OPERATING ENGINEERS LOCAL 101
HEALTH AND WELFARE PLAN

RESTATED PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Revised January 2012

Preamble

WHEREAS, a Declaration of Trust establishing the Operating Engineers Local 101 Health and Welfare Fund was entered into October 1, 1962, by and between the INTERNATIONAL UNION OF OPERATING ENGINEERS, HOISTING AND PORTABLE LOCAL UNION 101, AFL-CIO, and the HEAVY CONSTRUCTORS ASSOCIATION OF THE GREATER KANSAS CITY AREA, to provide health, sickness, accident, life insurance and other similar Benefits for participating Employees and their Dependents and Beneficiaries, said Trust having been subsequently amended as of October 1, 1972 and December 16, 1975, and amended and restated as of January 1, 1982 in the form of a Plan and Trust Agreement; and amended and restated as of January 1, 2006 in the form of a Plan and Trust Agreement, and

WHEREAS, Article VIII of said Plan and Trust Agreement provides that the Trust may be amended in writing at any time by the concurrence of a majority of the Trustees, provided that no amendment may change the purpose of the Trust or permit the diversion or application of any of the Trust assets for any other purpose; and

WHEREAS, the Trustees restated said Plan and Trust in their entirety, effective as of January 1, 1984, in the form of a separate Health and Welfare Trust Agreement and a separate Health and Welfare Plan hereinafter set forth;

WHEREAS, the Trustees desire to restate said Plan in its entirety, effective as of January 1, 2012;

NOW, THEREFORE, the Operating Engineers Local 101 Health and Welfare Plan is hereby restated, ***effective January 1, 2012***, as follows:

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January 2012

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NOTICE:

The Board of Trustees, the plan sponsor of this Health Plan, believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, David Barry, at 6601 Winchester Avenue – Suite 250 Kansas City, Missouri 64133 (816) 737-5959.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

About Your Plan

Today a working person's life is far more complicated than ever before. In addition to the responsibilities of getting and holding a job, most workers are vitally concerned about planning for some degree of financial security in a fast moving world.

Some of a family's needs such as the purchase of a home, major appliances or a car can be financed over time. Other needs, such as education for the children or security in one's old age, can be provided only through a careful savings plan. In other words, advance planning is required in order to take care of these needs.

However, no amount of personal financial planning can, by itself, provide adequate protection for major financial problems caused by Sickness or injury.

To help meet these needs, for you and your fellow workers, your Employer and the Union have established a Plan, which provides a specific, dependable plan of health and welfare Benefits. Since its beginning in 1962, the Plan has been managed in order to provide the best Benefits possible consistent with sound financial management.

The Plan, known as the Operating Engineers Local 101 Health and Welfare Plan, was established and is maintained as a result of Collective Bargaining Agreements (sometimes referred to as "labor contracts") between the Association and the Union.

The Plan receives the majority of its income through Employer Contributions as required under the terms of the Collective Bargaining Agreements. In some cases, Employees are permitted to make self-contributions in order to maintain eligibility for Benefits. The Plan also receives income from investments.

Decisions on Plan operations are made by a joint Board of Trustees which is comprised of an equal number of Employer representatives and Union representatives. Working together, the Trustees establish rules of eligibility, levels of Benefits, supervise the investment of the Plan's money and see that the Fund is in compliance with all applicable federal and state laws. The Board of Trustees has sole and exclusive discretion, power and authority to interpret all Plan provisions, subject only to review for an abuse of that broad discretion.

Although the Plan is affiliated with particular PPO Networks (Blue Cross Blue Shield of Kansas City, for instance), the Plan is not an insured Blue Cross plan. The Operating Engineers Local 101 Health and Welfare Plan provides the Benefits of the Plan and the affiliation with the Blue Cross PPO allows the Plan discount advantages and claims processing services.

This, then, is a brief description of how your Plan was established, its purpose and how it operates. The following pages describe how you and your family become eligible for Benefits from the Plan and what your responsibilities are under the Plan. Certain terms have special meaning as used in this document. See Section Seventeen on page 150 for a list of these defined terms. Of course, if you have any questions about the Plan, please feel free to contact the Fund Office. The staff will gladly answer your questions.

Board of Trustees

Completing Enrollment Forms

IF YOU HAVE NOT FILED ENROLLMENT FORMS, DO SO NOW!

The Fund Office requires each Participant to complete Enrollment Forms which provide certain basic information that is needed for your records. Please complete the Request for Information Form and the Member Information Card (including Beneficiary Designation). These Forms request your full legal name and the full legal names of all of your Dependents, your address, your Social Security number and the Social Security number of all of your Dependents, if applicable, your date of birth and the dates of birth of all of your Dependents, and the name of your Beneficiary(-ies) in the case of your death.

All of this information is vital! Without it, the Fund Office will have difficulty knowing what you and your family are entitled to under the Plan and keeping you informed about Plan changes.

NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, BENEFICIARY, DEPENDENTS, MARITAL STATUS, MEDICARE OR RETIREMENT ELIGIBILITY.

When there are Plan changes, you will be sent notice of the change. This means that in order to notify you, the Fund Office must have your current address. **IF YOU MOVE**, make sure to notify the Fund Office of your new address. **IF YOUR MARITAL STATUS CHANGES,** you are required to notify the Fund Office within 60 days of Legal Separation or Divorce. If you do not notify the Fund Office of your Legal Separation or Divorce, the Plan may recover any payments made for claims incurred by your former spouse in accordance with Section Fourteen, Paragraph K. The Fund Office must also receive a complete, signed and dated copy of the marriage certificate, divorce decree or Order of Legal Separation. These documents will be made a permanent part of your file and will be kept in the Fund Office. Failure to send copies of these documents may delay the processing of claims for Benefits.

If you wish to **CHANGE THE NAME OF YOUR BENEFICIARY, YOU MUST NOTIFY THE FUND OFFICE, IN WRITING, BY COMPLETING A NEW BENEFICIARY DESIGNATION CARD.** If you fail to notify the Fund Office of your wishes in writing, the Fund Office will be unable to pay any Death Benefits to anyone other than the person(s) in your latest **written** notification to the Fund Office prior to the time of your death.

If you need to **ADD OR DELETE DEPENDENTS,** you must notify the Fund Office, **in writing**. You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, etc. Since the Plan provides Benefits to Dependents, the Fund Office must know who your Dependents are at all times.

The Plan requires other documents, such as state issued birth certificates, marriage certificates, divorce documents, Certificates of Creditable Coverage from other plans, Social Security documents and other documents that assist the Fund Office in establishing the relationship between the Participant and the Dependent in order to complete the enrollment process. Benefits are subject to suspension pending completion of the enrollment process.

THE FUND OFFICE AND THE UNION OFFICE ARE SEPARATE ENTITIES AND THEREFORE, IT IS YOUR RESPONSIBILITY TO INFORM EACH OFFICE INDEPENDENTLY OF ANY CHANGES.

If the Plan makes any inadvertent, mistaken or excessive payments of Benefits, the Trustees or their representatives shall have the right to recover the payments from you, from the person who received the medical care, and/or from the person to whom the payment was made.

In accordance with Federal Law, this is notice that you may **not** decline enrollment in this Plan, if eligible for Benefits, and that the Participant and all Plan eligible Dependents are covered for Benefits on the Participant's Eligibility Date, and upon notification to the Plan any new Plan eligible Spouse or Child is eligible for Benefits on the Eligibility Date of the Participant. A Retiree may have a special enrollment period to add coverage for a new Dependent. See page 30 for more information regarding notification requirements for Dependents.

A Word about Confidential Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Fund, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (PHI). Broadly speaking, PHI includes demographic information about you and/or your Dependents, such as your name, address, telephone number and Social Security Number, in conjunction with information concerning you and/or your Dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care, administration of the Fund as required by law or for other purposes described in the Fund's Notice of Privacy Practices.

The Plan's use and disclosures of PHI is set out in detail in the Notice of Privacy Practices previously mailed to you. If you would like another copy of this notice, please contact the Fund Office.

The Plan and the Trustees are committed to observing these privacy rules and in ensuring the confidentiality of your PHI. Your cooperation and understanding in working with the Plan to achieve compliance with these federal requirements is appreciated.

Section One – Schedule of Benefits

The Plan offers Benefits to the following groups of Participants:

A. Active Eligible Employees and Dependents

B. Retired Participants and Dependents

C. Disabled Employees and Dependents

D. Owner-Operators and Dependents

E. Fund Employees and Union Employees and Dependents

EXCEPT WHERE OTHERWISE INDICATED, THE SCHEDULE OF BENEFITS COVERS ALL OF THESE GROUPS OF PARTICIPANTS. HOWEVER, BENEFITS FOR DISABLED AND RETIRED PARTICIPANTS WHO ARE ELIGIBLE FOR MEDICARE ARE PAID SUPPLEMENTAL TO MEDICARE BENEFITS.

The Fund has negotiated special contracts with a network of area Physicians and Hospitals known as a Preferred Provider Organization (PPO). These participating providers will render services for fees that, in most cases, are below prevailing prices. Providers that are *in* this network are referred to as In-Network. Providers that are *not in* this network are referred to as Out-of-Network. The Covered Person *will* be responsible for charges not covered by the Fund.

Preferred Payment Level

After satisfying the Deductible, the Preferred Payment Level pays:

80% of the next $4,000 of Covered Charges, then
95% up to $75,000 of Covered Charges, and then
100% up to any Calendar Year Maximum that applies.

Example: Mike is a Covered Person who has met his Deductible for the calendar year, but has his entire Calendar Year Maximum available to him. He incurs $50,000 in covered expenses for hospitalization in a PPO Hospital. His covered expenses are payable at the Preferred Payment Level. The Plan will pay:

80% of first $4,000 = $3,200, **plus**
95% of the next $46,000 = $43,700,

for a total payment of $46,900 out of the $50,000 Hospital bill.

Standard Payment Level

After the Deductible, the Standard Payment Level pays:

70% of the next $4,000 of covered expenses, and then
90% up to any Calendar Year Maximum that applies.

Example: Assume the same facts as in the previous Example, except assume that Mike was admitted to a non-PPO Hospital. The Plan will pay:

70% of first $4,000 = $2,800 **plus**
90% of the next $46,000 = $41,400

for a total payment of $44,200 out of the $50,000 Hospital bill. By using a PPO Hospital, Mike saves $2,700 in out-of-pocket expenses.

CALENDAR YEAR MAXIMUM (PER PERSON)
FOR COMPREHENSIVE MEDICAL BENEFITS $200,000

ANNUAL DEDUCTIBLE (PER PERSON) $300

The Comprehensive Medical Benefit has a $200,000 Calendar Year Maximum Benefit per person. This Calendar Year Maximum will be reduced by $2 for each $1 of services reimbursed for an Out-of-Network Provider. In addition, the calendar year deductible is $300 per person.

Some Benefits are only available to certain individuals. Please refer to Section Seventeen for the particular meaning of the terms Participants, Employees, Covered Person, Covered Employee and Dependent.

YOU ARE NOT REQUIRED TO USE AN IN-NETWORK PPO PROVIDER. COMPLETE FREEDOM OF CHOICE IS YOURS. HOWEVER, CHOOSING AN IN-NETWORK PPO PROVIDER FOR YOUR HEALTH CARE NEEDS WILL SAVE YOU AND THE FUND MONEY.

For the most up-to-date provider information for Preferred Care Network (Metropolitan Kansas City, including Johnson & Wyandotte counties in Kansas), CAPplus Network (State of Kansas), Alliance Network (Eastern Missouri), and BlueCross BlueShield of Kansas City, you can visit BCBS's website at www.bcbskc.com or call their Customer Service Department at (800) 810-BLUE (2583).

If you prefer receiving a printed directory for each network, you may:

- Stop by the Fund Office and pick them up;
- Call the Fund Office at (816) 737-5959 and ask that they be mailed to you; or,
- Call BlueCross BlueShield customer service at (800) 810-BLUE (2583) and ask that they be mailed to you.

Be aware that changes in the composition of the PPO network occur frequently. If you are using a printed directory, always call to verify the network status of your provider before obtaining services.

Important Terms Concerning Your Medical Benefits

To understand how your Plan works, it is important to become familiar with certain terms commonly used in the health care industry.

Annual Deductible

Generally, before Benefits are paid under the Plan, you may need to satisfy an "Annual Deductible." The Annual Deductible is the dollar amount of Covered Charges that you pay each year before the Plan pays any Benefits. The Annual Deductible is listed on the Schedule of Benefits and applies to each covered individual each calendar year. The Annual Deductible for Comprehensive Medical Benefits does not apply for some types of Benefits. For other types of Benefits under the Comprehensive Medical Benefits, the Annual Deductible only applies *if you go to an Out-of-Network Provider*. Also, for some types of Benefits under the Comprehensive Medical Benefits, *other additional and separate deductibles* may apply. Furthermore, some Benefits offered by the Plan are not part of the Comprehensive Medical Benefits. Those Benefits which are not part of the Comprehensive Medical Benefits may have *other, unique annual deductibles*. Finally, you should be aware that Co-Payments or payments you make for non-covered charges are not applied towards meeting your Annual Deductible.

Co-Payment and Coinsurance

Certain covered health services require you to pay either a "Co-Payment" or "Coinsurance." Co-Payments are typically expressed as a flat dollar amount that you are responsible for paying before the Plan will pay any Benefits. The Plan will pay for any Covered Charges after you have paid your Co-Payment subject to any Coinsurance for which you are responsible. Coinsurance is typically expressed as a percentage amount for which either you or the Plan is responsible according to the Schedule of Benefits. In most cases you must meet your Annual Deductible before the Plan is responsible for any Coinsurance amount. See page 6 for an explanation of the Plan's Coinsurance levels. Co-Payments and Coinsurance amounts are also shown on the Schedule of Benefits.

Covered Charges

The term "Covered Charges" refers to the total amount of charges for covered services or items upon which the Co-Payment and Coinsurance rules are based. This may be less than the total billed charges, if your provider's charges are higher than the Usual, Customary, and Reasonable Charge. Charges over the Usual, Customary, and Reasonable Charges are non-covered charges.

PPO Providers

The Fund has contracted with a "Preferred Provider Organization (PPO)" to help manage certain health care expenses for you and the Plan. PPO Providers, such as Hospitals and Physicians, have agreed to charge Negotiated Rates for services. At times this booklet will refer to PPO Providers as "In-Network" Providers and Non-PPO Providers as "Out-of-Network" Providers. PPO provider lists are furnished automatically, without charge, as a separate document. If you would like to know if your Physician is a PPO Provider, you may ask your Physician or check the BlueCross BlueShield Website at www.bcbskc.com.

Annual Maximums

Each person eligible for coverage under the Plan has a Calendar Year Maximum for Comprehensive Medical Benefits. In addition, there are specific annual maximums for Covered Charges relating to particular Benefits. These maximums are listed in the Schedules of Benefits.

Schedule of Benefits

The following is a summary of Benefits covered by the Plan. Each Benefit is explained in further detail beginning on page 45. All Coinsurance percentages apply to Usual, Customary and Reasonable (UCR) Charges allowed by the Plan. See Section Seventeen for the definition of UCR Charges.

Generally, the Plan's Coinsurance is either the Preferred Level or Standard Level (see page 6). Where a different Coinsurance percentage is applicable, it is stated in this Schedule of Benefits as a specific percentage.

BENEFIT	AMOUNT
A. Accidental Death and Dismemberment Benefit (Maximum Benefit)	$3,000

Active, Fund and Union Employees or Owner-Operator Only

B. Alcohol and Drug Treatment and Mental Health Benefit

- *The Alcohol and Drug Treatment and Mental Health Benefits are part of the Comprehensive Medical Benefits. However, the Comprehensive Medical Deductible does not apply to Benefits provided by In-Network Providers. The Out-of-Network Benefits do have separate deductibles which are outlined below.*
- *Payments made by a Participant for Out-of-Network Benefits according to the applicable Coinsurance percentages do not apply to the annual Comprehensive Medical Deductible.*
- ***Pre-certification is required for all services.***

Alcohol and Drug Treatment

Coinsurance *(Fund pays)*	
In-Network	80%
Out-of-Network	50%
Coinsurance *(Participant pays)*	
In-Network	20%
Out-of-Network	50%
Separate Calendar Year deductible (per person)	
Out-of-Network	$50 per person
Maximum In-Patient admissions	two per person in five years with at least a one year separation between admissions
Maximum Out-Patient Benefit	
In-Network	$1,600 per condition
Out-of-Network	$800 per condition

Mental Health

Coinsurance	
In-Network	80%
Out-of-Network	50%

Separate Calendar Year Deductible
Out-of-Network only .... $50 per person
In-Patient Treatment
Maximum admissions .... two per person in five years with at least a one year separation between admissions

Maximum confinement .... 14 days per admission
Out-Patient Treatment
Maximum Annual number of visits .... 25 per person

C. Ambulance Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only* ***after*** *the annual Comprehensive Medical Deductible has been met.*

Coinsurance
In-Network .... Preferred
Out-of-Network .... Standard
Maximum Benefit Payable per use
Ground Ambulance Service $500
Professional Air Ambulance $5,000

D. Chiropractic Expense Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only* ***after*** *the annual Comprehensive Medical Deductible has been met.*
- *See Benefit Description on page 51 for further information.*

Coinsurance .... Standard
Maximum Benefit per visit $70
Maximum Visits per Plan Year (including those applied to the deductible) 30
Maximum Benefit for x-rays (limit 2 series of x-rays per person per year) $85

E. Comprehensive Medical Benefit

Coinsurance
In-Network .... Preferred
Out-of-Network .... Standard

Annual Comprehensive Medical Deductible .... $300 per person
Calendar Year Maximum Benefit .... $200,000 per person

F. Death Benefit $15,000
Active, Fund and Union Employees, Owner-Operator and Self-Contributors Only

G. Death Benefit $10,000
Retired and Disabled Participants Only

H. Dental Benefit

- *The Dental Benefits are completely separate from the Comprehensive Medical Benefits. Therefore, the Comprehensive Medical Deductible does not apply. However, the Dental Benefits do have a separate deductible applicable to covered services outside of the Annual and Semi-Annual Exams.*
- *Payments made by a Participant according to the applicable Coinsurance percentages do not apply to the annual Comprehensive Medical Deductible.*

Preventative Dental Treatment
Coinsurance *(Fund pays)* 100%
Coinsurance *(Participant pays)* 0%

All other covered service (subject to Dental Benefit separate deductible)
Coinsurance *(Fund pays)* 80%
Coinsurance *(Participant pays)* 20%

Separate Deductible (Calendar Year) .... $25 per Family
Maximum Benefit (Calendar Year) .... $2,500 per Family

I. Diagnostic Laboratory and X-Ray Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only* ***after*** *the annual Comprehensive Medical Deductible has been met.*

Coinsurance
In-Network .... Preferred
Out-of-Network .... Standard

J. Hearing Care Benefit

- *The Hearing Care Benefits are completely separate from the Comprehensive Medical Benefits. Therefore, the Comprehensive Medical Deductible does not apply. Also, the Hearing Care Benefits do* ***not*** *have a separate deductible. However, services MUST be provided by Sonus/HearPO authorized providers in order to receive reimbursement from the Fund which will be according to the following schedule.*

Coinsurance
Active eligible Employees and Eligible Retirees 100%
Up to $575 per ear every 3 years
Dependent Spouse .... Covered Person receives discounted services; however, no additional Benefits are paid by the Fund

Maximum Benefit
Active eligible Employees and Eligible Retirees .... $575 per ear every 3 years

K. Home Health Care Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only* ***after*** *the annual Comprehensive Medical Deductible has been met.*
- *A Medically Necessary need for Home Health Care must be established.*

Coinsurance
In-Network .... Preferred
Out-of-Network .... Standard

L. Hospice Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only* ***after*** *the annual Comprehensive Medical Deductible has been met.*

Coinsurance

In-Network .... Preferred
Out-of-Network .... Standard

M. Human Papillomavirus (HPV) Vaccine Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only* ***after*** *the annual Comprehensive Medical Deductible has been met.*

Coinsurance

In-Network .... Preferred
Out-of-Network .... Standard

Frequency of Exam

Per person……………………One round of injections (three shots total) in a lifetime

N. Loss of Time Benefit

Active, Fund and Union Employees Only

Maximum Benefit .... $175 per week
Maximum number of weeks (within 12 months) .... 13 weeks per incident

O. Maternity Benefit (Participant or Dependent Spouse Only)

- *The Plan will pay according to the applicable Coinsurance percentages only* ***after*** *the annual Comprehensive Medical Deductible has been met.*

Coinsurance

In-Network .... Preferred
Out-of-Network .... Standard
Little Stars 100%

P. Physical Examination Benefit

- *The Physical Examination Benefits are not subject to the Comprehensive Medical Deductible except for the Laboratory charges as described above under Diagnostic Laboratory and X-Ray Benefit. Also, the Physical Examination Benefits do* ***not*** *have a separate deductible.*

Coinsurance

In-Network or Out-of-Network 100%

Eligibility and Frequency of Exam

Eligible Active or Retired Participant or Spouse age 35 and over
.... 1 exam per person per year

Maximum Benefit

For all non-laboratory charges $300

Laboratory charges are subject to deductibles and are payable at normal in and out of network rates as more fully described above under the heading *Diagnostic Laboratory and X-Ray Benefit.*

Q. Physician Services Benefit

- *The Out-of-Network Coinsurance percentages apply only **after** the annual Comprehensive Medical Deductible has been met except for inpatient Physician Services.*

Coinsurance

In-Network (Office Visit only - does not include the required $20 Participant Co-Payment.) 100%

In-Network (All other covered services) .... Preferred Level

Out-of-Network........ Standard Level

R. Prescription Drug Benefit

- *The Prescription Drug Benefits are completely separate from the Comprehensive Medical Benefits. Therefore, the Comprehensive Medical Deductible does not apply. However, the Prescription Drug Benefits do have a separate deductible.*
- *Payments made by a Participant according to the applicable Coinsurance percentages do not apply to the annual Comprehensive Medical Deductible.*
- *The Co-Payments apply **before** the separate deductible for Prescription Drug Benefit deductible is assessed.*
- *See Benefit Description on page 66 for further information.*

Non-Maintenance (Retail) Co-Payment *(Participant pays)*

Generic .... Greater of $10 or 10% of cost of drug

Brand Name .... Greater of $30 or 30% of cost of drug

Maximum days of medication allowed........ 30 days per person per Co-Payment

Maintenance (Mail Order) Co-Payment *(Participant pays)*

Generic $20

Preferred Brand Name $75

Maximum days of medication allowed........ 90 days per person per Co-Payment

Separate Calendar Year Deductible

Per Person $100

Per Family........ $200

Calendar Year Maximum (per person) $25,000

This Prescription Drug Benefit Calendar Year Maximum is a part of and not in addition to the $200,000 Calendar Year Maximum applicable to Comprehensive Medical Benefits. If the Calendar Year Maximum for Comprehensive Medical Benefits is reached before the Calendar Year Maximum for Prescription Drugs has been exhausted, the unused balance of the Prescription Drug Calendar Year Maximum shall be forfeited

S. Rehabilitative Therapy Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only **after** the annual Comprehensive Medical Deductible has been met.*

Coinsurance

In-Network........ Preferred

Out-of-Network........ Standard

T. Routine Colonoscopy Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only **after** the annual Comprehensive Medical Deductible has been met.*
- *Benefits are paid only for an Eligible Participant or Spouse age 50 and over*

Coinsurance
In-Network..Preferred
Out-of-Network.. Standard
Frequency of Exam
Per person……………………………………………….…..1 exam every 60 months

U. Routine Mammogram Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only **after** the annual Comprehensive Medical Deductible has been met.*
- *Benefits are paid only for an Eligible Female Participant or Spouse age 40 and over*

Coinsurance
In-Network..Preferred
Out-of-Network.. Standard
Frequency of Exam
Per person……………………………………………………..……1 exam per year

V. Skilled Nursing Facility (Hospital)

- *The Plan will pay according to the applicable Coinsurance percentages only **after** the annual Comprehensive Medical Deductible has been met.*
-

Coinsurance
In-Network..Preferred
Out-of-Network.. Standard

W. Sterilization Benefit (Voluntary)

- *The Plan will pay according to the applicable Coinsurance percentages only **after** the annual Comprehensive Medical Deductible has been met.*

Coinsurance
In-Network..Preferred
Out-of-Network.. Standard
Maximum Benefit $300

X. Surgical Expense Benefit

- *The Plan will pay according to the applicable Coinsurance percentages only **after** the annual Comprehensive Medical Deductible has been met.*

Coinsurance
In-Network..Preferred
Out-of-Network.. Standard

Y. Vision Care Benefit

- *The Vision Care Benefits are completely separate from the Comprehensive Medical Benefits. Therefore, the Comprehensive Medical Deductible does not apply. Also, the Vision Care Benefits do **not** have a separate deductible. However, to obtain coverage at the In-Network*

rates, the services or materials must be provided by a provider in the UnitedHealthcare Vision Network. Benefits are paid according to the following schedule.

Service	Frequency of Service	Network Provider Co-Payment*	Out of Network Maximum Benefit
Vision Exam	Once per calendar year	$10.00	$40.00
Frames**	Once per calendar year		$45.00
Lenses (any one type)	Once per calendar year		
Single Vision		$10.00	$40.00
Bifocal Vision		$10.00	$60.00
Trifocal Vision		$10.00	$80.00
Lenticular Vision		$10.00	$80.00

*The Network Provider Co-payment will apply once if frames and lenses are purchased at the same time.

**Frames purchased from Network private practice providers and Network retail optical providers that are outside UnitedHealthcare Vision selection will have a frame allowance. The frame allowance is as follows. For a private practice provider, it is $50.00 (wholesale). For a retail optical provider, it is $130.00 (retail).

Cosmetic Lens Extras: The following cosmetic lens extras are covered in full:
- Scratch-resistant coating

Contact Lenses at a Network Provider: In lieu of lenses and a frame, you may select contact lenses after a co-payment of $10.00. You will receive from a UnitedHealthcare Vision selection either one (1) box of standard contact lenses or four (4) boxes of covered disposables when obtained from a Network provider. When you elect contact lenses from a Network provider that are not from a UnitedHealthcare Vision selection, the co-payment does not apply. However, you will receive a $125.00 allowance that will be applied toward the evaluation, fitting and purchase of contact lenses once every 12 months. In order to receive the full allowance, you must receive your exam, fitting and evaluation at the same Network provider.

Contact Lenses at an Out-of-Network Provider: In lieu of lenses and a frame, you may select contact lenses from an Out-of-Network provider. We will pay a maximum annual benefit of $125.00 for elective contact lenses or prosthetic contact lenses and $210.00 for necessary contact lenses. If your contact lenses are medically necessary the provider must submit to UnitedHealthcare Vision for approval prior to dispensing the contact lenses.

