For Your Benefit

Operating Engineers Local No. 77

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Retirees: IRS Form W-4P Will Soon Be Mailed. Your Response is Required!

The IRS recently released a new mandatory federal tax withholding form intended specifically for withholding taxes from monthly pension benefits: **IRS Form W-4P**.

If you retired prior to 2023 and you are currently having a **flat-dollar amount** of federal tax withheld from your monthly pension benefit, then you will soon receive a Form W-4P in the mail to complete and return to the Fund Office. The IRS now requires your federal tax withholding to be determined using this new Form W-4P, and no longer allows for flat-dollar amount withholdings. (Note: this does not apply to your State tax withholdings.)

If you previously elected to have no withholding or $0.00 withheld for federal tax, you will not receive a Form W-4P in the mail, and the Fund will continue to honor your election to have no federal tax withheld.

If you receive this form in the mail from the Fund Office, you will have 60 days to complete the form and return it to the Fund Office. If the form is not completed and returned within **60 days**, the Fund will determine your federal withholding by applying the IRS' default election based on a filing status of single with no allowances. This could result in a higher or lower withholding from your pension checks in the future.

Although you are required to complete and return this form, you are not required to have federal tax withheld from your pension checks. You may choose to have no tax withheld from your monthly checks by writing the words "No Withholding" on Form W-4P in the designated box.

If you have any questions regarding federal tax withholdings or Form W-4P, please consult your tax advisor. If you receive this form in the mail and have any questions for the Fund Office, please contact the Fund Office. Note: The Fund Office cannot provide tax advice.

This issue—

Retiree Information Forms Sent: Return to Avoid Suspension of Pension Benefits

The Fund Office recently sent all retirees (and beneficiaries who are collecting a benefit) a Retiree Information Form ("RIF") to be completed and returned to the Fund Office. The form asks questions about your current address, your beneficiary, whether you and current employment information, if any.

It is very important that you review all sections of this form to be certain the information is correct. Mark any corrections on the form and promptly send it back to the Fund Office. It is critical that the Fund Office receives your completed RIF to avoid any interruption of your monthly benefits. To assist you, the Fund Office will include a postage-paid return envelope with the 1st RIF.

Helpful Reminders

- Do not attach checks or claims to the RIF.
- Retirees need to complete the employment section.
- Let us know if you or your spouse has other health coverage.
- Be sure to sign and date the RIF.

The only person who can sign the RIF form is the Retiree or Beneficiary named on the RIF form, unless another individual holds legal authority to sign on the individual's behalf, such as a Power of Attorney or legal guardian. A copy of any such Power of Attorney or other legal document must be submitted to the Fund Office and verified before a RIF will be accepted with a representative's signature. If, for health reasons, the individual is unable to sign the form and there is no Power of Attorney or legal authority on file, then the individual must sign an "X" on the RIF and have it notarized by a Notary Public.

We appreciate your cooperation!

Always Review Your EOB

An Explanation of Benefits ("EOB") is a statement sent to participants each time a medical claim is processed. Even though it resembles a medical bill, it is not a bill, and states that at the top of the first page.

An EOB contains a summary of services and items you have received and how much you may owe for them. It also lists how much your provider billed, the approved amount the Plan will pay, and how much you owe the provider, if anything. It explains how the service was covered and what percentage or dollar amount was applied toward satisfying your annual deductible. If any amount/service was not covered, the EOB will state that also.

You should always hold onto your EOBs, as they may later be needed as proof of what costs have been covered and/or paid. They can also be a powerful and priceless fraud and abuse detection tool, should you see that billed services were not incurred by you or your eligible dependent. Should you ever notice this on an EOB, please contact the Fund office right away.

Eligibility Requirements for Welfare Plan Coverage

Health coverage eligibility for yourself and your dependent(s) begins once you have worked 400 hours and your employer has paid contributions for 400 hours in a three-month period for initial eligibility, or 1,200 hours during the previous 12-month period. Coverage begins on the first day of the month following the time both you and your employer meet these requirements. Coverage continues month to month as long as you have worked and your employer has paid for 400 hours in the previous three-month period or 1,200 hours in the previous 12-month period. If contributions are not paid, for any reason, or if you have not worked 400 hours in the last three months or 1,200 hours in the last 12 months, then coverage will stop immediately. If you lose coverage, you can become eligible again when you have worked 400 hours and your employer has paid contributions for 400 hours in the last three-month period.

Your employer's contributions are made the month after you have performed work. Because of this, the three-month "look back" period for each eligibility month is shown below.

Eligibility Month	Look-back Period
January	September, October, November
February	October, November, December
March	November, December, January
April	December, January, February
May	January, February, March
June	February, March, April
July	March, April, May
August	April, May, June
September	May, June, July
October	June, July, August
November	July, August, September
December	August, September, October

Go To 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. 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 <u>not</u> 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 "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.

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 a 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.)

Pain in Your Jaw Could be a TMJ Disorder

Millions of people suffer from Temperomandibular Joint Disorder. Common causes of the disorder are teeth grinding and clenching. Many people do this unconsciously while they sleep.

TMJ disorders can be very painful, but they are usually temporary and treatable with self-managed care and/or nonsurgical treatments.

However, if your TMJ disorder is acute, your Plan provides coverage up to $1,500 per year. The benefit is subject to your annual deductible and coverage is at 80%.

Common symptoms of TMJ disorders include:

- pain or tenderness of your jaw;
- pain in one or both of the temporomandibular joints;
- aching pain in and around your ear;
- difficulty chewing or pain while chewing;
- aching facial pain; and
- locking of the joint, making it difficult to open or close your mouth.

Changing Your Benefits?

