OPERATING ENGINEERS LOCAL #49
HEALTH AND WELFARE FUND

2014 SUMMARY PLAN DESCRIPTION

Operating Engineers Health And Welfare Fund

Fund Office

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Toll-free: 800-535-6373
952-854-0795

Board Of Trustees
(Administrator, as defined by law)

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FUND AUDITOR
Legacy Professionals, LLP

INTRODUCTION

The Board of Trustees of the Operating Engineers Local #49 Health and Welfare Fund is pleased to provide you with this updated Summary Plan Description (SPD), which contains current health and welfare benefits information. The benefits described in this booklet are effective January 1, 2014.

It is the Trustees' goal to maintain a financially stable Fund while providing quality health care coverage to you and your family. The Fund has implemented some cost-saving methods such as medical deductibles and out-of-pocket maximums to ensure that we can meet your current and future health care needs. You can do your part in helping the Fund manage health care costs by:

If you have questions about how the Plan works, please call or write the Fund Office at:

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Toll-free: 800-535-6373
952-854-0795

Visiting network providers – Network providers and participating providers, including Hospitals, Physicians, and other health care providers, charge negotiated, reduced rates. In addition, the Plan pays a higher percentage when you use a network provider.

Examining emergency treatment alternatives – In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Health Care Provider's office or an urgent care facility as in an emergency room. Keep your Health Care Provider's telephone number easily accessible and locate the nearest facility so you will be prepared in case of an emergency.

Requesting generic medications – Often medications come in two forms: generic and brand name. Generic medications have to meet the same quality standards for pureness and effectiveness, but can cost much less than their brand name equivalent. Check with your doctor to see if a generic medication is appropriate for you.

This booklet has been organized to make it easy to find the information you are seeking. We would like to point out these helpful sections:

Contact Information – Tells you who to call when you need certain information.

Life Events – Details how your benefits are affected by the different events that can occur in your life.

How To File A Claim – Gives you a systematic process for filing claims, including what you need to do if a claim is denied.

Definitions – Explains important terms used throughout this SPD.

We urge you to read this information and, if you are married, share it with your spouse. Also, please keep this SPD with your important papers so you can refer to it when needed.

Sincerely,
Board of Trustees

This booklet has been prepared for Participants of the Operating Engineers Local #49 Health and Welfare Trust Fund and describes the benefits in effect as of January 1, 2014. This edition replaces and supersedes any previous Summary Plan Description. This SPD and the Trust Document establish the terms of the Plan. The Trustees reserve the right and have authority to amend, modify, or eliminate benefits, or terminate the Plan at any time. In addition, the Trustees, or such other persons as delegated by the Trustees, have broad discretion to interpret and construe the rules of the Plan. Eligibility or participation in the Plan does not guarantee benefits. The benefits under the Plan are not vested.

PLEASE FILL OUT AND RETURN THE
ENROLLMENT CARD IN BACK OF THIS
BOOK IF ONE OF THE FOLLOWING OCCURS:

1. A change in marital status
2. A change in dependent children.
3. You would like to change your beneficiary.
4. Address changes.

Send the newly completed enrollment card to:

I.U.O.E. – LOCAL 49 FRINGE
BENEFIT FUNDS
3001 METRO DRIVE – SUITE 500
BLOOMINGTON, MINNESOTA 55425

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HOW THE FUND WORKS

The Fund is operated by the Board of Trustees, consisting of an equal number (four) of Union and Employer representatives and a named alternate representative for each group. The Trustees make decisions for the Fund, including decisions about the benefits that are offered, eligibility requirements, and which service vendors to hire. The Board of Trustees delegates some functions to others, like the Fund Coordinator, who coordinates the activities of the Board and service vendors. In addition, the Board contracts with experts to provide members and their families the best benefits possible within the Fund's budget.

For each hour you work in Covered Employment, your Employer contributes a set dollar amount to the Fund. This amount is established by the Collective Bargaining Agreement in effect at the time. The Fund uses all of the Employer contributions to pay claims and administrative expenses. Any extra money is saved as reserves for high claims and future expenses. The Fund self-funds the benefits. That means that when you have a claim, the Fund pays for the claim out of its own assets or pocket. There is no insurance company.

The Fund provides benefits to eligible Active Employees (Actives), Pre-Medicare Retirees, Medicare Retirees, and their dependents; however, not all benefits are available to all participants. The benefits that are available to each group are:

- **Active Employees and Their Dependents:**
  - Active Employees Only:
    - Death Benefit
    - Accidental Death and Dismemberment
    - Accident and Sickness Weekly Benefit
  - Active Employees and Their Dependents:
    - Wellness Benefits
    - Comprehensive Major Medical Expense Benefit
    - Dental Benefits
    - Vision Care Program
    - Health Reimbursement Arrangement
- **Pre-Medicare Retirees and Pre-Medicare Dependents:**
  - Retiree Only:
    - Death Benefit
    - Accidental Death and Dismemberment
  - Retirees and Their Dependents:
    - Wellness Benefits
    - Comprehensive Major Medical Expense Benefit
    - Vision Care Program
    - Health Reimbursement Arrangement (You can use available funds in your account, but no new contributions will be added to your account.)
- **Medicare Retirees and Medicare Dependents:** These benefits are provided through Medicare and your Medicare Supplement Plan. Please refer to the booklet you received from your Medicare Supplement carrier.

Since there is no insurance company processing claims, the Fund contracts with a third party administrator (TPA), Wilson-McShane Corporation, to process claims and perform other administrative functions.

To help control costs, the Fund contracts with a Preferred Provider Organization (PPO). The PPO contracts with Physicians, Hospitals, and other health care providers to charge negotiated, discounted rates for services to our members and their families. The Fund passes on some of these discounts to you in the form of lower coinsurance that you have to pay. For example, the Plan pays in-network Hospital covered charges at 80% instead of 70% for out-of-network Hospital charges. See page 49 for more information about PPOs.

The Fund also contracts with several companies to provide the following services to members and their families:

- A Preferred Provider Organization is provided for **dental benefits** through Delta Dental. See page 58 for more information on dental benefits.
- **A patient advocacy program** through a patient advocacy vendor who can help you find resources for second opinions or treatment for transplants, cardio-vascular disease, cancer, and muscular-skeletal problems. This is a voluntary program designed to help you find and receive the best care possible. See page 50 for additional information on patient advocacy or page 10 for ***Contact*** information.
- **Fully covered physical examinations** through Health Dynamics or network providers (page 46).
- **Mental Health or Substance Abuse** referrals through TEAM, see ***Contact*** information on page 10.
- **Online Care Anywhere,** a BCBSMN program that provides live face-to-face video calls or secure text chats with trusted, licensed doctors who can discuss your health issues, provide diagnoses and prescribe medications, if appropriate. You can talk to a doctor without going to a doctor's office. To access Online Care Anywhere, complete the following steps:
  - Go to OnlineCareAnywhereMN.com
  - Register and enter your health summary
  - Choose a doctor
  - Click "Connect"
- **Fully covered Radiology** through Center for Diagnostic Imaging (CDI).

The Board of Trustees, along with all the people and organizations that work with the Fund, are committed to bringing you and your family the best benefits and service possible. To contact any of the organizations listed above, see the ***Contacts*** section on page 10.

SCHEDULE OF BENEFITS

DEATH BENEFIT - ACTIVE EMPLOYEES AND RETIREES

Active Employees $8,000

Retirees $2,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT - ACTIVE EMPLOYEES AND RETIREES

Principal Sum

Active Employees $8,000

Retirees $2,000

ACCIDENT AND SICKNESS WEEKLY BENEFIT - ACTIVE EMPLOYEES

Weekly Benefit for Active Employees $300

Maximum Number of Weeks Payable 26

Benefits are Payable from the ..... 1st day of a non-occupational Injury
8th day of a non-occupational Sickness

WELLNESS BENEFITS

Physical Exam and Routine Immunizations (Active Employees, Retirees, and Dependents)

Plan Payment

Participating Provider 100%

Non-Participating Provider 80%

Note: This benefit is available for you and your spouse. If you undergo a physical through Health Dynamics, you may elect to receive EITHER a $20 per month gym/health club membership reimbursement for you and your spouse for up to 12 months ($240 maximum for member and $240 maximum for spouse), OR have $240 reimbursed per year for copayments, deductibles and coinsurance amounts paid under the medical plan for you and your spouse. If both you and your spouse undergo a Health Dynamics physical, BOTH of you can be reimbursed up to a maximum of $240 each for your co-pays, deductibles and coinsurance amounts.

Routine Immunizations (Dependent Children)

Plan Payment 100%

Chiropractic Treatment

Plan Payment 100%

Maximum Visits ..... 19 visits per year

Expenses will not be considered under the Comprehensive Major Medical Benefit for any Wellness Benefits in excess of the amounts shown above.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT - ACTIVE EMPLOYEES, RETIREES, AND DEPENDENTS

Annual Maximum Benefit

Effective Date	Annual Maximum
June 1, 2013	$2,000,000
June 1, 2014	Unlimited

Calendar Year Deductible (Not Applicable to West River Participants in South Dakota)

Per Covered Person	$250
Per Family	$500

Calendar Year Deductible (Applicable to West River Participants in South Dakota Only)

Per Covered Person	$800
Per Family	$1,600

The copayment for Health Care Provider charges does not apply to the deductible.

Out-of-Pocket Maximum After Deductible Has Been Satisfied (Not Applicable to West River Participants in South Dakota)

Per Covered Person	$2,500
Per Family	$6,000

Out-of-Pocket Maximum (Applicable to West River Participants in South Dakota Only)

Per Covered Person	$6,350
Per Family	$12,700

Copayment After Deductible Has Been Satisfied For Hospital Charges

Actives, Retirees Under Age 65 and Dependents – Participating Providers 80%

Actives, Retirees Under Age 65 and Dependents – Non-Participating Providers 70%
Emergency Services.....80%

For Health Care Provider Charges (Not Applicable to West River Participants in South Dakota)

	Plan Copayment	Your Copayment
Office Visits and Lab Charges to Participating providers	The balance of the Participating Provider charges after your $25 copayment.	$25
Office Visits and Lab Charges to Non-Participating Providers	70%	30%
Services provided at Participating Providers in (or billed by) Hospitals, emergency rooms, outpatient clinics or Urgent Care Centers	80%	20%
Services provided at Non-Participating Providers in (or billed by) Hospitals, outpatient clinics or Urgent Care Centers Emergency services	70% 80%	30% 20%

For Health Care Provider Charges (Applicable to West River Participants in South Dakota Only)

	Plan Copayment	Your Copayment
Office Visits and Lab Charges to Participating Providers	The balance of the participating provider charges after your $15 copayment.	$15
Office Visits and Lab Charges to Non-Participating Providers	70%	30%
Services provided at Participating Providers in (or billed by) Hospitals, emergency rooms, outpatient clinics or Urgent Care Centers	80%	20%
Services provided at Non-Participating Providers in (or billed by) Hospitals, outpatient clinics or Urgent Care Centers Emergency services	70% 80%	30% 20%

Minute Clinic – or any other freestanding clinic found in a Retail Setting

Plan Payment 100%

Maximum Payment Per Visit..... $25

Prescription Drug Benefits for Actives, Non-Medicare Eligible Retirees, and Dependents

Your Copayment.....20%

Annual Out-of-Pocket Limit

Per Covered Person $2,500

Per Family $6,000

Erectile Dysfunction (up to six pills per month) 50%

When drugs prescribed for the treatment of erectile dysfunction are used to treat other conditions, the Plan will generally cover these expenses under the Comprehensive Major Medical Plan, subject to the deductible and the 80%/20% copayment structure. However, the prescription must be Medically Necessary and medical evidence must demonstrate that no reasonable alternative treatment exists.

Smoking Cessation Products

Over-The-Counter Products
When provided by the Plan's smoking cessation program…… 100%

Prescription Products
When enrolled in the Plan's smoking cessation program ……. 80%

Prescription Drug Benefits for Medicare Eligible Retirees (Refer to the booklet from your Medicare Supplement carrier.)

Ambulance

Plan Copayment 80%

Limited to travel to nearest appropriate facility as Medically Necessary for treatment.

Skilled Nursing Care

Maximum Number of Days ..... 2 days for each day of Hospital confinement up to 60 days
Plan Copayment 80%

Home Health Care

Maximum Number of Visits per Calendar Year 90

Plan Copayment 80%

Hospice Care

Maximum number of days 180

Plan Copayment 100%

The 180-day maximum may be waived when continued hospice care will be a cost savings to the Fund over inpatient hospitalization.

