OPERATING ENGINEERS LOCAL 101 HEALTH & WELFARE FUND
TENTH AMENDMENT TO THE PLAN DOCUMENT

WHEREAS, the Operating Engineers Local 101 Health and Welfare Fund Combination Plan Document and Summary Plan Description dated January 1, 2012, provides that the Plan may be amended by the Board of Trustees from time to time;

WHEREAS, it is the desire of the Trustees to amend the Plan;

NOW, THEREFORE, BE IT RESOLVED that the Plan document and Summary Plan Description shall be amended as follows, effective as of March 1, 2015.

Section Twelve – Claims and Appeal of Denied Claims Procedures

Section Twelve shall be amended by deleting the subsection C – Review of Adverse Benefit Determination, subsection D – Exhaustion of Administrative Remedies, and Subsection E – Voluntary Additional Appeal Level and inserting in its place the following:

Section C – Review of Adverse Benefit Determination

1. Filing an Appeal

This Plan maintains a one-level mandatory appeals process, with a voluntary second level of appeal. If a claim for benefits is denied, in whole or in part, or if the amount approved or paid varies in any other way from the total amount claimed, you may appeal the determination by filing a written request for review.

The Board of Trustees may designate, through a written contract, a named fiduciary of the Plan for the purposes of reviewing claims determinations and making final determinations on your appeal.

Appeals must be in writing to the Appropriate Claims Administrator for the first level of appeal review:

Medical and Chiropractic Benefits
Blue Cross and Blue Shield of Kansas City
P.O. Box 419169
Kansas City, MO 64141-6169

Dental Benefits
Delta Dental of Missouri
Attn: Appeals Committee
PO Box 8690
St. Louis, MO 63126-0690

Prescription Drug Benefits
CVS/Caremark
Attn: Appeals Department, MC 109
P.O. Box 52084
Phoenix. AZ 85072-2084

Vision Benefits
UnitedHealthcare Vision
Attn: Appeals
PO Box 30978
Salt Lake City, UT 84130

Loss of Time, Life Insurance, and Accidental Death & Dismemberment Benefits
Operating Engineers Local 101 Health & Welfare Fund
6601 Winchester Ave; Suite 250
Kansas City, MO 64133-4657

2. Deadline for Filing an Appeal

A request for review of claims (i.e. an appeal) for Life Insurance or AD&D Benefits must be made within 60 days after you receive notice of the adverse benefit determination.

A request for review of claims (i.e. an appeal) for Medical Benefits, Dental Benefits, Vision Benefits, Prescription Drug Benefits, Chiropractic Benefits, and Weekly Accident and Sickness Benefits must be made within 180 days after the Participant's receipt of the notice of adverse benefit determination.

3. Discretionary Authority

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and other fiduciaries and individuals to whom the responsibility of the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

4. Procedure for Full and Fair Review of Appeals

The entity deciding your appeal (i.e. the Appropriate Claims Administrator or Board of Trustees) will afford you with a full and fair review of an adverse benefit determination.

(a) As part of this full and fair review, you will be provided with:

1. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
2. Reasonable access to and, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
3. A full and fair review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

4. For all benefits other than AD&D and Life Insurance, a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(b) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or appropriate, the entity deciding your appeal will:

1. Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

2. Provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

5. Timing of Notification of Benefit Determination on Appeal

(a) Post-Service Appeals Decided by Claims Administrator

For Medical, Chiropractic, Dental, Vision and Prescription Drug Appeals, the Plan subcontracts the first-level mandatory appeal to the appropriate Claims Administrator listed above in Section C(1). The appropriate Claims Administrator who will make the first level determination on the appeal not later than 60 calendar days from receipt of the appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

This time may be extended up to another 60 days following the receipt of your request for review if the Claims Administrator:

1. Determines that special circumstances that require a further extension of time; and

2. Sends you a written notice of the extension prior to the termination of the initial 60-day period, explaining the special circumstances requiring the extension of time and the date the Claims Administrator will render a determination on your appeal.

(b) Post-Service Appeals Decided by Board of Trustees

For Loss of Time, Life Insurance, and Accidental Death & Dismemberment Benefits, first-level post-service appeals decided by the Board of Trustees, determination of your appeal shall be made no later than the date of the regularly scheduled quarterly meeting immediately following the Plan's receipt of your request for review. In your request for review is received within 30 days preceding the date of the next regularly scheduled meeting, the Trustee's review and determination will be made no later than the second meeting following the Plan's receipt of your request for review.

The Plan may extend this period until the third meeting following the Plan's receipt of your request for review if the Plan:

1. Determines that special circumstances that require a further extension of time; and

2. Sends you a written notice of the extension prior to the commencement of the extension, explaining the special circumstances requiring the extension of time and the date that the Trustees will render a determination on your appeal.