Z. <u>Well Baby/Child Care Benefit (Dependents only)</u>

In-Network Benefit does not include the required $20 Participant Co-Payment for office visits.
Refer to page 63 for a complete listing of covered immunizations.
Coinsurance

In-Network 100%
....Out-of-Network
Standard

Immunizations (See Page 63 for Immunizations allowed under the Plan)
In-Network 100%
Out-of-Network... 100%

Maximum Well Child Benefit
Dependent Children birth 0 up to age 1 year .... 6 visits per year
Dependent Children age 1 year thru age 6 years .... 1 visits per year

Section Two – Eligibility

The following topics are discussed under this Section on Eligibility:

A. Eligibility for Active Employees
B. Eligibility for Owner-Operators
C. Eligibility for Fund Employees and Union Employees
D. Eligibility under the Family and Medical Leave Act
E. Eligibility for Active Disabled Employee
F. Eligibility for Retired Participants
G. Eligibility for Retired Medicare Supplement Plan Participants
H. Eligibility for Dependent Coverage
I. Termination of Eligibility for Eligible Employees
J. Termination of Eligibility due to Non-Bargaining Employment
K. Reestablishment of Eligibility for Active Employees
L. Termination of Eligibility for Dependents
M. COBRA Continuation Coverage
N. Service in the Armed Forces
O. Uniformed Services Employment and Reemployment Rights Act (USERRA)
P. Fraud or Intentional Misrepresentation of Material Fact

All Employees working for a contributing Employer or Employers within the various jurisdictions of the Plan for whom sufficient contributions have been paid shall be eligible to receive Benefits after meeting the following eligibility requirements. HOWEVER, an Employee employed in the type of work within the jurisdiction of the Union by an employer having no obligation to contribute to the Plan shall be **immediately ineligible** for Employee and Dependent coverage under the Plan. See Subsection J. on page 31 for more details.

A. Eligibility For Active Employees

1. Initial Eligibility for Active Employees

a. Initial Eligibility
An Active Employee shall become eligible for Benefits from the Plan on the first day of the second calendar month following the first three consecutive calendar month period in which he has at least 300 Credited Hours.

Examples of Initial Eligibility Rules

Joe begins Covered Employment with a contributing employer during June, 2012. He works 80 hours in June, 120 hours in July, and 100 hours in August. Joe's enrollment date is September 1, 2012, the first day of his waiting period, and his eligibility for benefits commences October 1, 2012.

b. Accelerated Initial Eligibility for Employees of New Companies
An Employee who is not currently eligible under the Plan may establish initial eligibility under the following conditions:

i. Employee shall have, or have had within the 30 days immediately prior to eligibility with the Plan, bona fide medical coverage as an employee and not as a Dependent;

ii. Employee shall provide proof of existing or immediate past coverage as may be acceptable in the sole discretion of the Board of Trustees; e.g., a HIPAA Certificate of Creditable Coverage;

iii. Employee shall be employed in Covered Employment for an Employer who has become bound for the first time to a Collective Bargaining Agreement with the Union requiring contributions to the Fund;

iv. Employee shall have contributions of at least 100 hours made to the Fund for Covered Employment performed in the first or first full calendar month following the effective date of the initial Employer's Collective Bargaining Agreement requiring contributions or, if later, the first full calendar month during which the Employer has rendered services under the initial Collective Bargaining Agreement requiring contributions.

Benefit eligibility shall be established on the first day of the calendar month following the satisfaction of all the above conditions. Employees unable to satisfy the accelerated initial eligibility conditions above shall have to meet the initial eligibility criteria in Section Two A.1.a. prior to enrollment in the Plan. Accelerated initial eligibility may also be attained under Participation Agreements or arrangements approved by the Board of Trustees in their sole and exclusive discretion.

2. Continued Eligibility for Active Employee
Once having established eligibility to participate as an Active Employee, you must meet ***one*** of the following alternative tests in order to maintain your eligibility:

a. Work at least 200 Credited Hours during the first three of the four consecutive calendar months immediately preceding the calendar month in which your claim arises, or

b. Work at least 1,000 Credited Hours during the first 12 of the 13 consecutive calendar months immediately preceding the calendar month in which your claim arises.

Conversion to the retiree health Plan will be effective on the date of Benefit commencement of the pension Benefit that provides eligibility for participation as a Retired Participant, and any residual eligibility (banked hours) earned as an Active Employee will be forfeited and the prevailing retiree self-contributions initiated.

3. Reinstatement of Eligibility for Active Employee

An Active Employee who fails to maintain eligibility in accordance with the foregoing requirements of Section Two A.2. shall be reinstated as of the first day of the second calendar month next following the first period of three or fewer consecutive calendar months during which he has at least 200 Credited Hours. However, if an Active Employee remains ineligible for 12 or more consecutive months, he shall be required to again meet the Initial Eligibility requirements of Section Two A.1 in order to be reinstated as a Participant.

4. Reciprocity and Active Employees

The provisions of this Section Two A.4 shall apply to any Active Employee for whom contributions have been made to this Fund and to another Operating Engineers health and welfare fund qualifying under the provisions of Section 50l(c)(9) of the Internal Revenue Code, provided that a reciprocity agreement exists between this Fund and such other fund, and the Employee gives written authorization to the Administrative Manager of this Fund and such other fund to make and accept transfers of contributions as herein provided.

A "reciprocity agreement" for purposes of this Section means an agreement executed by the Trustees of this Fund and such other fund stipulating that each Fund will, when authorized by the Employee, transfer contributions to the other. Such periods of transfer may differ according to the agreement, but may not exceed 12 months. In no event may contributions be transferred for any month in which a claim for Benefits has been paid or for any period prior thereto. When Employee authorization is received, past contributions will be transferred (in accordance with the time limitations specified in the applicable reciprocity agreement), and all future contributions will likewise be transferred, until the Employee revokes the transfer authorization by written notice to each Fund's Administrative Manager.

The Administrative Manager of the Local 101 Fund will credit the Employee with Credited Hours in the number determined by dividing the amount of

money received from the other fund by the contribution rate in effect for this Fund for the months for which the transferred contributions are applicable.

Any claims incurred during the period for which such transferred contributions establish eligibility for the Employee will be paid in accordance with the terms and conditions of the Reciprocity Agreement then in effect.

5. Eligibility for Active Employees Receiving Worker's Compensation or Occupational Disease Benefits
An eligible Active Employee receiving Benefits from the Fund due to a disability or eligible for and entitled to benefits under any Worker's Compensation or Occupational Disease law, will receive 2l Credited Hours for each week the Active Employee is entitled to or is receiving such benefits. These credits shall begin with the eighth day of disability. Accumulation of Credited Hours under the provisions of this paragraph shall cease when the aforementioned benefits cease or when the Active Employee received 210 Credited Hours, whichever occurs first.

B. Eligibility For Owner-Operators
An Owner-Operator shall be eligible to participate in the Plan if he makes self-contributions in advance prior to the particular Benefit month, on a monthly basis determined by multiplying 160 times the hourly rate of Employer Contributions then being paid by Employers on behalf of Active Employees. An Owner-Operator who previously established eligibility to participate in the Plan as an Active Employee shall remain eligible on the basis of Credited Hours accumulated prior to becoming an Owner-Operator, and shall not be required to make self-contributions to the Plan until his eligibility lapses due to exhaustion of such previously Credited Hours. An Owner-Operator’s eligibility may be suspended if the Owner-Operator fails to make timely contributions for all employees covered under the Plan.

An Owner-Operator’s waiting period begins (his Enrollment Date occurs) on the first day of the month covered by a Participation Agreement between the Owner-Operator and the Fund and for which contributions are made. The waiting period consists of the first two calendar months for which contributions are made, with coverage being effective on the first day of the third month (the first day of the month following payment of the third monthly contribution, since monthly contributions are due before the first day of the month to which the contribution applies).

1. Initial Eligibility
A contributing Owner-Operator shall initially become eligible to participate in the Plan as of the first day of the calendar month next following his payment of the first three monthly contributions.

2. Continuation of Eligibility

Once having established eligibility to participate, an Owner-Operator shall maintain eligibility so long as he continues to make contributions to the Plan, and his eligibility shall terminate on the last day of the month for which he has made contributions.

3. Reinstatement of Eligibility

An Owner-Operator who fails to maintain eligibility in accordance with the foregoing requirements shall be reinstated as of the first day of the calendar month next following the month in which he has: (a) again satisfied the foregoing initial eligibility requirements for a contributing Owner-Operator, or (b) satisfied the initial eligibility requirements for Active Employees.

C. Eligibility For Fund Employees And Union Employees

Fringe Benefit Fund and Apprenticeship Fund Employees (collectively, Fund Employees) or Union Employees shall be eligible to participate on the terms and conditions hereinafter set forth, provided his Employer makes contributions to the Fund on his behalf in a monthly amount determined by multiplying the greater of the Employee's actual number of hours worked, or 40 hours per week, times the hourly contribution rate that is being paid by Employers on behalf of Active Employees.

The enrollment date for Fund Employees and Union Employees is the first day of employment, and the waiting period runs from the first day of employment through the last day of the first full calendar month of employment, and coverage is effective the first day of the month following the first full calendar month of employment.

1. Initial Eligibility

A Fund Employee or Union Employee shall initially become eligible to participate in the Plan as of the first day of the calendar month following his completion of one full calendar month of full-time employment.

2. Continuation of Eligibility

Once having established eligibility to participate, a Fund Employee or Union Employee must meet the same requirements for continuing eligibility that an Active Employee must meet.

3. Reinstatement of Eligibility

A former Fund Employee or Union Employee who is rehired may have his coverage reinstated as of the first day of the calendar month following completion of one full calendar month of full-time reemployment.

D. Eligibility Under The Family And Medical Leave Act

Pursuant to the requirements of the Family and Medical Leave Act of 1993 (FMLA), eligibility for Benefits shall be extended to Covered Employees and their Dependents if the Covered Employee has been granted paid or unpaid leave by

his/her Employer pursuant to the FMLA and if the Employer makes the required contributions to the Fund.

If a Covered Employee has been granted FMLA leave, the Employer shall notify the Fund Office at least 14 days before the onset of the leave, except in an emergency, and then no later than 7 days after the leave begins, to prevent a loss of eligibility. The Fund Office shall obtain a certificate of the Covered Employee's eligibility from the Employer. The Employer shall advise the Fund Office of the beginning date and ending date of the leave. The Employer shall notify the Fund Office of the date a Covered Employee advises the Employer that he/she does not intend to return to work.

The Employer will be required to pay the cost of continuing coverage in an amount equal to contributions the Covered Employee would have worked if not on FMLA leave for each week the Covered Employee is on FMLA leave. The Employer shall remit payment monthly, in arrears, upon billing by the Fund Office.

Eligibility will not be extended during the FMLA leave if the Employer does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if the Employer does not make timely contributions and a loss of eligibility will result.

If you have any questions regarding the FMLA, please contact the Fund Office.

E. Eligibility For Active Disabled Employees

A Disabled Employee shall be eligible to participate if he makes self-contributions to the Fund, on a monthly basis, in an amount determined by the Trustees, provided that he has been eligible for Benefits as an Active Employee for at least one month in the 12-month period immediately preceding his date of Disability Benefit commencement.

1. Initial Eligibility

A Disabled Employee who has commenced benefits from the Operating Engineers Local 101 Pension Fund must elect to make contributions, on a form prescribed by the Trustees, within 30 days after the later of: (a) the effective date of his Disability benefit commencement date, or (b) the date on which his eligibility to this Plan earned from Employer Contributions lapses.

2. Continuation of Eligibility as a Disabled Person

Once having established eligibility to participate in the Fund through self-contributions as a Disabled Employee, a Disabled Employee shall maintain eligibility until the last day of the calendar month in which he has made his last self-contribution, or until his eligibility as a Disabled Employee terminates or is withdrawn.

F. Eligibility for Retired Participants
An individual who qualifies as a Retired Participant, as that term is defined in Section Seventeen of this Plan Document, may participate in the Plan subject to the following eligibility requirements:

1. Annuity Starting Date prior to May 1, 1997
If the individual's initial annuity starting date under the Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund was prior to May 1, 1997, he shall be eligible to participate in the Plan if he makes self-contributions to the Fund, on a monthly basis, in an amount established from time to time by the Trustees, provided that he had been eligible for benefits as an Active Employee for at least one (1) month in the twenty-four (24) month period preceding his initial annuity starting date.

2. Annuity Starting Date on or after May 1, 1997 and before January 1, 2005
If the individual's initial annuity starting date under the Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund was on or after May 1, 1997, but before January 1, 2005, he shall be eligible to participate in the Plan if he makes self-contributions to the Fund, on a monthly basis, in an amount established from time to time by the Trustees, provided he had at least 500 Credited Hours in Covered Employment in at least three (3) of the five (5) years immediately preceding his initial annuity starting date.

3. Annuity Starting Date on or after January 1, 2005 and before January 1, 2011
If the individual's initial annuity starting date under the Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund was on or after January 1, 2005, but before January 1, 2011, he shall be eligible to participate in the Plan if he makes self-contributions to the Fund, on a monthly basis, in an amount established from time to time by the Trustees, provided that:

    - in the case of an Active Employee, he had at least one hundred (100) Credited Hours in Covered Employment in at least one (1) of the twelve (12) months immediately preceding his initial annuity starting date; and, further provided that he also had earned at least five (5) "service years" in Covered Employment in the seven (7) years immediately preceding his initial annuity starting date;

    - in the case of an Active Disabled Employee, he had at least one hundred (100) Credited Hours in Covered Employment in at least one (1) of the twelve (12) months immediately preceding the

effective date of his Disability Benefit commencement; and, further provided that he also had earned at least five (5) "service years" in Covered Employment in the seven (7) years immediately preceding the effective date of his Disability Benefit commencement.

4. Annuity Starting Date on or after January 1, 2011
   If the individual's initial annuity starting date under the Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund is on or after January 1, 2011, he shall be eligible to participate in the Plan if he makes self-contributions to the Fund, on a monthly basis, in an amount established from time to time by the Trustees, provided (a) he had at least 30 Years of Service under either Pension Fund or at least 100 Credited Hours in Covered Employment in at least one of the 12 months immediately preceding his initial annuity starting date; and, (b) further provided that he also had earned five "service years" of Covered Employment in the seven years immediately preceding his initial annuity starting date.

   For the purposes of subsection F only, a Participant earns one "service year" if the Plan receives at least 1,200 hours of Employer Contributions from work in Covered Employment during a Plan Year. Service years, based on the number of hours of Employer Contributions actually made on behalf of the Participant, may be earned as follows:

   0 to 299 hours = 0 service year;
   300 to 599 hours = ¼ service year;
   600 to 899 hours = ½ service year;
   900 to 1,199 hours = ¾ service year;
   1,200 to 1,999 hours = 1 service year; and
   2,000 or more hours = 1.5 service years.

   However, no service years shall be earned for hours in Covered Employment for which Employer Contributions are not received by the Plan.

   Former I.U.O.E. Local 16 Participants shall receive similar credit based upon employer contributions received by the Construction Laborers Health and Welfare Fund (Jefferson City) or from pension contribution records at the I.U.O.E. Central Pension Fund. No other current Participants, other than former Local 16 Participants, shall receive any credit towards the service year requirements of this Section.

5. Benefit Subsidy Formula. The Trustees shall from time to time set the unsubsidized premium for the Retired Participant Program, and shall from time to time establish a minimum premium. Retired Participants that

otherwise meet the eligibility requirements shall earn a premium reduction as a subsidy credit in the amount of two and one-half percent (2.5%) for each full service year earned in accordance with the crediting formula under subsection F.4. The maximum number of service years for earning a subsidy is thirty (30) years, and the maximum subsidy is seventy-five percent (75%). Any service years that would have been subject to forfeiture under the I.U.O.E. Local 101 Pension Plan rules, shall not be counted towards the premium subsidy. Under no circumstances shall the premium subsidy reduce the monthly premium below the minimum premium established by the Trustees. The premium subsidy for an eligible spouse shall be equal to that of the Participant spouse.

6. Initial Eligibility. An I.U.O.E. Local 101 Retired Participant who has commenced benefits with Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund must elect on a form prescribed by the Trustees to make self-contributions within thirty (30) days after the effective date of his retirement. Failure to make a timely election will bar participation in the Plan as a Retired Participant, subject to the right to re-elect set forth in subsection F.7 below.

7. Return to Employment. Eligibility for coverage as a Retired Participant shall be subject to immediate and permanent termination if the Retired Participant interrupts his retirement by performing disqualifying employment. For purposes of this subsection F.7, disqualifying employment shall mean: (a) working 40 or more hours in one month in any capacity, including employment as a supervisor, for an employer engaged in the building or construction industry; or (b) in the case of a former employee of Operating Engineers Local 101 Fringe Benefit Funds or Operating Engineers Local Union No. 101, working 40 or more hours in one month performing labor services that are similar in nature to those previously performed for the Funds or the Union. This rule applies regardless of whether the post-retirement employment is with a union or nonunion employer and regardless of the geographical jurisdiction in which the employment occurs.

   If a Retired Participant fails to notify the Plan about his return to employment and the Plan has reason to believe the Retired Participant may be working, the Presumption Rule applies. The Presumption Rule provides that until such time as the Retired Participant proves otherwise, the Plan may presume that he is engaged in employment that meets the conditions for termination of benefits, and the Retired Participant shall have the burden of overcoming such presumption. Consequently, benefits will be immediately terminated however, they shall be reinstated in the event the Retired Participant successfully demonstrates that at no time was he engaged in employment meeting the conditions for termination of benefits. If it is determined that benefits for certain months should not have been terminated, benefits for those months will be paid as soon as practicable after coverage is reinstated.

Notwithstanding any other provision in this section to the contrary, where a Retired Participant voluntarily and affirmatively elects to suspend his retirement benefits with the Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund to return to disqualifying employment (as defined in this subsection F.7), his eligibility for coverage as a Retired Participant shall be subject to immediate suspension but not termination.

8. Termination of Eligibility. A Retired Participant, or eligible spouse, shall lose eligibility under this Plan if the Plan is terminated by the Trustees, or for failure to timely pay a monthly premium, and at the end of the month the Covered Person attains age 65, and conditioned upon the continuation of prevailing premium payments shall be transitioned to the Medicare Supplement Plan effective on the first of the month after the month of attaining age 65 whether or not enrollment in Medicare is completed.

G. Eligibility For Retired Medicare Supplement Plan

A Medicare-eligible Retired Participant may participate in the Plan subject to the following eligibility requirements:

1. Annuity Starting Date prior to January 1, 2005
An I.U.O.E. Local 101 Retired Participant with an initial annuity starting date prior to January 1, 2005 who has commenced benefits with Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund, or who transitioned to the Plan as a Retired Participant, must elect on a form prescribed by the Trustees to make self-contributions within thirty (30) days after the effective date of his retirement. Failure to make a timely election will bar participation in the Plan as a Retired Participant, subject to the right to re-elect set forth in Paragraph 7 below.

2. Annuity Starting Date on or after January 1, 2005 and before January 1, 2011
A Retired Participant with an initial annuity starting date on, or after, January 1, 2005 from the Operating Engineers Local 101 Pension Fund, or the I.U.O.E. Central Pension Fund, or a Retired Participant that transitions from the Retired Plan, or an inactive Participant receiving a disability benefit under the Operating Engineers Local 101 Pension Plan that transitions to the Medicare Supplement Plan from the Retired Plan without a one-day break in coverage, shall be eligible to participate in the Medicare Supplement Plan if he makes self-contributions to the Fund, on a monthly basis, in an amount determined by the benefit subsidy formula provided he had at least one hundred (100) Credited Hours in Covered Employment in at least one (1) of the twelve (12) months immediately preceding his initial retirement from the Operating Engineers Local 101 Pension Plan or the I.U.O.E. Central Pension Fund; and, further he must also have earned five (5) Health and Welfare Plan "service

years" in Covered Employment in the seven (7), or less, years immediately preceding his initial annuity starting date with the Operating Engineers Local 101 Pension Plan or the I.U.O.E. Central Pension Fund, or is a Retired Participant in the Plan on his Medicare eligibility date. Failure to make a timely election to participate will bar participation in the Medicare Supplement Plan except as provided in Paragraph 7 below.

3. Annuity Starting Date on or after January 1, 2011

   If the individual's initial annuity starting date under the Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund is on or after January 1, 2011, he shall be eligible to participate in the Medicare Supplement Plan if he makes self-contributions to the Fund, on a monthly basis, in an amount determined by the benefit subsidy formula provided (a) he had at least 30 Years of Service under either Pension Fund or at least 100 Credited Hours in Covered Employment in at least one of the 12 months immediately preceding his initial annuity starting date; and, (b) further provided that he also had earned five "service years" of Covered Employment in the seven years immediately preceding his initial annuity starting date.

   For the purposes of subsection G only, a Participant earns one "service year" if the Plan receives at least 1,200 hours of Employer Contributions from work in Covered Employment during a Plan Year. Service years, based on the number of hours of Employer Contributions actually made on behalf of the Participant, may be earned as follows:

   0 to 299 hours = 0 service year;
   300 to 599 hours = ¼ service year;
   600 to 899 hours = ½ service year;
   900 to 1,199 hours = ¾ service year;
   1,200 to 1,999 hours = 1 service year; and
   2,000 or more hours = 1.5 service years.

   However, no service years shall be earned for hours in Covered Employment for which Employer Contributions are not received by the Plan.

   Former I.U.O.E. Local 16 Participants shall receive similar credit based upon employer contributions received by the Construction Laborers Health and Welfare Fund (Jefferson City) or from pension contribution records at the I.U.O.E. Central Pension Fund. No other current Participants, other than former Local 16 Participants, shall receive any credit towards the service year requirements of this Section.

4. Initial Eligibility Period

   The Initial Eligibility Period is the initial annuity starting date for Medicare-eligible Retired Participants, or the first of the month following the month a

Retired Participant becomes eligible for Medicare enrollment whether or not the Participant actually enrolls in Medicare.

5. Schedule of Benefits

The Benefits provided under the Medicare Supplement Plan shall be the same as Benefits provided under the Retired Participant Plan, and the Plan shall reimburse for Covered Charges to a maximum Benefit of twenty percent (20%) of the Covered Charge for covered Benefits. Medical procedures and supplies that are covered by Medicare but are not a covered Benefit under this Plan shall not be subject to Coordination of Benefits and payment by the Plan.

When applicable, the Plan will deem a Covered Person to be covered by Medicare for the purposes of determining how much this Plan will pay if the Covered Person could be enrolled in Medicare but is not. The Plan will estimate what Medicare would have paid as his primary carrier and will coordinate Plan Benefits on a secondary basis on the estimated Medicare reimbursement amount.

The preceding two paragraphs shall not apply to Prescription Drug Benefits. A Covered Person shall receive Prescription Drug Benefits from either this Plan or a Medicare Prescription Drug Program, but not both. This Plan will not take into consideration any benefits that could have been paid under a Medicare Prescription Drug Program for a Covered Person who is not enrolled in any Medicare Prescription Drug Program. A Covered Person who chooses to enroll in a Medicare Prescription Drug Program, and who is covered under this Plan as a Retiree or an Eligible Dependent of a Retiree, shall not be eligible to receive any Prescription Drug Benefits under this Plan. The premium required for any Retiree or Eligible Dependent who is not eligible for Prescription Drug Benefits under this Plan shall be adjusted by an amount determined by the Trustees. Before any Prescription Drug Benefits will be provided for any calendar year, each Retiree and Eligible Dependent must certify to the Trustees whether or not such person is enrolled in a Medicare Prescription Drug Program. Failure to provide such certification will permit the Trustees to presume that the Covered Person is enrolled in a Medicare Prescription Drug Program and is therefore ineligible for Prescription Drug Benefits under this Plan. That presumption may be overcome, and Benefits may be provided retroactively, by submission of a notarized statement, or other proof acceptable to the Trustees, that the Covered Person has not enrolled in any Medicare Prescription Drug Program for the applicable coverage period.

6. Premium Subsidy Service Credits

For the purposes of this Section only, a Participant earns one (1) “service year” if the Plan receives at least one thousand two hundred (1,200) hours of Employer Contributions from work in Covered Employment during a Plan Year. Service years, based on the number of hours of Employer Contributions actually made on behalf of the Participant, may be earned as follows:

0 to 299 hours = 0 service year;
300 to 599 hours = ¼ service year;
600 to 899 hours = ½ service year;
900 to 1,199 hours = ¾ service year;
1,200 to 1,999 hours = 1 service year; and
2,000 or more hours = 1.50 service years.

However, no service years shall be earned for hours worked in Covered Employment for which Employer Contributions are not received by the Plan.

Former I.U.O.E. Local 16 Participants shall receive similar credit based upon employer contributions received by the Construction Laborers Health and Welfare Fund (Jefferson City) or from pension contribution records at the IUOE Central Pension Fund. No other current Participants, other than former Local 16 Participants, shall receive any credit towards the service year requirements of this Section.

7. Benefit Subsidy Formula
The Trustees shall from time to time set the unsubsidized premium for the Medicare Supplement Plan, and shall from time to time establish a minimum premium. Retired Participants that otherwise meet the eligibility requirements shall earn a premium reduction as a subsidy credit in the amount of two and one-half percent (2.5%) for each full service year earned in accordance with the crediting formula under Paragraph 5. The maximum number of service years for earning a subsidy is thirty (30) years, and the maximum subsidy is seventy-five percent (75%). Any service years that would have been subject to forfeiture under the I.U.O.E. Local 101 Pension Plan rules, shall not be counted towards the premium subsidy. Under no circumstances shall the premium subsidy reduce the monthly premium below the minimum premium established by the Trustees. The premium subsidy for an eligible Spouse shall be equal to that of the Participant's subsidy.

8. Return to Employment
Eligibility for coverage as a Retired Participant under the Medicare Supplement Plan shall be subject to immediate and permanent termination if the Retired Participant interrupts his retirement by performing disqualifying employment. For the purposes of this Subsection 7, disqualifying employment shall mean: (a) working 40 or more hours in one month in any capacity, including employment as a supervisory, for an employer engaged in the building or construction industry; or (b) in the case of a former employee of Operating Engineers Local 101 Fringe Benefit Funds or Operating Engineers Local Union No. 101, working 40 or more hours in one month performing labor services that are similar in nature to those previously performed for the Funds or the Union. This rule applies regardless of whether the post-

retirement employment is with a union or nonunion employer and regardless of the geographical jurisdiction in which the employment occurs.

If a Retired Participant in the Medicare Supplement Plan fails to notify the Plan about his return to work and the Plan has reason to believe the Retired Participant may be working, the Presumption Rule applies. The Presumption Rule provides that until such time as the Retired Participant proves otherwise, the Plan may presume that he is engaged in employment that meets the conditions for termination of Benefits, and the Retired Participant shall have the burden of overcoming such presumption. Consequently, Benefits will be immediately terminated, however, they shall be reinstated in the event the Retired Participant successfully demonstrates that at no time was he engaged in employment meeting the conditions for termination of benefits. If it is determined that Benefits for certain months should not have been terminated, Benefits for those months will be paid as soon as practicable after coverage is reinstated.

