OPERATING ENGINEERS LOCAL 101

HEALTH AND WELFARE PLAN

RESTATED PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Revised Effective June 1, 2025

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; and amended and restated as of January 1, 2006 in the, and amended and restated as of November 6, 2013, 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 June 1, 2025;

NOW, THEREFORE, the Operating Engineers Local 101 Health and Welfare Plan is hereby restated, ***effective June 1, 2025***, as follows:

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Board of Trustees

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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 Fund Office, 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 (UMR for instance), the Plan is not an insured UMR plan. The Operating Engineers Local 101 Health and Welfare Plan provides the Benefits of the Plan and the affiliation with the UMR 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 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, unless a Spouse or Dependent child submits a written waiver as described in Section Two, subsection H – Waiver of Spouse or Dependent Child Age 19-26 Coverage. Notwithstanding the previous sentence, the Participant and all Plan eligible Dependents are covered for Benefits on the Participant's Eligibility Date. Upon notification to the Plan, any new Plan eligible Spouse or Child is eligible for Benefits on the Eligibility Date as determined in the Eligibility for Dependent Coverage on page 30. A Retiree may have a special enrollment period to add coverage for a new Dependent. See page 26 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. Please refer to Section Thirteen of this document for more information on HIPAA

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 NOW COVERED UNDER A SEPARATE FULLY INSURED MEDICARE ADVANTAGE WITH PRESCRIPTION DRUG PLAN (MAPD).

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 (In-Network)

After the Deductible, the Preferred Payment Level (In-Network) pays:

- 80% of Covered Charges until the $4,000 in Incremental Covered Charges (Plan pays $3,200 in Benefits), then
- 95% of Covered Charges until a cumulative total of $113,989 ($4,000 + $109,989) in Incremental Covered Charges (Plan pays an additional $104,490 in Benefits), then
- 100% of Covered Charges thereafter

Preferred Payment Level (In-Network) = Example

	Incremental Covered Charges	Plan Pays	Patient Pays
Deductible	$400	$0	$400
80% Coverage	$4,000	$3,200	$800
95% Coverage	$109,989	$104,490	$5,499
100% Coverage	$75,000	$75,000	$0
	$189,389	$182,690	$6,699

Standard Payment Level (Out-of-Network)

After the Deductible, the Standard Payment Level (Out-of-Network) pays:

- 70% of Covered Charges until $5,500 in Incremental Covered Charges (Plan pays $3,850 in Benefits), then
- 90% of Covered Charges thereafter

Standard Payment Level (Out-of-Network) = Example

	Incremental Covered Charges	Plan Pays	Patient Pays
Deductible	$400	$0	$400
70% Coverage	$5,500	$3,850	$1,650
90% Coverage	$183,489	165,140	$18,349
	$189,389	$168,990	$20,399

ANNUAL DEDUCTIBLE (PER PERSON) $400

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 the UnitedHealthcare Choice Plus Network, you can visit UMR's website at www.umr.com/find-a-provider or call their Customer Service Department Toll-Free: 800-826-9781.

In the event that a Covered Person: (1) receives incorrect information from the UMR provider directory regarding a provider or facility's participation status; or (2) UMR, with respect to a Covered Person's inquiry either (a) fails to respond; or (b) responds with incorrect information regarding a provider or facility's participation status, and the Covered Person receives an item or service from the provider that would otherwise be covered by the Plan, the Plan shall apply the deductible, coinsurance, copayment, and annual maximum that would apply had the item or service been provided by a PPO Provider and the amounts paid will count towards the PPO Provider annual maximum.

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*. 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 Section One, pages 5 and 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 UMR Website at www.umr.com.

Schedule of Benefits

The following is a summary of Benefits covered by the Plan. Each Benefit is explained in further detail beginning with Section 4 on page 38. 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.

When a Covered Person receives items or services from a non-PPO provider at an In-Network Hospital or facility, the Covered Person will generally pay the same Deductible and Co-Payment and/or Co-Insurance that (s)he would have paid had (s)he received the treatment from a PPO Provider (i.e., the Covered Person will generally pay the Preferred Payment Amount). However, to the extent an item or service is not an Ancillary Benefit, a Covered Person will pay the Standard Payment Amount when the non-PPO provider furnishes the Covered Person with notice of his or her rights under the No Surprises Act, and the Covered Person waives these rights with respect to the items and services provided by the non-PPO Provider.

BENEFIT AMOUNT

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

Active, Fund and Union Employees or Non-Bargaining Unit Employees Only

B. 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

After the Covered Person meets his or her Comprehensive Medical Deductible, the Plan will pay Covered Charges for air ambulance services provided by a non-PPO provider at the Preferred Payment Level, as if the services has been provided by a PPO Provider (i.e., the Co-insurance amount for air ambulance services provided by a non-PPO provider will be calculated using the Preferred Payment Level).

C. 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 41 for further information.

Coinsurance

In-Network ..... Preferred

Out-of-Network ..... Standard

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

D. Comprehensive Medical Benefit

Coinsurance

In-Network ..... Preferred

Out-of-Network ..... Standard

Annual Comprehensive Medical Deductible .....$400 per person

E. Death Benefit $15,000

Active, Fund and Union Employees, Owner-Operator and Self-Contributors Only

F. Death Benefit $10,000

Retired and Disabled Participants Only

G. 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

The Maximum Benefit does not apply to pediatric dental care up to age 19. However, expenses incurred for pediatric dental care for those up to age 19 will accumulate towards the Maximum Benefit per calendar year per family.

H. 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

I. 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 Amplifon 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

J. 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

K. 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

L. Loss of Time Benefit

Active, Fund and Union Employees Only

Maximum Benefit .....$350 per week

Maximum number of weeks (within 12 months)..... 26 weeks per incident

M. 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

N. Mental Health and Substance Abuse Benefit

*The Mental Health and Substance Abuse Benefits are not subject to the Comprehensive Medical Deductible. Also, these benefits do **not** have a separate deductible. Other than where mentioned throughout the document, benefits for Mental Health and Substance Abuse will be the same as benefits for sickness or injury.*

Coinsurance

In-Network ..... Preferred

Out-of-Network..... Standard

Office Visit

In-Network ..... 100% after $20 Participant Co-Payment

Out-of-Network ..... Standard

O. 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)

Primary Care Physician ..... 100% after $20 Participant Co-Payment

Specialist ..... 100% after $27 Participant Co-Payment

P. 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 **after** the separate deductible for Prescription Drug Benefit deductible is assessed.*

See Benefit Description on page 56 for further information.

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

Generic ..... Greater of $15 or 10% of cost of drug

Brand Name ..... Greater of $40 or 30% of cost of drug

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

Maintenance (Mail Order or CVS Retail Pharmacy) Co-Payment *(Participant pays)*

Generic $25

Preferred Brand Name $100

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

Separate Calendar Year Deductible

Per Person $135

Per Family $270

Q. Preventive Care Benefits

Coinsurance

In-Network 100%

Out-of-Network ..... Standard

R. 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

Limited to a combined limit of 25 visits and then must prove medical necessity.

S. Union Health and Wellness Center

The Benefits through the Union Health and Wellness Center *are not subject to the Comprehensive Medical Deductible, copayment or coinsurance and are free of charge to all eligible Participants and eligible Dependents age 2 and older*

T. 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

U. Sterilization Benefit for Males (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

V. 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

W. Telehealth Benefit

The Telehealth Benefit is an In-Network Benefit only and not subject to the Comprehensive Medical Deductible, copayment or coinsurance.

Coinsurance

In-Network 100%

Out-of-Network ..... Not Covered

X. 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 $45.00 (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.

Y. Continuing Care Benefit

When a PPO provider becomes a non-PPO provider, Covered Persons receiving continuing care from the provider shall be notified that the provider is a non-PPO provider and furnished with the opportunity to choose to continue receiving treatment from the provider as if the provider was still a PPO provider during the period ending on the earlier of: (1) ninety (90) days after the date that the Covered Person is notified that the provider is a non-PPO provider; or (2) the date the Covered Person is no longer a continuing care patient with respect to the provider.

A continuing care patient constitutes a Covered Person who is at least one of the following:

1. Undergoing a course of treatment for a serious and complex condition;
2. Undergoing a course of institutional or inpatient care;
3. Scheduled to undergo non-elective surgery, including receipt of post-operative care;
4. Pregnant and undergoing a course of treatment for the pregnancy; or
5. Terminally ill and is receiving treatment for such illness.

Z. Motorized Wheelchair or Scooter Benefit

The Plan will pay benefits if deemed medically necessary at:

Coinsurance

In-Network 80%

Out-of-Network 70%

Any out-of-pocket Expense incurred under this benefit shall NOT be included in or accrue towards the Out-of-Pocket Limit.