The Plan will provide you written notice of the decision on review (i.e. the appeal) as soon as possible, and in no event later than 5 calendar days after the decision is made.

(c) Review of Pre-Service Claims

A request for prior authorization (or for authorization after emergency admission, surgery, or other treatment) is a claim for benefits. The entity making the appeal decision shall notify you of the Plan's benefit determination on review within the reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt by the Plan of your request for review. No extension of time will be made.

(d) Expedited Review Procedure for Urgent Care Claims

If the claim involves urgent care, the expedited review procedures shall apply. The named fiduciary with responsibility for making the appeal decision shall notify you of the Plan's benefit determination on review by telephone or fax as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan's receipt of your request for review. Formal written notice will follow within 3 days after the initial oral or fax notice. No extensions of time will be made.

6. Content of Notification of Benefit Determination on Appeal

The named fiduciary with responsibility for deciding the appeal shall provide you with a written notification of the Plan's benefit determination on review, whether adverse or not. If your appeal is granted, you will receive a written notice that contains sufficient information to fully apprise you of the Plan's decision to grant your appeal.

If your appeal is denied, you will receive a written notice that includes:

(a) The specific reason(s) for the adverse benefit determination;

(b) Reference to the specific Plan provision(s) on which the determination is based;

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

(d) A statement of your right to bring a lawsuit under Section 502(a) of ERISA;

(e) If the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

(f) If the adverse benefit determination is based on medical necessity, or experimental or investigational treatment or similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of the claim, or the notice will contain a statement that such an explanation will be provided free of charge upon request; and

(g) A statement of the process and timeframe to proceed to a voluntary, second level of appeal with the Board of Trustees.

7. Exhaustion of Administrative Remedies

If you are dissatisfied with the resolution of the adverse benefit determination (i.e. appeal), you may bring a civil action challenging the decision under Section 502(a) of the Employment Retirement Income Security Act (ERISA) of 1974, as amended. However, unless the Plan fails to adhere to these claims procedures, no legal or equitable action may be sought unless and until you have:

1. Submitted a written or electronic claim for Benefits in accordance with the provisions above;

2. Been notified that an adverse benefit determination has been made;

3. Filed a written request for review of the adverse benefit determination (i.e. appeal) in accordance with the provisions above; and

4. Been notified, in writing, of an adverse benefit determination on review.

8. Additional Voluntary Level of Appeal

If, after following the first level appeal process described above, you still disagree with the determination made on your claim, you may submit your dispute to the Fund Office for review. This appeal must be submitted in writing, within 60 days of receipt of the appeal decision. This appeal step is voluntary, and is not required before exercising your ERISA rights.

Upon request, the Plan shall provide to you sufficient information to enable you to make an informed judgment about whether to submit a benefit dispute to this further level of appeal. This information shall include a statement of your right to representation and the applicable rules governing this level of appeal. Your decision to submit your benefit dispute to the voluntary additional appeal will have no effect on your right to any other Benefits under the Plan.

All reviews will be considered and decided by the Board of Trustees at the Board's regularly scheduled quarterly meeting immediately following the Plan's receipt of the request for additional review. If the request for review is received by the Plan within 30 days of such meeting, the review

decision may be made at the second meeting following the Plan's receipt of the request on review. In special circumstances, the Board may need additional information and so may extend the time for deciding by one quarterly meeting. In no event will a decision be made later than the third quarterly meeting following the Plan's receipt of the claimant's request for review.

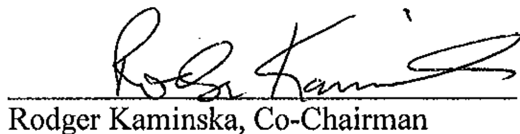
The written decision will include specific reasons for the decision and specific references to the Plan's provisions on which the decision is based.

If you decide not to file this voluntary appeal, the Plan waives its right to assert that you have failed to exhaust administrative remedies because you did not submit a benefit dispute to the voluntary level of appeal. The Plan also agrees that any statute of limitations or other defense based on timeliness shall be tolled during the time that the voluntary additional appeal is pending.

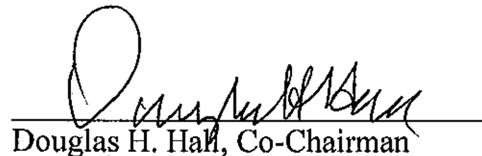
The Plan will not impose any fees or costs on you as part of this voluntary level of appeal.

IN WITNESS WHEREOF, we have approved this Tenth Amendment this _____day of ____________, 2015:

APPROVED:



Rodger Kaminska, Co-Chairman



Douglas H. Hall, Co-Chairman