Notwithstanding any other provision in this section to the contrary, where a Retired Participant voluntarily and affirmatively elects to suspend his retirement benefits with the Operating Engineers Local 101 Pension Fund or the I.U.O.E. Central Pension Fund to return to disqualifying employment (as defined in this Subsection 7), his eligibility for coverage as a Retired Participant shall be subject to immediate suspension but not termination.

9. Termination of Eligibility
A Medicare Supplement Plan Participant shall lose eligibility under this Plan for failure to timely pay a monthly premium, or upon termination of the Plan by the Trustees.

H. Eligibility For Dependent Coverage
Benefits for Dependents will become effective on the **latest** of the following dates:

1. The date the eligible Employee's Benefits become effective,

2. The date the eligible Employee or Retiree acquires a Dependent,

3. The date specified in a Qualified Medical Child Support Order.

If an eligible Employee acquires a Dependent while eligible for Benefits, the Employee should notify the Fund Office as soon as possible. The Dependent shall automatically become covered effective on the date of birth, adoption, placement for adoption, or marriage, as applicable. If a Retiree acquires a new Dependent, the Retiree must notify the Fund Office within 60 days of acquiring a Dependent and pay Dependent premiums for coverage; only then will such Dependent become covered. A new Dependent of a Retiree becomes eligible on the date of birth, adoption, placement for adoption, or on the first day of the month following the

Retiree's notice to the Fund Office, if the Dependent acquired Dependent status as a result of marriage (a new Spouse or step-child).

I. Termination Of Eligibility For Eligible Employees – General Provisions
Eligibility will terminate on any date that:

1. The Employee fails to satisfy the requirements set forth under the Continuation of Eligibility as explained in Section Two A.2. on page 19,

2. The Employee fails to elect COBRA Continuation Coverage,

3. The Employee fails to make a required self-payment, or

4. The Employee dies.

5. See Subsection J., below, for special termination rules that apply due to work in non-bargaining employment.

J. Termination Of Eligibility For Eligible Employees – Due To Work in Non-Bargaining Employment
Notwithstanding any provision or eligibility rule to the contrary, an Employee employed in the type of work within the jurisdiction of the Union by an employer having no obligation to contribute to the Plan shall be immediately ineligible for Employee and Dependent coverage under the Plan. The loss of coverage for the Employee and Dependent(s) will be effective as of the first of the month following the month during which the work for the non-contributing employer was first performed. The Plan will not retroactively rescind coverage under the Plan once an Employee is covered under the Plan unless the Trustees determine that the Employee has performed an act, practice or omission that constitutes fraud, or unless the Employee has made an intentional misrepresentation of material fact. In the event of fraud or an intentional misrepresentation of material fact, the Plan will provide thirty (30) days' advanced written notice to the Employee and any of that Employee's Dependent(s) who will be affected by a rescission. The loss of coverage will continue until the Employee discontinues employment with a non-contributing employer and thereafter meets the Initial eligibility rules of the Plan. The Employee and Dependents shall not be entitled to use the hour bank or to make self-payments (other than under COBRA Continuation Coverage or as required by applicable law). No Benefits will be payable as of the date of the loss of coverage regardless of any pre-certification or the initiation of provider services prior to such date. The Employee and/or Dependent(s) will be responsible and liable for the reimbursement to the Plan of any Benefits paid by the Plan on or after the date of the loss of coverage. In the event the Employee can demonstrate to the satisfaction of the Board of Trustees he or she could not have been aware the employment would result in his or her ineligibility and such employment has been or will be immediately discontinued, the Employee and Dependent(s) will not incur a loss of coverage.

K. Termination Of Eligibility For Dependents

The eligibility for Benefits for Dependents will terminate upon the occurrence of the first of the following:

1. The individual fails to satisfy the definition of Dependent as defined in Section Seventeen, number 16,

2. The individual fails to elect COBRA Continuation Coverage,

3. The individual fails to make a required self-payment.

4. In the case of an Eligible Spouse of a Retiree, the Eligible Spouse opts out of the retiree plan or fails to make a required self-payment.

Upon the death of an eligible Employee, the eligibility of that Employee’s Dependents shall be extended to the end of the eligibility period based upon the deceased eligible Employee’s accrued hours. Thereafter, the eligibility for Benefits will be governed by the COBRA Continuation Coverage provisions.

A Dependent’s coverage terminates when the Participant’s coverage terminates, or if earlier, the date the Dependent ceases to be a Dependent. Accordingly, when an eligible Active Employee dies, the eligibility of his Dependents for Benefits from the Fund shall cease as of the last day of the calendar month in which the Employee's eligibility would have lapsed had he left Covered Employment. Eligibility for any such months of extended coverage for the surviving Dependents of a deceased Active Employee shall be determined on the basis of the Employee's previously accumulated Credited Hours derived from Employer Contributions.

This exception does not apply to Owner-Operators or other similarly situated Participants that have no bank of Credited Hours for extended eligibility.

Notwithstanding other Plan provisions to the contrary regarding termination of Dependent Eligibility, the eligible surviving Spouse of a Retired Participant that was enrolled in the Retiree Health Plan while the Retired Participant was receiving eligible pension benefits may continue in the Retiree Health Plan after the Retired Participant’s death with payment of the prevailing self-contribution premium as set from time to time by the Trustees.

L. COBRA Continuation Coverage

Federal law requires that sponsors of group health plans such as the Operating Engineers Local 101 Health & Welfare Fund offer Covered Employees and their families a temporary extension of their health care coverage under the Plan, (called “COBRA Continuation Coverage”) in exchange for self-contribution payments to the Plan if they would otherwise lose coverage.

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage under this Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

1. What is COBRA Continuation Coverage?

   COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

   The Plan is required to offer COBRA Continuation Coverage which is identical to the health coverage that is provided under the Plan to similarly situated Employees, Retired Employees, and their Dependents. It does not include ancillary benefits, such as life insurance, Death Benefit, Accidental Death and Dismemberment, or Loss of Time (weekly disability income). Employee group term life insurance with a principal sum of $15,000 is available as an option for an additional premium.

   If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

   - Your hours of employment are reduced, or
   - Your employment ends for any reason other than your gross misconduct.

   If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

   - Your spouse dies;
   - Your spouse's hours of employment are reduced;
   - Your spouse's employment ends for any reason other than his or her gross misconduct;
   - Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
   - You become divorced or legally separated from your spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent."

2. <u>When is COBRA Continuation Coverage Available?</u>
The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator determines or has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator shall determine whether a qualifying event has occurred. The Plan Administrator will provide you with notice of your right to elect COBRA Continuation Coverage within 30 days after making a determination of your eligibility for COBRA Continuation Coverage.

3. <u>You Must Give Notice of Some Qualifying Events</u>
For the other qualifying events (<u>divorce</u> or <u>legal separation</u> of the Employee and Spouse or a <u>Dependent Child's losing eligibility for coverage</u> as a Dependent Child), you must notify the Plan Administrator <u>within 60 days</u> after the qualified beneficiary would lose coverage due to the qualifying event. You must provide this notice in writing to: Plan Administrator, Operating Engineers Local 101 Health & Welfare Plan, 6601 Winchester, Suite 250, Kansas City, MO 64133. The Plan has forms available that you may use to provide the required notice.

4. <u>How is COBRA Continuation Coverage Provided?</u>
Once the Plan Administrator determines or receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children. A qualified beneficiary will have up to 45 days after electing COBRA Continuation Coverage to make the first COBRA premium payment.

Thereafter, all premium payments must be made by the first day of the month for which coverage is being provided.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee’s hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended. These are an extension due to a disability (discussed in paragraph 5, below) or a second qualifying event (discussed in paragraph 6, below).

5. <u>Disability extension of 18-month period of continuation coverage</u>

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of continuation coverage. In order to get the 11-month disability extension, you must provide a copy of your notice from the Social Security Administration granting disability benefits. This notice must be provided to the Plan Administrator no later than 30 days after you receive the notice, or by the 60th day of your COBRA Continuation Coverage, whichever is later. COBRA premiums for the 11-month extension will be 150% of the prevailing non-disability COBRA premium.

6. <u>Second qualifying event extension of 18-month period of continuation coverage</u>

If your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent Children in

your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

7. Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will be terminated for any of the following reasons:

- Failure to make timely payment of monthly premiums on time and postmarked within the grace period prescribed by law.

- Completion of the 18, 29 or 36 month COBRA continuation period, as applicable.

- The date when the individual first becomes, after the date of election of COBRA Continuation Coverage, covered under any other group health plan as an Employee or otherwise except if the new group health plan has a pre-existing condition restriction that limits full benefits, COBRA Continuation Coverage shall extend until the earlier of when the restriction ceases to apply or COBRA Continuation Coverage is terminated for any other reason.

- The date the individual first becomes, after the date of election of COBRA Continuation Coverage, entitled to Medicare benefits.

- The date the Plan no longer provides Health Care Benefits.

8. General Information

If the address of a Spouse, former spouse or other adult dependent is different from that of the Employee, it is the responsibility of the Employee, Spouse, or adult dependent to provide the Fund Office with current address information.

Once COBRA eligibility has been established, premiums are to be mailed monthly, and premiums are due **prior to the first day of the month of coverage**, but will be considered timely if postmarked within the grace period prescribed by law. Regardless of any delay in enrollment and remittance of the initial payment, **the first payment must include all coverage months commencing with the first day of COBRA eligibility**.

Premium payments that are deficient by the lesser of $50 or ten percent (10%) of the assessed premium will be considered full payments if the Plan fails to provide notice of the deficiency in a timely manner, or if the deficiency is paid in full within 30 days following notice of the premium deficiency. Receipt date will be the postmarked date of the deficiency remittance. Once interrupted for failure to timely remit premiums, COBRA eligibility shall not be reinstated for the enabling qualifying event. Participants should contact the Plan Administrator for additional information regarding COBRA Continuation Coverage.

9. <u>If You Have Questions</u>
Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.ebsa.gov.)

10. <u>Keep Your Plan Informed of Address Changes</u>
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

11. <u>Plan Contact Information</u>

David Barry, Plan Administrator
Operating Engineers Local 101 Health & Welfare Plan
6601 Winchester, Suite 250
Kansas City, MO 64133
(816) 737-5959

12. <u>COBRA Continuation Coverage Procedures</u>

a. Initial (General) COBRA Notice

i. The general notice required by 29 C.F.R. § 2590.606-1 will be provided as part of the SPD. An SPD will be mailed to the home address of each new participant within 90 days after coverage begins.

ii. If the participant adds a Spouse to coverage later (such as by getting married after he already has coverage), a separate SPD will need to be provided to the new Spouse. If a Spouse or Dependent Child lives at a

different address from the participant, the SPD and the general notice will need to be mailed to them at the separate address.

iii. If the SPD is provided to new participants in any other fashion, a stand-alone initial COBRA notice will be mailed to the home of each new participant within 90 days after coverage begins, and it will be addressed to the Participant and Spouse.

b. Employer Qualifying Event Notice
Under this Plan, employers will not be required to provide notice of qualifying events to the Plan Administrator. The Plan Document provides that the Plan Administrator shall determine whether a qualifying event has occurred due to the Employee's termination of employment or reduction in hours of employment, the Employee's death, or the Employee's becoming entitled to Medicare. In order to make such determinations, the Plan Administrator shall use Plan records to determine loss of eligibility due to termination of employment or reduction in employment hours, and shall rely on timely notice from the Participant of other Qualifying Events.

c. Employee Qualifying Event Notice

i. An Employee must give written notice to the Plan Administrator within 60 days after a qualifying event that is a divorce or legal separation of the Employee (or Retired Participant) and Spouse or a Dependent Child's ceasing to meet the Plan requirements for Dependent.

ii. The Plan has a standard form which participants may use to provide such notice. Use of the standard form is not required.

d. COBRA Election Notice

i. The Plan has adopted a standard form for the Plan Administrator to use to furnish notice of a qualified beneficiary's eligibility for COBRA Continuation Coverage.

ii. The notice must be sent to each qualified beneficiary within 14 days after receipt of notice from an Employee of a qualifying event that is a divorce or legal separation or a Child's ceasing to qualify as an eligible under the terms of the Plan.

iii. When a qualifying event occurs that is the Employee's termination of employment, reduction of hours, death, or becoming entitled to Medicare, the notice will be sent to each qualified beneficiary within 44 days after the earlier of:

- the date on which the participant or beneficiary would lose coverage due to a qualifying event, or

- the date of the qualifying event (if coverage is to terminate immediately as of the qualifying event instead of at the end of the coverage period in which the qualifying event occurs).

e. Unavailability of COBRA Notice

   i. When the Plan Administrator receives a notice from an Employee or Beneficiary relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a Covered Employee, qualified beneficiary, or other individual, and the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator shall provide a notice to the person sending the notice explaining why the individual is not entitled to COBRA Continuation Coverage.

   ii. The unavailability notice shall be sent within 14 days from receipt of the notice from the Employee or other individual.

f. Termination of COBRA Continuation Coverage Notice

   i. Whenever COBRA Continuation Coverage is terminated prior to the latest date shown on the Election Notice, notice must be sent to all affected qualified beneficiaries explaining the reason for the termination, the date of termination, and any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

   ii. The termination notice will be provided as soon as practicable following the administrator's determination that continuation coverage shall terminate.

M. Service In The Armed Forces

Each Covered Employee, whose eligibility terminates because of entrance into active duty with the Armed Forces of the United States and who returns to active work with a contributing Employer within the time periods described in Subsection N.5. below shall become eligible under this Plan on the date of commencement of such active work, subject to USERRA, as explained in Section N, below.

If a Covered Employee's eligibility terminates because of entry into active duty with the Armed Forces of the United States, any Benefits hereunder with respect to any Dependent of such Employee on the date of such termination shall be continued in force while such Dependent continues to be a Dependent but not beyond the end of the eligibility quarter, subject to USERRA, as explained in Section N, below.

N. Uniformed Services Employment And Reemployment Rights Act (USERRA)

If a Covered Employee leaves Covered Employment for a period of "Uniformed Service", as defined below, special rules apply:

1. Effective Date

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994 to protect the eligibility of Employees and to offer contribution coverage to an Employee and the Employee's Dependents after the Employee enters into Military Service.

2. Return to Work Coverage Guaranteed

USERRA requires an Employer, or a multi-employer health care plan, to protect any health care Benefits an Employee has already earned up to the time an Employee enters Military Service if the Employee re-applies for work within prescribed time periods after an honorable discharge.

The Employee's eligibility status must be "frozen" when the Employee enters Military Service and must be fully restored when the Employee re-applies for work with the same Employer or, in the case of a multi-employer plan, with any Employer who is signatory to the Collective Bargaining Agreement.

When an Employee returns from Military Service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered Military Service.

3. Continuation of Coverage While in the Military

Coverage of the Covered Employee and his Dependents will terminate at the end of the month in which the Covered Employee's period of Uniformed Service begins. However, the Covered Employee may continue coverage for himself and his Dependents for up to 24 months. The Covered Employee may be required to pay up to 102% of the cost of continued coverage, for coverage in excess of 31 days. Coverage will automatically be continued throughout the period of service if the period of Uniformed Service does not exceed 31 days. No self-payment will be required in this case.

USERRA requires a group health care plan to offer identical health care coverage **up to 24 months** to persons who have coverage in connection with their employment but who are absent from such employment due to Military Service.

THE EMPLOYEE MUST NOTIFY THE FUND OFFICE IMMEDIATELY WHEN THE EMPLOYEE KNOWS HE/SHE IS ENTERING MILITARY SERVICE.

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months still begins with the initial date of entry into Military Service and a retroactive payment to that date may be charged. The Employee has an obligation to notify the Fund Office, as soon as the Employee knows he/she is entering Military Service **if the Employee wishes to take advantage of USERRA continuation coverage. Failure to notify the Fund Office may be taken as an indication that the Employee does not wish to purchase USERRA coverage for the Employee or the Employee's Dependents.**

4. Reinstatement of Coverage

If the Participant does not elect to continue coverage, or the continuation coverage terminates, upon his return to Covered Employment:

a. Any Credited Hours available to the Participant when his period of Uniformed Service began will be made available to the Participant upon his return to Covered Employment, provided he returns within 90 days after the Uniformed Service ends (this period may be extended to up to two years in certain cases); and

b. Neither the Participant nor his Dependents will be subject to any waiting period or coverage restriction under the Plan upon the Participant's return to Covered Employment (except that the Plan may impose coverage restrictions on Benefits for service-connected injuries or Sicknesses).

5. Re-employment Requirements when Returning from Military Service

The application period for re-employment is based on a time schedule keyed to the length of time spent in Military Service.

Military Service Less than 31 Days

For Military Service of less than 31 days, a Service member must apply for re-employment with a signatory Employer at the beginning of the next regularly scheduled work period on the first day after release from Service, taking into account safe transportation plus an eight-hour rest period.

Military Service More than 31 Days but Less than 181 Days

For Military Service of 31 days or more but less than 181 days, an application for re-employment must be filed within 14 calendar days (not work days) after the Service member's release from the Service.

Military Service Over 181 Days

For Military Service over 181 days, an application for re-employment must be submitted within 90 calendar days (not work days) after an honorable discharge.

6. Definitions

"Health Coverage" means Hospital, surgical, medical or dental coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modification.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to USERRA and any interpretive regulations or rulings).

“Covered Person” means a Covered Employee or Dependent as defined in Section Seventeen of this Plan.

“Service in the Uniformed Services” or “Military Service” means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

“Uniformed Services” means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

7. Continuation of Group Health Coverage

If Health Coverage ends because of Service in the Uniformed Services, a Covered Person may elect to continue such Health Coverage, if required by USERRA, until the **earlier** of:

a. The end of the period during which the Covered Employee is eligible to apply for reemployment in accordance with USERRA, or

b. 24 consecutive months after coverage ended.

To continue coverage, a Covered Person must pay the required premium, unless Service in the Uniformed Service is for fewer than 31 days. The Fund Office shall inform the Covered Person of the procedures to pay premiums. The USERRA premium shall be equal to the COBRA premium.

8. Health Coverage under USERRA Termination

A Covered Person’s continued Health Coverage under USERRA will end immediately after 11:59:59 pm on the **earliest** of:

a. The day the Plan is terminated,

b. The day a premium is due and unpaid,

c. The day the Covered Person again becomes covered under the Plan, or

d. The day the Health Coverage has been continued for the maximum period of time provided above (or any longer period provided in the Plan).

9. Conflict Resolution
In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply.

O. Qualified Medical Child Support Orders (QMCSOs)
A Qualified Medical Child Support Order (QMCSO) is a court order that requires an Employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. This Plan provides Benefits according to the requirements of the QMCSO. The Administrative Manager will notify affected Participants and alternate recipients if a QMCSO is received. For a complete explanation and free copy of the Plan's QMCSO procedures, you may contact the Fund Office.

P. Fraud or Intentional Misrepresentation of Material Fact
Notwithstanding any of the provisions of this Section Two to the contrary, the Plan will not retroactively rescind coverage under the Plan once a Participant, Retired Participant, or Beneficiary is covered under the Plan unless the Trustees determine, in their sole and absolute discretion, that the Participant, Retired Participant, or Beneficiary either intended to defraud the Plan or made an intentional misrepresentation of a material fact to the Plan. Intent to defraud may include an act, practice, or omission that constitutes fraud where the Participant, Retired Participant, or Beneficiary intended the resulting fraud. Intent to defraud may also include the deliberate concealment of a material fact from the Plan.

In the event of fraud or an intentional misrepresentation of material fact, the Plan will provide thirty (30) days advanced written notice to the Participant, Retired Participant, or Beneficiary and any of that Participant or Retired Participant, or Beneficiary's Dependent(s) who will be affected by a rescission. Failure to timely pay required premiums or contributions towards the cost of coverage may result in retroactive termination of coverage.

Section Three – Life Events at a Glance

There are several significant events that may occur while you are covered under the Plan. Please contact the Fund Office, in writing, if any of the following occurs:

- **YOUR ADDRESS OR YOUR DEPENDENT'S ADDRESS CHANGES.**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, divorce decree, custody agreement).
- **THE STATUS OF A DEPENDENT CHANGES.**
- **YOU BECOME A PARENT.** You must also submit the Child's state-certified birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- **YOU OR YOUR DEPENDENT BECOMES ELIGIBLE FOR MEDICARE.**
- **YOU OR YOUR DEPENDENT ACQUIRES OTHER MEDICAL OR DENTAL INSURANCE**
- **YOU RETIRE.**

Section Four – Medical Benefits

The Benefits listed in the table below are described in this Section. This table is only intended to give you a brief summary of Benefits available. Please refer to the description of Benefits that begins on page 49 immediately after the table to fully understand the Benefit and any specific maximums or limitations.

There are separate sections that describe the Plan's Prescription Drug Benefit, Dental Benefit, Vision, Hearing Benefit and Life or Loss of Time Benefit.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED PERSONS. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

Calendar Year Maximum **$200,000**

Calendar Year Deductible (per person) **$300**

Payment Levels

Preferred Payment Level

After satisfying the Deductible, the Preferred Payment Level pays:

80% of the next $4,000 of Covered Charges, then
95% up to $75,000 of Covered Charges, and then
100% up to any Calendar Year Maximum that applies.

Example: Mike is a Covered Person who has met his Deductible for the calendar year, but has his entire Calendar Year Maximum available to him. He incurs $50,000 in covered expenses for hospitalization in a PPO Hospital. His covered expenses are payable at the Preferred Payment Level. The Plan will pay:

80% of first $4,000 = $3,200, **plus**
95% of the next $46,000 = $43,700,

for a total payment of $46,900 out of the $50,000 Hospital bill.

Standard Payment Level

After the Deductible, the Standard Payment Level pays:

70% of the next $4,000 of covered expenses, and then
90% up to any Calendar Year Maximum that applies.

Example: Assume the same facts as in the previous Example, except assume that Mike was admitted to a non-PPO Hospital. The Plan will pay:

70% of first $4,000 = $2,800 **plus**
90% of the next $46,000 = $41,400

for a total payment of $44,200 out of the $50,000 Hospital bill. By using a PPO Hospital, Mike saves $2,700 in out-of-pocket expenses.

CALENDAR YEAR MAXIMUM (PER PERSON)
FOR COMPREHENSIVE MEDICAL BENEFITS $200,000

ANNUAL DEDUCTIBLE (PER PERSON) $300

The Comprehensive Medical Benefit has a $200,000 Calendar Year Maximum Benefit per person. This Calendar Year Maximum will be reduced by $2 for each $1 of services reimbursed for an Out-of-Network Provider. In addition, the calendar year deductible is $300 per person.

Some Benefits are only available to certain individuals. Please refer to Section Seventeen for the particular meaning of the terms Participants, Employees, Covered Person, Covered Employee and Dependent.

Common Disaster Provision
In the event that more than one Covered Person in the same family is injured by reason of any one Accident or in the event more than one Covered Person in the same family contracts a contagious disease which is otherwise covered hereunder (within thirty days), only one deductible amount will be applied to all such Covered Persons.

The following chart summarizes information on coverage and deductibles:

Description of Covered Benefit	Fund Co-Payment Amount or Level Co-Payment amounts are based on a percent of UCR Charge In-Network	 Out-of-Network	Do you need to meet your calendar year Deductible before receiving Benefit?
Alcohol and Drug Treatment and Mental Health Benefit *$50 deductible per calendar year* *Pre-certification Required* *See Benefit Description for Specific Limitations*	80%	50%	Out-of-Network Yes
Ambulance Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Chiropractic Expense Benefit *See Benefit Description for Specific Limitations*	Standard	Standard	Yes
Comprehensive Medical Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Diagnostic Laboratory and X-Ray Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Home Health Care Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Hospice Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Human Papillomavirus (HPV) Vaccine Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Maternity Benefit *(Participant or Dependent Spouse Only)* *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Physical Examination Benefit *See Benefit Description for Specific Limitations*	100%	100%	No
Physician Services Benefit – Office Visit Only *See Benefit Description for Specific Limitations*	100% Less $20 Co-payment	Standard	Out-of-Network Yes
Physician Services Benefit – All other covered services *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes

Description of Covered Benefit	**Fund Co-Payment Amount or Level** Co-Payment amounts are based on a percent of UCR Charge		Do you need to meet your calendar year Deductible before receiving Benefit?
	In-Network	**Out-of-Network**	
Rehabilitative Therapy Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Routine Colonoscopy Benefit (*Benefits are paid only for an Eligible Participant or Spouse age 50 and over)* *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Routine Mammogram Benefit (*Benefits are paid only for an Eligible Female Participant or Spouse age 40 and over)* *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Skilled Nursing Facility *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Sterilization Benefit (Voluntary) *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Surgical Expense Benefit *Pre-certification may be required* *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Well Baby/Child Care Benefit – Office Visit Only *See Benefit Description for Specific Limitations*	100%	Standard	Out-of-Network Yes

A. <u>Alcohol and Drug Treatment and Mental Health Benefit</u>

Alcohol and Drug Treatment Benefit

Benefits for treatment of alcoholism, chemical dependency or substance abuse are payable according to the Schedule of Benefits for the Usual, Customary and Reasonable Charges for medical expenses for treatment, if such care and services are ordered and prescribed by a Legally Qualified Substance Abuse Professional. For the purposes of this Benefit only, a "Legally Qualified Substance Abuse Professional" includes: a) Physician; b) certified mental health or substance abuse counselors, or a social worker who has a master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of alcoholism and substance abuse under the laws of the state or jurisdiction where the services are rendered and who acts within the scope of his or her license.

Covered Charges are:

1. Charges by a Hospital for room and board charges (semi-private room only),

2. Charges for treatments by a Legally Qualified Substance Abuse Professional,

3. Charges for individual therapy by a Legally Qualified Substance Abuse Professional,

4. Administration of drugs or medicine if prescribed by a Legally Qualified Substance Abuse Professional legally authorized and licensed to prescribe drugs or medicine, and

5. Out-Patient charges for both Hospital and office visits (limited to one Hospital or office visit per day).

Benefits for treatment of alcohol or drug abuse are **NOT** payable for:

1. Service or treatment rendered by anyone other than a Legally Qualified Substance Abuse Professional, or

2. Any charges related to a period of confinement or frequency of treatment which is considered custodial or not reasonable for the diagnosed conditions(s).

ALL SERVICES FOR TREATMENT OF ALCOHOL AND SUBSTANCE ABUSE MUST BE PRE-CERTIFIED WITH NEW DIRECTIONS AT 888-388-7303.

Benefit Levels
Coinsurance *(Fund pays)*
  In-Network 80%
  Out-of-Network ($50 Out-of-Network deductible) 50%
Coinsurance *(Participant pays)*
  In-Network 20%
  Out-of-Network ($50 Out-of-Network deductible) 50%

Benefit Limitations
Treatment Plan must be completed to receive Benefits.