It is important to remember that ANY time you are changing your Health Fund benefits or coverage, whether it's changing Plans or Coverage Levels (ex.: dropping a spouse or child), you MUST complete a new enrollment form. This is necessary to ensure that the Fund Office updates your benefit or coverage information correctly to maintain your benefits and coverage under the Health Plan.

Your Right to Request an Annual Pension Statement

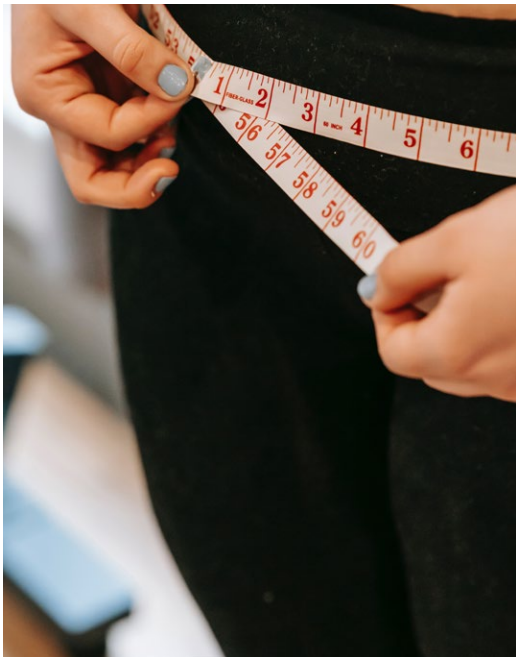
Active Participants in the Operating Engineers Local No. 77 Pension Plan have the right to request pension benefit statements on an annual basis. **You are entitled to one (1) benefit statement per 12-month period**.

To receive a statement of your estimated pension benefit, call the Fund Office at (877) 850-0977 and request a pension estimate. It will take approximately 4-6 weeks for the Fund Office to prepare and send your statement. The statement is provided free of charge. Written benefit statements are provided only via postal mail to the address on file with the Fund office. The Fund Office does not provide estimates or statements over the phone.

Your statement will tell you whether you are eligible to receive a pension at normal retirement age. If eligible, it will also detail what your estimated monthly benefit would be upon attaining normal retirement age, based on your current accrued service as of the date of your request. If not eligible, the statement will explain how many more years of service you must earn before you are eligible for a benefit, or at what age you will become eligible for a benefit.

The right to receive your statement is covered under the Employee Retirement Income Security Act of 1974 ("ERISA"), Section 105.

Carrying More Weight than Healthy? Your Plan Covers Bariatric Surgery



When dieting, healthy eating, and exercise prove ineffective at helping you shed pounds, you have the option to have bariatric surgery under your Plan.

If you suffer 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, then it could be time to discuss bariatric surgery with your doctor. The surgery makes the stomach smaller and sometimes changes the small intestine.

Your Plan covers the cost of Bariatric Surgery, subject to all other appropriate Plan provisions, provided the surgery is determined to be medically necessary by Conifer, and consists of one of the following types:

- Gastric Bypass (Roux-en-Y)
- Adjustable Silicone Gastric Banding
- Biliopancreatic Diversion with Duodenal Switch
- Vertical Gastrostomy (Sleeve Gastrectomy)

3 Ideas for Protecting Your Eyes in the Summer

1. **SUNGLASSES!** Wearing protective eyewear is an essential for summer. Larger frames will always protect more of your face so consider oversized styles for prolonged exposure. The most important feature to keep in mind is full UV coverage. You want to look for a sticker that says UV 400 which covers UVA and UVB lights or 100% UV protection.
2. **Large brim hats** are very much in style right now. When outside and exposed to the sun, wear one that shades your eyes.
3. **While at the pool, beach, lake, or river**, consider an umbrella to create a shaded spot for yourself and your family.

Don't Forget About Those Overcast Days

Even on days when you don't see the sun, your eyes are exposed to UV rays. Avoid the short and long-term effects of UV damage (and look stylish) by simply throwing on a pair of shades year-round.

Have a healthy, happy and safe summer...and don't forget... grab a great pair of sunglasses.

The above article was provided by Vision Service Plan (VSP).

When Skilled Nursing Services and Supplies Are Necessary

You must certify all skilled nursing facility care and skilled nursing supplies with Conifer Health Solutions. Coverage includes skilled nursing services and supplies and services related to skilled nursing, services provided in a skilled nursing facility, extended care facility, hospital or other acute care setting, provided the services are not for custodial care.

Skilled nursing/supply coverage includes:

1. semi-private room;
2. general nursing care;
3. meals;
4. special diets recommended by a physician; and
5. miscellaneous services, supplies, medications and dressings related to Skilled Nursing care.

The maximum amount payable under the Fund for Skilled Nursing Services and Supplies is sixty (60) days per participant per contract year. Skilled nursing services received in a hospital or other acute care setting count toward the maximum benefit.

CONIFER HEALTH SOLUTIONS® | Conifer Corner

Avoiding Too Much Sun Can Save Your Life.
The best ways to prevent skin cancer are to avoid the sun from 10 a.m. to 4 p.m., wear sunscreen daily with an SPF of 30 or more, shade your skin with a hat and protective clothing, and to talk with your provider about marks or spots on your skin that concern you.

Want to protect your health more?
Conifer Health Solutions and its Personal Health Nurses (PHNs) are a great option for you and your family's health needs. To get started, call your PHN, Elizabeth Woodrow, BSN, RN, CCM, at 410-919-0488.

Please Open and Reply to Fund Office Mail

The Fund Office regularly sends mail to participants: tax forms, requests for additional information regarding benefit claims, requests to complete a form, etc.

Each mailing you receive from the Fund Office is important as it may protect your coverage, and/or ensure proper administration of your benefits.

When you receive mail from the Fund Office, please open and reply as soon as you can if a reply is necessary.

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