Hearing Aids

Maximum Payment.....$1,000 once in 5 calendar years

Travel Benefit

Maximum Payment per covered person per episode of care $1,000

Maximum Daily Food Allowance $50

Maximum Lifetime Benefit per family..... $10,000

Note: This benefit is available to all eligible participants. The Plan may assist with out-of-pocket expenses associated with traveling to obtain expert services at a designated medical treatment facility. The facility chosen must be identified by the Patient Advocacy Program vendor. While you have the right to choose to see any provider, Travel Benefits will not be payable unless the facility has been identified as appropriate by the Patient Advocacy Program vendor. Examples of reimbursable expenses include food for the patient and his/her companion, patient personal needs, automobile gasoline and oil charges, parking, lodging and unexpected/unusual school transportation expenses for children who are not traveling with parents. Child or elder care expenses may be covered and will be evaluated on an individual basis. You must provide itemized receipts for reimbursement.

Cochlear Implants

The Plan will pay for initial installation with one technological upgrade.

LASIK Eye Surgery

Plan Copayment.....100%

Maximum Payment per Eye..... $500

NOTE: This benefit is payable for the examination, surgery, and follow-up care related to LASIK eye surgery treatment. This benefit will be paid only once per lifetime for each active member and Eligible Dependent. Payment of this benefit will not affect your Vision Benefits under the Plan. **This benefit is not available for retirees and their dependents.**

Medical Foods

Calendar Year Maximum……$5,000

Gastric Bypass and Xenical weight loss medication (with pre-authorization)

Lifetime maximum $20,000

Mental And Nervous Disorders, Alcoholism, Chemical Dependency and Drug Addiction

Plan Copayment.....80%

Genetic Testing

Testing for BRCA 1 & 2 gene through network provider only 100%

Maximum Payment per Calendar Year..... $1,000

Speech Therapy for all children 5 and under

Maximum Visits per Calendar Year 10

Restorative Speech Therapy if after accident or illness (like stroke) 80%

Speech Therapy for Participants with Cochlear Implants

Maximum Visits per Calendar Year 10

DENTAL BENEFITS

Maximum Payment per Calendar Year..... $2,000

This maximum does not apply to participants under the age of 19.

Plan Copayment..... 80%

TMJ

Maximum Payment per Lifetime $800

Plan Copayment..... 80%

Orthodontia (Medically Necessary for oral surgery, cleft palate repair or accidental injury to teeth**)**

Lifetime Maximum $2,000

Orthodontia (for dependent children only)

Lifetime Maximum $1,000

VISION CARE PROGRAM

	Plan Pays In-Network	Your Out-of-Network Reimbursement
Exam	100%	$200 Maximum Reimbursement for Exam, Frame, Lens, and Contact Lenses
Frames, Lens & Lens Options*	100% up to $200, then 20% of balance over $200	
Contact Lenses*		
Conventional	100% up to $160, then 15% of balance over $160	
Disposable	100% up to $160	
Medically Necessary	100%	
Lasik or PRK from U.S. Laser Network	85% off retail price or 5% off promotional	
Frequency (Exam and Glasses or Contact Lenses)	Once every 12 months	
Additional Pairs	40% discount on additional eyeglasses and a 15% discount on conventional contact lenses	Not applicable

* The Plan pays for either a pair of eyeglasses or a set of contact lenses, not both.

CONTACTS

If you need…	*Contact…*
To find a network medical provider	Refer to your medical ID card for information
Prenatal Care	Healthy Start at 651-6621818 or toll free at 866-489-6948 Web site: myhealthystart.org
Patient Advocacy	Medical Advocate Program (**MAP**) toll-free at 866-573-5745 Web site: DelphiMAP.com
To find a network dentist	Delta Dental at 651-406-5916 or toll-free at 800-553-9536 Web site: www.deltadentalmn.org
To find a network eye provider	EyeMed at 1-866-723-0514 Web site: www.eyemedvisioncare.com
Claims information or eligibility	Wilson-McShane Corporation at 952-854-0795 or toll-free at 800-535-6373
Information about Plan benefits	Wilson-McShane Corporation at 952-854-0795 or toll-free at 800-535-6373
Mental Health or Substance Abuse referrals	T.E.A.M. at 651-642-0182 or toll-free at 1-800-634-7710 Web site: www.team-mn.com
To schedule a physical examination	Health Dynamics at 1-866-443-0164 Web site: www.healthdynamics.com
Imaging & Radiology	Center for Diagnostic Imaging (CDI) at 1-866-765-7138 Web site: www.cdiradiology.com

DEFINITIONS

Allowable Expenses: For network providers, this is the contracted rate for the service or supply. For non-network providers, the rate is determined by the Board of Trustees.

Cosmetic Or Reconstructive Surgery: Any surgical procedure performed primarily to:

a. improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction, or

b. prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Employment: Employment under the jurisdiction of any collective bargaining agreement or agreement with an employer and Local Union #49 that requires the employer to contribute to the Operating Engineers Local #49 Health and Welfare Fund on behalf of employees.

Covered Person: Either an Eligible Employee or an Eligible Dependent.

Custodial Care: Any care intended primarily to help a disabled person meet basic personal needs when:

a. there is no plan of active medical treatment to reduce the disability, or

b. the plan of active medical treatment cannot reasonably be expected to reduce the disability.

Eligible Dependent: Any of the following persons:

a. the Eligible Employee's spouse.

b. a child of the Eligible Employee who meets one of the conditions listed below. Children include stepchildren, foster children, adopted children, children placed with the Eligible Employee in anticipation of adoption, grandchildren or step-grandchildren who do not have any parent age 18 or older exercising parental control and who live with the Eligible Employee, and grandchildren if the grandchild's parents are deceased or mentally or physically incapacitated. Proof of death or incapacitation must be furnished before the child will be considered eligible. A child is eligible if he or she meets any one of the requirements below:

   1. The child is less than 26 years of age, is the Employee's grandchild or step-grandchild who does not have any parent age 18 or older exercising parental control, or whose parents are deceased or mentally or physically incapacitated, and who resides with the Employee for more than one-half of the calendar year and is dependent on the Employee for more than one-half of the child's support during the calendar year.

   2. The child is less than 26 years of age and is the Employee's natural child, adopted child, child placed for adoption with the Employee, stepchild or foster child.

   3. The child is the child of the Eligible Employee or spouse who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). A QMCSO is a state court order that meets certain requirements and provides that the Plan will cover the named alternate recipients. The Plan has established written procedures for qualifying and administering QMCSOs. You may obtain a copy, free of charge, by contacting the Fund Office.

   4. Is required to be covered by virtue of a court order.

   5. Is incapable of self-sustaining employment by reason of mental or physical handicap and became handicapped prior to the termination age stated above. Age limits may be waived and the child

may remain covered under the Plan if the child is chiefly dependent upon the Eligible Employee for support and maintenance and if the Fund Office receives due proof of incapacity within 31 days of the date the child's coverage under the Plan would otherwise terminate. The child's coverage may be continued under the Plan as long as the Eligible Employee's coverage remains in force and the child remains incapacitated. The Fund Office may request proof of the continued existence of such incapacity from time to time.

A spouse will not be Eligible as a Dependent during any period that he or she is in the military, naval or air force of any country, except as required by the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended.

Eligible Employee: Any employee who is covered according to the rules explained under Eligibility.

Episode of Care: A single diagnosis and treatment plan that requires travel to a facility away from home within a calendar year.

Expense: The charge incurred for a covered service or supply. A Health Care Provider, as described in this Plan, must order or prescribe the service or supply. An Expense is considered incurred on the date the service or supply is received. An Expense does not include any charge for a service or supply which:

a. is not Medically Necessary;

b. is in excess of the Reasonable and Customary Charge for such services or supplies; or

c. is Experimental/Investigative.

Experimental/Investigative: A service or treatment on which the consensus of expert medical opinions, based on reliable evidence (i.e. published reports and/or articles) indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of such treatment or services compared to standard treatment.

Experimental or Investigative also means those services or treatments that are:

a. not recognized as having proven beneficial outcomes;

b. still primarily confined to a research setting; and

c. not appropriate based on medical circumstances and/or given the advanced stage of a person's Sickness or the likelihood that the service or treatment will measurably improve the person's Sickness or medical condition.

Health Care Provider: Any individual who is licensed to practice by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of the individual's practice.

Home Health Care Agency: Any agency or organization that:

a. is primarily engaged in providing nursing and other therapeutic services;

b. is federally certified and duly licensed by the state in which the care is given, if such licensing is required;

c. has policies established by a professional group associated with such agency, including at least one Physician and at least one registered nurse, to govern the services provided;

d. provides for full-time supervision of such services by a Physician or by a registered nurse;

e. has its own administrator; and

f. maintains a complete medical record on each patient.

Home Health Care Plan: Continued care and treatment of a Covered Person:

a. who is under the care of a Physician; and

b. who would need Hospital confinement without home health care.

A Home Health Care Plan must:

a. be approved in writing and established by the attending Physician with the home health care provider;

b. be provided for the same or related condition which required a Hospital confinement of at least 3 days or if there was not a hospitalization, the Physician must certify that without Home Health Care, hospitalization would have been necessary;

c. begin within 14 days following release from a Hospital or Skilled Nursing Facility; and

d. be reviewed at least every 30 days by the attending Physician.

Hospice Care Agency: An agency or organization that:

a. has hospice care available 24 hours per day;

b. is licensed or certified by the jurisdiction where it is located;

c. provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family;

d. establishes policies governing the provision of hospice care;

e. assesses the patient's medical and social needs;

f. develops a hospice care program; and

g. provides or arranges for services to meet those needs.

Hospice Care Program: A plan established by the patient's Physician and outlined in writing. A plan must:

a. be reviewed from time to time by the patient's attending Physician and Hospice Care Agency personnel;

b. provide palliative care to patients and supporting care to patients and their families; and

c. include an assessment of the patient's needs and a description of the care to be provided to meet those needs.

Hospital or residential treatment facility**:** An institution approved or licensed by an authorized state agency and lawfully operated in the jurisdiction in which it is located and is included in one of the following descriptions:

a. an institution for the care and treatment of sick and injured persons, with organized facilities for diagnosis and surgery and having 24-hour nursing service;

b. a residential treatment facility for the treatment of emotionally handicapped children;

c. a community mental health center or mental health clinic; or

d. a residential primary treatment facility, for treatment of alcoholism, chemical dependency or drug addiction.

This does not include institutions operated primarily as rest homes or homes for the aged or institutions that are primarily custodial in nature.

Hospital, as used by this Plan, also includes a freestanding ambulatory surgical center or facilities offering ambulatory medical services 24 hours a day, 7 days a week, which are not part of a Hospital, but which have been reviewed and approved by an authorized state agency to provide health care treatments or services.

Injury: Any unforeseen or unintended trauma to the body, excluding over-utilization of a body part, which is sustained directly and independently of all other causes. This Plan only covers injuries that are not employment-related.

Medically Necessary: A service or supply, which the Fund's medical staff and/or an independent review panel believes:

a. is appropriate and consistent with the diagnosis in accordance with accepted standards of community practice; and

b. could not have been omitted without adversely affecting the person's condition or the quality of medical care.

Mental and Nervous Disorder: A Mental and Nervous Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental and Nervous Disorders include, among other things, autism, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Mental Health Practitioners.

Physician: Any individual, including a psychiatrist, consulting psychologist, psychologist, chiropractor, osteopath, podiatrist, optometrist, and doctor of dental surgery, who is licensed to practice by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of the individual's practice.

Plan: This document adopted by the Trustees, which describes the benefits to be provided for Eligible Persons, eligibility requirements, termination rules and the rules and regulations pertaining to Plan administration. The Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

Reasonable & Customary (R&C) Charges: The usual and customary fee or charge for the services provided and supplies furnished in the area where such services are provided, or supplies furnished. The complexity of the service will be considered when determining the Reasonable and Customary Charge.

Sickness: A Sickness, disorder or disease that is not employment-related. Pregnancy is treated in the same manner as a Sickness under this Plan.

Skilled Nursing Care Confinement: Confinement in a Skilled Nursing Care Facility:

a. upon the specific recommendation and under the general supervision of a legally qualified Physician;

b. beginning within 7 days after discharge from a Medically Necessary Hospital confinement that lasted at least 3 days, for which room and board benefits are paid; and

c. for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the previous Hospital confinement.

A second Skilled Nursing Care Confinement that begins less than 60 days after a hospitalization or a Skilled Nursing Care Confinement will be considered as part of the first confinement.