In-Patient
Maximum admissions .... two per person in five years with at least a one year separation between admissions

Out-Patient
Preferred Plan Maximum Benefit per condition $1,600
Standard Plan Maximum Benefit per condition..$800

Mental Health Benefit
Benefits for Expenses Incurred by a Covered Person for treatment prescribed by a Physician for mental or nervous illness will be paid according to the Schedule of Benefits for Medically Necessary care and services.

Allowed charges are:

1. Mental health evaluations and assessment,
2. Diagnosis,
3. Treatment planning,
4. Referral services,
5. Medication management,
6. Short-term individual, family and group therapeutic services (including intensive Out-Patient therapy),
7. Crisis intervention,
8. Psychological testing.

ALL SERVICES FOR TREATMENT OF MENTAL HEALTH MUST BE PRE-CERTIFIED WITH NEW DIRECTIONS AT 888-388-7303.
Benefit Level
Coinsurance
  In-Network 80%
  Out-of-Network.. 50%

Deductible Amount .... $50 per person per Calendar Year

Benefit Limitations
Treatment Plan must be completed to receive Benefits.

In-Patient
Maximum admissions .... two per person in five years with at least a one year separation between admissions

Maximum Confinement per admission .... 14 days

Out-Patient
Maximum number of Out-Patient Treatment visits (Annual) .... 25 per person

Mental Health Benefits are **NOT** payable for:

1. Service or treatment rendered by anyone other than a Physician (as defined by the Plan), including social workers, nurses, clergy and certain counselors without proper licensing, or

2. Any charges related to a period of confinement or frequency of treatment which is considered custodial or not reasonable for the diagnosed condition(s).

B. Ambulance Benefit
Professional ground ambulance service to a per-use maximum of $500; and professional air ambulance including helicopter service, but not transportation by any other common carrier, to a per-use maximum of $5,000; subject to the annual deductible and annual Benefit maximum.

C. Chiropractic Expense Benefit

Chiropractic procedures may be an effective treatment for certain injuries and acute conditions, but medical studies indicate that over-frequent or over-extended treatments are not necessary or beneficial in attaining recovery. Covered Persons should seek medical attention for any condition that does not respond to chiropractic treatment within a few weeks of onset. When injury or Sickness causes a Covered Person to require chiropractic treatment, the Plan will pay covered expenses as follows:

- At the Standard Payment Level to a per-visit maximum of $70.

- For 30 visits per Plan Year including those applied to the deductible.

- Limit of two X-Ray payments per Plan Year with a per-use maximum of $85.

Chiropractic Expense Benefits are **NOT** payable for:

1. Any treatment by a chiropractor other than manual manipulation to correct subluxation, including (but not limited to) acupuncture, orthotics, massage therapy, allergy therapy, diet or hair analysis,

2. Any diagnostic x-ray or laboratory procedure other than an x-ray to diagnose subluxation, including (but not limited to) urinalysis or blood chemistry,

3. Nutritional or food supplements and/or vitamins which may be legally obtained with or without a Physician's prescription,

4. Pillows, supports or similar devices,

5. More than one treatment per day, or

6. Booklets or educational materials.

Benefit Limitations
Chiropractic Benefits are subject to the following additional limitations:

1. The Benefit period is a January 1 through December 31 (Plan Year).

2. Chiropractic Benefits may also be limited by the Plan's medical annual Benefit maximum.

D. Comprehensive Medical Benefit

Medical expenses included under the Comprehensive Medical Benefit will be payable based on the UCR Charge for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits.

Deductible Amount
$300 per person per calendar year

Coinsurance
Preferred Payment Level (In-Network)
Standard Payment Level (Out-of-Network)

Allowed charges
Medical expenses included under the Comprehensive Medical Benefit will be payable for the following Medically Necessary care and services which are ordered and prescribed by a Physician:

1. Hospital for room and board charges (semi-private room only); however, does not apply to Hospital confinements due to psychiatric problems (including alcoholism and drug abuse),

2. X-ray or radium services,

3. Anesthesia, however, if the same Physician provides the anesthesia that performs the surgery, the anesthesia is considered inclusive with the surgery and no additional Benefit is available

4. Administration and cost of blood or blood plasma,

5. Prescription drugs and medicine if prescribed by a Physician and dispensed by a licensed pharmacist,

6. Services of a licensed physiotherapist,

7. Durable Medical Equipment that meets each of the following criteria:

   a. Is certified, in writing, by the prescribing Physician as necessary in the treatment, habilitation or rehabilitation of a handicapped person,

   b. Is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience. The fact that the equipment or device is also useful for transportation, comfort or convenience will NOT serve as a disqualifying factor,

   c. Is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe),

   d. Would **NOT** be necessary in the absence of a Sickness or physical or mental disability, and

   e. Is appropriate for and intended for use in the home.

   Examples of Durable Medical Equipment include equipment to assist mobility, such as a standard wheelchair, a standard hospital-type bed, iron lungs, oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, braces that stabilize an injured body part, or mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. Nondurable supplies (i.e. tubing, connectors and masks) are an allowed charge when used with allowed Durable Medical Equipment. This Plan does not cover maintenance fees (i.e. batteries or warranties) related to allowed Durable Medical Equipment. Requests for Durable Medical Equipment must be accompanied by a Physician's Medically Necessary statement describing the length of use. The cost of these items will be limited to an amount determined by the Trustees.

   Rental of Durable Medical Equipment (such as wheelchairs, hospital beds, iron lungs, and equipment for administration of oxygen) is covered up to the purchase price, provided rental of such equipment has been pre-approved. **You should contact the Fund Office before purchasing or renting any of these items if you wish to know the cost that will be covered.**

8. Services for certain reconstructive procedures following mastectomy, as described below:

   If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

   a. All stages of reconstruction of the breast on which the mastectomy was performed;

   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

   c. Prostheses (Maximum 2 each Plan Year); and

   d. Treatment of physical complications of the mastectomy, including lymphedemas.

   These benefits will be provided subject to the same deductibles and Coinsurance applicable to other medical and surgical Benefits provided under this Plan. Therefore, the $300 annual Deductible must first be met, and thereafter, charges by In-Network providers are subject to the Preferred Payment Level and charges by Out-of-Network providers are subject to the Standard Payment Level.

   If you would like more information on WHCRA benefits, call the Administrative Manager at (816) 737-5959.

9. Human organ and tissue transplants (subject to all other Plan limitations and exclusions). Contact the Fund Office regarding coverage for donor expenses.

10. Prosthetic appliances, including (1) Prostheses (devices, that replace all or part of a body organ or that do the work of a poorly working or non-working body organ); (2) Appliances such as leg braces including shoes which are attached to the brace. However, there is no coverage for surgical insertion of a penile prosthesis. Complications from such a procedure are also excluded. However ancillary procedures such as injectables and suppositories to relieve the condition are covered. In addition the Plan covers for Durable Medical Equipment devices such as the Osbond EREC aid system. Also excluded is coverage for dental prostheses and appliances or nonhuman devices or artificial organs used for organ transplants such as, but not limited to, heart, lung, kidney and liver.

11. Allergy.

12. Emergency Room – When injury or sudden Sickness requires a Covered Person to seek treatment at a clinic, emergency room, or Out-Patient facility of a Hospital, Benefits will be paid at the Preferred Payment Level if treatment is

received at an In-Network facility, and at the Standard Level Payment level, if not.

13. Infusion Therapy - In-Patient or Out-Patient – Intravenous injections and solutions are covered. Medicare eligible Participants must follow Medicare guidelines for this to be paid.

14. Intravenous solutions and injections administered outside a Hospital are covered. Medicare eligible Participants must follow Medicare guidelines for this to be paid.

15. Injections.

16. Medical Supplies.

17. Cranial remodeling orthotic equipment for Children under the age of twenty-four (24) months.

E. Diagnostic Laboratory and X-Ray Benefit

Benefits are payable for x-ray and diagnostic laboratory tests or examinations for the diagnosis of an injury or Sickness. Benefits will be paid for such expenses at a Preferred Payment Level if service is provided at an In-Network facility, or at the Standard Payment Level, if not.

When a Covered Person's Physician orders Out-Patient laboratory tests, expenses are subject to the Annual Comprehensive Medical Deductible and Coinsurance.

Diagnostic X-Ray and Laboratory Benefits are NOT payable for routine screening except under the Annual Physical Examination Benefit and the Routine Mammogram Benefit. Benefits for diagnostic X-Ray and Laboratory Benefits are not payable for Vision Care Benefit or the fitting of hearing aids. Dental x-rays and laboratory examinations are excluded from this Benefit unless such services are necessary in the treatment of a fractured jaw or injury to natural teeth, and provided such services are rendered within 6 months following the date of injury.

F. Home Health Care

When accidental bodily injury or Sickness causes a Covered Person to require some level of professional nursing care at home, Benefits for such home health care will be paid as described below.

CONTACT BCBS CASE MANAGEMENT AT (888) 800-4474. BCBS WILL NEGOTIATE SERVICES/EQUIPMENT NEEDED FOR RECOVERY WITH THE APPROVAL OF YOUR PHYSICIAN.

Preferred Payment Level (In-Network)

Benefits will be paid at the Preferred Level.

Standard Payment Level (Out-of-Network)

Benefits will be paid at the Standard Level for the Out-Patient services of an Out-of-Network licensed nurse.

A Covered Person must demonstrate that home health care is Medically Necessary.

Establishing Care to be Medically Necessary
Benefits for home health care, as is the case with any other medical Benefit provided by the Plan, are paid only in cases where the care is Medically Necessary. Medical necessity:

- Must be established by the written authorization of a Physician, and
- Must be reestablished or confirmed on a regular basis.

Personal or comfort services are not provided by the Plan.

Home health care may include professional nursing (sometimes on a part-time basis) to monitor vital signs and medicinal dosage and to administer certain types of drugs, etc. Unfortunately, there are patients who do not need professional care, but do require custodial care such as feeding, washing, changing bed clothes, etc. However, custodial services are not provided by the Plan.

G. Hospice Benefit

Benefits, on behalf of a Covered Person, for Covered Services for Hospice Care will be paid according to the Schedule of Benefits.

Hospice Benefits will only be paid if the patient's attending Physician certifies, in writing, that the patient is terminally ill and that the patient is expected to die within six months or less.

Allowed charges are:

1. Room and board for confinement in a Hospice,

2. Services and supplies furnished by the Hospice while the patient is confined therein,

3. Part-time nursing care by or under the supervision of a Registered Nurse (RN), and

4. Counseling services by a licensed social worker or a licensed pastoral counselor.

Hospice Benefits are **NOT** payable for custodial care or services (i.e. room and board or other institutional or nursing services which are provided to or for a Covered Person due to the Covered Person's age, mental or physical condition) mainly to aid the person in daily living.

H. Maternity Benefit

Maternity Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any related medical conditions or complications.

Maternity Benefits are payable to or on behalf of a Participant or the Participant's Dependent Spouse, are paid in the same manner and the same extent as any other Sickness, and are deemed to have been incurred at the date the pregnancy is terminated.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Little Stars is a pre-natal risk assessment and education program. Contact Little Stars for additional information at 816-395-3964 or 800-892-6116 (ext. 3964)

Benefits will be paid for the nursery care of healthy babies during the period of their mother's confinement.

MATERNITY BENEFITS ARE PAYABLE UNDER THE COMPREHENSIVE MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.

Allowed charges are:

1. In-Patient stay of at least 48 hours for the mother and newborn Child following a vaginal delivery.

2. In-Patient stay of at least 96 hours for the mother and newborn Child following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the mother and/or the newborn Child earlier than these minimum time frames.

Benefit Limitations
Maternity Benefits are **NOT** payable for pregnancy expenses of Dependent Children.

Most obstetricians charge on the basis of a "global fee", that is, their fees include pre-and-post-delivery care, as well as the charge for the actual delivery itself. For this reason the Plan's Usual, Customary and Reasonable Charges are usually based on this single fee for a normal birth.

Multiple births, Caesarian deliveries, abortions, or other related complications are given consideration and additional, appropriate allowance is made therefore.

If separate charges are made for a special test, such as a sonogram, Benefits may be denied unless a Medically Necessary need for such tests is clearly established.

Benefits are payable with respect to any Expense Incurred for circumcision.

I. Physical Examination Benefit

The Plan will pay 100% of the Covered Charge for one physical examination per Plan Year up to an annual maximum limit of **$300** for all non-laboratory charges for each eligible person. For this Benefit, an "eligible person" is an Active or Retired Participant or his eligible Spouse during, and after, the Plan Year in which the individual attains age 35.

This Benefit is not subject to any Deductibles or Coinsurance charges. However, laboratory charges are subject to deductibles and are payable at normal in and out of network rates as more fully described in the Schedule of Benefits under the heading *Diagnostic Laboratory and X-Ray Benefit.* This Benefit is not available to any Dependent except for an eligible Spouse.

To minimize out-of-pocket expense, the eligible person undergoing the physical examination should arrange all of the blood or laboratory test components through Blue Cross Blue Shield Preferred Care Network. Blood tests performed other than by Blue Cross Blue Shield Preferred Care Network shall be allowed but will likely cause increased out-of-pocket expense.

The eligible person undergoing the physical examination shall be responsible for any incurred charges that are greater than the benefit maximum funded by the Plan.

Benefit Limitations

Routine bone density scans are not covered Benefits under the Plan.

This Physical Examination Benefit shall not include charges for pre-marital examinations, sports physicals, school-related physicals, or employment-related physical examinations.

Routine colonoscopy tests and routine mammograms are covered Benefits under the Plan but are separate from the Physical Examination Benefit.

J. Physician Services Benefit

When it is Medically Necessary to visit a Physician, Benefits will be paid according to the Schedule of Benefits. Office visits - In-Network providers will be subject to the office visit co-payment and Out-of-Network providers are subject to the deductible and Coinsurance.

Preferred Payment Level (In-Network)

- The Covered Person pays **$20** for the office visit, as a special separate Co-Payment,

- The balance of the office visit charge will be paid by the Plan, to the extent it is a Covered Charge, and

- X-rays and other Covered Charges are separate and subject to the annual deductible and Coinsurance at the Preferred level.

Standard Payment Level (Out-of-Network)
Benefits also will be paid to any qualified Out-of-Network Physician or Surgeon. Such Benefits will be paid at the Standard Payment Level in accordance with the Schedule of Benefits and subject to the annual deductible and Calendar Year Maximum.

Please note that Benefits will be paid for certain surgeries only on an Out-Patient basis, and *the Physician must obtain pre-certification for some surgical procedures* *as listed on page 61.*

K. Rehabilitative Therapy Benefit

Rehabilitative Therapy for an injury or Sickness shall be **considered** under the Plan according to the Schedule of Benefits.

Rehabilitation services are available subject to the same conditions as any other Benefit.

Covered physical therapy services include:

- Physical therapy wherever provided by a Physician, registered physical therapist (R.P.T.), or licensed physical therapist (L.P.T.).

Covered occupational therapy services include:

- Occupational therapy wherever provided by a Physician or registered occupational therapist (O.T.R.).

Covered speech therapy services include:

1. Benefits for the treatment of the loss or impairment of speech or hearing disorders provided by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-language and Hearing Association (ASHA), or both, and which fall within the scope of such license or certification.

2. Benefits are also payable for any testing required in diagnosing any loss or impairment of speech or hearing.

3. Covered services include the following:

a. Evaluations;
b. Examinations;
c. Treatments;
d. Counseling when received from a qualified provider.

Benefit Limitations

Rehabilitative Therapy Benefits excludes:

1. Screening examinations;

2. Services received under any program offered by any governmental body or entity including school districts;

3. Hearing aids except as provided under Hearing Care Benefit.

L. Skilled Nursing Facility
Benefits are available for covered services received in a skilled nursing facility on a case-by-case basis recommended and approved by case management. Benefits are NOT payable for custodial care or nursing home expenses.

M. Sterilization Benefit (voluntary)
Benefits will be paid for voluntary surgical sterilization procedures at the Preferred or Standard Payment Level (as the case may be) but such payments will be limited to a maximum Benefit of $300 for all charges. "All charges" include Hospital, medical and surgical expenses.

N. Surgical Expense Benefit
When a Surgical Procedure is performed on a Covered Person for treatment of a non-occupational Sickness or accidental bodily injury, the Plan will pay the surgical fee charged by the Physician performing the surgery at the Preferred or Standard Payment Level, as applicable.

Definitions
"Surgical Procedure" means certain invasive procedures, as well as the reduction of fractures or dislocations, in addition to recognized cutting procedures. Surgical Procedures may be performed in a Hospital, Physician's office or elsewhere.

"Surgical Benefits" include charges for necessary and related pre-operative and post-operative care (and any anesthetic customarily administered by the surgeon) as part of the Surgical Procedure.

Successive Periods of Surgery as One Disability
Successive periods of surgery in a Hospital will be considered as one continuous disability and period of surgery for the purpose of determining maximum Benefits payable **unless:**

1. The later surgery is due to causes entirely unrelated to the causes of the prior surgery, or

2. The Surgical Procedures are separated by 31 days, or

3. In the case of an eligible Employee, the Surgical Procedures are separated by a return to Covered Employment for at least one full working day.

NOTE: The following surgeries must be performed on an **Out-Patient basis. Pre-certification is required if the following is done on In-Patient basis:**

1. Knee Arthroscopy
2. Bunionectomy or Hammertoe Repair
3. Carpal Tunnel
4. Cataract Removal
5. Colonoscopy
6. Coronary Angiogram
7. Cystoscopy
8. Dilation & Curettage
9. EGD/Upper GI Endoscopy
10. Hemorrhoidectomy
11. Inguinal Hernia Repair
12. Laparoscopy (Pelvic)
13. Lithotripsy
14. Myelography
15. Septoplasty
16. Tonsillectomy/Adenoidectomy
17. Tympanostomy
18. Orthognatic Surgery

Benefit Limitations

Surgical Expense Benefits are **NOT** payable for:

1. Any Surgical Procedure pertaining to the periodontium,

2. Any dental work or treatment, except as otherwise specifically provided under the Plan,

3. More than one orthognatic surgery per individual per lifetime,

4. Any elective cosmetic or plastic Surgical Procedure, including but not limited to, rhinoplasty or breast augmentation; except for reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient,

5. Any Surgical Procedure not considered Medically Necessary,

6. Charges made by an assistant surgeon will be considered under the Major Medical Expense Benefit, provided such assistance is considered Medically Necessary.

O. Well Baby/Child Care Benefit

In addition to other Benefits available to Dependents, a Dependent Child shall be entitled to coverage of UCR Charges, according to the Schedule of Benefits, for Child Health Supervision Services from birth thru age six. Office visits to Non-PPO providers are payable at the Standard Level.

"Child Health Supervision Services" means Physician-delivered or Physician-supervised services including routine well-baby care, pediatric preventative services, developmental assessment and appropriate immunizations and laboratory tests which are delivered as stated in the Schedule of Benefits.

Allowed charges

The Plan will provide full coverage for most routine immunizations required for the placement of Dependent Children in a child care facility, school or similar programs.

Immunizations will be payable for Children ages one through age six. Immunizations are payable at 100% not subject to the deductible and Coinsurance or Co-Payment for In-Network and Out-of-Network providers. Covered immunizations are as follows:

1. Five Doses of Vaccine Against Diphtheria, Pertussis, Tetanus.
2. Four Doses of Vaccine Against Polio and Haemophilus B (Hib).
3. Three Doses of Vaccine Against Hepatitis B.
4. Two Doses of Vaccine Against Measles, Mumps and Rubella.
5. One Dose of Vaccine Against Varicella (Chicken Pox).

Maximum Well Baby/Child Care Benefit

Well baby care is limited to six exams for the first 12 months of a Child's life thereafter, one exam is covered each calendar year from age one to age six. Immunizations count toward an exam.

Dependent Children birth up to age 1-year.. 6 visits

Dependent Children age 1 year thru age 6 years ....1 visit per year

P. Routine Mammogram Benefit

Benefits will be paid for a routine mammogram screening obtained by an eligible individual. To be eligible for this benefit, the patient must be a female, age 40 or older, who is an Active or Retired Participant or Spouse. Each eligible individual is limited to one routine mammogram per calendar year. Fees charged for this procedure will be paid at the Preferred or Standard Payment Level, as applicable. This benefit is not available to any Dependent except for an eligible Spouse.

Q. Routine Colonoscopy Benefit

Benefits will be paid for a routine colonoscopy screening obtained by an eligible individual. To be eligible for this benefit, the patient must be an Active or Retired Participant or Spouse who is not less than 50 years of age. Each eligible individual is limited to one routine colonoscopy every 60 calendar months. Fees charged for this procedure will be paid at the Preferred or Standard Payment Level, as applicable. This benefit is not available to any Dependent except for an eligible Spouse.

R. Human Papillomavirus (HPV) Vaccine Benefit

Benefits will be paid for the quadrivalent human Papillomavirus (Types 6, 11, 16, 18) recombinant vaccine if treatment is incurred by eligible female and male individuals that are within the Center of Disease Control age guidelines and recommendations for this vaccine. Males are only covered for services incurred on or after June 1, 2012. To be eligible for this benefit, the Covered Person must be an Active Participant or an unmarried female or male Dependent of an Active or Retired Participant. Each eligible individual is limited to one round of intramuscular injections (three shots total) in his/her lifetime. The injections shall be administered in a clinical setting over a 6-month period according to a timetable prescribed by the treating physician. Fees charged for this procedure will be paid at the Preferred or Standard Payment Level, as applicable. **No benefit shall be payable until all three injections have been administered.** This benefit is not available to any Spouse or married Dependent.

S. Vision Care Benefit

You will be provided with benefits for each of the listed services and materials at the frequency stated in the Table of Benefits. Your rights to benefits are subject to the terms, conditions, exclusions of the insurance policy issued to the Fund by third-party administrator UnitedHealthcare Vision.

EXAMINATIONS

Coverage shall include a vision survey examination of the condition of the eyes and principal vision functions, to include:

1. a case history; and
2. examination for eye pathology and abnormalities.

Post examination procedures shall only be performed when materials are required.

CONTACT LENSES

In lieu of eyeglasses, you may receive contact lens services. The services and materials include contact lenses, fitting and examination as shown in the Table of Benefits. Contact lenses are medically necessary if the you or your Dependent have:

1. Keratoconus or irregular astigmatism;
2. Anisometropia of 3.50 diopters or more;
3. Post cataract surgery without intra ocular lens; or
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

NETWORK PROVIDERS LOCATIONS

To find a Network provider, call the UnitedHealthcare Vision Customer Service toll-free number: 1-800-839-3242. You may also access a listing of Network providers on the Internet at www.myuhcvision.com.

EXCLUSIONS

The following services and materials are excluded from coverage:

1. post cataract lenses;
2. non-prescription items;
3. medical or surgical treatment for eye disease, which requires the services of a physician;
4. services or materials for which the patient may be compensated under Worker's Compensation Law, or other similar employer liability law;
5. services or materials which the patient, without cost, obtains from any governmental organization or program;
6. services and materials which are not specifically covered by the Plan;
7. replacement or repair of lenses and/or frames which have been lost or broken;
8. cosmetic extras, except as stated in the Table of Benefits.
9. laser eye surgery

TABLE OF BENEFITS

Third Party Administrator: UnitedHealthcare Vision

Claim Administrator: UnitedHealthcare Vision., Claims Department, P. O. Box 30978, Salt Lake City, UT 84130. Telephone No. 1-800-638-3120.

Service	Frequency of service	Network Provider Co-payment*	Out of Network Maximum Benefit
Vision Exam	Once per calendar year	$10.00	$40.00
Frames **	Once per calendar year		$45.00
Lenses (Any one type)	Once per calendar year		
Single Vision		$10.00	$40.00
Bifocal Vision		$10.00	$60.00
Trifocal Vision		$10.00	$80.00
Lenticular Vision		$10.00	$80.00

* The Network Provider Co-payment will apply once if frames and lenses are purchased at the same time.

** Frames purchased from Network private practice providers and Network retail optical providers that are outside UnitedHealthcare Vision selection will have a frame allowance. The frame allowance for a private practice provider is $50.00 wholesale and for a retail optical provider is $130.00 retail.

Cosmetic Lens Extras: The following cosmetic lens extras are covered in full:

Scratch-resistant coating

Contact Lenses at a Network Provider: In lieu of lenses and a frame, you may select contact lenses after a co-payment of $10.00. You will receive from a UnitedHealthcare Vision selection either one (1) box of standard contact lenses or four (4) boxes of covered disposables when obtained from a Network provider. When you elect contact lenses from a Network provider that is not from a UnitedHealthcare Vision selection, the co-payment does not apply. However, you will receive a $125.00 allowance that will be applied toward the evaluation, fitting and purchase of contact lenses once every 12 months. In order to receive the full allowance, you must receive your exam, fitting and evaluation at the same Network provider.

Contact Lenses at an Out-of-Network Provider: In lieu of lenses and a frame, you may select contact lenses from an Out-of-Network provider. We will pay a maximum annual benefit of $125.00 for elective contact lenses or for prosthetic contact lenses and $210.00 for necessary contact lenses. If your contact lenses are medically necessary the provider must submit to UnitedHealthcare Vision for approval prior to dispensing the contact lenses.

Section Five – Prescription Drug Benefit

All Prescription Drugs must be purchased through the Plan's Pharmacy Benefit Manager (PBM) or the Plan's mail-order prescription drug service. Prescription Benefits will be payable according to the Schedule of Benefits. Your insurance card is also your prescription drug network card. You should present your insurance card at a participating pharmacy with each prescription drug purchase. The cards will permit eligible Participants and Retirees and their Dependents to purchase prescription drugs at a discounted price. You will only pay the required Co-Payment and deductible when you make a purchase with the card. The Plan will pay the remaining cost.

A. Retail and Mail Order

This Benefit includes both retail pharmacies and a mail-order service.

If you are taking maintenance drugs, you should have the prescription filled by mail, through the Plan's mail-order prescription drug service offered by the Plan's PBM using the information below. The mail-order service can provide your medication for 90 days per Co-Payment.

The Plan's current PBM is CVS/Caremark. CVS/Caremark's toll free phone number is (866) 260-4646. The website address is www.caremark.com

The phone number for the mail-order prescription drug service is the same as the toll free phone number shown above. You may also contact the Fund Office for this information.

If you need a non-maintenance drug, you should have your prescription filled at a retail pharmacy that is a member of the PBM's network. You should present your insurance card when filling the prescription and the participating pharmacy can provide medication for no more than 30 days per Co-Payment.

IN EVERY INSTANCE, YOU WILL PAY THE REQUIRED CO-PAYMENT FOR EACH PRESCRIPTION DRUG. IN ADDITION TO THE CO-PAYMENT AMOUNT YOU MUST MEET THE SEPARATE PRESCRIPTION DRUG BENEFIT DEDUCTIBLE ($100 PER PERSON OR $200 PER FAMILY) BEFORE FURTHER PRESCRIPTION DRUG BENEFITS ARE PAYABLE.