Section Two – Eligibility

The following topics are discussed under this Section on Eligibility:

A. Eligibility for Active Employees	I. Termination of Eligibility for Eligible Employees
B. Eligibility for Owner-Operators	J. Termination of Eligibility due to Non-Bargaining Employment
C. Eligibility for Fund Employees and Union Employees	K. Reestablishment of Eligibility for Active Employees
D. Eligibility under the Family and Medical Leave Act	L. Termination of Eligibility for Dependents
E. Eligibility for Active Disabled Employee	M. COBRA Continuation Coverage
F. Eligibility for Retired Participants	N. Service in the Armed Forces
G. Eligibility for Retired Medicare Supplement Plan Participants	O. Uniformed Services Employment and Reemployment Rights Act (USERRA)
H. Eligibility for Dependent Coverage	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 27 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 two or 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 Employers
An Employee who is not currently eligible under the Plan may establish initial eligibility under the following conditions:

i. Employee shall be employed by the Employer for at least 90 days prior to the date on which the Employer became bound for the first time to a Collective Bargaining; and

ii. 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 (or MAPD for a Medicare Eligible Retiree) 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 Apprenticeship Fund Employees And Union Employees

Apprenticeship Fund Employees (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

   - In the case of an Active Employee, 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 (1) of the twelve (12) months immediately preceding his initial annuity starting date; and, (b) further provided that he also had earned five (5) "service years" of 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 from the Operating Engineers Local No. 101 Pension Fund; 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.

   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 on behalf of himself, his Spouse and his Dependents. Failure to make a timely election for himself, his Spouse and his Dependents will bar participation in the Plan as a Retired Participant, subject to the right to re-elect set forth in subsection F.7 below. In the event a Spouse or a Dependent of a Retired Participant is removed from Retirement Coverage under the Plan no future opportunity for participation will be offered to the Spouse or a Dependent of a Retired Participant in the future.

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.

   If the Trustees formally declare that a severe labor shortage exists, a Retired Participant may return to employment for the duration of the severe labor shortage, as determined by the Trustees. A Retiree may only take advantage of this program if they have been retired for at least **six months**. During a severe labor shortage, Retired Participants shall not have their eligibility for coverage terminated for work in employment, so long as the Retired Participant notifies the Administrative Manager in writing of an election to return to work during the severe

labor shortage before returning to employment. A Retired Participant may have his eligibility as a Retired Participant terminated upon meeting the requirements for initial eligibility for Active Employees provided in subsection A.1. A Retired Participant who returns to employment other than under the rules set forth in this paragraph shall have his eligibility for coverage terminated in accordance with the provisions of this subsection F.7.

The duration of the severe labor shortage, as declared by the Trustees, shall automatically end on the last day of the month in which the next regularly scheduled Trustee meeting is held. The Trustees, upon a majority vote in favor, may vote to renew their declaration of a severe labor shortage at each quarterly Trustee meeting. There is no limit on the number of extensions permitted.

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 becomes eligible for Medicare, 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 payment and proof of enrollment in Medicare Part A and B. .

G. Eligibility For Retired Medicare Advantage with Prescription Drug plan (MAPD)

NOTE

If you are a Disabled or Retired Participant who is eligible for Medicare, you are covered by a separate Medicare Advantage with Prescription Drug Plan (MAPD) and you will not be eligible for benefits under this Section One. Instead, you will be eligible for benefits through the MAPD. For more information about the MAPD, please contact Retiree First at 816-205-8353 (TTY 711) or toll free 855-460-4377 (TTY 711).

***However, note that your eligibility for the MAPD Plan is as outlined below in this Section G.**

A Medicare-eligible Retired Participant may participate in the MAPD 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 MAPD from the Retired Plan without a one-day break in coverage, shall be eligible to participate in the MAPD 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 MAPD except as provided in Paragraph 7 below.

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

A Retired Participant with an annuity starting date on or after January 1, 2011, 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 MAPD without a one-day break in coverage, shall be eligible to participate in the MAPD if (s)he makes self-contributions to the Fund, on a monthly basis, in an amount determined by the benefit subsidy formula, provided the participant (a) had at least 30 Years of Service under either the Local 101 Pension Fund or the I.U.O.E. Central Pension Fund or at least 100 Credited Hours in Covered Employment in at least one (1) of the twelve (12) months immediately preceding his initial annuity starting date; and (b) further provided that he also had earned five (5) "service years" of Covered Employment in the seven (7) years immediately preceding his initial annuity starting date.

A Participant receiving a disability benefit from the Operating Engineers Local 101 Pension Plan is eligible for the MAPD if (s)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 or her 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. If the Participant had previously received coverage from the Plan as a Retiree under Section Two, subsection F(4) of this Plan, then the Participant may transition to the Plan's MAPD if the individual does not incur a one-day break in coverage from the Plan to the Medicare Advantage and Prescription Drug Plan ("MAPD").

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

NOTE: If you are a Disabled or Retired Participant who is eligible for Medicare, you are covered by a separate Medicare Advantage with Prescription Drug Plan (MAPD) and you will not be eligible for benefits under this Section One. Instead, you will be eligible for benefits through the MAPD. For more information about the MAPD, please contact Retiree First at 816-205-8353 (TTY 711) or toll free 855-460-4377 (TTY 711).

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 MAPD 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 MAPD 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 MAPD 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.

If the Trustees formally declare that a severe labor shortage exists, a Retired Participant may return to employment for the duration of the severe labor shortage, as determined by the Trustees. A Retiree may only take advantage of this program if they have been retired for at least **six months**. During a severe labor shortage, Retired Participants shall not have their eligibility for coverage terminated for work in employment, so long as the Retired Participant notifies the Administrative Manager in writing of an election to return to work during the severe labor shortage before returning to employment. A Retired Participant may have his eligibility as a Retired Participant terminated upon meeting the requirements for initial eligibility for Active Employees provided in subsection A.1. A Retired Participant who returns to employment other than under the rules set forth in this paragraph shall have his eligibility for coverage terminated in accordance with the provisions of this subsection 0.8. The duration of the severe labor shortage, as declared by the Trustees, shall automatically end on the last day of the month in which the next regularly scheduled Trustee meeting is held. The Trustees, upon a majority vote in favor, may vote to renew their declaration of a severe labor shortage at each quarterly Trustee meeting. There is no limit on the number of extensions permitted.

9. Termination of Eligibility

A MAPD 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).

Waiver of Spouse or Dependent Child Age 19-26 Coverage

If a Spouse has coverage under an employer provided health care plan, that Spouse may waive coverage under this Plan by providing proof of other coverage and filing a written waiver of coverage with the Fund Office. A Dependent child age 19-26 may waive coverage under the Plan by filing a written waiver of coverage with the Fund Office.

By waiving coverage, the Spouse, Dependent child and the Participant relieve the Plan from any liability or obligation for claims that may have resulted if the Spouse or Dependent child had been covered under the Plan. A waiver of coverage will be effective the first day of the month after the signed waiver is received by the Fund Office. A waiver of coverage form is available from the Fund Office. Upon waiving coverage, as applicable, the Spouse or Dependent child will receive a certificate of creditable coverage from the Fund Office.

If at a later date and for any reason (including loss of employer sponsored coverage), a Spouse or Dependent child age 19-26 would like to be a Dependent under the Plan again and is still eligible to be a Dependent under the Plan, the Spouse or Dependent child can once again be covered under the Plan by submitting a written revocation form acceptable by the Trustees to the Fund Office. The Spouse or Dependent child will again become eligible for coverage for claims incurred the first day of the month after the revocation form is received by the Fund Office. Claims for the Dependent child will not be paid if a new and complete enrollment form is not on file with the Fund Office.

If a spouse of a Retired Participant had ACA minimum coverage continuously after the Retired Participant took the Retiree coverage and then loses that coverage, the spouse may apply for coverage within 60 days of losing the other coverage.

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 surviving spouse my elect to continue coverage by paying the self-payment rate as if the participant was retired before death. Eligibility will terminate if the surviving spouse remarries or doesn't continue paying the premiums. If this coverage is not elected, then 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 unless the surviving spouse is self-paying as if the participant was retired at death to continue coverage.

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 or Disabled 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. When is COBRA Continuation Coverage Available?

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. You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days 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. How is COBRA Continuation Coverage Provided?

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. Disability extension of 18-month period of continuation coverage

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. Second qualifying event extension of 18-month period of continuation coverage

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. If You Have Questions

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. Keep Your Plan Informed of Address Changes

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. Plan Contact Information

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

12. COBRA Continuation Coverage Procedures

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 WITH CENTRAL PENSION FUND OR ANY OPERATING ENGINEERS LOCAL.**

EMPLOYEE ASSISTANCE PROGRAM

The Plan provides a free program to help Covered Person's cope with personal difficulties that can affect their lives both at home and at work. This free program is called the Optum Employee Assistance Program ("EAP") and is available to all Covered Persons.

The EAP assists Covered Persons with a variety of life problems including alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship discord; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and educational and career related problems.

The EAP offers assessment, short-term counseling (with up to 3 visits), and/or referral and follow-up services. Services provided by the EAP are available at **no cost** to you or your family; however, situations that require outside referral or continued counseling (beyond the 3 visits) may or may not be covered by the Fund. In such cases, please check the plan document or contact the Plan Administrator to determine what benefits may be available to you. Please be advised that all contact with the EAP is confidential.