Skilled Nursing Care Facility: An institution or that part of any institution that operates to provide convalescent or nursing care, and:

a. is primarily engaged in providing to inpatients:
    1. skilled nursing care and related services; or
    2. rehabilitation services;
b. has policies that are developed with the advice of (and with provisions for a review of such policies by) a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
c. has a medical staff responsible for the execution of such policies;
d. has a requirement that the health care of every patient be under the supervision of a Physician;
e. provides for having a Physician available to furnish necessary medical care in case of emergency;
f. maintains clinical records on all patients;
g. provides 24-hour nursing service that is sufficient to meet nursing needs in accordance with the policies developed and has at least one registered professional nurse employed full-time;
h. provides appropriate methods and procedures for the dispensing and administering of prescription medications;
i. in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:
    1. is licensed pursuant to such law; or
    2. is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
j. meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof.

Totally Disabled: The inability of the Eligible Employee to engage in or perform the duties of his or her regular occupation or employment within the first 2 years of disability. After the first 2 years of disability, Totally Disabled means the inability of the Eligible Employee to engage in any paid employment or work for which he/she may, by education and training, including rehabilitative training, be or reasonably become qualified.

The Board of Trustees will initially require proof of Total Disability and may require subsequent proof. In addition, the Trustees have the right to require the disabled Covered Person to submit to a medical examination at the Plan's expense.

Trustees: The Board of Trustees of the Operating Engineers Local #49 Health and Welfare Fund.

ELIGIBILITY

INITIAL ELIGIBILITY - NEW EMPLOYEES

If you start working under the jurisdiction of Local Union #49, you become eligible for coverage on the first day of the second calendar month after any six consecutive calendar month period in which you have been credited with at least 300 hours. If 300 hours are credited in less than the full six-month period, coverage will begin on the first day of the second calendar month after the last of the 300 hours was worked.

Non-Bargaining Employees see page 20 for eligibility rules.
Disabled Employees see page 18.
Retired Employees see page 21 for eligibility rules.

If you are not actively-at-work due to disability on the date coverage would be effective, Accident and Sickness Weekly Benefits will not begin until you are available for active employment.

Example of Initial Eligibility

John was hired on August 1, 2013 and completes his 300 hours by November 16. John would be eligible beginning January 1, 2014 (the first day of the second month following the month John completed 300 hours).

CONTINUED ELIGIBILITY

Once you are eligible, you will continue to be eligible for at least three months. You will remain eligible for succeeding three-month periods as long as the required contributions are made. All contribution hours will be counted. If you change employers, coverage will be continued as long as you have met the required hours.

Termination Of Eligibility

If you do not have the required hours of contributions, eligibility will terminate as follows:

a. On **August 31** - Unless you have worked:

300 hours during the previous May, June and July, or
600 hours during the previous February through July, or
900 hours during the previous November through July, or
1,200 hours during the previous August through July.

b. On **November 30** - Unless you have worked:

300 hours during the previous August, September, and October or
600 hours during the previous May through October or
900 hours during the previous February through October or
1,200 hours during the previous November through October.

c. On **the last day of February** - Unless you have worked:

300 hours during the previous November, December, and January or
600 hours during the previous August through January or
900 hours during the previous May through January or
1,200 hours during the previous February through January.

d. On **May 31** - Unless you have worked:

300 hours during the previous February, March, and April or
600 hours during the previous November through April or
900 hours during the previous August through April or
1,200 hours during the previous May through April.

Notwithstanding the above eligibility requirements, anyone with 100 or more hours of eligibility as of the date eligibility would otherwise terminate will receive one month of additional coverage for each 100 hours accumulated.

Examples of Continued Eligibility

Mary worked 125 hours in May, 100 hours in June and 90 hours in July for a total of 315 hours for the three months. That means that Mary's eligibility will continue for September, October, and November.

Pete worked 115 hours in November, 90 hours in December, 0 hours in January, which is only 205 hours for the three months, which means that Pete would lose eligibility on the last day of February. However, Pete worked 140 hours in August, 145 hours in September, and 125 hours in October, for a total of 615 hours in those six months (August 2013- January 2014). Pete's eligibility would continue for March, April, and May.

If Pete, above, only had 205 hours for November, December and January, and did not have enough hours to meet one of the conditions (a.-d.) above, he would still be able to continue coverage for two months after February (March and April) because he would receive an additional two months of coverage for his accumulated 200 hours.

Reserve Accumulation Account

All contribution hours in excess of the 300 hours required for eligibility are credited to a reserve accumulation account. You are allowed to accumulate up to 600 hours in this account. This account will be used to maintain eligibility when you have not worked enough hours to maintain eligibility in the Plan. These hours will be forfeited if you leave a bargaining unit represented by the Operating Engineers Local #49 and go to work within an industry under the jurisdiction of Local #49 for an employer who has no obligation to contribute to the Fund or if you become self-employed.

Examples of Reserve Accumulation Account

Sam worked 350 hours during May, June and July. Since Sam only needs 300 hours to continue eligibility, his extra 50 hours goes into his Reserve Accumulation Account.

Dylan has 580 hours in his Reserve Accumulation Account and works 340 hours during November, December and January. Even though he worked an extra 40 hours, only 20 hours can go into his Reserve Accumulation Account because he has reached the maximum of 600 hours.

Leslie did not work enough hours to continue eligibility beginning December 1; however, Leslie has 600 hours in her Reserve Accumulation Account. Leslie will be covered for at least for December through May with her Reserve Accumulation Account.

Reinstatement Of Eligibility

Coverage may be reinstated within 12 consecutive months following a loss of eligibility if you have at least 300 hours of contributions during a period of six consecutive months. Coverage is effective on the first day of the second calendar month following the end of the six-month period.

Eligibility During Disability

If you are unable to work because of a certified disability, you will be credited with 25 disability hours for each full week of disability. No more than 600 hours for disability will be credited during any consecutive 12-month period.

A certified disability is one for which you:

a. are receiving weekly disability benefits from the Fund; or

b. submit evidence that you are receiving weekly disability benefits from Workers' Compensation because of a disability that occurred while you were working in the jurisdiction of Local Union #49.

The Termination of Eligibility and Reserve Accumulation Account rules will be used to determine the normal termination of eligibility of a certified disabled employee. You will be notified of the opportunity to continue benefits other than Life, Accidental Death and Dismemberment and Accident and Sickness Weekly benefits. These benefits may be continued for a period of time by making self-payments to the Fund Office. The Trustees will determine the amount of self-payment. Payments must be received by the Fund Office as indicated on the self-payment notice sent by the Fund Office.

You must notify the Fund Office if you receive Medicare benefits because of your disability.

Family And Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) creates a federal right for Eligible Employees who qualify to take up to 12 weeks of unpaid leave if they are seriously ill, after the birth or adoption of a child or to care for their seriously ill spouse, parent or child, or up to 26 weeks of unpaid leave during any 12-month period to care for a service member who must be the son, daughter, parent, or next of kin of the Employee, undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the armed services, and an outpatient or on the temporary disability retired list of the armed services. Eligible Employees who qualify to take a family or medical leave must notify the Fund Office. The contributing employer must supply the Fund Office with the necessary information to verify that the leave qualifies under the FMLA, certify eligibility and pay the required premium for the extension of coverage. See page 41 for more information.

Service In The Armed Forces

Coverage for you and your Eligible Dependents will stop on the date you enter military service; however, you may choose to continue coverage for up to 25 months under USERRA. You may choose to have your eligibility status "frozen" when you enter military service and then fully restored when you return to work with a contributing employer, or to use your accumulated eligibility to continue coverage under USERRA, and then make self-payments for coverage upon reinstatement of coverage under USERRA. Coverage may be continued for up to 24 months by making self-payments in the same manner and amount as COBRA Continuation Coverage payments. You must notify the Fund Office in writing that you are entering military service. If you do not submit this notice, the Fund Office may determine that you do not wish to purchase continuation coverage under USERRA. See page 39 for more information.

The Fund Office may request that you provide documentation to establish the timeliness of your application for reemployment. Documentation may include a copy of your discharge papers, which show the date of enlistment, the date of discharge, and whether the discharge was honorable.

Special Continuation Rules

If you were involuntarily terminated from employment by any contributing employer, you may make self-payments to continue Wellness and Comprehensive Major Medical benefits. Coverage may be continued until the earlier of:

a. the date you become eligible for health care coverage under a group policy, contract or plan,

b. the date you become reemployed by a contributing employer and become eligible for Fund coverage, or

c. the last day of the sixth consecutive quarter following termination.

The Fund Office will send notification of the self-payment requirements. Payment must be received by the Fund Office by the due date specified on the statement. Payments received after the due date will not be accepted and coverage will terminate effective on the first day of the quarter for which self-payment was due. **It is your responsibility as the employee to keep the Fund notified of your and your dependents' current address so this contact can be made. You should use the enrollment card in this booklet to notify the Fund of any change of address.**

Self-payments must be made for consecutive quarters. If your eligibility terminates because you did not make the required self-payment, you lose the right to make future self-payments unless you return to work and reinstate eligibility. Any remaining hours in your reserve accumulation account will be eliminated when eligibility is terminated. Your coverage through self-payments runs concurrently with any COBRA Continuation Coverage to which you may be entitled (see page 33 for additional information).

Health Coverage Continuation - Dependents Of Deceased Active Eligible Employees

If an active employee dies, benefits for dependents will be continued until the Reserve Accumulation Account is depleted.

After the Reserve Accumulation Account is depleted, coverage may be continued under the Retiree Contribution Allowance Plan, if eligible. COBRA Continuation Coverage will be offered; but the Retiree Contribution Allowance Plan is more generous. You must waive COBRA coverage to take the Retiree Contribution Allowance Plan.

ACTIVE NON-BARGAINING EMPLOYEES

Eligibility

Non-bargaining unit employees who are currently covered by the Fund will be entitled to continued coverage by the Fund unless the terms of a particular employer's participating agreement are violated, or in the discretion of the Board of Trustees, coverage is terminated

If you are a non-bargaining unit employee, you will be eligible for all benefits except Accident and Sickness Benefits once contributions have been paid into the Fund on your behalf. (See the Accident and Sickness Weekly Benefit section on page 45 to determine if you are eligible for Accident and Sickness benefits from the Plan.) Your contributing employer must make payment at least 15 days prior to the beginning of the next insurance month for your benefits to begin on the first day of that month. Payments will not be accepted by the Fund Office unless the employer is making payments for all employees. The amount of the contribution will be determined by the Trustees.

Coverage will be subject to the terms of the non-bargaining unit employee participating agreement and is provided at the discretion of the Board of Trustees.

Termination Of Coverage

Coverage for you and your dependents will terminate when your employer does not make monthly payments as required by the Fund, or when the Board of Trustees, in its sole discretion, decides to terminate coverage.

RETIRED EMPLOYEES

Eligibility

Retired Employees Who Retired Prior To March 1, 1999

You may be eligible for retired employee benefits for you and your dependents. You must make application within 60 days after you lose eligibility and meet the following requirements:

a. 1. be at least age 62, or

2. be at least age 55 and have been awarded a pension by the Central Pension Fund of Operating Engineers, and

b. 1. have been eligible for benefits provided by this Fund during the 12 months prior to retirement, or

2. be at least age 62 and have been covered for at least 10 consecutive years under this Fund immediately prior to retirement, or

3. be at least age 65 and have been covered for at least 5 years under the Fund immediately prior to retirement, and

c. 1 . have worked for contributing employers under the jurisdiction of Operating Engineers Local #49 during the 60-month period prior to retirement.

Coverage will begin on the earlier of the:

a. first day of the month following the month that regular Fund benefits are terminated; or

b. first day of the month following the month your application for retired employee benefits is approved.

You can choose employee-only coverage or employee and dependent coverage. If you choose employee-only coverage, you will be allowed to add coverage for dependent under the special enrollment rules. If you choose dependent coverage and later decide to drop coverage for your dependents, you will not be allowed to cover your dependents again except under the special enrollment rules. If you choose coverage under retired employee benefits, you must waive any right to COBRA Continuation Coverage.

Employees Who Retired On Or After March 1, 1999

Refer to the *Retiree Contribution Allowance* section, beginning on page 25, for details of this program. To be eligible for the Retiree Contribution Allowance program you must have been employed under the jurisdiction of the Operating Engineers Local Union #49 on or after March 1, 1999. If you do not meet the eligibility requirements as outlined on page 16, you will not be eligible for any retiree program of the Health and Welfare Fund. If you retired, became disabled or were a surviving spouse before March 1, 1999, the Retiree Contribution Allowance does not apply to you.

If you choose coverage under retired employee benefits, you waive any right to COBRA Continuation Coverage.

Non-Bargaining Employees Who Retire On Or After January 1, 2012

A non-bargaining unit participating employee is eligible to become a participating retiree under the Health and Welfare Fund if:

a. The employee is age 55 or older and has at least 10 consecutive years of employment with one of more participating employers; and
b. The employee retires from employment with a participating employer while participating in the Health and Welfare Fund. The retired non-bargaining unit employee will only receive Retiree Contribution Allowance credits for years of participation in the Health and Welfare Fund.