B. Co-Payments

In most cases, there are different levels of Co-Payments. What you pay will depend upon the Drug Type (Generic or Brand) of prescription drug you are purchasing and where it is being purchased (at a Retail Pharmacy or through Mail Order). Co-Payments are payable for every Prescription Drug purchased. The usual Co-Payment levels are shown in the table on the following page. The only times that your Co-Payment levels will vary from the usual levels will be when the Step Therapy Programs apply to you. You will find information about these special programs in sections F below.

Drug Type	Non-Maintenance Retail Pharmacy (30-day supply)	Maintenance Mail Order (90-day supply)
Generic	Greater of $10 or 10% of cost	$20
Brand	Greater of $30 or 30% of cost	$75

C. Separate Deductible

Prescription Drug Benefits are subject to a separate deductible, which is not reimbursable under the Comprehensive Medical Benefit, and it does not count towards satisfying the Comprehensive Medical Benefit annual deductible. This deductible must be met every calendar year **before** the Plan will pay any cost for Prescription Benefits, and must be paid in addition to any applicable Co-Payment. The separate Prescription Drug Benefit deductibles are:

● $ 100 per person per calendar year
● $ 200 per family per calendar year

D. Annual Maximum

The Plan's Prescription Drug Benefit has a Calendar Year Annual Maximum of **$25,000** per person. This maximum is part of, and not in addition to, the Plan's Comprehensive Medical Benefit Calendar Year Annual Maximum of **$200,000** per person.

E. Required Generic Substitution of Prescribed Brand Drugs

The Plan design requires generic substitution when an FDA approved generic drug is available for the prescribed brand name drug. In the event a Physician requires a Dispense as Written (DAW) prescription, the Covered Person shall pay, upon satisfaction of the separate deductible, the generic co-payment plus the difference between the generic drug cost and the brand name drug cost.

F. Step Therapy Program

Effective January 1, 2012, the Plan has also elected to implement the CVS/Caremark Step Therapy Program in an effort to maintain and preserve a high quality and cost-effective program for you. This program is **mandatory** for certain medication classes. If you are not taking any Proton Pump Inhibitors, ARB antihypertensives, oral osteoporosis medications, cholesterol-lowering statins, sleep aids, SSRI antidepressants, or steroid nasal sprays medications this program will NOT apply to you. There is also an exception if you are currently taking any medications in the SSRI antidepressants category. If you are currently taking any of these medications, you will NOT be subject to the mandatory Step Therapy Program. However, if you are prescribed a new medication in this class after

January 1, 2011 you will be required to follow the Step Therapy Program for that new prescribed medication in this class.

The Step Therapy Program through CVS/Caremark is designed to ensure you take the most cost-effective medications to treat certain conditions. The program promotes the use of generic medications because they are proven to be as safe and effective as brand name medications for most patients, but cost much less. There is plenty of time to avoid disruption to obtain your current medications in these certain classes. This program will take effect January 1, 2012. Please contact your physician and CVS to ensure a smooth transition prior to this date.

The Step Therapy Program groups certain medications into “steps”. The Step Therapy Program steers members to take first-step medications prior to coverage of a second step medication and to take a second step medication prior to coverage of a third step medication.

- Step 1 - Generic medications, which are the most cost effective, fall into the “first-step” category;
- Step 2 - Preferred brand-name medications fall within the “second-step” category; and
- Step 3 - Non-preferred brand-name medications, which are the least cost effective, fall into the “third-step” category.

A generic drug is a “copy” of a brand-name drug sold under a different (chemical) name. It has the same active ingredients as its brand-name counterpart, so it works the same. The U.S. Federal Drug Administration (FDA) requires a generic drug to have the following as the brand-name drug it copies:

- the SAME active ingredients, and
- the SAME route of administration, and
- the SAME dosage form, and
- the SAME strength, and
- the SAME conditions of use.

A generic medication may look different (different color), but it has the same quality and effectiveness (how it works in the body) as the Brand.

A preferred drug is any drug that has been approved and/or recommended on the basis of a clinical review by the CVS Caremark National P&T Committee, and reflects CVS Caremark’s recommendations regarding which pharmaceutical products should be given favorable consideration by plans and their members.

A non-preferred drug is any brand drug that has a preferred alternative (within the same therapeutic category) listed on the CVS Caremark standard drug list

The medication classes which qualify for the Step Therapy Program include: Proton Pump Inhibitors, cholesterol-lowering statins, ARBs (antihypertensives), ARB/HCTZ (antihypertensives), sleep aids, oral osteoporosis medications, steroid nasal sprays, SSRI antidepressants. On the next page is a chart illustrating the brand name drugs that fall within these drug classes required for Step Therapy.

DRUG CLASS	**BRAND NAME**
Proton Pump Inhibitors (PPI)	Aciphex, Kapidex, Protonix, Prevacid, Prilosec, Zegerid, Nexium
Cholesterol Lowering Statins	Crestor, Lescol XL, Livalo, Mevacor, Pravachol, Zocor, Lipitor, Advicor, Vytorin, Simcor
ARBs (antihypertensives)	Cozaar, Avapro, Teveten, Atacand, Benicar, Diovan, Micardis
ARB/HCTZ (antihypertensives)	Hyzaar, Avalide, Teveten HCT,Atacand HCT, Benicar HCT, Diovan HCT, Micardis HCT
Sleep Aids	Ambien, Sonata, Lunesta, Rozerem, Ambien CR
Osteoporosis	Fosamax, Actonel, Boniva, Fosamax Plus D
Steroid Nasal Sprays	Nasacort, Astepro, Flonase, Omnaris, Beconase, Patanase, Rhinocort, Astelin, Veramyst, Nasonex
SSRI Antidepressants	Cymbalta, Pristiq,Celexa, Lexapro, Paxil, Paxil CR, Prozac, Zoloft, Effexor, Effexor XR, Sarafem, Pexeva

You will receive a letter directly from CVS/Caremark notifying if you or your Dependents are taking medications in any "second-step" or "third-step" category. A letter will also be sent to your prescribing physician. The letter will outline the procedure you must follow beginning January 1, 2012. On or after this date, your prescription for any of these "second-step" or "third-step" categories will be denied unless physician has determined that you require a different medication for medical reasons and the CVS/Caremark Clinical Department have provided a prior authorization.

Effective January 1, 2012, You will be required to use the following procedures if you are currently taking any "second-step" or "third-step" prescriptions of the above medication classes:

1. Contact your physician and share the step therapy information contained in your letter. Your physician can decide which first-step medication is right for you.

2. If you have already tried one of the first-step medications and your physician has determined that you require a different medication for medical reasons, then your physician can call CVS/Caremark to request a prior authorization for you to continue taking the medication. The CVS/Caremark Clinical Department will advise your physician if a second-step medication is required. If your doctor receives prior approval, your brand name may be covered under the Plan. Just remember that you pay a higher co-pay for brand medications.

3. You have the option to take any medication that your physician prescribes, however it may not be covered under the benefit plan if the proper steps are not taken first.

EXCEPTION: If you are currently taking any medications in the SSRI antidepressants category you will NOT be subject to the mandatory Step Therapy Program. However, if you are prescribed a new medication in this class after January 1, 2012 you will be required to follow the Step Therapy Program for that new prescribed medication in this class.

If you have any questions regarding the Prescription Drug Benefit or have any problems with a purchase at a participating pharmacy, please contact the Fund Office at (816) 737-5959.

Section Six – Dental Expense Benefit

When a Participant or Dependent incurs a covered Dental expense, the Plan will pay 100% (or 80%, as applicable) of all reasonable dental charges subject to the Calendar Year maximum set forth in the Schedule of Benefits.

Dental Benefits are payable, in accordance with the Schedule of Benefits and descriptions in the following pages, for:

- all eligible Active Participants, Fund and Union Participants, and Owner-Operators and their Dependents, and

- on an *optional* basis, Retired and Disabled Participants that commenced benefits under the Operating Engineers Local 101 Pension Plan on, or after, January 1, 1986, and who elected coverage at benefit commencement.

- Other self-contributors may also be covered for Dental Benefits if they so elect at the initiation of their self-contribution period.

Definitions
The following definitions apply to the Dental Expense Benefit:

"Dentist" means a duly licensed Dentist or Physician who is operating within the scope of a Dentist's or Physician's license.

"Dental Hygienist" means a duly licensed dental hygienist that works under the supervision of a Dentist.

"Dental Expense" means that part of a charge for dental services that meets all of the following:

1. is covered under the Dental Expense Benefit Schedule,

2. does not exceed the Prevailing Fee for the service, and

3. is incurred while the patient is eligible for Dental Expense Benefit.

"Covered Percent" means the portion of a Dental Expense which is payable under the Plan.

"Calendar Year Deductible" means the out-of-pocket amount to be borne each Calendar Year by the Covered Person before dental expenses will be paid by the Plan. Such Deductible will be paid to the Dental Care Provider with respect to initial charges for services in each Calendar Year, and is separate from (in addition to) the Deductible for medical Benefits.

“Calendar Year Maximum” means the total amount paid for covered dental expenses, which may be provided within a Calendar Year to a Covered Person in accordance with the Usual, Customary and Reasonable Charges. This maximum is also separate from (in addition to) the Calendar Year Maximum that applies to Comprehensive Medical Benefits.

“Family” means the Covered Employee or Retiree and their Dependents.

“Calendar Year” means January 1 through December 31 of each year.

“Course of Dental Treatment” means a planned program for the treatment of a dental condition that:

1. may be done by one or more Dentists,

2. is diagnosed by the attending Dentist by oral examination, and

3. begins on the date the Dentist first treats the condition.

“Dental Treatment Plan” means the attending Dentist’s written report of recommended treatment on a form that is satisfactory to the Trustees. The report:

1. must itemize the dental procedures required including ADA code,

2. must show the charge for each procedure, and

3. must contain x-rays and any other diagnostic material as required by the Trustees.

“Emergency Care or Treatment” means treatment required for the alleviation of pain caused by an acute unexpected dental condition for which a Dental Treatment Plan cannot be submitted.

“Schedule of Benefits” means those dental services that are available and will be provided to Covered Persons under the Plan.

“Prevailing Fee” means a charge for Dental Expense that is the lesser of the fee assessed by the attending dentist, or a Dental Expense that does not exceed the 90th percentile of the Usual and Customary dental care schedule.

Covered Dental Services

Annual and Semi-Annual Exams with Prophylaxis and Bitewings, plus Fluoride for Children up to age 15 (not subject to Dental Benefit deductible)

Coinsurance *(Fund pays)* 100%

Coinsurance *(Participant pays)* 0%

All other covered service (subject to Dental Benefit deductible)
Coinsurance *(Fund pays)* 80%
Coinsurance *(Participant pays)* 20%

Deductible (Calendar Year) .... $25 per Family
Maximum Benefit (Calendar Year) .... $2,500 per Family

Following is a list of procedures covered under the Dental Benefits Plan. These services are generally divided into three areas: **Basic, Preventive** and **Major Care**. Note that certain procedures are limited as to frequency. Any procedure or treatment not listed is not a covered Benefit and is excluded.

Basic Dental Care

- Routine office visits
- Non-routine visits
  - Emergency palliative treatment
  - Consultation by other than practitioner providing treatment
- X-ray and pathology
  - Entire denture series, including bitewing, if necessary (limited to once every three years)
  - Intra-oral, occlusal view, maxillary or mandibular (limited to once every three years)
  - Bitewing films, two including examination (limited to twice per year but separated by at least four months)
  - Diagnostic casts
  - Biopsy and examination of oral tissue
- Sealants (limited to Covered Persons up to age 15 years)
- Oral surgery
  - Includes local anesthesia and routine post-operative care
- Extractions
- Removal of impacted teeth
- Alveolar or gingival reconstructions
- Cysts and neoplasms
  - Removal of cyst or tumor
  - Incision and drainage of abscess
- Drugs – injectable antibiotics
- Anesthesia
  - General in conjunction with surgical procedures only
- Periodontics
- Endodontics
- Root canals
- Restorative dentistry
  - Multiple restorations in one surface will be considered as a single restoration
- Amalgam restorations – primary teeth and permanent teeth
- Synthetic restorations
- Pins

- Space maintainers, fixed or removable
  - Includes all adjustment within six months after installation (limited to initial appliance only and to Children under age 16)

Preventive Dental Care

- Prophylaxis and fluoride applications
  - Prophylaxis treatments, to include scaling, polishing and application of stannous fluoride (limited to two treatments per calendar year, fluoride additionally limited to Covered Persons up to age 15.)
  - Exams when done with prophylaxis (limited to two treatments per year).
  - Bitewings (two or more) when done with prophylaxis (limited to twice per year and separated by four months.

Major Dental Care

APPLICABLE TREATMENTS FOR MAJOR DENTAL CARE ARE ELIGIBLE FOR PAYMENT TO THE PROVIDER ON THE "SEAT DATE" AND NOT ON AN "IMPRESSION DATE."

Restorative

  - Cast restorations and crowns are covered only when necessitated by decay or traumatic injury and cannot be restored with a routine filling material
- Inlays or onlays
- Crown
- Prosthodontics
  - Bridge abutments
- Pontics
- Removable bridge
- Periodontics
- Repairs, crowns and bridges
- Dentures and partial dentures
  - Covered Charge for dentures and partial dentures includes adjustments and relines with six months after installation or prior reline. Specialized techniques and characterizations are not covered
- Repairs, partial dentures
  - Partial denture repairs (metal)(Covered Charge based upon extent and nature of damage and type of materials involved)
- Adding teeth to partial denture to replace extracted natural teeth
- Crowns
  - Stainless steel (when tooth cannot be restored with a filling material)
- Full and partial denture repairs, acrylic
- Recementation
  - Inlay, crown, bridge
- Denture relinings and rebasings
  - (allowable after six months from initial installation or prior reline of appliance)
  - Denture duplication (jump case) per denture (limited to once every three years)
  - Denture reline, full and partial (limited to one per 12 month period)

- Tissue conditioning per denture (maximum of two treatments per arch, limited to once per 12 month period)
- Denture adjustments
  - Adjustments to denture more than six months after installation or if by other dentist providing appliance

Benefit Limitations

Maximum Amount: The maximum **Family** Benefit for Dental Expense Benefits during a Calendar Year shall NOT exceed **$2,500**.

Dental Benefit Exclusions

- For dental care for cosmetic purposes;

- For dental care of a congenital or developmental malformation, or Expenses Incurred for services or appliance necessary to increase vertical dimension or to restore occlusion for the purpose of splinting;

- For Hospitalization, surgical facilities or pharmaceutical supplies except as set forth below;

- For any procedure or treatment which performed before a Participant or Dependent became eligible for Benefits;

- For an orthodontic service or procedure;

- For replacement of lost or stolen appliances;

- For appliances, restorations, or procedures for the purpose of altering vertical dimensions, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint;

- For a service not furnished by a licensed dentist or dental hygienist;

- For the replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within three years of the date of the last placement, unless such replacement is required as a result of an accidental bodily injury;

- For initial placement of any fixed prosthetic appliance (crown/bridge) unless such replacement is necessitated by the extraction of one or more natural teeth. Any such appliance must include the replacement of the extracted tooth or teeth;

- For any services or procedures for the treatment of tempromandibular joint syndrome (TMJ); and,

- For dental implants.

Pre-Authorization for Dental Treatment

Covered Persons are encouraged to have their Dental Care Providers submit a pre-authorization treatment plan form (the same form upon which final billing is rendered) whenever:

- The Dental Treatment Plan exceeds $200,
- The primary Dental Care Provider recommends a specialist, or
- The Dental Care Provider believes **exceptional** time, materials, or treatment are necessary for any given dental service.

Benefits for covered Dental Expenses will be paid at the amount covered by the Plan whether or not pre-authorization is requested; however, use of this procedure advises both the Dental Care Provider and the Covered Person, in advance, of the actual Benefit that will be paid for proposed treatment.

Hospital Confinement for Dental Procedures

When the Dental Care Provider deems it Medically Necessary for a dental procedure to be performed in the Hospital or other surgical center, the following special rules apply:

- A Treatment Plan must be submitted for review.
- Prior approval must be obtained. A supporting Physician's statement that the confinement is Medically Necessary will usually be required.
- If approved, Benefits for Hospital expenses will be paid under the Comprehensive Medical Benefit provisions of the Plan and subject to the annual deductible and annual maximums that apply under such provisions, and limited to:

  Hospital Room and Board...Per report
  All other Hospital Expenses.. Usual, Customary and Reasonable

- If the dental procedures are performed in a surgical center or in the Out-Patient section of a Hospital, total Benefits for the use of such facility will be limited to Usual, Customary and Reasonable Charges.
- Charges for dental procedures shall be applied to Dental Benefits.

Coordination of Benefits

Dental Benefits are coordinated with other benefit plans in the same manner and to the same extent as medical Benefits. See page 108 for a discussion concerning how this Plan coordinates Benefits with other plans.

Section Seven – Hearing Care Benefit

The Fund will provide certain Hearing Care Benefits through Sonus/HearPO for eligible Active Employees and eligible Retirees up to the maximum set forth in the Schedule of Benefits. The Fund will also provide discounted services for Dependents.

Covered Benefits
Hearing Care Benefit covers the following procedures:

Active Eligible Employees and Eligible Retirees

Procedure	CPT Code
Air Screening	92551
Air, bone, SRT & Discrimination Test	92557
Hearing Aid Evaluation	92591
Hearing Aid Device	Various

Services MUST be provided by Sonus/HearPO authorized providers.

Maximum Hearing Care Benefit

Fund pays	100% up to $575 per ear every three Years
Employee pays	All Fees above $575 per ear every three Years
Maximum Benefit paid by Fund	$575 per ear every three Years

Dependent Benefits

Dependents are eligible to receive Hearing Care evaluation tests and hearing aid devices provided at Sonus/HearPO associated providers at the prevailing discount as established from time to time by Sonus/HearPO and assigned to the Plan. No Benefits are paid by the Fund for Dependent Hearing Care Benefits.

Benefit Limitations
Hearing Care Benefits will be limited to a $575 per ear per Active Employee or Eligible Retiree every three years.

The Fund will not pay Hearing Care Benefits for Expenses Incurred by a Dependent. Dependents are only eligible to receive discounts from Sonus/HearPO associated providers.

Section Eight – Loss of Time Benefits

Loss of Time Benefits will be payable at the weekly rate stated in the Schedule of Benefits when an Active Employee or a Fund or Union Employee is disabled by an accidental bodily injury or sickness which:

1. prevents him from performing the material and substantial duties of his occupation, and

2. requires the regular care and attendance of a Physician or Surgeon.

Successive periods of disability, due to the same or related causes, not separated by return to active employment or medical certification of availability for employment will be considered as one period of disability.

Since medical attention and/or treatment is required for the initial (and continuing) payment of this Benefit, the Active Employee's disability must be confirmed by a Physician. Claim forms and other information, if needed, are available at the Fund Office.

Loss of Time Benefits are not payable for:

1. injury or Sickness which arises out of, or occurs in the course of, any occupation or employment for wage or profit, or

2. loss of time commencing when the Employee:

   - is eligible for Benefits through self-contributions under COBRA Continuation Coverage,
   - is eligible as an Owner-Operator,
   - is an eligible non-bargaining unit Employee of a Contributing Employer, or
   - is receiving Benefits under the Operating Engineers Local 101 Pension Plan or Central Pension Fund (CPF is for former Local 16 participants only).

Benefit Limitations:

Maximum Benefit .... $175 per week
Maximum number of weeks (within 12 months) .... 13 weeks per incident

Section Nine – Death and Accidental Death and Dismemberment Benefits

A. Death Benefit

Upon the death of an eligible Participant, the Plan will pay the Benefit stated in the Schedule of Benefits to the designated Beneficiary. See the Schedule of Benefits for details on eligibility.

B. Accidental Death and Dismemberment Benefit

When bodily injury to an Active, Fund or Union Employee or Owner-Operator caused solely by an Accident results in any of the following losses within 90 days after the date of the Accident, the Plan will pay the Benefit stated in the Schedule of Benefits and in the table below.

Loss	Amount
Life	$3,000
Both Hands or Both Feet	$3,000
Entire Sight of Both Eyes	$3,000
One Hand **and** One Foot	$3,000
One Hand **or** One Foot **and** Entire Sight of One Eye	$3,000
Speech and Hearing	$3,000
One Hand **or** One Foot	$1,500
Entire Sight of One Eye	$1,500

The Benefit for accidental loss of life will be paid to the designated Beneficiary. The Beneficiary must notify the Fund Office and provide proof of death within 90 days of death.

Definition

The following definition applies to the Accidental Death and Dismemberment Benefit:

"Loss" with reference to the hand or foot means complete severance through or above wrist or ankle joint, and with reference to the eye means the irrevocable loss of the entire sight thereof. In the event of multiple losses, Benefits will be paid for the greatest loss sustained as a result of any one Accident.

Benefit Limitations

No Accidental Death and Dismemberment Benefit will be paid if the loss results, directly or indirectly, from:

1. Suicide or intentionally self-inflicted injury while sane; combat, war (whether or not declared), or any act of war or as a result of terrorism;

2. Physical or mental Sickness or disease;

3. Intentional ingestion of intoxicants or narcotics, unless directed by a Physician;

4. Intentional taking of poison of any kind;

5. Travel in an aircraft if the insured is the pilot or a crew member, the aircraft is being used for training, or is being used by any military unit, or is a naval or air force aircraft;

6. Commission of a felony; or

7. Active participation in a riot.

Section Ten – Medicare And Plan Benefit Payments

Eligible Active Employees (and Dependents of eligible Active Employees) who are entitled to Medicare are covered under the Operating Engineers Local 101 Health and Welfare Plan to the same extent as any other Covered Person. In compliance with federal law, this Plan does not take into account Medicare entitlement or eligibility for current employees or Dependents of current employees. In technical terms, the Plan is (in most cases) "primary" for the Covered Person's covered Hospital and medical expenses and Medicare is "secondary". That is, the Plan pays Benefits first, then Medicare may provide back-up coverage for some care if the Plan does not pay the full cost. However, under some circumstances, Medicare is primary (pays first) and the Plan is secondary (pays second).

In some cases the Plan will deem a Covered Person to be covered by Medicare, for purposes of determining how much this Plan will pay, even if the Covered Person could be enrolled in Medicare but is not.

If a Covered Person is entitled to Medicare but, as of the date he incurs a medical expense he is not enrolled in Medicare Part A and Part B, and Medicare would have been primary for him had he enrolled, the Plan will estimate what Medicare would have paid as his primary carrier and will coordinate Plan Benefits on a secondary basis with the amount. Under these circumstances, the Covered Person could be out-of-pocket a significant amount. **SO, IT IS VERY IMPORTANT THAT COVERED PERSONS ENROLL IN MEDICARE PART A AND PART B AS SOON AS THEY ARE ELIGIBLE TO DO SO.**

Medicare eligible Employees must enroll in Medicare Part A and Part B to participate in the Retiree Supplemental Health Plan.

<u>Section Eleven – Benefit Exclusions and Limitations</u>

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an <u>exclusion</u> even though not expressly stated as such.**

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS EXCLUDED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

GENERAL EXCLUSIONS APPLICABLE TO ALL BENEFITS:

Benefits **WILL NOT** be paid for or shall be limited as follows:

1. Loss caused by accidental bodily injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit; or any accidental bodily injury or Sickness for which the Covered Employee is entitled to any benefits under any Worker's Compensation or Occupational Disease Law. The Fund retains the option to withhold Benefits for any injury which may be questionable or compensable under a Worker's Compensation or Occupational Disease Law, until such time as the Covered Employee shows that such Employee has made reasonable efforts to exhaust a claim for benefits under a Worker's Compensation or Occupational Disease Law.

2. Hospital, medical or surgical treatment provided because of loss suffered in war, while serving in the Uniformed Services, or any act of war, declared or undeclared, or by participating in a riot, or as the result of the commission of a felony or an assault by the Covered Person.

3. Any service furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, a convalescent home or any institution of like character or for convalescent or custodial services, unless pre-approved medical services are provided under the Rehabilitative Therapy Benefit provided in Section 4 (K) of this document.

4. Routine foot care procedures such as the trimming of nails, corns or calluses, fallen arches or other symptomatic complaints of the feet, impression casts for prosthetics and appliances, including prescriptions for orthotics.

5. Services or procedures which are not customary and generally accepted by the medical profession and services or procedures which are Experimental or for the purpose of research. For any Experimental or Investigational service or supplies that have not been established by the American Medical Association (AMA).

6. Services or supplies related to sex transformations or sexual dysfunction.

7. Visual analysis, eye examination or the correction of vision, eyeglasses, therapy or training for muscular imbalance of the eye, or fitting of glasses or orthotics except as otherwise provided under the Vision Care Benefit.

8. Services provided by an audiologist when not performed in connection with a Sickness, hearing aids and other devices to improve hearing and their related fittings, except as stated under the Hearing Care Benefit on page 77.

9. Rehabilitation therapy for an injury, unless performed by a licensed physiotherapist.

10. Loss suffered for which a contributing cause was the Covered Person's commission of or attempt to commit a felony or the Covered Person's engaging in an illegal occupation.

11. Any Expense Incurred for obesity or morbid obesity such as weight reduction programs, drugs, surgical and non-surgical treatments and procedures and reversion of such procedures, including bariatric surgery, gastric bypass, gastric banding, open or laproscopic vertical banded gastroplasty, laproscopic adjustable gastric banding (Lap-Band system), lipotomy, or any other such procedure, as well as cosmetic or other surgery for removal of excess fat or skin following weight loss, pregnancy or surgery, regardless of Medical Necessity or supervision by a Physician. Complications from any excluded expenses are also excluded.

12. Treatment or services in connection with an elective abortion.

13. Tooth extractions or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue except as otherwise provided under the Dental Expense Benefit, or when treatment is provided within 180 days following an accidental injury to the jaw, sound natural teeth, mouth or face.

14. Alternative Treatments as defined by the Office of Alternative Medicine of the National Institutes of Health. Examples of some treatments not covered are aromatherapy, hypnotism, massage therapy and rolfing.

15. Charges for personal care items that are primarily for personal comfort or convenience, including, but not limited to, diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, incontinence pads, ramps, snug seats, recreational items, home improvements and home appliances, spas, wigs and braces for sports.

16. Charges for motor driven wheelchairs or scooters, implantable spinal column stimulator, ThAIRapy vests or non-standard equipment of any type. Any equipment that does not meet the covered Durable Medical Equipment criteria on page 53, is NOT a covered Benefit. Any nondurable supplies related to equipment that is not covered will also not be a covered Benefit.

17. Services for cosmetic and reconstructive surgery except certain reconstructive procedures following mastectomy as described on page 54.

18. Fertility treatments, artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, penile prosthesis and any related prescription medication treatment.

19. Genetic or chromosomal testing, counseling or therapy.

20. Treatment of hair loss including wigs, toupees, hairpieces, hair implants or transplants and drugs to treat hair loss.

