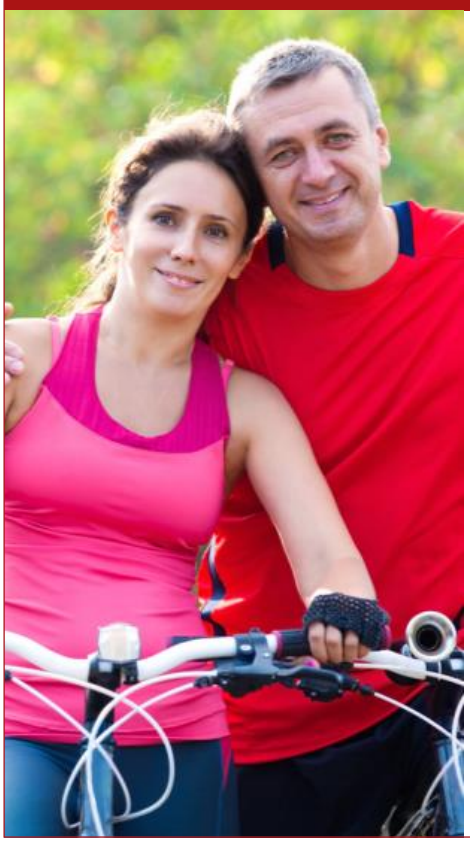

February is American Heart month!

There are so many things that you can do to live a heart-healthy life. These include exercising at least 2.5 hours a week, consuming a heart healthy diet, reducing stress in your life and sleeping 7-8 hours at night.

Take care of your heart together!

Your Personal Health Nurse (PHN) with Conifer Health Solutions' Personal Health Management program can work with you and your family to find ways to stay heart healthy all year round. To get started, call your PHN, Lindsey Luma , at 410-919-0520.

Whether you're looking for fashion-forward designs from bebe, or modern frames from Nine West, classic and youthful options from Calvin Klein and Calvin Klein Jeans, or durable frames from Flexon—there's something for everyone.

From November 1, 2021, through March 31, 2022, VSP members will receive an Extra $40 to spend on frames by bebe, Calvin Klein, Calvin Klein Jeans, Flexon, and Nine West.

Out-of-Network Vision Benefits

Exams: Up to $52

Single vision lenses: up to $34

Lined bifocal lenses: up to $50

Lined trifocal lenses: up to $66

Progressive Lenses: up to $66

Eyeglass Frame: up to $70

Contacts: up to $105

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