Retirees Who Return To Active Employment

Effective September 1, 2002, if you are a retired employee and you return to active employment, you will become eligible for regular Fund benefits on the first day of the second calendar month after any six consecutive calendar month period in which you have been credited with at least 300 hours. If 300 hours are credited in less than the full six-month period, coverage will begin on the first day of the second calendar month after the last of the 300 hours was worked.

If you have earned Service Credits under the Retiree Contribution Allowance Program, the amount of each credit will not change when you subsequently retire and go back into the retiree program.

You will not earn any additional Service Credit when you return to active employment unless you work 1,600 hours after returning to active service. The amount of any new Service Credit earned will be the amount that Service Credits are worth when you return to the retiree program.

If you are retired and intend to return to active employment, you must notify the Fund Office before you return to active employment.

Medicare

When you reach age 65 and are eligible for Medicare, you should apply for both Medicare Parts A and B. When Medicare becomes your primary coverage, you will no longer be enrolled in Blue Cross Blue Shield AWARE Participating Provider Organization (PPO). You will receive information regarding enrollment in the Medicare Program available at that time. Your prescription drug coverage will change. You will receive information on the Medicare program at the time of your retirement.

If you have coverage under Medicare or Medicaid and become eligible for medical assistance, you may waive the Fund's coverage. If your spouse is not eligible for medical assistance, your spouse can continue to be covered through the Fund if you continue making timely self-payments.

You must notify the Fund when you intend to retire, when you become disabled, or when you become eligible for Medicare.

Termination Of Eligibility - Retired Employees

Benefits will terminate for you and your Eligible Dependents on the last day of the benefit month preceding any month for which a timely self-payment has not been made.

Health Coverage Continuation - Dependents Of Deceased Retired Employees

If a retired employee dies, Eligible Dependents may continue health benefits by making self-payments to the Fund Office. The amount of the self-payment will be determined by the Trustees.

The Fund Office will send notification of the self-payment requirements. Payment must be received by the Fund Office by the due date specified on the statement. Payments received after the due date will not

be accepted and coverage will terminate effective on the first day of the quarter or month for which self-payment was due. Otherwise coverage will end on the earliest of:

a. the day the surviving spouse remarries, or

b. the day coverage would otherwise terminate for dependents.

If a dependent's coverage ends because of failure to make self-payments, the right to make future self-payments is forfeited.

SPECIAL ENROLLMENT RIGHTS

If you are an Employee and you decline coverage for yourself or an Eligible Dependent because of other group health plan coverage, you may, in the future, be able to enroll yourself and your Eligible Dependents in this Plan, provided that you request enrollment within 30 days after the other coverage ends. If that other coverage was COBRA coverage, a special enrollment is only available after the COBRA continuation coverage has been exhausted. If that other coverage was coverage under Medicaid or the State Child Health Insurance Program (SCHIP) or you became eligible to participate in a financial assistance program through Medicaid or SCHIP for coverage under the Plan, you must request special enrollment within 60 days after that other coverage ended.

If you acquire a new Eligible Dependent because of marriage, birth, adoption, or placement of a child for adoption, you may enroll yourself and your Eligible Dependents, provided you enroll within 30 days of the marriage, birth, adoption, or placement for adoption.

CERTIFICATE OF COVERAGE

When your coverage ends, you will be provided with certification of your length of coverage under this Plan. This Certificate of Coverage may help reduce or eliminate any pre-existing limitation under a new group medical plan.

The Plan will automatically provide this certification when coverage ends for you and your Dependents. If you choose to continue coverage through COBRA Continuation Coverage, the Plan will provide another certificate. You may also request a Certificate of Coverage, as long as you do so in writing before losing coverage, or within 24 months after losing coverage.

RESCISSION OF COVERAGE

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

a. The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.

b. The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.

c. The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

RETIREE CONTRIBUTION ALLOWANCE

The Retiree Contribution Allowance provides an allowance (based on your service in Covered Employment) to help pay for retiree coverage. This section describes eligibility for the allowance and how the allowance is calculated.

ELIGIBILITY

To be eligible, you must have been employed under the jurisdiction of the Operating Engineers Local Union #49 on or after March 1, 1999. If you do not meet the eligibility requirements as outlined below, you will not be eligible for any retiree program of the Health and Welfare Fund. If you retired, became disabled or were a surviving spouse before March 1, 1999, the Retiree Contribution Allowance does not apply to you.

For Normal or Early Retirement you must be:

a. 1. At least 55, be receiving a pension from the Central Pension Fund of Operating Engineers and have been eligible for benefits provided by this Fund during the 12 months prior to retirement, or

   2. At least 62 and have been covered for at least 10 consecutive years under this Fund immediately prior to retirement, or

   3. At least age 65 and have been covered for at least 5 consecutive years under this Fund immediately prior to retirement, and

b. Eligible for coverage under the Health and Welfare Fund at the time of retirement, death, or disablement.

For Disability retirement you must have 10 service credits and be totally disabled as defined in the rules and regulations for the Central Pension Fund of Operating Engineers. If you were injured and applied for Workers' Compensation because your injury occurred on the job, and you are at least age 54, then you are eligible to self-pay for no more than one year to bridge the gap to age 55 and then be eligible for the Retiree Health Benefit Plan.

For pre-retired Surviving Spouse coverage, you must have had 10 service credits.

An employee of an employer covered under the Operating Engineers Local #49 Health and Welfare Fund Participation Agreement for Non-Bargained Employees will be eligible to participate in the Fund's Retiree Plan if:

a. The employee is age 55 or older and has at least ten (10) consecutive years of employment with one or more participating Employers, and
b. The employee retires from employment with a participating Employer while participating in the Fund.

Such individuals will receive a Retiree Contribution Allowance credit only for years of participation in the Fund.

You must elect to participate in the Retiree Health Benefit Plan within 30 days of either of the following dates:

a. Receipt of initial payment from the Central Pension Fund of Operating Engineers, or

b. The last day of the sixth consecutive quarter of full self-payment.

Failure to enroll in the Retiree Health Benefit Plan within the above-described timeline will disqualify you from future enrollment in the Retiree Health Benefit Plan.

West River Retired Employees can receive retiree coverage upon meeting the eligibility requirements. However, as a West River Retired Employee, you will not receive any contribution allowance and will need to pay the entire cost of coverage.

Reserve Accumulation Account (Bank)

You will stay on active coverage until all bank hours have been used. You can make a partial self-payment to make up any difference in a final month and commence participation in the Retiree Contribution Allowance Program in the month following the last coverage month where your bank hours were totally depleted. You may also forfeit your partial month of hour bank and commence participation in the Retiree Contribution Allowance Program immediately.

ONE-TIME OPT-OUT PROVISION

This provision allows you and your dependents to opt out of the Retiree Contribution Allowance program if you have group health coverage elsewhere. You and your dependents must opt out together. During the opt-out period, you will not need to make any retiree self-payments for coverage with the Fund. For example, if you are retired, but your spouse is still working and has health coverage through his/her employer, if your spouse's coverage is available to dependents, that coverage may be less expensive for your family than the Retiree Contribution Allowance program. Once this other coverage ends, you may return to the Retiree Contribution Allowance program. This section describes the rules related to the opt out provision.

Eligibility for Opt Out

To be eligible, you and your dependents must:

a. be eligible to enroll in other group health coverage (including coverage under the Veterans' Administration); and

b. have exhausted all bank hours and must not be making self-contributions or COBRA payments.

You must provide the Fund Office with:

a. documentation of the other group health insurance coverage, with the effective dates and who is eligible for coverage; and

b. a completed and executed opt-out application form (available from the Fund Office).

Documentation and application forms must be received by the Fund Office at least 15 days prior to the one-time opt-out period and will be effective on the first day of the applicable month.

Re-Enrollment in the Fund

You and your eligible dependents have a one-time opportunity to re-enroll in the Fund provided you meet the following conditions:

a. You and your dependents lose the coverage due to retirement, termination of employment, reduction in work hours, or by becoming eligible for Medicare; or

b. You, the retiree, are no longer eligible as a dependent under your spouse's health plan due to divorce or legal separation. In this case, only you, the retiree, would be allowed to re-enroll in the Fund.

To re-enroll, you must provide documentation to the Fund of one of these two events. Coverage will begin on the first of the month after the Fund Office receives the notice of intent to re-enroll with the appropriate documentation. If you or your dependents lose the other coverage and do not re-enroll in the Fund, you and all your dependents will lose the right to re-enroll in the Fund in the future.

Coverage with the Fund will begin the first day of the month after the Fund's receipt of the retiree's notice of intent to re-enroll, along with the required documentation. For example, if the Fund Office receives your notice of intent to re-enroll on March 10, coverage will begin on April 1.

Medicare Eligibility after Opt Out

You and your dependents must each re-enroll in the Fund once you, the retired member, become eligible for Medicare, unless you and your dependents continue to be covered under a group plan associated with active employment. In that case, you and your dependents may defer re-enrollment until you and/or all your dependents experience another change in eligibility.

HOW THE RETIREE CONTRIBUTION ALLOWANCE PROGRAM WORKS

If you retire on or after June 1, 2007, your self-pay rates are set at the actual full cost of retiree benefits, as determined annually by the Trustees. If you retire prior to June 1, 2007, you are subject to different self-pay rates. Your self-pay amount is then reduced by the Retiree Contribution Allowance, which is based on your period of work as an Operating Engineer within the jurisdiction of Local 49. Subject to certain maximums, the longer you have worked as an Operating Engineer, the larger your Retiree Contribution Allowance will be and the less you will have to pay. Your period of work will be measured in "service credits."

How Service Credits Are Determined

a. Your past service credits under the Health and Welfare Fund will be determined by using cumulative contribution hours in the Central Pension Fund of Operating Engineers through February 28, 1999 divided by 1,600. If you are not a Central Pension Fund participant, past service credits will be determined by your total years of covered employment under the Health and Welfare Fund through February 28, 1999, with a maximum of one service credit being awarded for each year you worked in covered employment, as determined by Trustees.

b. For service after March 1, 1999, cumulative contribution hours under the Health and Welfare Fund are divided by 1,600.

c. Service credits are provided for employer contribution hours only. Self-pay hours do not count.

d. For each week of disability, 25 hours will be credited, to a maximum of 600 hours during any 12 consecutive month period. No disability credit hours will be awarded after the initial 600 were credited in that 12 consecutive month period. For this purpose, you must meet the definition of disability in the Central Pension Fund of Operating Engineers rules and regulations.

e. Prior service is lost if you have no eligibility for benefits for five consecutive years. A break in service can be repaired by earning eligibility after the break.

f. A non-bargaining or bargaining premium participant will be credited with 1 year of service for each calendar year he was covered by the Health and Welfare Fund.

How Your Contribution Allowance is Determined

The Accrued Amount used in determining the Retiree Contribution Allowance is calculated by multiplying the total number of service credits earned at retirement, ***subject to a maximum of 30 total service credits***, by the applicable "Multiplier." If you retired prior to March 1, 2011, and earlier than age 62, your Multiplier will be reduced for each year that your retirement age precedes age 62. When you first retire, the amount of your Retiree Contribution Allowance is calculated and fixed at the appropriate level as described below. Your Multiplier for determining your Retiree Contribution Allowance stays at the original pre-Medicare and Medicare levels even if you return to covered work and subsequently retire again.

The program is not intended to provide free coverage or coverage at a stationary self-pay amount for life. As self-pay requirements rise to keep up with the increasing cost of health care, you will be charged 100% of the actual increase in self-pay amounts into the future.

For example, if the monthly self-pay rate is $1,168 per month and your Contribution Allowance is $900, your Out-of-Pocket payment is $268 per month ($1,168 minus $900). If health care costs increase 10% in the following year, or $115 per month, then your Out-of-Pocket payment will increase $115 from $268 per month to $383 per month.

Your Multiplier is based on when you retire and whether or not you are eligible for Medicare. The Multiplier amounts are described below:

Date of Retirement	March 1, 1999 through August 31, 2002	September 1, 2002 through November 30, 2003	December 1, 2003 through June 30, 2005	July 1, 2005 through May 31, 2007	June 1, 2007 And after
Pre-Medicare	$17.00	$20.00	$23.00	$20.00	$30.00
Medicare	$10.00	$12.00	$14.00	$12.00	$12.00

The "accrued amount" is determined as the product of the service credits, described above, and the applicable Multiplier, also described above. The Contribution Allowance, which is the credit used to reduce your self-pay requirement, is your accrued amount adjusted based on your type of retirement as shown in the chart below:

Type of Retirement	Contribution Allowance
Normal	Full accrued amount.
Early Retirement	▪ If you retired prior to March 1, 2011, and earlier than age 62, your Multiplier was reduced $1 for each year your retirement preceded age 62. ▪ If you retire after March 1, 2011 then no early retirement reduction is used. ▪ Early retirements prior to June 2007 are subject to a different retirement reduction factor.
Disability	▪ Prior to Medicare Eligibility – Full accrued amount for a maximum of 29 months ▪ After Medicare Eligibility – Full accrued amount.
Surviving Spouse	100% of the early retirement amount that would have been provided at participant's earliest retirement age.