21. Home Health Care except as provided for under the Home Health Care and Hospice Benefits. The following are examples of excluded services:

    a. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational and social activities,

    b. Services rendered by registered or licensed practical nurses, other health professionals and other allied health workers who are not employed by or functioning pursuant to a contractual arrangement with a Community or Hospital Home Health Care Agency, and

    c. Services provided to persons who are not essentially homebound for medical reasons.

22. Expenses Incurred for contraceptives, other than oral contraceptives, and related supplies. Contraceptives for Dependent Children are not covered unless medically necessary.

23. Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when the sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

24. Physical conditioning programs such as athletic training, bodybuilding, exercise fitness, flexibility, and diversion or general motivation.

25. Growth hormone medications and similar biopharmaceuticals.

26. Services and supplies for which the individual is not legally required to pay for or which no charge would be made if this coverage did not exist.

27. Maternity or obstetrical services for a Dependent Child in connection with pregnancy or resulting complications. Maternity or obstetrical services are limited to the eligible Participant or eligible Spouse of a Participant.

28. Treatment pertaining to the periodontium, except as covered under the Dental Expense Benefit.

29. Any dental treatment, except as covered under the Dental Expense Benefit or when such treatment is made necessary by injury to face, jaw, or sound teeth.

30. Any treatment not considered Medically Necessary.

31. Any expenses not actually incurred by a Covered Person.

32. Any expenses for treatment of tempromandibular joint syndrome.

33. Any expenses for dental x-rays except as covered under the Dental Expense Benefit.

34. Any expenses for Hearing Aids or Examinations for the fitting of hearing aids, except as covered under the Hearing Care Benefit.

35. Charges made by an assistant surgeon unless assistance is considered Medically Necessary.

36. Expenses Incurred with respect to Hospital confinement, operations performed, services rendered, medical treatment received, X-rays or laboratory examinations, or Expenses Incurred while confined in a U.S. Government Hospital or in any other Hospital operating by a government unit, unless a charge is made that the Covered Person is legally required to pay.

37. For any services, supplies or procedures for or in connection with refractive eye surgery, including Radial Keratotomy, refractive laser surgery, and similar procedures to enhance or restore visual acuity.

38. With respect to a Hospital confinement for which entrance has been denied in the Pre-Certification process.

39. For care provided by a non-licensed person.

40. For the services of a person who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

41. For routine physicals or immunizations, except as otherwise provided in the Plan.

42. For any Expense Incurred prior to eligibility under the Plan.

43. For simple detoxification or "drying-out".

44. For drugs or medications which may be obtained without a prescription even though such drugs or medications may be prescribed.

45. For any amount that is greater than Usual, Customary and Reasonable Charge.

46. For sonograms, unless there are clear indications of complications and the sonogram is Medically Necessary.

47. Chelation Therapy except for extreme conditions of metal toxicity.

48. Penile prosthesis exclusion - excludes surgical insertion of a prosthesis including the cost of the prosthesis and complications thereof, regardless of the diagnosis.

49. Infertility - for testing or treatment thereof.

50. Any loss caused by or resulting from Dental treatment except when such treatment is made necessary by injury to face, jaw, or sound teeth.

51. Dental expenses for cosmetic purposes.

52. Any Orthognatic Surgery, except as covered under the Surgical Expense Benefit.

53. Medical claims or Expenses Incurred while in a foreign country.

54. Body Scans.

55. Any procedure not listed in the Schedule of Benefits as a Covered Benefit.

56. Educational Services and programs (i.e. diabetes lifestyle training, dietary training, smoking cessation, etc.).

57. Any services or treatment for smoking cessation.

58. Retired and COBRA Participants are not eligible for Loss of Time Benefit.

59. Spouses of Eligible Participants are not eligible for Loss of Time Benefit, Life Insurance Benefit or Accidental Death and Dismemberment Benefit.

60. Hyperbaric Oxygen treatment, regardless of diagnosis.

61. Prenatal and birth-related expenses for (1) a Covered Person who is serving as a surrogate mother, or (2) a woman who is serving as a surrogate mother for a Covered Person.

62. Expenses incurred by a Child born to a Covered Person serving as a surrogate mother.

63. Expenses incurred for Donor Testing or Typing to determine eligibility or suitability for Organ or Tissue donation.

Section Twelve – Claims and Appeal of Denied Claims Procedures

Benefits under this Plan shall be paid only upon approval by the Trustees, or their designated representative. All written or electronically filed claims must be submitted by a Participant in accordance with the provisions set forth below. The Trustees may designate a claims processing representative either by contracting with a company or organization to provide specified services for the Plan or through resolution at a properly held Board of Trustees meeting.

A. Form, Manner, and Time for Submitting Claims for Benefits

All claims (other than claims for Life Insurance or Accidental Death and Dismemberment Benefits, which are processed as described in Paragraph A.3. below) must be submitted in a written or electronic form approved by the Board of Trustees within 180 days after the product or service is provided to the Participant. If it is not reasonably possible to submit the claim within the applicable period, a Participant may request consideration of a claim after this deadline by submitting such request in writing to the Trustees along with a statement of the circumstances preventing timely submission. The Trustees will respond to the request to submit a late claim at their next regularly scheduled meeting, and notice of their decision will be sent to the Participant no more than five calendar days after that meeting. No claim, other than a claim for treatment of nervous and mental disorders or substance abuse, or a claim involving surgery or In-Patient Hospitalization, will be denied or reduced solely because the Participant failed to obtain approval (pre-certification) of the requested care or treatment prior to obtaining the requested care or treatment. Paragraph 1 below, addresses how to submit a claim for benefits for Comprehensive Medical, Dental, Chiropractic, Prescription Drug, Mental Health Care, and Substance Abuse Treatment Claims. Paragraph 2 addresses how to submit a claim for Loss of Time Benefits and Paragraph 3 addresses how to submit a claim for Life Insurance and Accidental Death and Dismemberment (AD&D) Benefit.

1. Presenting Claims for Comprehensive Medical, Dental, Chiropractic, Prescription Drug, Mental Health Care, and Substance Abuse Treatment Claims

The Plan may contract with one or more appropriate companies, organizations, or other entities to act as third party claims administrator. In such event, the terms of any such contract shall contain a description of the claims filing process to be used, shall be incorporated herein by reference, and shall constitute a part of the governing Plan documents. In the absence of any such contract, all claims for Benefits under this Plan shall be filed with the Administrative Manager at the Fund Office. Providers and institutions may submit claims on behalf of individuals covered under this Plan.

Claims forms shall be available at the Fund Office at:

Operating Engineers Local 101
Health & Welfare Fund
6601 Winchester, Suite 250
Kansas City, Missouri 64133-4657
Phone: (816) 737-5959 or Toll Free (888) 272-5911
Fax: (816) 737-8754

The Plan shall provide identification cards to each Participant. The card shall identify the individual as a Participant in this Plan and identify the applicable preferred provider organization (PPO), and provide information about where and how to file claims for Benefits. Each Participant should present his or her identification card to both In-Network and Out-of-Network providers in order to facilitate claims processing.

ALL CLAIMS FOR IN-PATIENT HOSPITALIZATION, MENTAL HEALTH CARE, SUBSTANCE ABUSE TREATMENT AND SOME SURGERY MUST BE PRE-CERTIFIED, SUBJECT TO CERTAIN LIMITED EXCEPTIONS AS DESCRIBED BELOW.

The terms of any contract with a PPO, third party claims administrator, utilization review service provider, or other managed care service provider may provide further pre-certification requirements or exceptions. In the case of any conflict between this document and such contract with respect to pre-certification, the contract will control. If the Participant fails to obtain pre-certification for surgery or In-Patient Hospitalization, the Plan may reduce Benefits to 50% of the Usual, Customary and Reasonable (UCR) Charges or deny Benefits, at the Plan's option. When the Participant fails to obtain pre-certification for mental health care or substance abuse treatment, the Plan may deny any Benefits for the care or treatment.

Benefits will not be reduced or denied for failure to obtain pre-certification in the following circumstances:

a. if the claimant's circumstances at the time of Hospitalization or at the time the surgery is provided would make obtaining pre-certification impossible;

b. if the process of obtaining pre-certification (such as the delay involved in calling to obtain pre-certification) could seriously jeopardize the life or health of the claimant; or

c. in any other circumstance in which a delay in Hospitalization or in obtaining surgery could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum

function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the Hospitalization or surgery that is the subject of the claim.

In these instances, the claimant must contact the pre-certification entity by telephone within 48 hours after admission, after the surgery, or after the condition or circumstances preventing the claimant from obtaining pre-certification ends. The claimant must provide to the pre-certification entity details of the circumstances that prevented him or her from obtaining pre-certification.

When pre-certification is required, the Participant may obtain the certified treatment after following all pre-certification procedures, and the Participant will not be required to submit an additional claim. Payment will be made directly to the provider for all treatment and services that have been pre-certified.

Claims for mail order Prescription Benefits will be submitted and/or processed by the Plan's pharmacy benefit manager or other prescription drug claims administrator. Claims for prescription drugs or devices provided by a retail pharmacy may be submitted to the Plan by the pharmacy. If the pharmacy does not submit the claim for Prescription Drug Benefits, the Participant may request reimbursement by submitting a written claim form, along with the pharmacy receipt, to the claims administrator.

All claims must contain the name and social security number of the Participant; the name and date of birth of the patient and relationship to the Participant; the date or dates the health care service or treatment was provided; the name, billing address, and taxpayer identification number of the provider; the type of treatment or service provided; the number of units (for anesthesia and certain other claims); the diagnosis for which the treatment or service was provided; if the care or treatment is provided as a result of an Accident, the details of the Accident; information on any other insurance coverage available to the patient; and the billed charge. Claims filed directly by the Participant must be accompanied with the provider's billing statements and/or receipts. In addition, electronically filed claims must also contain the CPT-4 code (the code for Physician services and other health care services found in the *Current Procedural Terminology,* (Most Recent Edition), as maintained and distributed by the American Medical Association) and the ICD-9 code (the diagnosis code found in the *International Classification of Diseases,* (Most Recent Edition), as maintained and distributed by the U.S. Department of Health and Human Services).

If a claim does not contain all elements necessary to determine whether, or to what extent, Benefits are payable, the Administrative Manager will send notice to the claimant as set forth below requesting the necessary additional information. That notification will inform the claimant of the additional information necessary to perfect the claim and the date by which the information must be submitted to the Administrative Manager, and it will contain a statement of the Plan's claims filing procedures. The Participant will be given at least 45 days to submit the needed information. The deadline for processing the claim will be suspended until the earlier of the date the Plan receives the requested information or the date by which the Participant was to have submitted the information to the Plan, if the Participant does not supply the needed information.

No communication with or inquiry to the Administrative Manager or the Fund Office that does not contain at least the name of a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested will be construed as an attempt to file a claim for Benefits. No communications with or inquiry to any person or organizational unit not customarily responsible for handling Benefit matters will be construed as an attempt to submit a claim for Benefits. Neither the Administrative Manager nor the Plan will have any obligation to solicit further information from a Participant unless the communication or inquiry can reasonably be construed as an attempt to submit a claim for Benefits. General inquiries, such as regarding eligibility for participation in the Plan, whether certain services are covered by the Plan generally, or other questions about the terms of the Plan will not be construed as attempts to submit a claim for Benefits. Attempts to fill a prescription at a retail pharmacy do not constitute submission of claims for Benefits.

If a Participant attempts to request pre-certification for surgery, In-Patient Hospitalization, nervous and mental health care, or substance abuse treatment, but fails to follow the proper procedure for requesting pre-certification, the Administrative Manager shall cause a notice to be sent to the claimant within five days (24 hours in the case of a claim involving urgent care) informing the claimant of the failure and of the proper procedures for filing claims.

2. <u>Presenting Loss of Time Claims</u>
   Claims for Loss of Time Benefits must be filed with the Fund Office on forms available at the Fund Office. All items on the claim form must be completed, and a Physician's certification must be included.

3. <u>Presenting Claims for Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits</u>
   The Beneficiary, personal representative, or next of kin must notify the Fund Office and provide proof of death within 90 days after the

Participant's death. In the case of loss of hands, feet, sight, or speech and hearing, the Participant or an authorized representative must notify the Fund Office within 90 days after the date of the loss. The Fund Office will automatically begin processing the applicable Benefits upon receiving such notice. The Fund Office will send claim forms to the designated Beneficiary within five business days after receiving such notice. The claim forms must be completed and returned to the Fund Office, along with proof of death or dismemberment (e.g., death certificate, police report, coroner's report, Physician's statement), and/or proof of (e.g., police report, coroner's report) within 90 days after the Beneficiary's receipt of the claim form.

B. Notification of Claims Determinations

All claims will be processed promptly upon receipt. The time frames described below are maximums, and the Plan will use its best efforts to process claims in as expedient a manner as is reasonable for the circumstances. Any denial, in whole or in part, any decision to approve for payment less than the total billed charge, or any decision to grant a claim that varies in any other way from the claim will be considered an "**adverse benefit determination**" (or "denied") for purposes of these rules and procedures.

1. Categories of Claims for Comprehensive Medical, Dental, Chiropractic, Prescription Drug, Mental Health Care, and Substance Abuse Treatment Benefits

Benefits for some surgeries or In-Patient Hospitalization are subject to being reduced if pre-certification is not obtained. All treatment for mental health care or for substance abuse treatment must be pre-certified before the Plan will pay any Benefits with respect to such treatment. All requests for pre-certification will be processed as **pre-service claims**. If application of the time frame described immediately above could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the requested Hospital admission or surgery, the claim will be considered to be one **involving urgent care**. Any request to extend or expand the scope of care or treatment already pre-certified will be treated as a **concurrent care claim**. All other claims for Comprehensive Medical Benefits, Dental Benefits, Chiropractic Benefits, Prescription Drug Benefits will be processed as **post-service claims**.

2. Pre-Service Claims

Pre-service claims will be decided within a reasonable period of time appropriate to the circumstances, but not later than 15 days after the Plan's receipt of the claim. Notice of the Plan's determination of the claim will be sent the same day the decision is made, whether adverse or not.

If the Administrative Manager determines that an extension of time to process the claim is necessary due to matters beyond the control of the Plan and notifies the claimant of the circumstances necessitating the extension and the date by which the Plan expects to render a decision prior to the expiration of the initial 15 day period, the period for deciding the claim may be extended one time by the Plan for up to 15 days. If an extension is necessary due to a failure of the claimant to submit all information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. If the claimant has not submitted the requested information or requested additional time to do so within the time specified in the notice, the Administrator will decide the claim based on the information available and may decide to deny the claim if that information does not support a grant of Benefits. The Administrative Manager will notify the claimant of the Plan's determination within 15 days after the earlier of when the Plan receives the requested additional information or the end of the period afforded the claimant to submit the additional information.

3. Claims Involving Urgent Care

Whether application of the 15 day turn-around time could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function will be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If any Physician with knowledge of the claimant's medical condition determines that the claim meets the criteria to be considered a claim involving urgent care, the Plan shall consider the claim to be one involving urgent care, without regard to any other judgment or determination to the contrary.

For any claim involving urgent care, the Administrative Manager will notify the claimant of the Plan's determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan. If the claimant fails to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the Administrative Manager shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant will be afforded at least 48 hours to provide the specified information. The Administrative Manager shall then notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of when the Plan receives the specified information or the end of the period afforded the claimant to provide the specified additional information.

The Trustees of this Plan intend that no Plan provision will require a Participant to delay obtaining necessary care when such delay could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, would subject the claimant to severe pain that cannot be adequately managed without the requested care. For this reason, if the claimant or his or her health care provider believes in good faith that application of the time periods for deciding pre-service claims could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, would subject the claimant to severe pain that cannot be adequately managed without the requested care, the Plan will permit the claimant to file the pre-service claim within 48 hours (or within one business day if the period ends on a weekend or holiday) after admission, after the surgery, or after the condition or circumstances preventing the claimant from obtaining pre-certification ends.

4. Concurrent Care Decisions

Any decision by the Plan to reduce the approved length of stay of an already certified In-Patient Hospitalization, to reduce the approved period of time for treatment or number of treatments or visits for an already certified course of treatment, or otherwise to terminate or reduce payment therefore (except in the case of a Plan amendment or termination), will be treated as an adverse benefit determination, and appropriate notification will be given to the claimant. The Administrative Manager shall notify the claimant of the Plan's decision at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on appeal of that decision before the Benefit is reduced or terminated.

Any request to extend the certified length of stay of an already certified In-Patient Hospitalization, or to extend the certified period of time for treatment or number of treatments or visits for an already certified course of treatment, shall be treated as a new claim for Benefits. To avoid an interruption of Benefits, the claimant should obtain an additional pre-certification prior to the end of the certified period or before obtaining additional treatments or visits.

If the request to extend the Hospital stay or treatment involves urgent care, as defined above, the claim shall be decided as soon as possible, taking into account the medical exigencies, and the Administrative Manager shall notify the claimant of the benefit determination (whether adverse or not) within 24 hours after the Plan's receipt of the claim, provided that the claim is made at least 24 hours prior to the expiration of the certified period of time. All other such requests will be treated as pre-service claims and processed accordingly.

5. Post-Service Claims

The Administrative Manager will send notice of any adverse benefit determination of a claim for Comprehensive Medical Benefits (except some Surgery Benefits and In-Patient Hospitalization Benefit), Dental Benefits, Chiropractic Benefits, or Prescription Drug Benefits to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim. If matters beyond the control of the Plan prevent the determination from being made or communicated to the claimant within 30 days, the Administrative Manager will notify the claimant of the need to extend the time, within the initial 30-day period. The notification of extension will explain the circumstances necessitating the extension and the date by which the Plan expects to render a decision. That date will be no more than 15 days after the end of the initial 30-day period.

If an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall contain a description of the information or documentation needed, the date by which the Participant must submit that information or documentation to the Administrative Manager, and a description of the Plan's claims filing and appeals procedures. The Participant will be given at least 45 days to supply the requested information or documentation, and that period may be extended upon written request of the claimant or his or her treating health care provider. The deadline for deciding the claim will be suspended from the date on which the request for additional information is sent to the claimant until the earlier of the date on which the claimant provides the specified information or the end of the period within which the claimant was to have provided the requested information. Upon the happening of the earlier of these, the Plan will render a decision on the claim as soon as possible, but within 15 days, or the number of days remaining in the original 30 day period when the notice requesting additional information was sent, if more than 15 days then remained.

6. Loss of Time Benefits

The Administrative Manager will notify the claimant of any adverse determination on a loss of time claim within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. If the Administrative Manager determines that an extension of time to make the decision is necessary for reasons beyond the control of the Plan and notifies the claimant of the need for an extension, including the reasons for the extension and the date by which the Plan expects to render a decision, the period for deciding a Loss of Time claim may be extended for up to 30 days. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the

period for making the determination may be extended for up to an additional 30 days, provided that the Administrative Manager notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. Any notice of extension under this paragraph shall specifically explain the standards on which entitlement to the Benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If additional information is needed from the claimant, the claimant shall be afforded at least 45 days within which to provide the specified information. The deadline for deciding the claim will be suspended from the date on which the notice requesting additional information is sent to the Participant until the earlier of the date on which the Plan receives the requested information or the date by which the Participant was to have submitted the information, if the Participant fails to provide the requested information. The Plan will then render a decision on the claim within 30 days, or within the time remaining in the initial 45 day period, if more than 30 days remained in that period when the notice requesting additional information was sent to the claimant.

If additional information is needed that the claimant cannot provide, the notice will state the means by which the Plan is attempting to obtain the specified information, and the date by which it expects to receive the information.

7. Life Insurance and Accidental Death and Dismemberment Benefits

If a claim for Life Insurance or AD&D Benefits is wholly or partially denied, the Administrative Manager shall notify the claimant of the decision within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Administrative Manager determines that special circumstances require an extension of time for processing the claim. In that case, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of the initial 90-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a benefit determination.

8. Manner and Content of Notice of Adverse Benefit Determination

Written notice of any initial adverse benefit determination (regardless of whether the claim was a pre-service claim, post-service claim, concurrent care decision, or a claim involving urgent care) will be sent to the claimant within the appropriate deadlines set forth above. If the claim involves urgent care, the initial notice may be provided orally, by fax, or by other similarly expeditious method, with formal written notice following within

three days. Any notice of adverse benefit determination will set forth, in a manner calculated to be understood by the claimant:

a. the specific reason or reasons for the adverse determination,

b. references to the specific Plan provisions on which the determination is based,

c. a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and

d. a description of the Plan's appeals procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse determination on appeal.

e. for all claims other than life insurance or AD&D, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion in full, or it will contain a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in making a determination, and that a copy of the specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.

f. for all claims other than life insurance or AD&D, if the adverse benefit determination is based on a Medically Necessary or Experimental treatments or similar exclusion or limitation, the notice will contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or the notice will contain a statement that such an explanation will be provided free of charge upon request.

g. if the claim involves urgent care, the notice will also contain a description of the expedited appeal process applicable to such claims.

C. <u>Review of an Adverse Benefit Determination</u>

Any adverse benefit determination, including a full or partial denial of a claim, or an approval or payment that varies in any other way from the total amount claimed, may be appealed by filing a written request for review to the Board of Trustees, Operating Engineers Local 101 Health and Welfare Fund, 6601 Winchester, Suite 250, Kansas City, Missouri 64133-4657, or to another

appropriate named fiduciary of the Plan as selected from time by time by the Board of Trustees, and evidenced by an appropriate written contract between the Plan and such fiduciary. The Board of Trustees may designate, through a written contract, an Administrative Manager as a named fiduciary of the Plan for purposes of making and reviewing claims determinations and for making final determinations on a claimant's appeal. Such Administrative Manager shall make all final determinations on review for all pre-service claims, including claims involving urgent care and concurrent care decisions.

At any time that a named fiduciary other than the Board of Trustees is charged with making final determinations on an appeal of an adverse benefit determination, the Board shall establish an optional alternative dispute resolution procedure in which the full Board of Trustees shall participate. All claimants shall be given the opportunity to elect whether or not to participate in this optional procedure.

1. <u>Time for Requesting Review of Adverse Benefit Determinations</u>
   A request for review concerning a claim for Life Insurance or AD&D Benefits must be made <u>within</u> <u>60</u> <u>days</u> after the Participant's receipt of the notice of adverse benefit determination. All other requests for review must be made <u>within</u> <u>180</u> <u>days</u> after the Participant's receipt of the notice of adverse benefit determination. The Board of Trustees, or other appropriate named fiduciary of the Plan, will provide a full and fair review of the claim and the adverse benefit determination.

2. <u>Procedures for Making Benefit Determinations on Review</u>
   The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Review of the appeal will include comparison of the claim being reviewed to all previous appeals decisions involving similar circumstances or issues.

   All claimants requesting review will have the opportunity to submit written comments, documents, records, and other information relating to the claim for Benefits. The claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for Benefits. A document, record, or other information shall be considered relevant to a claimant's claim if such document, record, or other information:

   a. was relied upon in making the benefit determination,

   b. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such

document, record, or other information was relied upon in making the benefit determination, or

c. demonstrates compliance with the administrative processes and safeguards required to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan documents, and that the Plan provisions have been applied consistently with respect to similarly situated claimants.

d. in addition, for Health Benefit claims and Loss of Time Benefit claims, a document, record, or other information will also be considered "relevant" if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or Benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

3. Additional Procedures for Review of Claims Other Than Claims for Life Insurance or AD&D Benefits

The review will afford no deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination being reviewed, nor the subordinate of any such individual. In deciding an appeal of any benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the appropriate named Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted on appeal shall not be any individual who was consulted previously with respect to the claim for Benefits, nor the subordinate of any such individual. Upon notice of a request for review, the Plan shall notify the claimant of the identification of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Expedited review procedures are available in the case of any health care claim involving **urgent care**. A request for an expedited appeal may be submitted orally or in writing to the Administrative Manager who has been designated as the appropriate named fiduciary for purposes of making Health Benefit claims determinations on review. The Plan's contract with such Administrative Manager shall specify the means by which claimants may initiate an expedited review. All necessary information, including the claimant's initial request and the Plan's benefit

determination on review, shall be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method.

4. Timing of Notification of Benefit Determination on Review

a. Review of Post-Service Claims
The Board of Trustees shall make a benefit determination no later than the date of the regularly scheduled quarterly meeting immediately following the Plan's receipt of the request for review. If the request for review is received by the Plan within 30 days preceding the date of such meeting, the benefit determination on review may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the date of the meeting following the meeting at which the determination otherwise would have to be made. If such an extension of time is required, then the Administrative Manager shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, by the date on which the decision otherwise would have to be communicated to the Participant. The Administrative Manager shall notify the claimant of the benefit determination on review as soon as possible, but not later than five days after the benefit determination is made.

b. Review of Pre-Service Claims
A request for pre-certification (or for certification after emergency admission, surgery, or other treatment) is a claim for Benefits. The named fiduciary making the appeal decision shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt by the Plan of the claimant's request for review. No extension of time will be made.

c. Expedited Review Procedure
If the claim involves urgent care, the expedited review procedure shall apply. All communications between or among the Plan, the Plan's fiduciary, and the claimant, including the claimant's request for review and the Plan's appeal decision, shall be made orally, by fax, or by similarly expeditious means. The named fiduciary with responsibility for making the appeal decision shall notify the claimant 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 the claimant's request for review. Formal written notice will follow within three days after the initial oral or fax notice. No extensions of time will be made.

5. <u>Manner and Content of Notification of Benefit Determination on Review</u>
The named fiduciary with responsibility for deciding the appeal shall provide the claimant with a written notification of the Plan's benefit determination on review, whether adverse or not. If the appeal concerns a claim involving urgent care, notification of the decision on review will be provided to the claimant by telephone or fax, with a formal written notification sent to the claimant no more than three days after such oral or fax notification is provided.

If the determination is not fully favorable to the claimant, the notification shall set forth, in a manner calculated to be understood by the claimant:

a. the specific reason or reasons for the adverse determination,

b. reference to the specific Plan provisions on which the benefit determination is based,

c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for Benefits (relevance shall be defined for this purpose the same as defined above in Paragraph C.2. above),

d. a statement describing any voluntary appeal procedures offered by the Plan, and the claimant's right to obtain information about such procedures, and

e. a statement of the claimant's right to bring an action under Section 502(a) of the Employees Retirement Income Security Act of 1974, as amended (ERISA).

f. for all claims other than claims for life insurance and AD&D Benefits:

i. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion in full, or it will contain a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in

making a determination, and that a copy of the specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.

ii. if the adverse benefit determination is based on a Medically Necessary or Experimental treatments or similar exclusion or limitation, the notice will contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or the notice will contain a statement that such an explanation will be provided free of charge upon request.