The Trustees encourage you to take advantage of the services offered by the EAP before you seek inpatient or outpatient treatment for mental health or substance abuse.

To utilize this program, please contact the Optum EAP at 866-248-4096. Information is also available at: www.LiveandWorkWell.com

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 40 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 Deductible (per person) $400

Payment Levels

Preferred Payment Level (In-Network)

After the Deductible, the Preferred Payment Level (In-Network) pays:

- 80% of Covered Charges until $4,000 in Incremental Covered Charges (Plan pays $3,200 in Benefits), then
- 95% of Covered Charges until a cumulative total of $113,989 ($4,000 + $109,989) in Incremental Covered Charges Plan Pays an additional $104,490 in Benefits; then
- 100% of Covered Charges thereafter

Preferred Payment Level (In-Network) = Example

	Incremental Covered Charges	Plan Pays	Patient Pays
Deductible	$400	$0	$400
80% Coverage	$4,000	$3,200	$800
95% Coverage	$109,989	$104,490	$5,499
100% Coverage	$75,000	$75,000	$0
	$189,389	$182,690	$6,699

Standard Payment Level (Out-of-Network)

After the Deductible, the Standard Payment Level (Out-of-Network) pays:

- 70% of Covered Charges until $5,500 in Incremental Covered Charges (Plan pays $3,850 in Benefits); then
- 90% of Covered Charges thereafter

Standard Payment Level (Out-of-Network) = Example

	Incremental Covered Charges	Plan Pays	Patient Pays
Deductible	$400	$0	$400
70% Coverage	$5,500	$3,850	$1,650
90% Coverage	$183,489	$165,140	$18,349
	$189,389	$168,990	$20,399

Standard Payment Level

ANNUAL DEDUCTIBLE (PER PERSON) $400

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. However, when a Covered Person receives items or services from a non-PPO provider at an In-Network Hospital or facility, the Covered Person will generally pay the same Payment Amount or Level that (s)he would have paid had (s)he received the treatment from a PPO provider. (i.e., the Covered Person will generally pay the Preferred Payment Amount). However, to the extent an item or service is not an Ancillary Benefit, a Covered Person will pay the Standard Payment Amount when the non-PPO provider furnishes the Covered Person with notice of his or her rights under the No Surprises Act, and the Covered Person waives these rights with the respect to the items and services provided by the non-PPO Provider.

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**	
Mental Health and Substance Abuse Benefits *See Benefit Description for Specific Limitations*	Preferred	Standard	No
Ambulance Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Chiropractic Expense Benefit *See Benefit Description for Specific Limitations*	Preferred	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
Hospice Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes

Maternity Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Preventive Care Benefits *See Benefit Description for Specific Limitations*	100% Co-payment	100%	No
Physician Services Benefit – All other covered services Specialist Office Visit Only *See Benefit Description for Specific Limitations*	Preferred 100% Less $27 Co-payment	Standard	Yes Out-of-Network Yes
Rehabilitative Therapy Benefit *See Benefit Description for Specific Limitations*	Preferred	Standard	Yes
Skilled Nursing Facility See Benefit Description for Specific Limitations	Preferred	Standard	Yes
Sterilization Benefit for Males (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
Telehealth Benefit *See Benefit Description for Specific Limitations*	100%	Not Covered	No

A. Mental Health and Substance Abuse Benefit

Coinsurance

Preferred Payment Level (In-Network)

Standard Payment Level (Out-of-Network)

Deductible Amount

This Benefit is not subject to any Deductibles.

Copayment

$20 copayment for In-Network Office Visits

Benefits for treatment of mental health 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 Physician. Benefits for treatment of alcohol or drug abuse are **NOT** payable for service or treatment rendered by anyone other than a Physician.

To the extent Alcohol and Drug Treatment and Mental Health items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

Covered Charges are:

1. Charges by a Hospital for room and board charges (semi-private room only),
2. Charges for treatments by a Physician,
3. Charges for individual therapy by a Physician,
4. Administration of drugs or medicine if prescribed by a Physician legally authorized and licensed to prescribe drugs or medicine, and
5. Out-Patient charges for both Hospital and office visits.
6. Mental health evaluations and assessment,
7. Diagnosis,
8. Treatment planning,
9. Referral services,
10. Medication management,
11. Individual, family and group therapeutic services (including intensive Out-Patient therapy),
12. Crisis intervention,
13. Psychological testing.

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

a) 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

b) 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 and professional air ambulance including helicopter service, but not transportation by any other common carrier; subject to the annual deductible and coinsurance.

Once a Covered Person meets his or her calendar year Deductible, the Plan will pay Covered Charges for air ambulance services provided by a non-PPO provider at the Preferred Payment Level, as if the services had been provided by a PPO provider.

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 Preferred Payment Level for In-Network and at the Standard Rate for Out-of-Network.

- For 30 visits per Plan Year including those applied to the deductible.
- Limit of two X-Ray payments per Plan Year.

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

The Benefit period for Chiropractic Benefits is January 1 through December 31 (Plan Year).

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

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

$400 per person per calendar year

Coinsurance

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

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

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),
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 UMR 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 $400 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, as well as covered donor services, must be Prior Authorized by UMR according to their medical necessity guidelines (subject to all other Plan limitations and exclusions). Contact UMR at 800-826-9781 regarding coverage for these services.
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, regardless of whether the treatment is received at an In-Network facility, an Out-of-Network facility, or provided by a non-PPO provider.
13. Infusion Therapy - In-Patient or Out-Patient – Intravenous injections and solutions are covered.
14. Intravenous solutions and injections administered outside a Hospital are covered.
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.

Benefits will further be paid for such expenses at a Preferred Payment Level if the item or service is provided by a non-PPO provider at an In-Network Hospital or facility.

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 UMR CASE MANAGEMENT AT 800-826-9781. UMR 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 <u>not</u> provided by the Plan.

G. <u>Hospice Benefit</u>

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.

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

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. <u>Maternity Benefit</u>

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. Birth centers will be included for coverage.

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).

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

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

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. 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 a Primary Care Physician office visit including urgent care and walk-in retail clinics, as a special separate Co-Payment,
- The Covered Person pays **$27** for a Specialist Physician 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.

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.*

J. Preventive Care Benefits

Please note that the Deductible Does Not Apply to Preventive Care Benefits.

Benefits for Preventive Care as detailed below will be paid at 100% when received from an In-Network Provider without application of the Deductible Amount or coinsurance. These benefits will be provided to all eligible non-Medicare Eligible Person regardless of benefits previously paid or applied to the Deductible Amount under the Major Medical Benefit.

Preventive Care Benefits are available for the following items and services:

1. Evidence-based items or services that have in effect rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
2. Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. A recommendation is considered to be for "routine use" if it appears on the Immunization Schedules of the CDC;
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, to the extent not already included in recommendations from USPSTF, evidence-informed preventive care and screenings provided for in comprehensive guidelines by the Health Resources and Services Administration.

The Plan will rely on established techniques and relevant evidence to determine the frequency, method, treatment or setting for which a recommended preventive service will be available without cost-sharing requirements. If preventive services are received as a part of a regular office visit, the Plan can require you to pay a portion of the costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your provider bills you for the preventive services separately from the office visit.

For a list of Preventive Care items and services that may be covered by the Plan, please see:

- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
- https://www.cdc.gov/vaccines/schedules/index.html
- Periodicity Schedule found here: https://mchb.hrsa.gov/programs-impact/bright-futures
- https://www.hrsa.gov/womens-guidelines

Please note that the Plan is generally not required to cover a new or updated Preventive Care Benefit item or service until the first day of a plan year beginning one year after the final issue date of recommendation about the new or updated Preventive Care Benefit item or service. This means that a new or updated item or service may be listed on one of the above resources, but is not yet covered by the Plan. If you have questions about whether a new or updated Preventive Care item or service is covered by the Plan, please contact the Fund Office.

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.

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

Services will be limited to a combined total of 25 visits and then future visits must be medically necessary.

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.), including aquatic therapy

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.

4. Coverage for Cochlear Implants when medically Necessary

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.

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

M. Sterilization Benefit for Males (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.

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

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.

To the extent such items and services are provided by a non-PPO provider at an In-Network Hospital or Facility, Benefits will be paid in accordance with the rule listed in the Medical Benefits chart.

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.

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. Orthognathic 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 orthognathic surgery per individual per lifetime,
4. Any elective or reconstructive Surgical Procedure for cosmetic purposes; 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. Cosmetic rhinoplasty whether an independent procedure or done in conjunction with any other surgical procedure. Reduction mammoplasty unless the procedure meets medical necessity guidelines, Breast reductions are allowed if medically necessary.
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. 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. Telehealth Benefits

The Telehealth Benefit utilizes Teladoc to give covered persons the capability to speak with a certified physician online (with a webcam) or through a smartphone in order to get quick access to certain prescriptions or other advice regarding a medical situation. This online doctor visit is available 24 hours a day, 7 days a week and can be accessed at. This benefit is not meant for emergency situations but it can help in deciding whether a medical situation is an emergency. If the online doctor directs you to go to the emergency room or an urgent care center, you will not be charged. Benefits for Telehealth Visits are payable according to the Schedule of Benefits. No benefits will be payable for any other online program or telemedicine service.