Examples

Below are some examples of how the Retiree Contribution Allowance affects the amount you would pay for coverage. These examples are based on the March 1, 2012 retiree rates.

Example 1

A Member age 62 retires on June 1, 2012 with 15 service credits.

Monthly Full Cost Rate	Monthly Contribution Allowance	Monthly Retiree Out-of-Pocket Expense
$1,168	$450*	$718

* 15 service credits times $30 per service credit.

Example 2

A Member age 60 retires on June 1, 2012 with 35 service credits.

Monthly Full Cost Rate	Monthly Contribution Allowance	Monthly Retiree Out-of-Pocket Expense
$1,168	$900*	$268

* 30 maximum service credits times $30 per service credit.

Example 3

A Member age 65 retires on June 1, 2012 with 10 service credits.

Monthly Full Cost Rate	Monthly Contribution Allowance	Monthly Retiree Out-of-Pocket Expense
$530	$120*	$410

* 10 service credits times $12 per post-Medicare service credit.

Self-Payments and Termination of Coverage

The Fund office will send notification of the self-payment amount. Payment must be received by the due date specified on the statement. Payments received after the due date will not be accepted and coverage will terminate effective on the first day of the month for which the self-payment was due.

Coverage for surviving spouses will end on the day the surviving spouse remarries, or on the day coverage would otherwise terminate for surviving spouses.

You must waive COBRA coverage in order to take advantage of the Retiree Contribution Allowance Plan.

Retirees must waive COBRA to take this coverage.

LIFE EVENTS

Your benefits are designed to meet your needs at different stages of your life. This section describes how your Plan benefits are affected when different life events occur after you become a participant.

GETTING MARRIED

When you get married, your spouse is eligible for medical, dental, and vision coverage, if you are an active employee or if you are a retiree. Once you provide any required information, coverage for your spouse begins on the date of your marriage. At this time, you also may want to update your beneficiary information for your Life and AD&D Insurance. **You must notify the Fund Office within 30 days of the date of your marriage to cover your spouse under the Plan**.

If your spouse is covered under another group medical plan or Medicare, you must report the other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage; benefits for your spouse under this Plan will be paid after any benefits are payable from your spouse's plan.

ADDING A CHILD

Your natural born child will be eligible for coverage on his or her date of birth. If you adopt a child, have a child placed with you for adoption, or have a grandchild or step-grandchild who does not have any parent age 18 or older exercising parental control and who lives with you, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a dependent. Stepchildren are eligible for coverage on the date of your marriage, provided they are living in your home and dependent on you for support. Adopted children or children placed for adoption with you will be eligible on the actual date of adoption or placement. Forster children are also eligible on the date they are placed with you. Once you provide any required information, coverage for your child will begin. The child must meet the dependent eligibility requirements, as described on page 11, provided you enroll the child within 30 days of the birth, adoption, or placement for adoption.

When you add a child, provide the Fund Office with a completed enrollment form and:

- The birth date, effective date of adoption or placement for adoption, or the date of your marriage (for stepchildren).
- When you add a stepchild, you must submit a copy of your spouse's divorce decree to establish if there is other coverage for that child.
- A copy of the birth certificate, adoption papers, court order, or marriage certificate (for stepchildren).
- A copy of your child's other medical insurance information, if he or she is covered under another plan.
- Other information as may be requested by the Fund Office in order to demonstrate eligibility.

GETTING LEGALLY DIVORCED

If you and your spouse get a divorce, your spouse will no longer be eligible for coverage as a dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse **must** notify the Fund Office **within 60 days** of the divorce or legal separation date for your spouse to obtain COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation for your Life and AD&D Insurance, if eligible.

If you legally divorce, provide the Fund Office with:

- A full copy of your separation or divorce decree.
- If you have children for whom you do not have custody, a copy of any QMCSO.

If your spouse wants to continue coverage, he or she must:

- Contact the Fund Office; and
- Enroll for COBRA Continuation Coverage.

This Plan recognizes Qualified Medical Child Support Orders and provides benefits for eligible dependents, as determined by the order. A Qualified Medical Child Support Order (QMCSO) is a court order or administrative order, which has the force of law pursuant to the state's administrative procedures related to child support that provides for a child's coverage under the Plan. A copy of the Plan's QMCSO qualification procedures and a sample is available, free of charge, by contacting the Fund Office.

LOSING ELIGIBILITY

A detailed description of the requirements needed to continue eligibility is shown on page 16. If you are an active employee and your eligibility ends under the active Plan, you can become eligible again by meeting the initial eligibility requirements as described on page 16. When your coverage ends, you may be eligible to continue coverage by using your reserve accumulation account, making monthly self-payments for self-pay continuation coverage, or self-paying for COBRA Continuation Coverage (see page 33).

If your child is no longer eligible for coverage under the Plan, he or she can elect to continue coverage under COBRA Continuation Coverage. Within 60 days of losing eligibility for coverage, he or she must:

- Notify the Fund Office of the loss of dependent status.
- Enroll for COBRA Continuation Coverage if he or she plans to continue coverage under the Plan.

CHILD LOSING ELIGIBILITY

In general, your child is no longer eligible for coverage at the end of the month in which your child reaches age 26. You must notify the Fund Office within 60 days of the date your child is no longer eligible for coverage. When your child loses eligibility for this reason, your child may elect to continue coverage by making COBRA self-payments for up to 36 months.

WHEN YOU ARE OUT OF WORK DUE TO DISABILITY (FOR ACTIVE EMPLOYEES)

If you are out of work due to a non-work related disability, you may receive Accident and Sickness Weekly Benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first. In addition, you may be credited with 25 hours for each full week of disability, up to 600 hours during any consecutive 12-month period to continue eligibility.

If you are out of work due to a non-work related disability:

- Notify your employer and the Fund Office.
- Provide the Fund Office with proof of your disability.
- Apply for Weekly Benefits.

The Fund requires proof that you are under the care of a Physician to be eligible for Accident and Sickness Weekly Benefits and the continued eligibility benefit. The Fund also has the right to require you to submit to a medical examination.

If you become disabled due to an injury that is covered by AD&D Insurance, you may also be eligible for an AD&D Insurance benefit.

If you are out of work due to a work-related disability, you may be eligible for Workers' Compensation benefits. Contact your employer to file a Workers' Compensation claim. The Fund does not provide coverage for work-related disabilities.

After your disability ends, you must notify the Fund Office.

IN THE EVENT OF YOUR DEATH

If you are eligible for coverage on the date of your death, your beneficiary will receive a Life Insurance Benefit (and an AD&D Insurance benefit, for active employees only if your death is caused by an accident). See pages 43-44 for more information about Death Benefit and AD&D Benefits.

In the event of your death, your spouse or beneficiary should:

- Notify the Fund Office.
- Provide the Fund Office with a copy of your death certificate.
- Apply for your Life Insurance (and AD&D Insurance, if applicable).
- If your dependents want to continue coverage under the Plan, enroll for self-pay continuation coverage or COBRA Continuation Coverage.

Active Employees

If you die while you are an active employee, coverage for your eligible dependents will be continued until your reserve accumulation account is depleted. Then, coverage may be continued under the Retiree Contribution Allowance Plan, if you qualify. If you do not qualify, then your spouse and/or eligible dependents may continue health care coverage for up to 36 months by electing COBRA Continuation Coverage (see below). Your dependents must waive COBRA Continuation Coverage if they elect the Retiree Contribution Allowance Plan.

Retirees

If you are a retiree and you elected coverage for your dependent, your dependent's coverage will continue until the last day of the month in which you die. Your surviving dependent can continue coverage through self-payments. If the self-payments are discontinued for any month, or if your dependent does not elect to make self-payments when first eligible, your dependent will not be eligible to continue coverage by making self-payments. See page 19 for more information. Your dependents may also elect COBRA Continuation Coverage; however, the self-payments and COBRA Continuation Coverage run concurrently.

COBRA CONTINUATION 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 become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage (qualified beneficiaries). This section gives only a summary of your COBRA Continuation Coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office.

When your COBRA Continuation Coverage ends, you will be provided with certification of your length of coverage under the Plan. This may help reduce or eliminate any pre-existing condition limitation under a new group medical plan.

If you have a newborn child, adopt a child, or have a child placed with you for adoption while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement and provide a completed enrollment form and other necessary documentation (i.e., birth certificates, legal documents) to have this child added to your coverage. Children born, adopted, or placed for adoption as described above have the same COBRA rights as a spouse or dependents who were covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

COBRA Continuation Coverage In General

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 later in this section. 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 a qualifying event.

Type of coverage. COBRA Continuation Coverage includes the same type of coverage that you had before the event that triggered COBRA: medical, dental, and vision coverage. However, COBRA Continuation Coverage does not include Accident and Sickness Weekly Benefits, Life Insurance, or Accidental Death and Dismemberment Insurance Benefits.

Cost of coverage. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Fund is permitted to charge the full cost of coverage for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 50% for members of the family that includes the disabled person for the 11-month disability extension period.

Qualifying Events

If you are an active 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.

Your spouse will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happen:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than gross misconduct;
- You become entitled to Medicare benefits. (Becoming entitled to Medicare means that you were eligible for Medicare benefits *and* enrolled in Medicare, under Part A, Part B, or both. Your entitlement date is your date of enrollment.); or
- You become divorced.

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

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- The parent-employee becomes entitled to Medicare benefits. (The parent-employee's becoming entitled to Medicare means that the parent-employee was eligible for Medicare benefits *and* enrolled in Medicare under Part A, Part B, or both. The entitlement date is the date of enrollment.);
- The parents become divorced; or
- The child stops being eligible for coverage under the Plan as a dependent child.

If an employee's dependent child is covered by a Qualified Medical Child Support Order (QMCSO), the dependent child will be offered the same COBRA rights as other dependents if coverage ends for any of the above reasons. Notices will be sent to such a dependent in care of the custodial parent, following notification of the above event to the Fund Office.

If you or a Covered Dependent enters service in the uniformed services as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA) for at least 30 days, your service is considered a qualifying event under COBRA because it is a reduction in hours or end of employment. You or the dependent is entitled to elect to make self-payments for COBRA Continuation Coverage, regardless of any coverage provided by the military or government. Under USERRA, you are eligible to continue coverage for up to 24 months.

When COBRA Continuation Coverage Is Available

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred.

Electing COBRA Continuation Coverage

To elect COBRA Continuation Coverage, you must complete an Election Form and furnish it according to the directions on the form. You must send your election to the Fund Office within 60 days of the date of the Election Notice. Each qualified beneficiary has a separate right to elect COBRA Continuation Coverage. For example, either you or your spouse, or both of you may elect COBRA Continuation Coverage. Parents may elect to continue coverage on behalf of their dependent children regardless of the election made on behalf of the parents.

A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect COBRA Continuation Coverage under the Plan. A qualified beneficiary may change a prior rejection of COBRA Continuation Coverage any time until that date.

There may be other coverage options for you and your family. You can buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Employer Must Give Notice Of Some Qualifying Events

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 (qualified for *and* enrolled in coverage under Part A, Part B, or both), the employer must notify the Fund Office of the qualifying event within 30 days of any of the events.

You Must Give Notice Of Some Qualifying Events

For the other qualifying events (divorce or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Fund Office. You are required to notify the Fund Office within 60 days of the later of the date the qualifying event occurs or the date coverage is lost. You must send this notice to:

Operating Engineers #49 Health and Welfare Fund
c/o: Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

How COBRA Continuation Coverage Is Provided

Once the Fund Office receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each qualified beneficiary. For each qualified beneficiary who elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin ***on*** the date that Plan coverage would otherwise have been lost, provided the required self-payment for such coverage is made on time. If you are not eligible for COBRA Continuation Coverage, the Fund Office will send you a notice that COBRA Continuation Coverage is unavailable to you.

Length Of COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's entitlement to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), divorce or a dependent child losing eligibility as a dependent child, COBRA Continuation Coverage lasts up to a maximum 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 (qualified for *and* enrolled in) 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. However, the covered employee's maximum coverage period will be 18 months. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months, measured from the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation Coverage lasts up to a total of 18 months. This 18-month period of COBRA Continuation Coverage can be extended in two ways, as explained below. If you are continuing coverage under a USERRA leave, your coverage lasts up to a total of 24 months.