D. Exhaustion of Administrative Remedies

If a Participant is dissatisfied with the benefit determination on review, he or she has the right to bring a civil action challenging the decision under Section 502(a) of ERISA, 29 U.S.C. Section 1132(a). However, unless the Plan fails to adhere to these claims procedures, no legal or equitable action for Benefits under the Plan may be brought unless and until the claimant has:

1. Submitted a written or electronic claim for Benefits in accordance with the provisions above (or an oral claim involving urgent care);

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

3. Filed a written request for review of the adverse benefit determination in accordance with the provisions above (or properly filed a request for review of a claim involving urgent care); and

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

E. Voluntary Additional Appeal Level (Optional Alternative Dispute Resolution Procedure)

Despite having exhausted all administrative remedies, as described above, and only after having exhausted all of the administrative appeals described above, any claimant whose final benefit determination on review was made by a fiduciary other than the full Board of Trustees may choose to submit his or her dispute to the Board of Trustees for an additional level of review before proceeding to court. All such reviews shall 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 preceding the date of such meeting, the review decision may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, the Board may make its decision at the third meeting following the plan's initial

receipt of the request for additional review. The Board shall cause notice to be sent to the claimant describing the benefit determination on review as soon as possible, but not later than five days after the benefit determination is made.

All other procedures for the conduct of review by the Board of Trustees, as described above, shall apply to the voluntary additional review. In addition, the Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a Benefit dispute to the voluntary additional 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 shall also provide to any claimant, upon request, sufficient information relating to the voluntary additional appeal to enable the claimant to make an informed judgment about whether to submit his or her Benefit dispute to the voluntary additional appeal. Included in any such information shall be a statement that the decision of the claimant as to whether or not to submit his or her Benefit dispute to the voluntary additional appeal will have no effect on his or her rights to any other Benefits under the Plan. The information sent will also include a description of all of the applicable rules and procedures governing the voluntary additional appeal, a statement of the claimant's right to representation, a description of the process by which Trustees are selected, and a statement of the circumstances, if any, that may affect the impartiality of any of the Trustees, such as any financial or personal interests in the result or any past or present relationship with any part to the review process. No fees or costs shall be imposed on the claimant as part of the voluntary additional appeal.

Section Thirteen – Privacy and Security of Protected Health Information

A. The Plan will use and/or disclose protected health information (PHI) only to the extent and in accordance with the provisions of the HIPAA Privacy Rule, a federal statue and its regulations. The Plan does not perform any treatment activities, but may disclose information to health care providers treating a Participant in order to facilitate the providers' treatment of the Participant. The Plan has a need to use and/or disclose protected health information in the course of health care operations and payment activities.

B. The Board of Trustees, as Plan Sponsor, is permitted to use and/or disclose protected health information for the purpose of making Benefit claims determinations on review. The Board shall receive and use only the minimum information necessary to decide the appeal, and shall avoid making any disclosure of the information unless necessary to the claim determination, such as for the purpose of obtaining medical, legal, or actuarial advice regarding the claim determination that is being reviewed. When disclosing any such information, the Board shall obtain adequate assurance of confidentiality from the party to whom the information is being disclosed. Any business associate agreement entered into between the third party and the Plan shall protect the Board of Trustees to the same extent it protects the Plan.

   1. It is the Plan's practice to de-identify all appeals coming before the Board of Trustees for review. Nonetheless, on occasion, the Board may need certain individually identifiable information in order to review an appeal fully and fairly. Only the minimum information, if any, necessary to decide the appeal shall be disclosed by the Plan to the Board of Trustees in connection with any appeal.

   2. This Subsection B shall apply only in cases when protected health information is disclosed to the Board of Trustees.

C. To the extent it maintains or controls any protected health information, the Board of Trustees, as Plan Sponsor, shall use and/or disclose protected health information when specifically compelled by law, including, but not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a government or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits; and pursuant to requests of the Secretary of HHS or his or her designee. Unless specifically directed by the governing legal document or authority, the Administrative Manager and other Employees of the Fund Office will ordinarily respond to legal process compelling the disclosure of PHI, without the necessity of any action on the part of the Plan Sponsor.

D. The Board of Trustees is further permitted to use and disclose de-identified or summary health information for the following purposes, and is permitted to use and/or disclose individually identifiable health information in connection with the following activities only when the Board's responsibilities cannot be carried out without the particular individually identifiable health information being requested:

1. administering the Plan or amending its provisions, including but not limited to:

    a. management activities relating to implementation of and compliance with the requirements of the Privacy Rule,

    b. customer service, including the provision of data analyses for Participants, participating Unions, and contributing Employers, provided that protected health information is not provided to the Participants, Unions, or Employers,

    c. resolution of internal grievances,

    d. the sale, transfer, merger, or consolidation of the Plan with another employee welfare benefit plan, and due diligence related to such activity, and

    e. creating de-identified health information or a limited data set;

2. developing protocols, policies, and procedures for the administration of the Plan;

3. conducting quality assessment and improvement activities;

4. reviewing the competence or qualifications of health care providers and institutions contracting with the Plan;

5. actuarial and related activities relating to the creation, renewal or replacement of health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

6. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

7. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

8. to carry out payment activities (as the term "payment" is defined in 45 C.F.R. Section 164.501) of the Plan that cannot be delegated to Fund Office staff.

E. Neither the Plan nor any business associate servicing the Plan will disclose protected health information to the Board of Trustees unless and until the Plan receives a certification by the Board of Trustees that the Plan documents have been amended to incorporate the following provisions, and that the Board of Trustees agrees to each of the following provision. By adopting this Plan amendment, the Board of Trustees is agreeing:

1. to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that the Board or the Plan create, receive, maintain or transmit on behalf of the Plan,

2. not to use or further disclose the information other than as permitted or required by the Plan documents or required by law,

3. to ensure that any agents, including a sub-contractor, to whom it provides protected health information received from the Plan agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to the information,

4. to ensure that any agent, including a sub-contractor, to whom the Board or the Plan provide electronic protected health information (that is, any protected health information that is transmitted by electronic media or that is maintained in electronic media, including but not limited to: magnetic tape, computer hard drive, computer disks, CD's, CD-ROM, Flash memory devices, backup tapes or disks, etc.) agrees to implement reasonable and appropriate security measures to protect the information,

5. not to use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan established pursuant to the Collective Bargaining Agreements that establish this Plan,

6. to report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

7. to report to the Plan any security incident (that is, any attempted or successful unauthorized access, use, disclosure, modification or destruction of information, or interference with system operations in an information system) of which the Board becomes aware,

8. to the extent that the Board of Trustees maintains any protected health information in a designated record set, to make available protected health information in accordance with 45 C.F.R. Section 164.524,

9. to the extent that the Board of Trustees maintains any protected health information in a designated record set, to make available protected health information for amendment and to incorporate any amendments to

protected health information in accordance with 45 C.F.R. Section 164.526,

10. to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528,

11. to make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of HHS for purposes of determining compliance with the Privacy Rule by the Plan,

12. if feasible, to return or destroy all protected health information received from the Plan that the Board of Trustees still maintains in any form and to retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible, and

13. to ensure that the adequate separation between the Plan and the Board of Trustees, as required by 45 C.F.R. Section 164.504(f)(2)(iii), is established and is supported by reasonable and appropriate security measures..

F. All employees of the Fund Office (that is, employees of the Plan), including the Administrative Manager, claims processor(s), and/or customer service representative(s), do and shall have access to protected health information in the course of the services they perform for the Plan. These individuals are employed by the Plan itself, and are not employees of the Board of Trustees, which is the Plan Sponsor. No employees of the Board of Trustees, or of any member of the Board of Trustees, shall have any access to PHI held by the Plan, except as specifically provided by this Plan Document. All Plan employees shall protect the privacy of individually identifiable health information received, created, or maintained in the course of their employment, and shall use and/or disclose such information only in accordance with the terms of this Plan Document.

G. Plan employees, including the Administrative Manager, will have access to Plan Participants' protected health information only to perform the Plan administration functions that the Fund Office provides for the Plan.

H. Any Plan employee who fails to comply with the preceding paragraph shall be subject to the disciplinary procedures and sanctions, up to and including termination of employment or affiliation with the Plan, in appropriate circumstances, as established by the Plan or by the Board of Trustees relating to unauthorized use or disclosure of protected health information, for any use or disclosure of Plan Participants' protected health information in violation of or noncompliance with the provisions of this Amendment to the Plan documents.

I. The Plan shall develop and distribute to all Participants a Notice of Privacy Practices, which notice shall comply with 45 C.F.R. Section 164.520, shall be

approved by the Board of Trustees, shall describe the uses and disclosures of protected health information that may be made by the Plan, and shall describe the policies and procedures that the Plan will follow with respect to protecting the privacy of protected health information.

J. It is expected that the Board of Trustees will not have a need for access to protected health information except in connection with review of an adverse benefit determination or in unusual circumstances. The Board has delegated the daily responsibility for administering the Plan to the Administrative Manager and his or her staff. The Administrative Manager and Fund Office staff will carry out their administrative duties on behalf of the Plan, such as regular Plan administration, without disclosing protected health information to the Board of Trustees unless such a disclosure is necessary, and then shall disclose only the minimum information necessary to carry out the purpose of the disclosure to the Board of Trustees, and only in accordance with the terms of the Privacy Rule and this Plan Document.

K. Beginning no later than April 20, 2005, the Board of Trustees shall:

1. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Board or the Plan create, receive, maintain, or transmit on behalf of the Plan;

2. ensure that the adequate separation between the Board of Trustees and the Plan, as required by 45 C.F.R. Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

3. ensure that any agent, including a sub-contractor, to whom the Board or the Plan provide electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

4. report to the Plan any security incident of which the Board becomes aware.

The term electronic protected health information, as used in this Plan Document, means protected health information that is transmitted by or that is maintained in an electronic media, including but not limited to: magnetic tape, computer hard drive, computer disks, CD's, CD-ROM, Flash memory devices, backup tapes or disks, etc.

Section Fourteen - Administrative Information

The following topics are discussed under this Section on Administrative Information:

A. Coordination of Benefits
B. Determination of Benefits
C. Employer Rights to Contributions
D. Encumbrance of Benefits
E. Facility of Payment
F. Reciprocity and Portability
G. Amendment of Plan
H. Termination of Plan
I. Right to Release or Request Information
J. Subrogation of Benefits
K. Reimbursement and Savings
L. Duty of Cooperation
M. Fraud Policy

A. Coordination of Benefits

The Plan coordinates its Benefit payments with payments to which a Covered Person is entitled from other sources, such as other health insurance plans. The purpose is to ensure that a Covered Person does not have the same claims paid twice by two different plans. The following rules govern the Coordination of Benefits ("COB").

Plan Conflict

When these rules do not resolve a conflict between plans such as when This Plan's rules say the Other Plan should pay first, and the Other Plan's coordination rules say This Plan should pay first, then this Plan will pay the covered claims up to 50% of the Usual, Customary and Reasonable (UCR) Charge subject to the annual deductible and Calendar Year Maximum.

COB Definitions

There are a number of key terms that apply in the context of these rules. For example:

1. "Allowable Expenses" means any necessary, reasonable, and customary medical expense covered by this Plan, and at least a portion of which is covered under at least one of the Other Plans covering the Person for whom claim is made.

   The difference between the cost of a private and semi-private Hospital room will not be considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in this Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a Benefit paid.

When benefits are reduced under a Primary Plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services and preferred provider arrangements.

2. "Birthday Rule" means the protocol used to determine the primary/secondary payer Plan for Child Dependents of married Covered Persons. The Plan of the spouse with the earliest birthday in a calendar year shall be primary payer for Dependent Children.

3. "Other Plan" means the following types of plans providing benefits or services for or by reason of medical or dental care or treatment:

   a. group insurance contracts and group subscriber contracts,

   b. group or group-type coverage (insured or uninsured),

   c. employer Sponsored Blue Cross, Blue Shield, and other pre-payment coverage, including health maintenance organizations ("HMOs").

   d. any coverage under labor-management trusteed plans, or employee benefit organization plans, and

   e. coverage under governmental programs, and any coverage required or provided by any statute, including Medicare.

4. "Person" means a Covered Person eligible for Benefits under Operating Engineers Local 101 Health & Welfare Plan.

5. "Primary Plan" means the Plan determined to be the first payer of benefits in a particular instance.

6. "Secondary Plan" means the Plan determined to be the second payer of benefits in a particular instance.

7. "This Plan" means the Operating Engineers Local 101 Health & Welfare Plan.

Coordinating Benefits

Generally, the Plan coordinates Benefits in such a way that two or more plans do not pay more than the amount of a given claim. If any Person, while covered under this Plan is also covered under one, or more Other Plans, and the sum of the benefits payable under this Plan together with the benefits payable under all Other Plans exceeds the Person's Allowable Expenses, then the Benefits otherwise payable with respect to such Person shall be reduced so that the benefits payable under all of the plans involved shall not exceed the Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had the claim been duly made therefore.

Primary/Secondary Payer Determinations

If a Person is covered under two or more plans, the order in which benefits shall be paid is a follows:

1. Any Other Plan that has no coordination of benefits provision will be deemed to have primary payment responsibility.

2. Generally, the plan that covers the person as an employee or retiree pays before the plan that covers the person as a Dependent. The Spouse of a Covered Employee or Owner-Operator must file all claims first with the Dependent's employer's plan, and unpaid expenses may then be filed with the Operating Engineer's Local 101 Plan, along with an "Explanation of Benefits Paid" from the Other Plan.

3. Notwithstanding the rule in the preceding paragraph, if the Dependent is a retiree entitled to Medicare, and if as a result of the Medicare coordination rules Medicare is secondary to the plan covering the person as a Dependent, but primary to the plan covering the person as a retiree, then the plan covering the person as a Dependent pays first.

4. Active/In-Active Rule: A plan which covers an individual as an active employee is the primary plan over the plan covering the individual as a retired or laid-off employee. The same order applies if a person is a dependent of an active employee and of a retired or laid-off employee.

5. The plan that provides COBRA Continuation Coverage of the person pays after the plan that provides non-COBRA coverage.

6. Length of coverage**:** If the above rules do not determine the order of benefits, the benefits of a plan covering an employee, member, or subscriber for a longer period of time has primary payment responsibility.

7. The "Birthday Rule" shall be used to determine the plan that pays first with respect to Dependent Children of married Participants. The primary plan is the plan of the parent whose birthday, occurs earlier in a calendar year. If both

parents have the same birthday, the plan that has covered either of the parents longer is primary.

8. For Dependent Children when the parents are separated or divorced:

   a. If there is a court decree that establishes financial responsibility for the medical, dental, or other health care expenses with respect to Children, the benefits are determined in agreement with the court decree.

   b. Otherwise, if the parent with custody has not remarried (or was never married), the plan of the parent with custody is primary;

   c. If the parent with custody has remarried (or marries, if the parent had not previously been married), the plan of the parent with custody is primary, the stepparent's plan is secondary, and the plan of the parent without custody pays third.

   d. If the above rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary.

   e. Any plan that does not contain a coordination of benefits provision is automatically primary.

Special Coordination Rules

For the purposes of Coordination of Benefits, Operating Engineers Local 101 Health & Welfare Plan shall comply with the HIPAA Privacy Rules and request or disclose only that Protected Health Information that is necessary to process a claim for benefits. The Plan:

1. May release to or obtain from any insurance company or other organization or person any claim information, and any Person claiming benefits under this Plan shall furnish any information that the Claim Office may request.

2. Has the right, if an overpayment is made, to recover such overpayment from the Covered Person, or any other insurance company or organization.

3. Has the right to pay any other organization an amount it shall determine to be warranted, if payments which should have been made by This Plan have been made by such organization.

4. Shall not apply these provisions nor investigate other possible coverage with respect to Allowable Expenses which are less than $50. If, however, additional liability increases Allowable Expenses to an amount in excess of $50, then the entire liability shall be subject to these Coordination of Benefits provisions.

Married Participants
If both husband and wife are eligible for Benefits as Active Employees, Expenses Incurred by the claimant spouse shall be coordinated as if he/she were eligible under another plan to the extent that not more than 100% of Covered Charges can be paid. For these purposes, the claims of Dependent Children of eligible married Active Employees will also be coordinated as if one of the spouses were insured by another plan in an amount not to exceed 100% of Covered Charges.

Coordinating Benefits with Medicare
If a Covered Person is eligible for Benefits under the Plan as an Active Employee and also covered by Medicare, claims should be filed first with the Operating Engineers Local 101 Health and Welfare Fund, and only afterward with Medicare. Under this provision, Medicare is a secondary payer.

If a Covered Person is covered as a Retired Participant or as a Dependent of a Retired Participant, and is also eligible for Medicare Benefits, claims should first be filed with Medicare, and then filed with the Plan, along with a copy of the Medicare Pay-Sheet.

Coordination of Medicare and Plan Benefit Payments
Eligible Active Employees and Dependents of eligible Active Employees who are entitled to Medicare are covered under the Operating Engineers Local 101 Health and Welfare Plan to the same extent as other Covered Persons. The Plan is, in many cases Primary for the Covered Person's covered Hospital and medical expenses, and Medicare is secondary payer. Accordingly, the Plan pays Benefits first, and then Medicare may provide alternative coverage for some care if this Plan does not pay the full cost. Under some circumstances, Medicare is primary and the Plan is secondary.

If a Covered Person is entitled to Medicare but as of the date he incurs a medical expense he is not enrolled in Medicare Part A or Part B, and Medicare would have been primary for him had he properly enrolled, the Plan will estimate what Medicare would have paid as his primary carrier and will coordinate Plan Benefits as the secondary payer, and pay the Benefit it otherwise would have been obligated to pay. The Plan shall not pay any Benefits that would have been the responsibility of the primary payer.

Right of Recovery
If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of:

i. The persons it has paid or for whom it had paid,

ii. Insurance companies, or

iii. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

B. Determination of Benefits

The Trustees have full authority and sole discretion to make determinations of entitlements to and amounts of Benefits. Subject to the right of appeal, the determination shall be final and binding upon all parties claiming Benefits under the Plan.

C. Employer Rights to Contributions

Except in the case of mistaken contributions, the Employers shall have no right, title or interest in the contributions made by them to the Fund and no part of the Fund shall revert to the Employers in the event of a termination of the Fund.

D. Encumbrance of Benefits

No monies, property or equity of any nature whatsoever in the Fund, policies, Benefits or monies payable therefrom, shall be subject in any manner by a Covered Person or person claiming through a Covered Person, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, mortgage, lien or charge and any attempt to cause any Benefit to be subject thereto shall be null and void; provided however, that Benefits may be assigned by the Covered Person or Beneficiary to the health care provider who furnished the services or supplies for which a Benefit is payable.

E. Facility of Payment

Whenever payments which should have been made under This Plan in accordance herewith have been made under any Other Plans, the Trustees have the right, exercisable alone and in their sole discretion, to pay to the other organization making such payments any amounts which they determine to be warranted in order to satisfy the intent of this provision. Any amounts paid shall be deemed to be Benefits paid under This Plan and the Trustees shall be fully discharged from any future liability.

F. Reciprocity and Portability

The Trustees may enter into or amend portability or reciprocity agreements with other welfare funds.

G. Amendment of Plan

The Trustees strive to maintain and improve the Benefits available to you and your Dependents. However, the Trustees do reserve the right to amend the Plan in any way they feel necessary or desirable. Proper notice will be given of any changes in the Plan of Benefits. The Trustees further reserve the right to interpret and apply all provisions of the Plan, including those which relate to eligibility for Benefits and the proper payment of Benefits.

H. <u>Termination of Plan</u>

The Benefits provided under this Plan are NOT vested benefits and the Trustees have the authority to terminate any Benefit, including Retiree Benefits, or the entire Plan, at any time.

In the event of termination of the Plan, the Trustees shall apply the Fund to pay or provide the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Fund. No part of the corpus or income of the Fund will be used for or diverted to purposes other than for the expenses of the Fund or for other payments in accordance with the provisions of the Fund. Under no circumstances will any portion of the corpus or income of the Fund, directly or indirectly, revert to or accrue to the benefit of the Employers, the Association or the Union.

I. <u>Right to Release or Request Information</u>

For the purpose of determining the applicability and implementing the Coordination of Benefits and/or Subrogation provisions or any similar provisions in other plans, to the extent allowed by law, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information with respect to any person which the Trustees deem necessary for such purposes. In so acting the Trustees shall be free from any liability that may arise in relation to such action. Any person claiming Benefits under this Plan must furnish such information as the Trustees may reasonably deem necessary in order to implement this provision.

THE TRUSTEES WILL HAVE NO OBLIGATION TO FURNISH ANY BENEFIT UNDER THE PLAN UNTIL ALL ADDITIONAL INFORMATION REQUESTED HAS BEEN RECEIVED.

J. <u>Subrogation of Benefits</u>

The Fund shall be subrogated to the extent of Benefits paid – including, without limitation, Medical or Loss of Time Benefits under this Plan – to any monies recovered or recoverable by an Eligible Individual from any other plan or person by reason of the injury, Sickness or illness which occasioned the payment of Benefits under this Plan. (The term "Eligible Individual" as used herein shall refer to any Participant or Dependent covered by this Plan.) The Fund shall also be subrogated to the extent of Benefits paid under this Plan to any claim or recovery an Eligible Individual may have against any other plan or person for the injury, Sickness or illness which occasioned the payment of Benefits under this Plan. The Fund shall be subrogated to the extent of its Benefits paid to the Eligible Individual's claim to or recovery of compensation for his damages (alleged, suffered, or otherwise) from any person or plan. Damages shall include, but shall not be limited to, compensation received or claimed for personal injury, property loss, or medical expenses.

Upon written notification to the Eligible Individual, the Fund may, but shall not be required to, collect the claim directly from the other plan or person in any manner the Fund chooses without the consent of the Eligible Individual.

The Fund shall apply any monies collected from any other plan or person to payments made under this Plan and to any reasonable costs and expenses, including attorney's fees, incurred by the Fund in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to the Eligible Individual as soon as administratively practicable.

The Fund's right to subrogation takes priority over any other use of monies recovered, including an Eligible Individual's payment of attorney's fees or expenses and regardless of whether the Eligible Individual obtains a full or partial recovery for his injury, Sickness or illness. Although the Fund may agree to accept less than a full recovery of the Benefits it has paid on behalf of an Eligible Individual, for example, by agreeing to share in payment of reasonable attorney's fees incurred by him in obtaining reimbursement from another plan or person, the Fund is not required to accept less than full recovery, regardless of the attorney's fees and costs incurred. In particular, the Fund's subrogation rights under this Paragraph are not limited by the "common fund" doctrine.

The characterization of any amount recovered or recoverable by an Eligible Individual from another plan or person, whether through a settlement agreement or otherwise, shall not affect the Fund's priority right to recover the full amount of Benefits paid to the Eligible Individual under this Section Fourteen. Nor will the amount of the Fund's recovery right be limited simply because the amount recovered by the Eligible Individual from another plan or person is insufficient to reimburse him for all of his damages, including such non-medical expense items as "pain and suffering." In other words, the Fund's subrogation rights under this Section Fourteen Paragraph J. are not limited by the "make whole" doctrine sometimes applicable in other legal contexts.

Indeed, the Fund's subrogation rights shall not be diminished, restricted, or in any way eliminated by state statutory or case law or state administrative regulation. The Trustees or their designee may, within their sole discretion, apportion the monies such that the Fund receives less than full reimbursement.

The Fund's Benefits shall be secondary to any no-fault or personal injury protection insurance benefits paid or payable to the Eligible Individual or his estate as a result of any illness, Sickness or injury.

K. <u>Reimbursement and Savings</u>

Whenever the Fund makes payments, including, without limitation, payments of Medical or Loss of Time Benefits under this Plan:

1. to or for or with respect to an Eligible Individual for an injury, Sickness or illness for which he has received or is entitled to receive compensation of any kind from another plan or person - whether by judgment, compromise, settlement, or otherwise - for damages which include, but are not limited to, personal injury, property loss, or medical expenses; or

2. which exceed, under the terms of this Plan, the Benefits properly payable to the plan or person to or for or with respect to whom the payments were made,

the Trustees shall have the right to recover such payments, from among one or more of the following, as the Trustees shall determine: any person to or for or with respect to whom such payments were made, any insurance companies, or from any other person or organization that may be responsible for the benefits or services that were provided and paid for. Alternatively, the Trustees may set off the amount of such payments, against any amount owing, at that time or in the future, to one or more of the following, as the Trustees shall determine: any person to or for or with respect to whom such payments were made, any insurance companies, or from any other person or organization that may be responsible for the benefits or services that were provided and paid for.

The Trustees have the sole and absolute discretion to determine from whom they will recover.

For example, but not by way of limitation, if the Fund pays a claim submitted by an Eligible Individual or by a health care provider who treated him, and it is later determined that the claim was for an expense not covered under this Plan, the Fund is entitled to recover the payment from said Eligible Individual or the provider, or to recover part of the payment from him and part from the provider, or the Fund may set off the amount of the payment from amounts the Fund owes in the future to him or the provider, or both. This same rule applies if the Fund makes payment to an Eligible Individual or a provider of an expense which is a covered expense, but the amount the Fund pays exceeds the amount this Plan requires it to pay.

These provisions also apply where the Fund makes payments of allowable Expenses Incurred for treatment of an injury, Sickness or illness for which another person is or may be liable, and where this Plan's subrogation provisions do not provide the Fund with a right to recover amounts the Fund pays for treatment of the injury, Sickness or illness. If the other person or the other person's insurer, or anyone else on behalf of the other person, makes payment to an Eligible Individual or on his behalf as compensation for the injury, Sickness or illness, and the Fund is not subrogated with respect to the payment, the Fund is entitled to reimbursement in an amount equal to the lesser of the Benefits paid by the Fund for treatment of the injury, Sickness or illness, or the amount paid to him or on his behalf by the other person or its insurer. This provision shall not apply where the other person or its insurer is a medical plan with respect to which the Fund pursuant to its Coordination

of Benefits provisions is the primary payer of the Eligible Individual's Allowable Expenses.

In addition, where another person or its insurer pays compensation to the Eligible Individual or on his behalf for an injury, Sickness or illness for which the other person is or may be liable, and the Eligible Individual incurs, either before or after payment of such compensation, otherwise Allowable Expenses for treatment of the injury, Sickness or illness, a special rule applies. In that case, such otherwise Allowable Expenses which were incurred after the date on which the compensation was paid, or which were incurred prior to such date but not paid by the Fund as of such date, shall be excluded to the extent of the excess, if any, of the compensation the Eligible Individual receives over the Allowable Expenses which the Fund has already paid for treatment of the injury, Sickness or illness. Application of the rule in this paragraph may be waived by written consent of the Trustees or their designee. Furthermore, the rule in this paragraph shall not apply with respect to Allowable Expenses the Eligible Individual incurs for treatment of asbestosis and/or its related conditions, after his receipt of compensation from another person or such person's insurer related to his claim against such other person for compensation on account of his having contracted asbestosis.