Q. 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.

R. Motorized Wheelchair or Scooter Benefit

The Plan shall pay for expenses according to the Schedule of Benefits for the rental (up to the purchase price) or purchase of a motorized wheelchair or scooter or like equipment for a disabled individual when deemed medically necessary. If rented, benefits will only be paid up to the purchase price.

A motorized/power or manual assist wheelchair is considered medically necessary when ALL the following criteria are met:

- Without use of a wheelchair the patient would be confined to bed or chair and be unable to move around in their residence; AND
- A wheelchair is considered medically necessary; AND
- The patient is physically unable to operate a manual wheelchair; AND
- The patient can safely operate and control a power wheelchair; AND
- The patient can safely transfer in or out of a motorized/power wheelchair.

If documentation does not support the medical necessity of a power wheelchair but does support the medical necessity of a manual wheelchair, payment is based on the allowance for the least costly medically appropriate alternative.

If the length of need for a power wheelchair is 6 months or less, rental only will be covered. In this situation, purchase would not be medically necessary.

Only one wheelchair may be rented, or if less costly, purchased at a time. The type of wheelchair is based on the patient's physical condition and should be able to be used primarily inside, but also outside the home. The Plan follows Medicare guidelines when determining what type of wheelchair is covered for the individual.

A replacement wheelchair is considered medically necessary only when there is a change in the patient's physical condition or when the wheelchair is inoperative and cannot be repaired at a cost less than rental or replacement.

A one month rental of a wheelchair is covered if a patient owned wheelchair is being repaired.

Any out-of-pocket Expense incurred under this benefit shall NOT be included in or accrue towards the Out-of-Pocket Limit.

S. Continuing Care

When a PPO provider becomes a non-PPO provider, Covered Persons receiving continuing care from the provider will be notified that the provider is a non-PPO provider and furnished the opportunity to choose to continue receiving treatment from the provider as if the provider was still a PPO provider during the period ending on the earlier of:

1. Ninety (90) days after the date that the Covered Person is notified that the provider is a non-PPO provider; or

2. The date the Covered person is no longer a continuing care patient with respect to the provider.

A continuing care patient constitutes a Covered Person who is:

1. undergoing a course of treatment for a serious and complex condition;
2. undergoing a course of institutional or inpatient care;
3. Scheduled to undergo non-elective surgery, including receipt of post-operative care;
4. Pregnant and undergoing a course of treatment for the pregnancy;
5. Terminally ill and is receiving treatment for such illness.

T. Union Health and Wellness Center

The Plan has contracted with a third party to operate a health care clinic to provide primary medical care that will include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses within the licensure and qualification level of the on-site medical staff. Primary care is performed and managed by a Physician collaborating with other health professionals, and utilizing consultation or referral as appropriate for more complex and time-intensive diagnostic procedures and/or treatments. The health care clinic is located at 6601 Winchester Avenue, Suite 240, Kansas City, MO, 64133.

The hours of operations for the Union Health and Wellness Center will be as follows: 7:30 a.m. to 5:30 p.m. (Monday through Friday)

The Union Health and Wellness Center provides the following eligible services at no cost to the eligible Participant or the eligible Dependent age 2 and older:

1. **BENEFITS**
   a. Primary/Urgent Care:
      i. First aid services within the licensure and qualification level of the on-site staff
      ii. General physical examinations
      iii. Annual physical examinations
      iv. School/Sports physical examinations
      v. Coordination of referrals for specialist visits and/or additional diagnostics
      vi. Routine Laboratory services, including any in-house or outside laboratory tests that the provider deems appropriate and necessary for diagnostic and treatment purposes
      vii. Patient education regarding illness, medications, chronic conditions, wellness, disease awareness, and preventive care
      viii. Chronic condition management
      ix. Vaccination program for eligible Participants and eligible Dependents age 2 and older. Advance notification to the Union Health and Wellness Center is suggested to ensure requested vaccines are in stock prior to arrival.
      x. HIV testing but not including treatment of HIV/AIDs
      xi. Initial screening and treatment of mild behavior health conditions but not including ongoing management of moderate to severe anxiety or other psychiatric services. Referrals to in network providers can be made for these services when identified.

b. Health and Wellness
   i. Biometric testing
   ii. Preventive Screenings including but not limited to blood pressure and skin cancer
   iii. Wellness educational materials
   iv. Influenza and Shingles Vaccines. Advance notification to the Union Health and Wellness Center is suggested to ensure requested vaccines are in stock prior to arrival.

c. Occupational Health
   i. Pre-Placement physical examinations
   ii. DOT physical examinations
   iii. Return to Work physical examinations
   iv. Breath Alcohol Testing. Including post-accident, random, for cause and department of transportation.
   v. Drug Screening collection and testing. Including post-accident, random, for cause and department of transportation.

2. **EXCLUSIONS**
   a. Services for Dependent children under age 2
   b. Diagnostic X-rays including but not limited to mammograms, CT scans, MRIs or PET scans.
   c. Emergency Trauma Care. If there is an emergency medical situation support will be provided until arrival of EMS.
   d. Prescription refills obtained by a physician not affiliated with the Union Health and Wellness Center
   e. Any other services not detailed in these sections.

U. 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, or at a CVS Retail Pharmacy, Costco Pharmacy or Kroger's Pharmacy. The mail-order service or CVS Retail Pharmacy or at a CVS Retail Pharmacy, Costco Pharmacy or Kroger's Pharmacy 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 ($135 PER PERSON OR $270 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 or CVS Retail Pharmacy (90-day supply)
Generic	Greater of $15 or 10% of cost	$25
Brand	Greater of $40 or 30% of cost	$100

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:

- $ 135 per person per calendar year
- $ 270 per family per calendar year

D. Routine Preventive Care Prescription Drugs

The Plan will waive the Prescription Drug Benefit Deductible and pay 100% of the cost of Routine Preventive Care Prescription Drugs purchased at retail pharmacies that participate in the CVS network.

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. Utilization Management

The Plan has also elected to implement the CVS/Caremark utilization management strategies to maintain and preserve a high quality and cost-effective program for you. This program is **mandatory** for certain medication classes. Utilization management can include prior authorizations/medical necessity, step therapy and quantity limits.

For more information about utilization management strategies and to see if your medication requires utilization management please contact CVS Caremark at 1-866-260-4646 or visit www.caremark.com. Both are available 24x7.

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.

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

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.

"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 19 (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

The Maximum Benefit limit does not apply to pediatric dental care up to age 19. However, expenses incurred for pediatric dental care for those up to age 19 will accumulate towards the Maximum Benefit per calendar year 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 19.)
  - 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**.

The above Maximum Amount does not apply to pediatric dental care up to age 19. However, expenses incurred for pediatric dental care for those up to age 19 will accumulate towards the Maximum Benefit per calendar year per family.

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 temporomandibular 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. Please contact Delta Dental at 800-335-8266 to submit a pre-authorization request.

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 101 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 Amplifon 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 Amplifon 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 Amplifon associated providers at the prevailing discount as established from time to time by Amplifon 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 Amplifon 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 or her occupation, and
2. requires the regular care and attendance of a Physician or Surgeon.

Note: An injury or sickness related to pregnancy may qualify for Loss of Time Benefits.

Successive periods of disability, due to the same or related causes will be considered as one period of disability, unless separated by a return to full-time work for at least six weeks or medical certification of availability for employment.

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. Claim forms must be filed with the Fund Office within 12 months of the onset of an injury or sickness which prevents you from working and requires the regular care of a Physician or Surgeon.

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 (unless specifically provided for in a Participation Agreement), 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 .....$350 per week
Maximum number of weeks (within 12 months)..... 26 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 Non-Bargaining Unit Employee 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.

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.

Section Eleven – Benefit Exclusions and Limitations

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 exclusion 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 64.
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 (except as covered under the preventive care benefit), including bariatric surgery, gastric bypass, gastric banding, open or laparoscopic vertical banded gastroplasty, laparoscopic 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, unless otherwise covered under the ACA. 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 ThAIRapy vests or non-standard equipment of any type. Any equipment that does not meet the covered Durable Medical Equipment criteria on page 43, 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 43 or reduction mammoplasty that meets medical necessity guidelines.

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 other than approved limited genetic testing for certain treatments related to Oncotype DX Breast Cancer Assay and BRAC 1 and BRAC 2 testing (subject to the Plan's guidelines on medical necessity, a copy of which can be obtained from the Fund Office).

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 except as covered under the preventive care benefit.

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, except for claims for implantable neurostimulators.

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

32. Any expenses for treatment of temporomandibular 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 under the preventive care benefit or for immunizations that are needed due to cancer diagnosis.