If you elected coverage through regular self-payments, that coverage runs concurrently with your COBRA Continuation Coverage, so that once you have made the maximum self-payments allowed, you may make COBRA payments for the balance of any remaining COBRA period. COBRA payments are due on the first day of the month for which payment is made (with a 30-day grace period for making your payment). If you elect retiree coverage under the Plan, you waive any right to COBRA Continuation Coverage.

Disability Extension Of 18-Month Period Of COBRA 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 Fund Office 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 coverage.

You must make sure that the Fund Office is notified of the Social Security Administration's determination of disability within 60 days of the date of the determination and before the end of the 18-month period of COBRA Continuation Coverage. You must also notify the Fund Office within 30 days of the date that the Social Security Administration determines that you or your dependent is no longer disabled. You must send this notice to the Fund Office at the address listed on page 36.

Second Qualifying Event Extension Of 18-Month Period Of COBRA 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 may receive up to an additional 18 months of COBRA Continuation Coverage, up to a maximum of 36 months, if you give notice of the second qualifying event to the Plan within 60 days of the event. This extension is available to the spouse and dependent children if:

- The employee or the former employee dies;
- The employee or the former employee becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both);
- The employee or the former employee gets divorced or legally separated; or
- The dependent child stops being eligible under the Plan as a dependent child.

The extension is available 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.

In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Office at the address listed on page 36.

Making Your Payments For COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment for COBRA Continuation Coverage with the Election Form. However, you must make your first payment for COBRA Continuation Coverage within 45 days after the date your election form is returned to the Fund Office. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA Continuation Coverage within that 45 days, you will lose all COBRA Continuation Coverage rights under the Plan.

Your first payment must cover the cost of COBRA Continuation Coverage from the time your coverage under the Plan would have otherwise ended up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Fund Office to confirm the correct amount of your first payment.

After you make your first payment for COBRA Continuation Coverage, you will be required to pay for COBRA Continuation Coverage for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA Continuation Coverage are due on the first day of the month for which payment is made. If you make a monthly payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. A COBRA self-payment will be considered on time if it is received within 30 days of the due date (your grace period explained in the next paragraph). A COBRA self-payment is considered made when it is mailed (postmarked) or personally delivered.

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. You should note that the grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA Continuation Coverage, as described in the previous paragraphs. Your COBRA Continuation Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month and you submit a claim within that period, you may receive an explanation of benefits that is a denial of your benefits, and you may have to resubmit your claim after making your COBRA payment.

Payments for COBRA Continuation Coverage should be sent to:

Operating Engineers #49 Health and Welfare Fund
c/o: Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

If you fail to make a monthly COBRA payment before the end of the grace period for that payment, you will lose all rights to COBRA Continuation Coverage under the Plan.

Loss of Continued Coverage

The period of COBRA Continuation Coverage for you or your Eligible Dependents may be cut short if:

- You or your Eligible Dependents do not make the required self-payments within 30 days of the due date;
- The Plan ceases to provide any group health benefits;
- You or your Eligible Dependents first become covered under any other group health care plan after election of COBRA continuation coverage (provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions);
- You or your eligible spouse become entitled to Medicare; or
- Your Employer withdraws from the Plan.

KEEP PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, you should keep the Fund Office informed of any changes in the addresses for you and any family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

SERVING IN THE UNIFORMED SERVICES (FOR ACTIVE EMPLOYEES)

If you enter the uniformed services (active duty or inactive duty training), you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Health coverage means medical, prescription drug, dental, vision, and hearing coverage provided under the Plan.

If you enter military service:

- Notify your employer and the Fund Office.
- Make self-payments if you wish to continue your coverage.

Service in the uniformed services 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 you are absent from a position of employment for an examination to determine your fitness for duty.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you will continue to receive coverage in accordance with USERRA for up to 31 days. If your service continues for more than 31 days, you may elect to continue coverage under the Plan by making monthly self-payments. To continue coverage, you or your dependent must pay the required self-payment. Payments will be made in the same manner and in the same amount as COBRA Continuation Coverage payments.

Uniformed services means the:

- United States Armed Forces;
- Army National Guard;
- Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
- Commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or emergency.

Your coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your coverage would have otherwise ended.

Reemployment
Following your discharge from service, you may be eligible to apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes your reinstatement of health care coverage provided by your employer.

However, your coverage will end the earliest day:

- Your coverage would otherwise end as described above;
- Your former employer ceases to provide any health plan coverage to any employee;
- You lose your rights under USERRA, such as for a dishonorable discharge;
- Your self-payment is due and unpaid; or
- You again become covered under the Plan.

Your coverage ends on the first day of the month following the date you enter the uniformed services and elect not to continue coverage under USERRA. If you do not elect continuation coverage under USERRA, your eligible dependents may continue coverage under the Plan by electing and making payments for COBRA Continuation Coverage.

You need to notify the Fund Office when you enter the military and when you return to covered employment. For more information about continuing coverage under USERRA, contact the Fund Office.

Reinstating Your Coverage

Following discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Reemployment includes the right to reinstatement in the existing health coverage provided by your employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a contributing employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a contributing employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for a contributing employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to or make yourself available for work for a contributing employer, as limited by USERRA. If you do not return to work within the required timeframes, you must again meet the initial eligibility requirements to be eligible for coverage.

FAMILY AND MEDICAL LEAVE ACT (FOR ACTIVE EMPLOYEES)

If you and your spouse both work for the same employer, you and your spouse are eligible for a combined total of 12 (or 26, if applicable) weeks of leave during a 12-month period.

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 weeks of unpaid leave for your serious illness, to care for a child after the birth, adoption, or placement for adoption of a child, or to care for your seriously ill spouse, parent, or child. In addition, the FMLA allows you to take up to 26 weeks to care for a service member who is your son, daughter, parent, or next of kin, who is undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the armed services, and who is an outpatient or on the temporary disability retired list of the armed services. The Family and Medical Leave Act requires employers to maintain health coverage under any health plan for the length of a leave as if you were still employed. In addition, the Act states that if you take a family or medical leave, you may not lose any benefits that you had accrued before the leave.

Eligibility

Any employer who employs 50 or more Employees within a 75-mile radius for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year is covered by FMLA.

To be eligible for FMLA benefits, you must:

- Work for a contributing employer, who is covered under FMLA;
- Have worked for the employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where the employer has at least 50 employees within 75 miles.

If you believe you are entitled to FMLA, please contact your employer, not the Fund Office. Your eligibility for a FMLA leave is determined by your employer. The Fund will not intervene in any employer-employee disputes.

Maintenance Of Health Benefits
A covered employer is required to maintain the same health coverage for you on FMLA leave as the coverage that was provided before the leave was taken and under the same terms as if you had continued work. Therefore, an employer covered under FMLA must continue to contribute on your behalf while you are on FMLA leave as though you had been continuously employed.

FMLA And Other Benefits
You will not accrue additional benefits during an unpaid FMLA leave, but you cannot lose benefits you had accrued before your leave. Welfare benefits other than health care must be reinstated when you return to work without any new conditions or the need to meet eligibility requirements.

How FMLA Works With COBRA
Taking a family or medical leave is not itself considered a COBRA qualifying event. If you return from leave within 12 weeks (or 26 weeks, if applicable), there will not be a loss of coverage.

If you do not return from leave, that is considered a COBRA qualifying event (a reduction in hours causing a loss of coverage). You will have up to 12 weeks (or 26 weeks, if applicable) of maintained health care coverage during FMLA leave and an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA.

WHEN YOU RETIRE

When you retire, you may be eligible for coverage under the retiree medical benefits program if you meet the eligibility requirements described on page 21. In general, benefits under the retiree program are the same as those for active employees, except you are not eligible for Life Insurance, AD&D Insurance, or Accident and Sickness Weekly Income Benefits. If you choose coverage under the retiree medical benefits program, you waive your right to COBRA Continuation Coverage.

When you retire:

- Notify the Fund Office in advance of your retirement.
- Apply for retiree benefits if you are eligible.
- If you want to continue coverage under the Plan, enroll for COBRA Continuation Coverage, unless you qualify for retiree coverage.

RETURNING TO WORK

Active Employees
If your eligibility ended and you start working again for an employer who contributes to the Fund, your coverage will be reinstated as described on page 16. If you return to work following a military leave of absence, your coverage will be reinstated as described on page 39.

Retirees
Your retiree coverage under the Plan will end when you return to employment and you become eligible for active coverage (see page 16 for the Plan's initial eligibility requirements).

DEATH BENEFIT - (EMPLOYEES AND RETIREES ONLY)

The Death Benefit is payable to your beneficiary if you die from any cause while eligible for benefits under this Plan. The amount of the Death Benefit shown in the Schedule of Benefits will be paid to your beneficiary in a lump sum after proof of death is submitted to the Fund Office. Non-bargaining employees who are not eligible for the Accident and Sickness Weekly Benefit (see page 45) are not eligible for the Death Benefit.

Beneficiary

Your beneficiary is any person or persons named on a designated form kept on record at the Fund Office. You may change your beneficiary at any time by filing a new enrollment card listing your new beneficiary with the Fund Office. Consent of your current beneficiary is not required for any change of beneficiary. A change of beneficiary will become effective upon receipt of the new beneficiary form by the Fund Office.

If you have not named a beneficiary or if your beneficiary dies before you, payment will be made by the Fund Office as follows:

a. to your surviving spouse,

b. equally to any child and/or children,

c. equally to parents,

d. to your estate.

If your beneficiary is a minor or legally incapable of giving valid receipt for any payment due him, the Fund may make payment in monthly installments of no more than $50 to the person(s) who have been caring for or supporting the beneficiary. This will continue until a claim is made for the remainder of the benefit by a duly appointed guardian or committee of the beneficiary.

Assignment

Death Benefits provided by this Plan are not assignable.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT - (EMPLOYEES AND RETIREES ONLY)

If you have a bodily Injury, the Accidental Death and Dismemberment Benefit will be paid based on the Principal Sum stated in the Schedule of Benefits. The loss must occur within 90 days of the accident. The amounts payable are:

a. the Principal Sum for loss of life; or

b. the Principal Sum for loss of:

    1. both hands,
    2. both feet,
    3. both eyes, or
    4. any such two members; or

c. one-half the Principal Sum for loss of:

    1. one hand,
    2. one foot, or
    3. one eye.

Loss of foot means the severance of a foot at or above the ankle joint. Loss of hand means the severance of a hand at or above the wrist joint. Loss of sight of an eye means the total and irrecoverable loss of sight. No more than the full amount of the benefit will be paid for any one accident.

Exclusions

The Accidental Death and Dismemberment Benefit will **not** be paid for:

a. bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections caused by pyogenic organisms which occur through an accidental cut or wound), or disease or illness of any kind; or

b. intentional self-destruction or self-inflicted injury; or

c. injury resulting from the participation in a felony; or

d. loss sustained in war or act of war, or service in the military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization; or

e. loss occurring 90 days or more after an accident.

ACCIDENT AND SICKNESS WEEKLY BENEFIT - (EMPLOYEES ONLY)

The Accident and Sickness Weekly Benefit will be paid if you are Totally Disabled due to an Injury or a Sickness that is not employment-related and you are under the regular care and attendance of a legally qualified Physician (not a Chiropractor). **Active non-bargaining employees are not eligible for this benefit unless:**

a. they are not an owner or officer of the employer; and

b. they are not receiving accident/sick pay from their employer**.**

The amount of the Weekly Benefit and the Maximum Number of Weeks Payable are shown in the Schedule of Benefits. The Accident and Sickness Weekly Benefit will begin on the first day of a disability due to an Injury and on the 8th day of a disability due to a Sickness.

During partial weeks of disability, you will be paid at the daily rate of 1/7th of the Weekly Benefit.

NOTE: Accident and Sickness Weekly Benefits are subject to taxes as gross income.

Successive Periods Of Disability

Two or more periods of disability are considered one period of disability unless you return to active full-time work for at least two weeks between disability periods. Subsequent disabilities due to entirely unrelated causes are considered separate periods of disability as long as you return to active full-time work for at least one full eight-hour day between disability periods.

Exclusions

The Accident and Sickness Weekly Benefit will **not** be paid for any:

a. disability resulting from Sickness or accidental Injury for which you are not under the care of a legally qualified Physician (not a chiropractor);

b. disability covered by Workers' Compensation or any occupational Sickness law; or

c. disability due to an occupational Injury that occurred while working for pay or profit; or

d. disability, which is not certified by a medical doctor; or

e. automobile accidents, as required by state insurance law up to the no-fault coverage limits, or

f. if you are receiving unemployment benefits, or

g. if you are receiving pension benefits from the Central Pension Fund of Operating Engineers.