The Fund's right to reimbursement takes priority over any other use of monies recovered, including the Eligible Individual's payment of attorney's fees and expenses and regardless of whether he obtains a full or partial recovery for his injury, Sickness or illness. The Fund shall not be responsible for any costs or Expenses Incurred by the Eligible Individual in connection with any recovery from any other plan or person unless the Fund agrees in writing to pay a part of those expenses. Although the Fund may agree to accept less than a full recovery of the Benefits it has paid on behalf of the Eligible Individual, for example, by agreeing to share in payment of reasonable attorney's fees he incurs in obtaining reimbursement from another plan or person the Fund is not required to accept less than full recovery. In particular, the Fund's reimbursement rights under this Section Fourteen, Paragraph K. are not limited by the "common fund" doctrine.

The characterization of any amount recovered by an Eligible Individual from another plan or person, whether through a settlement agreement or otherwise, shall not affect the Fund's priority right to recover the full amount of Benefits paid to the Eligible Individual, or the Fund's right to characterize otherwise Covered Charges as excludable expenses pursuant to the provisions of this Section Fourteen. Nor will the amount of the Fund's recovery right be limited simply because the amount recovered by the Eligible Individual from another plan or person is insufficient to reimburse him for all of his damages, including such non-medical expense items as "pain and suffering." In other words, the Fund's reimbursement rights under this Section Fourteen, Paragraph K. are not limited by the "make whole" doctrine sometimes applicable in other legal contexts.

Indeed, the Fund's reimbursement rights shall not be diminished, restricted, or in any way eliminated by state statutory or case law or state administrative regulation.

L. Duty of Cooperation

Every Eligible Individual has a duty to cooperate with the Fund and, at the request of the Trustees or their designee, he shall take any action, give information and assistance, and execute documents required by the Fund to enforce its rights under this Article. The Fund will make no payment to any Eligible Individual or on his behalf until it is satisfied that he has complied with the requirements of this Section. The Trustees or their designee without the consent of or notice to any person may release to or obtain from any person any information, with respect to any person, which the Trustees or their designee deems necessary to implement this Article.

M. Fraud Policy

Every Covered Individual is subject to the *Operating Engineers Local 101 Health and Welfare Fund Anti-Fraud Policy Guidelines*, which were adopted by the Trustees. Under these Guidelines, you may be denied Benefits and/or coverage if you commit "claims fraud" against the Fund. The Fund may also assert its reimbursement rights under Section Fourteen, Paragraph K. In addition, the Fund may bring a civil action against you or another person to recover Benefits wrongfully obtained by you or at your behest. Also, the Fund may refer cases of fraud to the appropriate law enforcement officials for investigation and prosecution under applicable criminal laws.

"Claims fraud" is defined as a "false representation of a matter of fact, whether by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed, which deceives and is intended to deceive the Fund so that the Fund will pay a claim that is not properly payable."

For purposes of this policy, claims fraud includes misrepresentation perpetrated by any person in order to obtain health coverage for an individual who is not eligible to enroll in the Plan. As used herein, "claims abuse" is defined as any incident or practice of a provider, physician, supplier, participant, Dependent, or other third party that, although not usually considered fraudulent, is inconsistent with accepted and sound business practices. Intent is the key distinction between fraud and abuse. An allegation of abuse can escalate into a fraud investigation if intent to defraud is determined.

Examples of Participant Fraud

- Using someone else's coverage or insurance card to obtain treatment.
- Providing false statements on an enrollment application, such as Dependent information, to obtain health coverage for an ineligible person.
- Providing false or fabricated documentation (e.g., marriage or birth certificates) to obtain health coverage for an ineligible person.

- Failure to notify the Fund Office of work in non-bargaining employment as explained in Section Two, subsection J.
- Using the Fund as the Participant's primary insurance when, in fact, another insurance carrier is that Participant's primary coverage.

Section Fifteen – Your Rights Under Federal Law

READ THIS SECTION CAREFULLY. This is the only way to ensure that you have the information you need to protect your rights and your best interests under this Plan.

Your ERISA Rights as a Participant

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA. As a Participant of Operating Engineers Local 101 Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

A. Receive Information About Your Plan and Benefits

Examine, without charge, at the Administrative Manager's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Administrative Manager, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of this summary annual report.

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of

insurability (including conditions arising out of domestic violence); or, (8) disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn Child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Administrative Manager.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical Benefits with respect to mastectomies shall include medical and surgical Benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery Benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and Coinsurance.

B. <u>Continue Group Health Plan Coverage</u>

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Restated Plan Document and Summary Plan Description (Combo Plan) and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

You should be provided a Certificate of Creditable Coverage, free of charge, from this Plan (any other group health plan), or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

D. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, all review and appeal procedures described in the Plan usually must be followed and exhausted before a Claimant may institute any legal action including any action or proceedings before any court, administrative agency or arbitrator ("legal bodies"). Generally, such legal bodies require a Claimant to follow and exhaust the Fund's review procedures before allowing a Claimant's legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

E. Assistance with your Questions

If you have any questions about your Plan, you should contact the Administrative Manager. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative

Manager, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section Sixteen – Other Important Information

One of the main goals of the Employee Retirement Income Security Act of 1974 (ERISA) is expanded reporting and disclosure of benefit plan operations and provisions, that is, reporting to the Department of Labor, Internal Revenue Service and to the Plan Participants and Beneficiaries.

It is the intention of the Trustees to comply with all aspects of ERISA. Thus the required information in this Section has been reported to the appropriate federal agencies and is hereby "disclosed" to you.

A. Administration of Plan

The Plan is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association. The Trustees have hired an Administrative Manager to perform the day-to-day operations of the Plan, such as maintaining records, making Benefit payments and handling general administrative matters. The Administrative Manager is:

David Barry
6601 Winchester Avenue – Suite 250
Kansas City, MO. 64133
(816) 737-5959

B. Employer Identification Number

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is 44-0663379.

C. Funding Medium for the Accumulation of Plan Assets

All contributions and investment earnings of the Plan are accumulated in a Trust Fund which is utilized to pay Benefits to eligible individuals and to defray reasonable costs of administration.

D. Name of Plan

The full legal name of the Plan is the Operating Engineers Local 101 Health and Welfare Plan.

E. Person to Receive Service of Legal Process

Fund Counsel
Blake & Uhlig, P.A.
475 New Brotherhood Building
753 State Avenue
Kansas City, KS 66101

Service may also be made on any Plan Trustee or the Administrative Manager.

F. Plan Fiscal Year
The Plan Year is the calendar year, January 1 through December 31.

G. Plan Number
The Plan Number is 501.

H. Plan Year
The Plan Year is the calendar year, January 1 through December 31.

I. Sources of Contributions
This Plan is funded through contributions by the Employers on behalf of their Employees, under the terms of a Collective Bargaining Agreement, and by investment income earned on a portion of the Fund's assets. In some cases, a Covered Person will be entitled to make self-payments in order to maintain eligibility for Benefits.

J. Type of Plan
A health and welfare plan providing group Medical, Dental, Life,l Vision and Accidental Death and Dismemberment, and Loss of Time Benefits.

K. Collective Bargaining Agreement
The Plan is maintained pursuant to Collective Bargaining Agreements between the International Union of Operating Engineers, Hoisting and Portable Local Union 101, AFL-CIO and the Heavy Constructors Association of the Greater Kansas City Area, the Builders Association of Kansas City, and the Associated General Contractors (AGC) of Missouri. A copy of such agreement(s) and list of contributing Employers may be obtained upon written request to the Administrative Manager, who may make a reasonable charge for the copies, and is available for examination, by Participants and Beneficiaries at Operating Engineers Local 101 Health and Welfare Fund Office, 6601 Winchester Avenue, Suite 250, Kansas City, Missouri 64133.

Upon request, the Fund Office will also inform you if a particular employer or union participates in the Plan and, if so, the address of that employer or union.

L. Amendment
The Trustees reserve to right to amend, modify or terminate this Plan as circumstances dictate.

Section Seventeen – Definitions

THIS BOOKLET CONTAINS MANY IMPORTANT TERMS. THESE TERMS HAVE SPECIAL MEANINGS, OR DEFINITIONS, WHICH ARE SET FORTH BELOW. THESE SPECIAL TERMS ARE CAPITALIZED THROUGHOUT THIS BOOKLET.

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1. Accident
2. Active Employee
3. Administrative Manager
4. Association
5. Beneficiary
6. Benefits
7. Child or Children
8. COBRA Continuation Coverage
9. Coinsurance
10. Collective Bargaining Agreement
11. Covered Charge
12. Covered Employee
13. Covered Employment
14. Covered Person
15. Credited Hour
16. Dependent
17. Disabled Employee
18. Eligibility Rules
19. Employee
20. Employer
21. Employer Contributions
22. ERISA
23. Expense Incurred
24. Fund Employee
25. Hospice
26. Hospital
27. In-Patient
28. Medically Necessary
29. Out-Patient
30. Owner-Operator
31. Participant
32. Participation Agreement
33. Payments
34. Physician
35. Plan
36. Plan Year
37. PPO
38. Retired Participant
39. Sickness
40. Spouse
41. Totally Disabled
42. Trust Agreement
43. Trust Fund
44. Trustees
45. Union
46. Union Employee
47. Usual, Customary and Reasonable Charge (UCR Charge)

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1. Accident

   The term **"Accident"** means a physical injury, such as a cut, break, sprain or bruise, occurring from an unexpected, undesirable and unavoidable act. This does NOT include overuse of muscles resulting in strains or aching arms and legs. **Intentionally inflicted injuries are excluded, unless such intentionally inflicted injury is the result of a medical condition.**

2. <u>Active Employee</u>
The term "**Active Employee**" or "**Active Participant**" means a person who is or has been employed by an Employer on whose behalf the Employer is or was required to make contributions to the Fund pursuant to an applicable Collective Bargaining Agreement or Participation Agreement, and who does not meet the definition of "Disabled Employee", "Fund Employee", "Owner-Operator", "Retired Employee", or "Union Employee".

3. <u>Administrative Manager</u>
The term "**Administrative Manager**" means the person employed by the Trustees to carry out the day-to-day management and administration of the Fund in accordance with the provisions of this Plan.

4. <u>Association</u>
The term **"Association"** means the Heavy Constructors Association of the Greater Kansas City, the Builders Association of Kansas City, or the Associated General Contractors of Missouri or other duly designated exclusive bargaining agent of an Employer.

5. <u>Beneficiary</u>
The term **"Beneficiary"** means a person designated by an Employee or by the terms of the Plan of Benefits established pursuant to the Trust Agreement who is, or who may become, entitled to receive any type of Benefit from the Fund. When a Benefit is payable to a Beneficiary, it will be paid to the Employee-designated Beneficiary on file at the Fund Office. In the event the Employee fails to designate a Beneficiary or if the designated Beneficiary dies before the Employee, the Benefit will be payable to the first of the following, if living:

a. his legal Spouse; or

b. if no legal Spouse is living, to his surviving children, in equal shares ("children" means all natural or adopted children, but not stepchildren);

c. if no legal Spouse or children are living, to his parents (equally or to the survivor);

d. if no legal Spouse, children or parents are living, to his estate.

If the Beneficiary dies before payment, Benefits will be payable to the Participant's first surviving class in the aforementioned order of preference.

In the event of a divorce, any designation of the Spouse as Beneficiary will be invalid as of the date of dissolution unless a Participant redesignates the ex-spouse as Beneficiary after the dissolution. If a Participant fails to designate a valid Beneficiary, the Beneficiary will be determined by the order of preference. If a

Participant names a Spouse and other individuals as Beneficiaries and subsequently divorces his Spouse, the previous designation of the other individuals shall continue to be valid unless a subsequent Beneficiary designation is received.

The Employee may designate a new Beneficiary at any time by filing a written request with the Fund Office.

6. Benefits
The term **"Benefits"** means the Health and Welfare benefits to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Board of Trustees.

7. Child or Children

The term "Child" or "Children" means an individual who is

a. (i) a son, daughter, stepson, or stepdaughter of the Participant, or

(ii) an eligible foster child of the Participant.

b. Adopted Child. In determining whether any of the relationships specified in subparagraph a.(i) exists, a legally adopted individual of the Participant, or an individual who is lawfully placed with the Participant for legal adoption by the Participant, shall be treated as a child of such individual by blood.

c. Eligible Foster Child. For purposes of subparagraph a.(ii), the term "eligible foster child" means an individual who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

8. COBRA Continuation Coverage or COBRA
The term **"COBRA Continuation Coverage"** or **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, and any amendments thereto and any governmental regulations, guidance or interpretations issued thereto, requiring that health and welfare plans offer Employees and their families the opportunity for a temporary extension of health coverage.

9. Coinsurance
The term **"Coinsurance"** means the portion of the Covered Charge that the Participant pays and the portion of the Covered Charge that the Plan pays. Please see page 7 for further information regarding Coinsurance.

10. Collective Bargaining Agreement
The term **"Collective Bargaining Agreement"** means the labor agreement between an Employer, the Association and the Union and any supplemental amendment or extension thereof, which requires Employers to make contributions to the Fund.

11. Covered Charge
The term **"Covered Charge"** refers to the total amount of charges for covered services or items upon which the cost-sharing rules are based. This may be less than the total billed charges, if your provider's charges are higher than the Usual, Customary and Reasonable Charge.

12. Covered Employee
The term **"Covered Employee"** means an Employee for whom Payments are made to the Fund as provided by a Collective Bargaining Agreement or other written agreement approved by the Trustees and who is covered according to the provisions set forth under the Eligibility Rules.

13. Covered Employment
The term **"Covered Employment"** means employment of an Employee with an Employer for which the Employer is required to make contributions to the Plan pursuant to the provisions of an applicable Collective Bargaining Agreement or Participation Agreement.

14. Covered Person
The term **"Covered Person"** means either the Covered Employee or Retiree and any Dependent of either.

15. Credited Hour
The term **"Credited Hour"** means each hour for which Employer Contributions are made to the Fund on behalf of an Active Employee; and each hour for which an Active Employee receives credit for eligibility purposes under the provisions of this Plan for periods during which he is receiving Benefits from the Fund or under any Worker's Compensation or Occupational Disease law.

16. Dependent
The term **"Dependent"** means any of the following:

a. the lawful Spouse of the Participant.

b. the Child or Children of the Participant who is under 26 years of age provided that the Child is not eligible to enroll in another employer-sponsored group health plan other than a group health plan of a parent. Effective January 1, 2014, the term Dependent means the Child or Children of the Participant who is under 26 years of age without regard to whether the Child is eligible to enroll in another employer-sponsored group health plan.

c. any Child or Children for whom the Fund Office has received a court order that requires the eligible Participant to support such Child or Children, or the Fund Office receives a Qualified Medical Child Support Order to the Administrative Manager in accordance with the procedures of the Fund.

d. any Dependent Child, incapable of self-support due to mental retardation or physical handicap, and dependent upon the Participant for support and maintenance, on the date such Dependent Child's coverage would otherwise terminate due to attainment of the termination age for Children, if within thirty-one days of such date the Plan receives a copy of the Social Security Total and Permanent Disability Award for the Dependent. The coverage of such Dependent Child may be continued for so long as the Participant remains eligible and the Dependent is deemed incapacitated.

The above persons become eligible on the date the Participant becomes eligible or on the date they acquire Dependent status, provided they are not employed by a contributing Employer. If any of the above persons are eligible as an Employee they cannot be eligible as a Dependent.

The term "Dependent" does not include a child or children born to a Covered Person serving as a surrogate mother.

17. Disabled Employee
The term **"Disabled Employee"** means an Active Employee who is no longer able to perform the material and substantial duties of his occupation and who is receiving Total and Permanent Disability Benefits from the Operating Engineers Local 10l Pension Plan.

18. Eligibility Rules
The term **"Eligibility Rules"** means the rules in order to become eligible to receive Benefits and to maintain eligibility and apply to Active Employees and their Dependents, retired Employees and their Dependents, total and permanently disabled Employees and their Dependents, Employees and Dependents on COBRA Continuation Coverage, Fund Employees and their Dependents, Union Employees and their Dependents and Owner-Operators and their Dependents.

19. Employee
The term **"Employee"** means a person who works for an Employer that is required to make contributions to the Fund on his behalf pursuant to a Collective Bargaining Agreement or Participation Agreement. If the foregoing conditions are met, an Employee can include:

a. any full time Employee of the Union or of a participating Union;

b. any full time Employee of the Association;

c. any full time Employee of the Board of Trustees; and

d. any other Employee of any Employer who has been accepted as such by the Trustees.

20. Employer
The term **"Employer"** means an employer who is obligated to make Payments to the Fund on behalf of Active Employees pursuant to an applicable Collective Bargaining Agreement or Participation Agreement, whether or not such employer is a member of the Association; and as to their respective Employees, the Union, Fringe Benefit Office and Apprenticeship Fund.

21. Employer Contributions
The term **"Employer Contributions**" means Payments by an Employer to the Fund on behalf of Employees for work in Covered Employment.

22. ERISA
The term **"ERISA"** means the Employee Retirement Income Security Act of 1974, any amendments as may from time to time be made, and any regulations promulgated pursuant to the provisions of said Act.

23. Expense Incurred
The term **"Expense Incurred"** includes only those charges made for services and supplies which are reasonably priced and are appropriate and consistent with the diagnosis according to accepted standards of community practice, and could not have been omitted without adversely affecting the person's condition or the quality of medical care. All Expenses Incurred will be considered on a Usual, Customary and Reasonable Charge basis in the given geographical area where the services were performed which shall be no higher than the 90th percentile of prevailing health care charges data.

24. Fund Employee
The term **"Fund Employee"** means a permanent Employee of the Fringe Benefit Office or Apprenticeship Fund who works at least 21 hours per week.

25. Hospice
The term **"Hospice"** means a licensed agency that provides counseling and medical services to the terminally ill and which meets **all** of the following tests:

a. has obtained any required state or governmental Certificate of Need approval,

b. provides services on a 24 hour, 7 day a week basis,

c. is under the direct supervision of a Physician,

d. has a nurse coordinator who is a Registered Nurse (R.N.),

e. has a social service coordinator who is licensed,

f. is an agency that has as its primary purpose the provision of Hospice services,

g. has a full time administrator,

h. maintains written records of services provided to the patients, and

i. is licensed in the jurisdiction in which it is located, if licensing is required.

26. Hospital

The term **"Hospital"** means only a facility which meets **all** of the following criteria:

a. is licensed as a hospital by the state, county or municipality where it is located,

b. operates primarily for the active care of the sick and injured and not for custodial care or educational service,

c. provides 24 hour a day, on the premises, nursing services by registered nurses (R.N.),

d. has a staff of one or more Physicians available at all times,

e. provides organized facilities for diagnosis and surgery on its premises,

f. is not primarily a clinic, nursing, rest or convalescent home or extended care facility, and is not a place for substance abuse treatment including but not limited to drug addiction, alcoholism, etc., unless pre-approved medical services are provided under the Rehabilitative Therapy Benefit provided in Section 4 (K) of this document,

g. maintains permanent and full time facilities for bed care of 50 or more resident patients.

h. is accredited by the Joint Commission on Accreditation Healthcare Organizations (JCAHO) and/or certified as an approved Medicare facility, but does not include institutions operated primarily as rest homes or homes for the aged even if accredited or Medicare eligible.

i. for purposes of Alcohol and Drug Treatment Benefits and Mental Health Benefits, Hospital means, (a) facilities or institutions as defined in Subsection a, above; or (b) a facility licensed by the appropriate state governmental authority and certified under Medicare as a participating hospital for the treatment of mental and nervous disorders or alcohol or substance abuse disorders. The facility described in (b) shall be located within the States of Kansas or Missouri if a duly accredited facility exists therein, or otherwise shall be approved as a qualified facility by the Trustees prior to treatment.

"Hospital" also means a duly licensed "ambulatory surgical center" that provides services that: are covered as a Hospital In-Patient Benefit, are within the scope of the center's license, and would normally require a Hospital rather than office or clinic care.

27. In-Patient

The term **"In-Patient"** means a person who is a resident patient using and being charged for the room and board facilities of a Hospital.

28. Medically Necessary

The term **"Medically Necessary"** means only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based upon the opinion of a qualified medical professional, to identify or treat a Covered Person's Accident or Sickness and which:

a. are consistent with the symptoms or diagnosis and treatment of the Covered Person's condition, disease, ailment, or injury,

b. are appropriate according to standards of good medical practice,

c. are not solely for the convenience of the Covered Person, Physician or Hospital,

d. are the most appropriate which can be safely provided to the Covered Person,

e. are not deemed to be Experimental or Investigative,

f. are not furnished in connection with medical or other research, and

g. must be a benefit provided by the Plan.

Services and supplies shall not automatically be considered Medically Necessary merely on the basis of being prescribed by a Physician.

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug equipment, device, or supply) is considered to be "Experimental" or "Investigative" if the use is not yet generally recognized as accepted medical practice, or if the use of any such item requires federal or other governmental agency approval which has not been granted at the time the service or supply is provided, or if the service, supply or procedure is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

a. is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty,

b. has a definite positive effect on health outcome,

c. over time leads to improvement in health outcomes under standard means of treatment under standard conditions of medical practice outside clinical investigatory settings (i.e. the beneficial effects outweigh the harmful effects), and

d. is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

"Reliable Evidence" includes only the following:

a. published reports and articles in authoritative medical and scientific literature,

b. the written investigational or research protocols and/or written informed consent used by the treating facility or another facility which is studying the same service, supply or procedure, and

c. compilations, conclusions, and other information which is available and may be drawn or inferred from a. or b. above.

Consideration may be given to any or all of the following factors:

a. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, and

b. if Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials to determine its maximum tolerated dosage, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis, or

c. if Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis.

d. final determination of whether the use of a treatment is Experimental or Investigative shall rest solely in the discretion of the Trustees.

29. Out-Patient

The term **"Out-Patient"** means a person who receives services and treatments in a Hospital (provided that there is no charge for room and board), ambulatory clinic, free-standing surgical unit, or Physician's office.

30. Owner-Operator

The term **"Owner-Operator"** means a self-employed person who is bound by a Collective Bargaining Agreement with the Union, or who is a bona fide member of an Association that is party to a Collective Bargaining Agreement with the Union, and who is eligible to Participate in the Plan via a Participation Agreement under the provisions of applicable Eligibility Rules.

31. Participant

The term **"Participant"** means an Employee, Owner-Operator, or former Employee who has met the eligibility requirements for participation in the Plan and is covered by the Plan or whose Beneficiaries may become eligible to receive any such Benefit.

32. Participation Agreement

The term **"Participation Agreement**" means a binding agreement executed by an Employer, in a form satisfactory to the Trustees, and any supplemental amendment or extension thereof, which requires the Employer to make contributions to the Fund on behalf of Employees.

33. Payments

The term **"Payments"** means the money paid to the Fund by Employers in accordance with the provisions of the Collective Bargaining Agreement(s).

34. Physician

The term "Physician" means medical doctors, osteopaths, surgeons, dentists, podiatrists, chiropractors, nurse practitioners , physician assistants, psychiatrists (with an MD or DO) and psychologists (with a Ph.D., Psy.D, Ed.D.) or Social Workers (LSCSW or LCSW only), when practicing within the scope of their respective licenses. Specifically with regard to Behavioral Health Treatment, the Fund recognizes the following licensures for talk therapy:

State of Kansas: LCPC Licensed Clinical Professional Counselor
State of Missouri: LPC Licensed Professional Counselor

Other states may use LCPC, LPC or other suffixes to designate a Licensed Professional Counselor. In states other than Nebraska and Georgia, the Fund will recognize that the licensure of Professional Counselor can treat and diagnose independently. With regard to other Talk Therapists:

LCSW	Licensed Clinical Social Worker
LMFT	Marriage & Family Therapist
LMSW	Masters Level Social Worker (Michigan Only)
PHD/PSYD	Psychologist

All talk therapists must have five (5) years Post Master's Degree and able to treat and diagnose independently. With regard to Medical Doctors and Nurses:

MD/DO	Psychiatrist
ARNP	Nurse Practitioner (Med Management)

35. Plan
The term **"Plan"** means the amended and restated Health and Welfare Fund Plan, which shall be known as the "Operating Engineers Local 101 Health and Welfare Plan", including the Schedule of Benefits and the rules and regulations of the thereto, the Trust Fund and any amendments, modifications or interpretations by the Trustees for the administration of the Trust Fund and Plan.

36. Plan Year
The term **"Plan Year"** means the calendar year.

37. PPO
The term **"PPO"** means a Preferred Provider Organization as a supplier of medical, dental or nursing services or goods at a discounted or reduced cost to Covered Persons. A PPO provider is referred to as "In-Network" and a non-PPO provider is referred to as "Out-of-Network."

38. Retired Participant
The term **"Retired Participant"** shall mean a person who has been an Active Employee, who is no longer actively working at the Trade and who is receiving Retirement Benefits under either the Operating Engineers Local 101 Pension Plan or Central Pension Plan.

39. Sickness
The term **"Sickness"** includes physical illness, pain or a fever not caused by an Accident.

40. Spouse
The term **"Spouse"** means an individual who is the legal spouse of, and not divorced nor legally separated from, an eligible Employee at the time a Benefit becomes payable from the Fund. Notwithstanding any contrary provisions of law or in the Plan, the Participant and his spouse must be of opposite sexes in order for such spouse to qualify as a "Spouse" within the meaning of this Section.

41. Totally Disabled
The term **"Totally Disabled"** unless otherwise specifically defined, refers to a disability resulting solely from a Sickness or Accident which prevents the Covered Employee from performing work as defined in the work jurisdiction definition of the Collective Bargaining Agreement or prevents the Covered Employee's Dependent(s) from engaging in substantially all of the normal activities of a person of like age and sex in good health. Both the Covered Employee and the Covered Employee's Dependent(s) must be under the regular care and actual attendance of a Physician.

42. Trust Agreement
The term **"Trust Agreement"** means the amended Agreement and Declaration of Trust effective October 1, 1962, including the original Trust Agreement.

43. Trust Fund, Fund or Trust
The term **"Trust Fund", "Fund"** or **"Trust"** means the Operating Engineers Local 101 Health and Welfare Fund and all assets thereof, including policies, all investments made and held by the Trustees, and any and all other property or funds received and held by the Trustees under the terms of this Plan.

44. Trustees
The term **"Trustees"** means the persons designated in the Trust Agreement, their predecessors or their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees shall constitute the "Administrator", the "Plan Sponsor" and the "Named Fiduciaries" of the Trust Fund and of the Plan established and maintained under the authority of the Trust Agreement.

45. Union
The term **"Union"** means the International Union of Operating Engineers, Hoisting and Portable Local Union 101, AFL-CIO

46. Union Employee
The term **"Union Employee"** means a permanent Employee of the Union who works at least twenty-one (21) hours per week.

47. Usual, Customary and Reasonable Charge (UCR Charge)
The term **"Usual, Customary and Reasonable Charge (UCR Charge)"** means that the charge by any provider for a service must be similar to all other like providers of the same service in that geographical area where the services are performed and which is no higher than the 90th percentile of prevailing health care data on such charges. The "geographical area" reference is the zip code for the general level of charges being made by a Physician of similar training and experience.