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

43. Gene therapy, including any services, supplies and/or drugs related to gene therapy.
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 Orthognathic 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.) unless otherwise covered as a preventative services benefit.
57. Retired and COBRA Participants are not eligible for Loss of Time Benefit.
58. Spouses of Eligible Participants are not eligible for Loss of Time Benefit, Life Insurance Benefit or Accidental Death and Dismemberment Benefit.
59. Hyperbaric Oxygen treatment, regardless of diagnosis.
60. 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.
61. Expenses incurred by a Child born to a Covered Person serving as a surrogate mother.
62. Expenses incurred for Donor Testing or Typing to determine eligibility or suitability for Organ or Tissue donation.
63. Topical Analgesics with ingredients that have not been FDA approved in combination with one another to manage pain in patch form.
64. For certain infusion therapy/injectables unless obtained from a designated specialty pharmacy or designated home infusion vendor.
65. Expenses incurred for acupuncture.
66. Expenses incurred for bereavement counseling.
67. Topical analgesic/pain patches are not covered.

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, and Loss of Time Benefits, which are processed as described in Paragraph A.2 below) must be submitted in a written or electronic form approved by the Board of Trustees within 365 days after the product or service is provided to the Participant, unless it is a claim for dental benefits, which must be submitted within 365 days after the product or services 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 SURGERY AND IN-PATIENT HOSPITALIZATION MUST BE PRE-CERTIFIED, INCLUDING CLAIMS FOR SURGERY AND IN-PATIENT HOSPITALIZATION PROVIDED UNDER THE MENTAL HEALTH CARE AND ALCOHOL ANDSUBSTANCE ABUSE PROVISIONS 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. If a Participant attempts to request pre-certification for surgery or In-Patient Hospitalization, 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.

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-10 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. Presenting Loss of Time Claims

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. Claim forms must be filed with the Fund Office within 12 months of the onset of an injury or sickness which prevents you from working and requires the regular care of a Physician or Surgeon.

3. Presenting Claims for Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits

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 any surgery or In-Patient Hospitalization are subject to being reduced if pre-certification is not obtained. If a Physician recommends either surgery or in-patient hospitalization for treatment covered under either the Mental Health or Alcohol and Substance Abuse coverage, pre-certification must be obtained in the same manner that services provided under the comprehensive medical benefit must be pre-certified. 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 for All Claims Except for Loss of Time (Weekly Disability) Claims

Written notice of any initial adverse benefit determination (except Loss of Time (Weekly Disability claims), 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.

9. Manner and Content of Notice of Adverse Benefit Determination – Loss of Time Claims

Written notice of an initial adverse benefit determination on a Loss of Time (Weekly Disability) claim will be sent to the claimant within the appropriate deadlines set forth above. Any notice of adverse benefit determination on such a claim will set forth, in a manner calculated to be understood by the claimant:

a. The specific reason or reasons for the denial;

b. Reference to the specific Plan provisions on which the adverse benefit determination is based;

c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

d. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   i. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

   ii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination; and

   iii. A disability determination regarding the Claimant presented by the claimant to the Plan made by the Social Security Administration;

e. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, 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 a statement that such explanation will be provided free of charge upon request; and

f. The specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the adverse benefit determination on review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

g. 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.

h. The notification of adverse benefit determination shall be provided in a culturally and linguistically appropriate manner as described below, if necessary under the "10% Rule" discussed at the end of this Section.

   The Plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements:

   i. The Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

   ii. The Plan must provide, upon request, a notice in any applicable non-English language; and

   iii. The Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an "applicable non-English language" if ten percent or more ("10% Rule") of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS.

C. Review of Adverse Benefit Determination

1. Filing an Appeal

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

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

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

Medical and Chiropractic Benefits
UMR Claims Appeal Unit
P.O. Box 30546
Salt Lake City, UT 84130

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

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

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

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

2. Deadline for Filing an Appeal

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

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

3. Discretionary Authority

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

4. Procedure for Full and Fair Review of Appeals

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

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

1. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
2. Reasonable access to and, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
3. A full and fair review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
4. For all benefits other than AD&D and Life Insurance, a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

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

1. Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
2. Provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

5. Timing of Notification of Benefit Determination on Appeal

(a) Post-Service Appeals Decided by Claims Administrator

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

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

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

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

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

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

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

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

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

(c) Review of Pre-Service Claims

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

(d) Expedited Review Procedure for Urgent Care Claims

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

6. Content of Notification of Benefit Determination on Appeal

Notices For All Appeals Other Than Loss Of Time Or Disability Appeals

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

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

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

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

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

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

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

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

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

Notices For Determination For Loss Of Time Or Disability Appeals

In the case of an adverse benefit determination of a disability benefit on review, the notification shall set forth, in a manner to be understood by the claimant:

(a) the specific reason or reasons for the adverse benefit determination on review;

(b) reference to the specific Plan provisions on which the adverse benefit determination on review 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 disability benefits;

(d) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

i. the views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

ii. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination on review, without regard to whether the advice was relied upon in making the adverse benefit determination on review; and

iii. a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

2. if the adverse benefit determination on review is based on a medical necessity or experimental treatment or similar exclusion or limit, 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 a statement that such explanation will be provided free of change upon request; and

3. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination on review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

4. a statement of the claimant's right to bring an action under ERISA Section 502(a); which lawsuit must be filed within three years from the date of the denial on appeal to be considered timely. The statement shall include the calendar date the three-year period would run.

In the case of an adverse benefit determination on review, the notification shall be provided in a culturally and linguistically appropriate manner as described below. The Plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements as described below, if necessary under the "10% Rule" discussed at the end of this Section.

1. the Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;
2. the Plan must provide, upon request, a notice in any applicable non-English language; and
3. the Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a "non-English language" is an "applicable non-English language" if ten percent or more ("10% Rule") of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS.

Before the Plan can issue an adverse benefit determination on review on a disability benefit claim, the Board of Trustees shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, or other person making the benefit determination on review (or at the direction of the Plan or such other person) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

In addition, before the Plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the Board of Trustees shall provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

If the Plan fails to strictly adhere to all the requirements of the claims and appeals sections of the Plan with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, except for de minimis violations explained below. As such, the claimant is entitled to pursue any available remedies under ERISA Section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under ERISA Section 502(a) under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under a Plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to

be deemed exhausted. If a court rejects the claimant's request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

7. Exhaustion of Administrative Remedies

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

1. Submitted a written or electronic claim for Benefits in accordance with the provisions above;
2. Been notified that an adverse benefit determination has been made;
3. Filed a written request for review of the adverse benefit determination (i.e. appeal) in accordance with the provisions above; and
4. Been notified, in writing, of an adverse benefit determination on review.

8. Additional Voluntary Level of Appeal

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

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

All reviews will be considered and decided by the Board of Trustees at the Board's regularly scheduled quarterly meeting immediately following the Plan's receipt of the request for additional review. If the request for review is received by the Plan within 30 days of such meeting, the review decision may be made at the second meeting following the Plan's receipt of the request for review. In special circumstances, the Board may need additional information and so may extend the time for deciding by one quarterly meeting. In no event will a decision be made later than the third quarterly meeting following the Plan's receipt of the claimant's request for review.

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

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

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

D. External Review of Claims

This External Review process is intended to comply with the Consolidated Appropriations Act of 2021 (CAA) external review requirements as set forth in federal regulations and other guidance issued in connection with the implementation of the CAA.

If your appeal of a health care claim - implicating the surprise billing protections or other rights outlined in the No Surprises Act, as articulated in the CAA - is denied, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

The Board of Trustees may designate, through a written contract, a named fiduciary of the Plan for the purposes of conducting the External Review of Claims. Dental Benefits and Vision Benefits are characterized as excepted benefits under HIPAA for the purpose of external review of claims.

External Review of Standard Claims

Your request for external review of a standard (not urgent) claim must be submitted, in writing, within four (4) months of the date that you receive notice of an initial claim determination or adverse appeal claim determination. For convenience, such a determination is referred to below as an "Adverse Determination," unless it is necessary to address the determination separately.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for appeal claim determinations.

Preliminary Review Procedures

1. Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
    c. You have exhausted the Plan's internal review and appeals process, unless you are not required to exhaust the internal review and appeals process under the federal interim final regulations (which involve certain limited exceptional circumstances); and,
    d. You have provided all of the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan will send you a notice in writing as to whether your request for external review meets the threshold requirements for external review.
    a. If your request for external review is complete but not eligible for external review, the notice will include the reasons for the request's ineligibility and contact information for the Employee Benefits Security Administration (EBSA) - toll-free number (866) 444-EBSA (3272).