WELLNESS BENEFITS

Wellness Benefits cover physical examinations, immunizations, hearing aids and chiropractic treatments. You do not have to pay a deductible before benefits start. See the Schedule of Benefits for any limits on these benefits. Other tests such as mammograms, PSA tests, and colonoscopies are covered under the Routine Physical Exam Benefit, if the Physical Exam Benefit has not been exhausted. If your Physical Exam Benefit is exhausted, then benefits will be covered under the Comprehensive Major Medical Benefit.

PHYSICAL EXAMINATION AND ROUTINE IMMUNIZATIONS BENEFIT

This benefit is available for eligible Active Employees, Pre-Medicare Retirees, and Dependents. The Physical Examination Benefit covers one routine physical examination (including x-ray and laboratory Expense) and immunizations each calendar year for each Covered Person. Physical Examination Expenses are paid at 100% if you use network providers. If you use non-network providers, the benefit is paid as shown in the Schedule of Benefits. The Plan pays 100% for urine and blood tests only when the samples are sent out of the doctor's office to a laboratory.

In lieu of the Physical Examination Benefit, you may have a physical through Health Dynamics, which will be covered in full with no copayment. Additionally, you may elect to receive EITHER a $20 per month gym/health club membership reimbursement for yourself and your spouse for up to 12 months ($240 maximum for member and $240 maximum for spouse), OR have $240 reimbursed per year for copayments, deductibles and coinsurance for you and your spouse paid under the medical plan. If both you and your spouse undergo a Health Dynamics physical, both of you can be reimbursed up to a maximum of $240 for your co-pays, deductibles and coinsurance amounts. You should check with the Fund Office for eligibility and current plan provisions. You must be a member or dependent spouse to receive a physical through Health Dynamics. If you have a mammogram through Health Dynamics, it will be covered in full. If you have a physical through Health Dynamics and then have a mammogram at another facility, the mammogram will not be covered under the Physical Examination Benefit, but it will be covered under the Comprehensive Major Medical Benefit, subject to the deductible and coinsurance. The cost of an annual Pap Smear along with any routine immunizations will be covered in full through Health Dynamics or through the Physical Examination Benefit (if you have not exhausted your Physical Examination Benefit amount). If you have exhausted your Physical Exam Benefit then benefits will be paid under the Comprehensive Major Medical Benefit.

The following mandated preventive services are paid at 100% only if you use Health Dynamics or any BlueCross PPO Health Care Provider:

THE PREVENTIVE CARE EXAM

- Comprehensive health history questionnaire
- Physician directed physical exam
- 43-point blood chemistry analysis
- 16-point urine analysis
- Blood pressure measurement
- Electrocardiogram (EKG)
- Cardiovascular fitness test
- Pap smear & screening mammogram (women)

- Prostate cancer screening (men)
- Colorectal cancer screening
- Strength & flexibility assessment
- Measurement of height, weight & body-fat percentage
- Pulmonary function (lung capacity) testing
- Analysis of diet
- Stress inventory

The following mandated preventive services are paid at 100% if you use any BlueCross PPO Health Care Provider:

- Well-woman visits (including prenatal care)
- Screening for gestational diabetes
- Breast feeding support, supplies and counseling (including equipment rental or purchase)Human papillomavirus (HPV) testing every 3 years beginning at age 30
- Counseling for sexually transmitted infections
- Counseling and screening for HIV (includes testing)
- Contraceptive methods and counseling for all FDA-approved methods and sterilization (includes barrier and hormonal methods and implanted devices)
- Services related to follow up and management of side effects from contraceptives, counseling for continued adherence and device removal
- Over-the-Counter (OTC) contraceptives for women if prescribed by a Health Care Provider
- Screening and counseling for interpersonal and domestic violence
- Aspirin and other OTC items that are recommended by a Health Care Provider
- Removal of polyps during a screening colonoscopy
- BRCA genetic testing
- Any tests or services NOT provided above by Health Dynamics that meet any of the following criteria:
  - Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
  - Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
  - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
  - With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

ROUTINE IMMUNIZATIONS

The Routine Immunization Benefit is payable for Reasonable and Customary Charges. A deductible or copayment is not required.

HEARING AID BENEFIT (ACTIVES, RETIREES, AND DEPENDENTS)

The Fund will pay 100% of Reasonable and Customary Charges for a hearing aid instrument up to the maximum benefit listed in the Schedule of Benefits. You will not have to pay a deductible. Hearing aid expenses in excess of the Schedule of Benefits will **not** be considered an Expense under any other benefits of this Plan, including the Comprehensive Major Medical Expense Benefit.

Covered hearing aid Expenses are charges for a hearing aid instrument prescribed by an audiologist, otologist, otolaryngologist, or a person certified to dispense hearing aids.

If you have an exam and order a hearing aid, and then lose eligibility, benefits will be paid if the hearing aid is delivered within 60 days after the exam and within 30 days after losing eligibility.

Exclusions

Hearing Aid Benefits will **not** be paid for:

a. hearing aids not prescribed by an audiologist, otologist or otolaryngologist, or one certified to dispense hearing aids;

b. charges made by a speech pathologist or any charges for speech therapy, speech readings or lessons in lip reading;

c. charges for rental or purchase of amplifiers; or

d. hearing aid batteries.

CHIROPRACTIC BENEFIT

The chiropractic benefit will cover services up to the limits shown in the Schedule of Benefits for the detection, treatment, and correction of structural imbalance, subluxation or misalignment of the vertebral column for the purpose of alleviating pressure on nerves.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT - (EMPLOYEES, PRE-MEDICARE RETIREES, AND DEPENDENTS)

The Comprehensive Major Medical Expense Benefit will be paid if you incur covered Expenses as the result of an Injury or Sickness that is not employment-related.

BENEFITS

The Plan will pay 80% of Expenses after the deductible has been met. After a Covered Person has reached the out-of-pocket maximum, the Plan will pay Expenses at 100%, subject to certain exceptions listed in the Schedule of Benefits.

The annual maximum benefit paid by the Plan for each Covered Person is listed in the Schedule of Benefits.

DEDUCTIBLE

The deductible is the amount of covered Expenses the Covered Person pays before the Plan pays Comprehensive Major Medical Expense Benefits. The deductible per Covered Person is listed in the Schedule of Benefits.

When two or more Covered Persons of the same family satisfy the deductible, no other deductible will be required by other Covered Persons in that family for the remainder of the calendar year. The family deductible is listed in the Schedule of Benefits.

MEDICAL PPO NETWORK

The Plan has an agreement with a medical Participating Provider Organization (PPO). A PPO is a network of Physicians, Hospitals and other Health Care Providers that offer quality health care at a reduced rate. Both you and the Fund will save money because the charge for most medical services received from participating providers will be discounted. You will find the name of the Fund's PPO network on your ID card. **It is entirely your choice whether to use a PPO provider or not.** You may refer to the contact information on your ID card to find a participating provider or to obtain a list of providers in your area, free of charge.

Copayment

You will pay the copayment listed in the Schedule of Benefits for office visits. The Plan will pay 100% of the remaining charges. There is **no** copayment for services that do not require an office visit such as allergy injections, diagnostic x-ray and lab tests, and routine immunizations for children.

For other services, see the Schedule of Benefits charts beginning on page 3 to determine your copayment.

Out-Of-Pocket Maximum

You must make the copayment listed in the Schedule of Benefits even if you have reached the calendar year out-of-pocket maximum.

PATIENT ADVOCACY

The Plan uses a Patient Advocacy Program to help you and your family receive the information you need to make informed health care decisions. If you need a transplant, have cardiovascular disease, cancer, or need muscular-skeletal treatment (other than chiropractic) or bariatric surgery, a Patient Advocacy Program vendor can direct you to a Center of Excellence or other resources for diagnosis or treatment. If the vendor refers you to another facility away from the area in which you live, the patient's transportation costs may be covered under the Plan (see the Travel Benefit section below). For more information call the Fund Office.

TRAVEL BENEFIT

The Plan may assist with paying out-of-pocket Expenses associated with traveling to obtain expert services at a designated medical treatment facility. The Travel Benefit is intended to minimize financial barriers that would otherwise prevent you or your eligible dependent from receiving an accurate comprehensive diagnosis and/or the most effective treatment for certain medical conditions.

Travel Benefits will be paid only if you satisfy **each** of the following four requirements:

a. The designated medical treatment facility must be staffed by trained and experienced sub-specialists with specific expertise and focus, including research, in the treatment of the patient's condition and must be located at least 100 miles (one way) from your primary residence.

b. The facility chosen must be identified by the Patient Advocacy Program vendor. While you have the right to choose to see any provider, Travel Benefits will not be payable unless the facility has been identified as appropriate by the Patient Advocacy Program vendor.

c. You need to apply and receive approval for this benefit prior to travelling.

d. To apply for benefits, you should contact the Plan Administrator, Wilson-McShane Corporation, at (952) 854-0795 or, toll-free, at (800) 535-6373. They will provide you the required application form and further information regarding the application process. This application will require that you describe the diagnosis (if known), treatment plan (if formulated), facility, and your anticipated financial needs to cover travel to and from the facility. The Plan Administrator will review the application and advise you if the request is approved or denied.

e. As part of the application process, you must certify that the following statement is true and correct:

> "The travel benefit I am applying for is needed to meet a financial need that otherwise would prevent me (or my dependent) from being able to seek treatment at the designated medical facility. I understand that the Plan may audit my use of this benefit and that I will be required to repay any benefit provided if my application is not true and correct in every respect, or if I do not use the Travel Benefit in the manner approved by the Plan."

If you are approved for this benefit, you should keep all your itemized receipts from your trip. **You must provide these itemized receipts for reimbursement**. Non-itemized credit or debit card receipts will not be accepted.

See the Schedule of Benefits for covered Expenses and benefit maximums.

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT BENEFITS

Mental health and substance abuse treatment may be managed through the Fund's Mental Health and Substance Abuse treatment program. See page 10 for contact information regarding the Fund's Mental Health and Substance Abuse treatment management provider to be directed to a Center of Excellence. The Plan will only pay benefits for covered services that are Medically Necessary, in accordance with generally accepted professional medical standards, and are not Investigative or Experimental.

See page 62 for exclusions and limitations.

HEALTHY STARTPRENATAL PROGRAM

This program provides services to ensure a healthy start to your baby's life. This program is provided through Blue Cross & Blue Shield of Minnesota at no charge to you. Visit myhealthystart.org or call 651-662-1818 or toll free at 866-489-6948 to enroll.

PREAUTHORIZATION

You must obtain preauthorization for the following services/procedures before they will be covered:

- Gastric Bypass;
- Xenical Weight Loss;
- Cosmetic or non-emergency reconstructive surgery; and
- Transplants.

To receive preauthorization, call the Fund Office.

COVERED CHARGES

Covered Charges are the Reasonable and Customary Charges for the following Medically Necessary services and supplies recommended by a Health Care Provider for the treatment of an Injury or Sickness:

a. **Inpatient and Outpatient Hospital Expenses** - including:
   1. Hospital Room and Board, up to the average semi-private room rate charged by the Hospital.
   2. Operating room, medicines, drugs, blood and blood plasma (including administration thereof), anesthetic (including administration when billed as part of Hospital charges), x-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings and medical supplies.

b. **Surgical Expenses** - For the performance of an operation or the repair of a dislocation or fracture (excluding assistant surgeon) and for the services of an anesthetist not included in the Hospital charges.

c. **Skilled Nursing Care Facility** - Room and board and miscellaneous charges for a Skilled Nursing Care Confinement up to the maximum amount listed in the Schedule of Benefits. The maximum amount will be paid if there was a Hospital confinement or the Physician certifies in writing that confinement would have been necessary without Skilled Nursing Care. In this case, the benefit will be 2 days for every day the Physician certifies that Hospital confinement would have been required. See page 13 for definitions.

d. **Home Health Care** services for:

1. nursing care provided by a registered nurse or a licensed practical nurse supervised by a registered nurse,
2. medical services,
3. physical, occupational or speech therapy,
4. medical supplies and drugs furnished by a Home Health Agency, in the patient's home and according to a Home Health Care Plan. One home health care visit is one visit by a Home Health Agency representative or a visit of 4 hours or less by a home health aide.