If your request for external review is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect your request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review by Independent Review Organization (IRO)

If your request for external review meets the threshold requirements for external review, the Plan will assign the request to an IRO. The IRO will be assigned in accordance with the Plan's rules,

which provide an assignment or rotation method that ensures independence and avoids a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

Once the claim is assigned to an IRO, the following procedures will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you must submit in writing to the assigned IRO within ten (10) business days following the date you receive the notice from the assigned IRO, additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten (10) business days.
2. Within five (5) business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making its Adverse Determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to provide the documents and information within this time, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or the final adverse internal appeal determination. Within one (1) business day after making the decision, the IRO will notify you and the Plan.
3. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
4. The IRO will utilize legal experts, where appropriate, to make coverage determinations under the Plan.
5. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO—to the extent the information or documents are available and appropriate—may consider additional information (including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer[s]).
6. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives your request for external review.
7. The assigned IRO's decision notice will contain:
    a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount [if applicable], the diagnosis code and its corresponding

meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

b. The date that the IRO received the assignment to conduct the external review and the date of the IRO's decision;

c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching its decision;

d. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

e. A statement that the IRO's determination is binding, except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;

f. A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

g. A statement that judicial review may be available to you; and,

h. Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or,
2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services (but you have not yet been discharged from a facility).

Preliminary Review

Upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request as soon as possible to determine whether the request meets the reviewability requirements set forth in the Preliminary Review Procedures section above. The Plan will send you a notice as soon as possible informing you as to whether your request for review meets the threshold requirements for external review, along with other information described in the Preliminary Review Procedures section above.

Review by an Independent Review Organization (IRO)

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo (as if it is

new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth for standard reviews, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will provide coverage or payment for the reviewed claim as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a). The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under State or Federal law.

The IRO will maintain records of all claims and notices associated with the External Review process for a minimum of six (6) years. An IRO will make such records available for examination by you, the Plan, or a state or federal government oversight agency, upon request, except where such disclosure would violate state or Federal privacy laws.

Section Thirteen – Privacy and Security of Protected Health Information

The following topics are discussed under this Section on Privacy and Security of Protected Health Information ("PHI"):

A. Definitions for this Section Thirteen Only
B. Use and Disclosure of PHI by the Plan
C. Use and Disclosure of PHI to and by the Board of Trustees
D. Conditions of Disclosure of PHI to the Board of Trustees and Agreement by the Board of Trustees
E. Adequate Separation between the Plan and the Board of Trustees
F. Compliance with the HITECH Act

This Section provides a summary of the Plan's legal obligations and your legal rights regarding your PHI held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

In general, PHI is Individually Identifiable Health Information, including demographic information, that is created or received by the Plan that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

The Plan has a separate Notice of Privacy Practices that provides a complete description of your rights and the Plan's legal duties with respect to your PHI. The Notice of Privacy Practices also tells you when the Plan may Use or Disclose your PHI, when your permission or written authorization is required, how you can get access to your PHI and what actions you can take regarding your PHI. You can obtain a copy of the Notice of Privacy Practices by contacting the Fund Office.

A. Definitions for this Section Thirteen Only

The terms in this Section 13(A) are specifically defined in the Standards for Privacy of Individually Identifiable Health Information found at 45 C.F.R. Part 160 and Subparts A and E of Part 164 (the "Privacy Rule") and the Security Standards for the Protection of Electronic Protected Health Information found at 45 C.F.R. Part 160 and Subparts A and C of Part 164 (the "Security Rule"). The definitions set forth in the HIPAA Privacy Rule and the HIPAA Security Rule shall govern the meaning of the following terms when they are used in this Article:

1. Business Associate
2. Covered Entity
3. Disclosure
4. Electronic Protected Health Information (ePHI)
5. Health Care Options
6. Health Care Provider
7. Individually Identifiable Health Information
8. Payment
9. Protected Health Information (PHI)
10. Required By Law
11. Secretary
12. Security Measures
13. Security Incident
14. Treatment
15. Use

B. Use and Disclosure of PHI by the Plan

The Plan may Use and Disclose PHI for the purposes listed in this Section 13(B) to the extent such Use or Disclosure is permitted by and in accordance with the provisions of the HIPAA Privacy Rule, the HIPAA Security Rule and all other applicable law.

1. Use and Disclosure of PHI to a Covered Person or his Personal Representative

The Plan is required to and will Disclose your PHI to you or your personal representative upon written request. You (or your personal representative) may request your PHI by sending a written request to the Fund Office. If your personal representative is requesting your PHI, he must also submit documentation demonstrating that he has the authority to act on your behalf (for example, a power of attorney).

For purposes of this Section 13(B)(1) an individual is considered your personal representative if under applicable law, he has the authority to act on your behalf in making decisions related to health care. For example, state law will determine the extent to which a parent may act on behalf of a minor child with regard to the child's PHI.

The Plan will provide your personal representative with access to your PHI in the same manner as it would provide you with access unless, in the exercise of professional judgment, the Plan decides that treating an individual as your personal representative would not be in your best interest and the Plan has a reasonable belief that:

a. You have been or may be subjected to domestic violence, abuse or neglect by the person seeking to be treated as your personal representative; or

b. Treating the individual as your personal representative could endanger you

2. Use and Disclosure of PHI Pursuant to a Valid Authorization

The Plan will Disclose your PHI to your authorized representative upon receipt of a completed written Protected Health Information Authorization Form. Protected Health Information Authorization Forms are available at the Fund Office.

The Plan will provide your authorized representative PHI in accordance with the Protected Health Information Authorization Form, HIPAA, and all other applicable law. You can revoke a Protected Health Information Authorization Form at any time by sending a written request for revocation to the Fund Office. A request for revocation will become effective on the date that it is received by the Fund Office.

3. Use and Disclosure of PHI for Treatment, Payment or Health Care Operations

The Plan does not perform any Treatment activities, but may Disclose PHI to Health Care Providers treating a Covered Person in order to facilitate the providers' Treatment of the Covered Person. For example, the Plan may disclose the name of your treating radiologist to your treating primary care Physician so that your primary care Physician may ask your radiologist for your x-rays. The Plan may Use and Disclose the minimum necessary PHI for Payment activities and Health Care Operations in accordance with the following rules:

a. The Plan may Use and Disclose the minimum necessary PHI for the Plan's Payment activities.

Payment generally means the activities of the Plan to collect contributions, premiums and self-payment amounts; to fulfill its coverage responsibilities and provide benefits under the Plan; and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to the following:

- Determining your eligibility and coverage for Plan benefits

For example, the Plan may Use information obtained from your Employer to determine whether you are an Eligible Employee.

- Determining and fulfilling the Plan's responsibility to provide benefits

  For example, the Plan may Use your healthcare claims to determine if services provided by your Physician are covered by the Plan.

- Enforcing the Plan's rights to recovery, reimbursement and/or subrogation

  For example, if you are in an auto accident due to another driver's fault and the Plan pays expenses for the treatment of your injuries, the Plan may Use and Disclose information regarding the accident, expenses and treatment in order to enforce the Plan's subrogation rights.

- Coordinating benefits with other plans under which you have health coverage

  For example, the Plan may Use information about your benefits from another group health plan to determine the benefits that this Plan will pay for a specific claim.

b. The Plan may Use and Disclose the minimum necessary PHI for the Plan's Health Care Operations.

Health Care Operations generally means certain administrative, financial, legal and quality improvement activities of the Plan that are necessary to run its business and to support the core functions of Treatment and Payment. These specific activities are limited to those listed in the definition of Health Care Operations found at 45 C.F.R. Section 164.501. The following is a summary of these activities:

- Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination and contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment.

  For example, a case manager may contact you or your provider to discuss Treatment alternatives.

- Reviewing the competence or qualifications of health care professionals, evaluating provider and Plan performance, training health care and non-health care professionals, accreditation, certification, licensing or credentialing activities.

  For example, the Plan may train new claims processors by having them process health benefit claims under close supervision.

- Underwriting and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims.

  For example, if the Plan decides to purchase stop-loss insurance, it may disclose your demographic information (such as your age) to carriers to obtain quotes.

- Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs.

  For example, the Plan's auditor (who is a Business Associate) may review your health care claims to determine if they were paid correctly.

- Business planning and development, such as conducting cost-management and planning analysis related to managing and operating the Plan.

  For example, the Plan's consultant (who is a Business Associate) may review PHI to project future benefit costs.

- Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other administrative simplification rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set and fundraising for the benefit of the Plan.

  For example, the Plan may Use your PHI for the purpose of creating de-identified information.

c. The Plan may Use and Disclose the minimum necessary PHI for the Payment activities of another Covered Entity or Health Care Provider.

   For example if you have secondary coverage from another plan, this Plan may disclose information to that other plan regarding this Plan's Payment for your health care.

d. The Plan may Use and Disclose the minimum necessary PHI for certain (but not all) Health Care Operations of another Covered Entity if the Covered Entity has a relationship with the Covered Person, the PHI pertains to that relationship, and the Disclosure is permitted by and made in accordance with 45 C.F.R. Section 164.506.

   For example, the Plan may Disclose your PHI to another Covered Entity for quality assessment and improvement, case management, performance evaluation and fraud abuse and detection.

4. Use and Disclosure of PHI for Notification and Involvement in a Covered Person's Care

The Plan may Disclose your PHI to a family member, other relative, close personal friend or other person that you identify, to the extent the PHI is directly relevant to such person's involvement with your care or the Payment is related to your care, and the Disclosure is in accordance with this Section 13(B)(4) and 45 C.F.R. Section 164.510.

The Plan may also Disclose your PHI to notify (or assist in the notification of, including identifying or locating), a family member, your personal representative or another person responsible for your care of your location, general condition or death in accordance with this Section 13(B)(4) and 45 C.F.R. Section 164.510.

The following rules apply to Disclosures made pursuant to this Section 13(B)(4):

a. Uses and Disclosures with the Covered Person Present

   If you are present for, or otherwise available prior to, a Use or Disclosure permitted by this Section 13(B)(4), and you have the capacity to make health care decisions, the Plan may Use or Disclose your PHI if the Plan:

   - obtains your agreement;
   - provides you with the opportunity to object to the Disclosure and you do not express an objection; or
   - exercises professional judgment and reasonably infers from the circumstances that you do not object to the Disclosure.

b. Uses and Disclosures if the Covered Person is not Present

If you are not present, or you cannot agree or object to a Use or Disclosure because you are incapacitated or there is an emergency circumstance, the Plan may, in the exercise of professional judgment, determine whether the Use or Disclosure is in your best interests, and, if so, Disclose only the PHI that is directly relevant to the person's involvement with your health care.

5. Use and Disclosure of PHI Required by Law

The Plan may Use or Disclose your PHI to the extent that such Use or Disclosure is Required By Law and the Use or Disclosure complies with and is limited to the relevant requirements of such law.

6. Disclosures about Victims of Abuse, Neglect or Domestic Violence

Except for reports of child abuse or neglect that are permitted to be Disclosed to a public health authority in accordance with Section 13(B)(9) below, the Plan may Disclose your PHI to a government authority (including a social service or protective services agency) that is authorized by law to receive reports of such abuse, neglect or domestic violence if the Plan reasonably believes that you are a victim of abuse, neglect or domestic violence and you agree to the Disclosure.

Even if you have not agreed to the Disclosure, the Plan may Disclose your PHI to a government authority to the extent the Disclosure is Required By Law and the Disclosure complies with and is limited to the relevant requirements of such law. The Plan may also Disclose your PHI to a government authority if the Disclosure is expressly authorized by statute or regulation and at least one of the following applies:

a. The Plan, in the exercise of professional judgment, believes the Disclosure is necessary to prevent serious harm to you or other potential victims; or

b. You do not have the capacity to agree and law enforcement (or other public official authorized to receive the report) represents that the information is not intended to be used against you and immediate law enforcement activity depends on the Disclosure.

If the Plan makes a Disclosure permitted by this Section 13(B)(6) the Plan will promptly notify you that the Disclosure has or will be made unless, in the exercise of professional judgment, (i) the Plan believes informing you would place you at risk of serious harm; or (ii) the Plan would be informing a personal representative and, in the exercise of professional judgment, the Plan reasonably believes that the personal representative is responsible for abuse, neglect or other Injury and informing such person would not be in your best interests.

7. Disclosures for Judicial and Administrative Proceedings

The Plan may Disclose your PHI in the course of any judicial or administrative proceeding in response to:

a. an order of a court or administrative tribunal so long as the Plan only Discloses the PHI that is expressly authorized by such order; or

b. a subpoena, discovery request or other lawful process that is not accompanied by an order of a court or an administrative tribunal if the Plan receives satisfactory assurances (as defined by 45 C.F.R. Section 164.512) from the party seeking the information that reasonable efforts have been made by such party to ensure that you have been given notice

of the request or that the party seeking the PHI has made reasonable efforts to secure a qualified protective order.

8. Disclosures for Law Enforcement Purposes

The Plan may Disclose your PHI to a law enforcement official for a law enforcement purpose in accordance with this Section 13(B)(8) and 45 C.F.R. Section 164.512.

a. The Plan may Disclose your PHI as Required By Law, including laws that require the reporting of certain types of wounds or other physical injuries (except for Disclosures for public health reporting and Disclosures about victims of abuse, neglect or domestic violence which are governed by the more specific rules in Section 13(B)(7) and Section 13(B)(9)(b).

b. The Plan may Disclose your PHI in compliance with, and as limited by, the relevant requirements of a court order, a court-ordered warrant, a subpoena or summons, or an investigative demand or similar process so long as the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited to the extent reasonably practicable in light of the purpose for which the information is sought and de-identified information could not reasonably be used.

c. The Plan may Disclose your PHI in response to a law enforcement official's request for the information for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The information the Plan may Disclose for this purpose is limited to your name, address, date and place of birth, Social Security number, ABO blood type and Rh factor, type of Injury, date and time of treatment, date and time of death (if applicable) and certain distinguishing characteristics (for example, height, weight and gender).

d. The Plan may Disclose your PHI in response to a law enforcement official's request for the information if you are (or are suspected to be) a victim of a crime and you agree to the Disclosure or the Plan is unable to obtain your agreement because of your incapacity or an emergency circumstance and the law enforcement official represents that the information is needed to determine whether a person (other than you) has violated the law, the information is not intended to be used against you, immediate law enforcement activity depends on the Disclosure and in the exercise of professional judgment the Plan determines that the Disclosure is in your best interest.

e. The Plan may Disclose your PHI to law enforcement officials after your death for the purpose of alerting them of your death if the Plan has a suspicion that your death may have resulted from criminal conduct.

f. The Plan may Disclose your PHI that the Plan believes in good faith constitutes evidence of criminal conduct that occurred on the Plan's premises.

9. Use and Disclosure of PHI for Public Health Activities

The Plan may Disclose your PHI to the following entities for the public health activities and purposes described in this Section 13(B)(9) in accordance with 45 C.F.R. Section 164.512:

a. The Plan may Disclose your PHI to a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, such as the reporting of disease, injury or vital events (e.g. birth, or death), and conducting public health surveillance, public health investigations and public health interventions.

b. The Plan may Disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect.

c. The Plan may Disclose your PHI to a person who has responsibility to the Food and Drug Administration ("FDA") regarding the quality, safety or effectiveness of such FDA-regulated product or activity.

d. The Plan may Disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition if the Plan is authorized by law to notify such person.

10. Use and Disclosure of PHI for Health Care Oversight Activities

The Plan may Disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits; civil administrative or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other appropriate oversight activities. This Section 13(B)(10) does not apply if you are the subject of an investigation or other activity that does not arise out of and is not directly related to the receipt of health care, a claim for public benefits related to health, or the qualification for or receipt of public benefits or services when a patient's health is integral to the claim for public benefits or services.

11. Use and Disclosure of a Decedent's PHI

The Plan may Disclose your PHI to a coroner or medical examiner after your death for the purpose of identifying you, determining your cause of death or other duties as authorized by law. The Plan may also Disclose your PHI to funeral directors either upon your death or before and in reasonable anticipation of your death, consistent with applicable law, and as necessary for the funeral director to carry out his duties.

12. Use and Disclosure of PHI for Cadaveric Organ, Eye or Tissue Donation Purposes

The Plan may Disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

13. Use and Disclosure of PHI to Avert a Serious Threat to Health or Safety

The Plan may, consistent with 45 C.F.R. Section 164.512, all other applicable law(s) and standards of ethical conduct, Use or Disclose your PHI if the Plan in good faith believes that the Use or Disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may only Disclose PHI for this purpose if the Disclosure is to a person reasonably able to prevent or reduce the threat, including the target of the threat.

14. Use and Disclosure of PHI for Specialized Government Functions

The Plan may Disclose your PHI if you are in the Armed Forces and the PHI is deemed necessary by the appropriate military command authorities. The Plan may also Disclose your PHI to authorized federal officials for the conduct of national security activities and protection of the President, and to a correctional institution where you are being held.

15. Use and Disclosure of PHI for Workers' Compensation

The Plan may Disclose your PHI as authorized by and to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

16. Disclosure of PHI to the Secretary of Health and Human Services

The Plan is required to and will Disclose your PHI to the Secretary of Health and Human Services ("HHS"), or his designee, when such PHI is required by the Secretary to investigate or determine the Plan's compliance with the Privacy Rule.

C. Use and Disclosure of PHI to and by the Board of Trustees

The Board of Trustees has delegated the daily responsibility for administering the Plan to Business Associates. The Plan's Business Associates will carry out their administrative duties on behalf of the Plan, such as claims processing and regular Plan administration, without Disclosing PHI to the Board of Trustees unless such 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, the Security Rule and this Plan document.

The Plan and its Business Associates may Disclose the minimum necessary Individually Identifiable Health Information to the Board of Trustees for the Plan administrative functions that the Board of Trustees performs for the Plan. The Board may Use and Disclose only the minimum Individually Identifiable Health Information necessary for the Board to perform the Plan administrative functions described in this Section 13(C) or as otherwise permitted or required by HIPAA. Notwithstanding any provisions of this Plan to the contrary, in no event shall the Board of Trustees (or any member of the Board of Trustees) be permitted to Use or Disclose PHI in a manner that is inconsistent with 45 C.F.R. Section 164.504(f).

1. Payment

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to perform Payment activities (as the term Payment is defined in 45 C.F.R. Section 164.501) that the Board has not delegated to a Business Associate (in other words, Payment activities that the Board of Trustees performs for the Plan). The Board of Trustees may Use and Disclose only the minimum information necessary to perform such Payment activities. The Payment activities that the Board of Trustees performs for the Plan include, but are not limited to the following:

a. Benefit Determinations on Review (i.e., Appeals)

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to render determinations on appeals. The Board may Use and Disclose 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 appeal. When Disclosing any such information, the Board shall obtain adequate assurances from the party to whom the information is being Disclosed that such party will protect the privacy of the information. In order to accomplish this purpose efficiently, the Board shall avoid making any Disclosure of PHI to any entity that has not entered into a Business Associate Agreement with the Plan. 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.

b. Collection Activities and Subrogation

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to make determinations related to collection activities and subrogation, such as for the purpose of deciding whether or not the Plan

should attempt to recover an overpayment or whether or not the Plan should settle with a Covered Person or outside party in a collection or subrogation matter. The Board may Use and Disclose only the minimum information necessary to render determinations regarding collection activities and subrogation, and shall avoid making any Disclosure of the information unless necessary, such as for the purpose of obtaining legal or actuarial advice regarding the collection activity or subrogation matter. When Disclosing any such information, the Board shall obtain adequate assurances from the party to whom the information is being Disclosed that such party will protect the privacy of the information. In order to accomplish this purpose efficiently, the Board shall avoid making any Disclosure of PHI to any entity that has not entered into a Business Associate Agreement with the Plan. 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.

2. Health Care Operations

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to perform Health Care Operations (as the term Health Care Operations is defined in 45 C.F.R. Section 164.501) that the Board has not delegated to a Business Associate (in other words, Health Care Operations that the Board performs for the Plan). The Board of Trustees may Use and Disclose only the minimum information necessary to perform such Health Care Operations.

D. Conditions of Disclosure of PHI to the Board of Trustees and Agreement by the Board of Trustees

Neither the Plan nor any Business Associate servicing the Plan will Disclose PHI 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 provisions in this Section 13(D). By adopting this Plan, the Board of Trustees agrees:

1. Not to Use or Disclose PHI other than as permitted or required by the Plan documents or as required by law;
2. To ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to such information and that such agent (including a subcontractor) agrees to implement reasonable and appropriate Security Measures to protect the PHI;
3. Not to Use or Disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan that receives contributions in accordance with the Collective Bargaining Agreement;
4. To report to the Plan any Use or Disclosure of the PHI that is inconsistent with the Uses or Disclosures provided for of which it becomes aware;
5. To make available PHI in accordance with 45 C.F.R. Section 164.524 to the extent that the Board of Trustees, rather than a Business Associate, has control of such PHI;
6. To make available PHI for amendment and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526 to the extent that the Board of Trustees, rather than a Business Associate, has control of such PHI;
7. To make available the information required to provide an accounting of Disclosures in accordance with 45 C.F.R. Section 164.528, to the extent that the Board of Trustees rather than a Business Associate has control of such information;

8. To make its internal practices, books and records relating to the Use and Disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance with the Privacy Rule by the Plan;

9. If feasible, to return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and to retain no copies of such information when it is no longer needed for the purpose which the Disclosure was made, except that, if such destruction is not feasible, to limit future Uses and Disclosures to those purposes that make the return or destruction of the information infeasible;

10. To ensure that adequate separation required by 45 C.F.R. Section 164.504(f)(2)(iii) is established and is supported by reasonable and appropriate Security Measures;

11. To implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Trustees create, receive, maintain or transmit on behalf of the Plan; and

12. To report to the Plan any Security Incident of which the Board of Trustees becomes aware.

E. Adequate Separation between the Plan and the Board of Trustees

Adequate separation will exist at all times between the Plan and the Board of Trustees. All members of the Board of Trustees may have access to PHI when such access is required to perform the Plan administrative functions that the Board of Trustees performs for the Plan. No member of the Board of Trustees shall have any access to PHI except as provided for in Section 13(C) or as otherwise permitted or required by HIPAA (for example, the Plan will Disclose PHI to the Board of Trustees if the Disclosure is necessary for the Board of Trustees to comply with its obligations under Section 13(D)).

The Board of Trustees does not have any employees, thus it is not possible for any employee of the Board of Trustees to have access to PHI. The Board of Trustees shall protect the privacy of Individually Identifiable Health Information received, created or maintained and shall Use and/or Disclose such information only in accordance with the terms of this Plan document. The Board of Trustees has developed a privacy policy that includes an effective mechanism for resolving any issues of noncompliance with this Article. Any member of the Board of Trustees that does not comply with this Article will be subject to the privacy policy's disciplinary provisions for noncompliance.

The Board has delegated the daily responsibility for administering the Plan to Business Associates, including a third-party administrator, a prescription benefit manager and a PPO. These Business Associates and their employees do and shall have access to PHI in the course of the services they perform for the Plan. The Plan has entered into contracts with its Business Associates in accordance with the Privacy Rule, the Security Rule and the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

F. Compliance with the HITECH Act

The Plan shall comply with the provisions of the HITECH Act and its implementing regulations.

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..

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 UMR, 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:

- Any Other Plan that has no coordination of benefits provision will be deemed to have primary payment responsibility.
- 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.
- 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.

- 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.
- The plan that provides COBRA Continuation Coverage of the person pays after the plan that provides non-COBRA coverage.
- 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.
- 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.

Married Dependents

1. 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 Dependent Child gains their own coverage or gets married and has coverage through their spouse, then this becomes primary to the parents' coverage.
    d. 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.
    e. 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.
    f. 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. Termination of Plan

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. Right to Release or Request Information

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. Subrogation of Benefits

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. Reimbursement and Savings

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. Continue Group Health Plan Coverage

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 Third-Party Administrator to perform the day-to-day operations of the Plan, such as maintaining records, making Benefit payments and handling general administrative matters. The Third-Party Administrator (also referred to as Administrative Manager) is:

Zenith American Solutions, Inc.
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.
6803 West 64th Street, Suite 300
Overland Park, KS 66202

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, 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.

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)

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. Active Employee

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. Administrative Manager

The term "**Administrative Manager**" means the Third-Party-Administrator 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. Association

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. Beneficiary

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. These forms may be submitted through the Fund's online Participant portal.

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. any Child until the end of the month in which the Child turns age 26.

c. any Child who is under age 26 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 a mental or physical handicap that occurred before age 19, 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 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 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 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, unless pre-approved medical services are provided under the Rehabilitative Therapy Benefit provided in Section 4 (K) of this document, maintains permanent and full time facilities for bed care of 50 or more resident patients.

g. 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.

h. for purposes of Alcohol and Drug Treatment Benefits and Mental Health Benefits only, in addition to the above listed criteria, Hospital also means, 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.

"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)

Specifically with regard to Alcohol and Drug Treatment, the Fund recognizes Legally Qualified Substance Abuse Professionals. For the purposes of the Alcohol and Drug Treatment Benefit only, a "Legally Qualified Substance Abuse Professional" includes:

1) a Physician; and,

2) a certified mental health or substance abuse counselor, 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.

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

Effective February 10, 2014, the term "Spouse" means an individual who, under any state law, 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. This term includes an individual married to an eligible Employee of the same sex who were legally married in a jurisdiction that recognizes such marriages but who are domiciled in a state that does not recognize such marriages.

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. However, with respect to: (1) non-PPO providers and/or Out-of-Network Hospitals or facilities that render services to a Covered Person for an injury or sudden Sickness that requires the Covered Person to seek treatment at a clinic, emergency room, or Out-Patient Facility at a Hospital; or (2) non-PPO providers

that render non-ancillary benefit-related services to a Covered Person at an In-Network Hospital or facility, such that the UCR Charge means: (1) the rate articulated in an All-Payer Model Agreement if the services are rendered in a state that has such an agreement; (2) the rate specified by state law; or (3) the Qualifying Payment Amount. Moreover, the UCR Charge for air ambulance benefits means the lesser of: (1) the billed amount; or (2) the Qualifying Payment Amount.

48. Qualifying Payment Amount

The term "**Qualifying Payment Amount**" means the median of the contracted rates recognized by the Plan on January 31, 2019 for the same or similar item or service that is provided in a geographic region increased for inflation.

49. Ancillary Benefit

The term "**Ancillary Benefit**" means any one of the following:

1. Items and services that relate to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-physician practitioner;
2. Diagnostic services, including radiology and laboratory services (but not to the extent an appropriate federal agency determines that particular diagnostic services are not ancillary benefits;
3. Items and services provided by assistant surgeons, hospitalists, and intensivists;
4. Items and services provided by non-PPO providers when there is no PPO provider that can furnish such item or service at the PPO Hospital or facility; and
5. Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.