Benefits will not be paid for:

1. services of a housekeeper, companion or sitter,
2. services and supplies not included in the Home Health Care Plan,
3. services provided by a person who is part of the patient's family or who lives in the patient's home.

e. **Maternity Expenses** resulting from a pregnancy are covered immediately for Expenses incurred on or after the effective date of the Covered Person's coverage under the Plan. Under Federal law, the Plan may not restrict the Hospital stay for childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following delivery by 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 newborn earlier than 48 hours (or 96 hours as applicable). The Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

f. **Nursery care** for newborn dependent children.

g. **Office visits and lab charges** for routine examinations for dependent children.

h. **Diagnostic Laboratory and X-Ray** charges for laboratory tests or x-rays made or recommended by a Health Care Provider while not Hospital confined. Urine and blood tests made at the doctor's office are covered only if the samples are sent to a laboratory.

The following services are not covered:

1. examinations made for routine check-up purposes;
2. dental care or treatment;
3. eye refractions; or
4. therapeutic x-rays.

i. **LASIK eye surgery** for Active Employees and their Dependents and payable only once per eye in a lifetime.

j. **Reconstructive Surgery** when necessary because of:

1. injuries, or
2. repair of congenital defects of newborn children, or
3. repair of defects that result from surgery, or
4. for which preauthorization has been received from the Fund.

Reconstructive Surgery Expenses in connection with a mastectomy, as required by Federal law, are also covered for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas**.**

k. **Hospice Care** for a person who has received a prognosis of six months or less to live. Covered Expenses includes:

1. part-time or intermittent nursing care provided for up to eight hours a day by a Hospice Care or Home Health Care Agency;
2. medical supplies, drugs and medicines;
3. medical social services;
4. room and board and services and supplies for pain control and other acute and chronic symptom management in a Hospital or inpatient hospice facility or Skilled Nursing Care Facility.

Covered Hospice Care does not include:

1. bereavement counseling, pastoral counseling, financial or legal counseling (such as estate planning and drafting of a will), or funeral arrangements
2. services that are not for the care of the patient such as sitter or companion services, transportation, house cleaning or maintenance;
3. respite care provided to give the primary caregiver time away from the patient for any reason.

THE 180-DAY MAXIMUM MAY BE WAIVED WHEN CONTINUED HOSPICE CARE WILL BE A COST SAVINGS TO THE FUND OVER INPATIENT HOSPITALIZATION.

l. **Human Organ Transplant Surgery** including Human Organ Acquisition. Acquisition Expenses are limited to:

1. testing to identify a suitable donor,
2. acquisition of organ,
3. transportation of donor, if living,
4. life support for donor, and
5. transportation of the organ or donor on life support.

All transplant and stem cell support procedures must be performed by a Center of Excellence. For more information or to find a Center of Excellence, contact the Fund Office.

m. **Dental Services** – orthodontic treatment, provided within six months of an Injury to the jaw or natural teeth, including the initial replacement or repair of the teeth and any necessary dental x-rays. Orthodontic treatment must begin within six months after the Injury and be completed within two years after the Injury**. Initial treatment may begin more than six months after the Injury ONLY when Medically Necessary.**

   Additionally, anesthesia for children age five and under when dental procedures are needed is covered, as are extractions of impacted wisdom teeth if deemed Medically Necessary by the Patient Advocacy vendor.

   Tooth extractions will be covered under the Major Medical Expense Benefit only when such extractions are necessary in order to perform medically necessary procedures to treat mouth-related illnesses.

n. **Charges incurred in a foreign country** will be covered the same as any other Expense.

o. **Cochlear implants -** includes an initial installation and one upgrade due to technological advances only.

p. **Colonoscopy**.

q. **Other Expenses** - including:
   1. Treatment by a legally qualified Health Care Provider.
   2. Treatment by a physiotherapist (other than a member of the Covered Person's immediate family).
   3. Dental treatment by a Physician, dentist, or dental Surgeon for a fractured jaw or for an Injury to natural teeth including replacement of such teeth within six months after the date of the accident.
   4. X-ray or radium treatment.
   5. X-ray and laboratory examinations, excluding dental X-rays unless rendered for dental treatment of a fractured jaw or for an Injury to natural teeth within six months after the date of the accident.
   6. Professional ambulance service for:
      a) ground vehicle transportation to the nearest appropriate facility as Medically Necessary for treatment of medical emergency, acute illness or inter health care facility transfer.
      b) air transportation to the nearest qualified facility only, as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient.

r. Human growth hormone injections.

s. Gastric Bypass surgery and Xenical weight loss medication for morbid obesity are covered only if pre-authorized by the Patient Advocacy Program vendor, up to a lifetime maximum of $20,000, including services related to surgical complications and/or follow up surgery to remove excess skin, as defined below:

   1. A weight of at least 100 pounds more than normal body weight for the patient's age, sex, height and body frame based on weight tables used by the Plan and based on the following criteria:
   2. Body Mass Index (BMI)* of 40 or higher; or
   3. BMI greater than 35 in addition to any of the following co-morbidities:
      a) Coronary heart disease
      b) Type II diabetes
      c) Clinically significant obstructive sleep apnea
      d) Hypertension (Blood pressure >140 systolic and/or 90 diastolic)

      (*BMI is calculated by dividing weight in pounds, divided by height in inches squared, multiplied by 704.5. BMI between 18.5 and 24.99 is considered to be within normal range.)

t. Medical Foods are payable for persons with "Inherited Metabolic Disorders" (as defined below) to a maximum of $5,000 per calendar year, subject to the following provisions, as determined by the Plan Administrator or designee:

   1. Medical Foods must be prescribed by a Health Care Provider to treat a diagnosis of Inherited Metabolic Disorder.
   2. The patient must require specially processed or treated Medical Foods that must be consumed throughout their life, without which the patient may suffer serious mental or physical impairment.
   3. The patient must be under the regular supervision of a Health Care Provider to monitor the Inherited Metabolic Disorder.

   Documentation to substantiate the presence of an Inherited Metabolic Disorder and that the products purchased are Medical Foods may be required before the Plan will reimburse the participant for the costs associated with this benefit.

   "Inherited Metabolic Disorder" means: a genetically acquired disorder of metabolism involving the inability to metabolize amino acids, carbohydrates or fats properly, as diagnosed by a Health Care Provider using standard blood, urine, spinal fluid, tissue or enzyme analysis.

   Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia and diabetes is not an Inherited Metabolic Disorder under this Plan.

u. "Medical Foods" means special foods or formulas that are essential for the growth, health and metabolic homeostasis of a person who has an Inherited Metabolic Disorder that are administered under the direction of a Health Care Provider. Medical Foods includes:

   1. Modified low-protein foods and formulas that are specially formulated to contain less than one gram of protein per unit of serving and are administered for the medical and nutritional management of a person who has limited ability to metabolize food or nutrients properly.
   2. Metabolic Formulas, which are solutions consumed or administered through the gastrointestinal tract and are processed or formulated to metabolize food or nutrients properly.

"Medical Foods" are NOT natural foods low in protein and/or galactose, spices, flavorings, or foods or formulas required by persons who do not have an Inherited Metabolic Disorder, as defined in this document.

v. The following Medical Supplies:
   1. drugs and medicines legally obtained from a licensed pharmacist only upon prescription of a currently licensed Health Care Provider, but specifically excluding those drugs or any other form of medication, which may be obtained without such a prescription, even though they may be so prescribed. However, prescribed infant formula and prescribed supplements to the formula may be covered if the Trustees decide, based on the preponderance of medical evidence, that they are Medically Necessary and that no reasonable alternative for the formula or supplements exists. The Fund's mail-order plan is provided for long-term prescriptions and will dispense up to a 90-day supply per prescription.
   2. blood and blood plasma;
   3. artificial limbs and eyes to replace natural limbs and eyes;
   4. surgical dressings;
   5. casts;
   6. splints;
   7. trusses;
   8. braces;
   9. crutches;
   10. oxygen and the rental of equipment for its administration; and
   11. rental of durable medical equipment prescribed by a Health Care Provider but not to exceed the actual purchase price.

w. Prophylactic Mastectomy and Prophylactic Oophorectomy for women with any of the following:
   1. Women who possess or have a first or second degree relative that possesses BRCA1 or BRCA2 gene mutation confirmed by molecular susceptibility testing for breast and/or ovarian cancer; or
   2. Women with three or more affected first or second degree blood relatives on the same side of the family, irrespective of age at diagnosis; or
   3. Women who themselves or have a first or second degree relative with multiple primary or bilateral breast cancers; or
   4. Women with one or more cases of ovarian cancer AND one or more first or second degree blood relatives on the same side of the family with breast cancer; or
   5. Women with a first or second degree male relative with breast cancer: or
   6. Women who are at increased risk for specific mutation(s) due to ethnic background (for instance: Ashkenazi Jewish descent) and who have one or more relatives with breast cancer or ovarian cancer at any age; or
   7. Women diagnosed with breast cancer at 45 years of age or younger.

x. Genetic Testing:
   1. BRCA1 and BRCA2 genetic testing will be covered at 100% if the testing is done through a network provider**.**
   2. All other genetic testing is subject to an annual limit of $1,000 per participant per year.

y. Speech therapy:

   1. For participants with cochlear implants, up to 10 visits per year.

   2. For children under the age of 5, up to 10 visits per year.

   3. Restorative speech therapy in case of accident or illness will be paid under Comprehensive Major Medical benefits at 80%.

z. Medications prescribed for the treatment of erectile dysfunction (up to six pills per month) are covered at 50%. Birth control pills and erectile dysfunction medications that are prescribed for the treatment of other conditions are subject to the deductible and the copayment structure only if the following conditions are met:

   1. The drug must be Medically Necessary; and

   2. A preponderance of medical evidence must demonstrate that no reasonable alternative treatment exists.

aa. Smoking cessation products, see *Schedule of Benefits*. The participant must enroll in the Blue Cross Blue Shield of Minnesota *Quit Coach Program* to receive coverage.

bb. Orthopedic shoes, orthotics (including impressions) or other supportive devices for the feet, once every 12 months for adults and once in a period of six months for children under age 19 when replacement is required due to growth. The annual maximum plan benefit for foot orthotics is $400 per person.

cc. Treatment of Keratoconus.

DENTAL BENEFITS - (ACTIVE EMPLOYEES AND THEIR DEPENDENTS)

Dental Benefits will be paid for covered dental charges. This benefit will not exceed the Calendar Year Maximum shown in the Schedule of Benefits. Expenses in excess of the Calendar Year Maximum shown in the Schedule of Benefits will **not** be covered under the Comprehensive Major Medical Expense Benefit. It is recommended that a plan for dental treatment be submitted before work is done so you will know in advance what benefits the Plan will pay.

Services, supplies and treatment must be provided by a legally qualified practitioner for oral examination and treatment of accidentally injured or diseased teeth or supporting bone or tissue. In the event of an accidental Injury to sound and natural teeth, the Comprehensive Major Medical Benefit will be paid first and then Dental Benefits will be considered.

The Fund Office may, at its discretion, request supporting proof of loss such as clinical reports, charges and X-rays.

Covered Dental Expenses are considered to have been incurred on the date the dental service is performed.

Delta Dental

The Fund has contracted with Delta Dental Plan of Minnesota to offer their Delta USA Provider Network. If you use a Delta Dental dentist, your 20% copayment will be calculated on a discounted fee. Delta Dental dentists will file all claims for you. You still have the choice of which dentist you use. You do not have to use a Delta Dental dentist.

You can locate a Delta Dental dentist by:

- Going to http:www.deltadentalmn.org and following the instructions.
- Calling Delta Dental's Customer Service at:

  651-406-5916
  Toll Free 1-800-553-9536
  7 a.m. to 7 p.m. Monday through Friday (Central Time)

COVERED DENTAL CHARGES

Covered Dental Charges include Expenses for the following:

a. Oral examinations, including scaling and cleaning of teeth, but not more than one examination or scaling and cleaning in any six consecutive month period.

b. Topical application of sodium or stannous fluoride, once in each period of 12 consecutive months, but only if the Covered Dependent is less than 15 years old.

c. Dental X-rays.

d. Extractions.

e. Oral surgery, including excision of impacted teeth (if Medically Necessary, then covered under Comprehensive Major Medical Expense Benefit; see page 51).

f. Fillings (including composite fillings).

g. General anesthetics administered in connection with oral surgery or other covered dental services. For children age five and under, anesthesia is covered under Comprehensive Major Medical.

h. Injection of antibiotic drugs by the attending dentist.

i. Drugs for treatment of dental disease, which can be dispensed by a licensed pharmacist only upon a prescription by a legally qualified dentist or Health Care Provider operating within the scope of his license.

j. Space maintainers.

k. Treatment of periodontal and other diseases of the gums and tissues of the mouth.

l. Endodontic treatment, including root canal therapy.

m. The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework, provided that installation is required as a result of the extraction of one or more natural teeth, accidentally injured or diseased, and such denture or bridgework includes the replacement of teeth so extracted.

n. The replacement or alteration of full or partial dentures or fixed bridgework, which is necessary because of:

1. oral surgery resulting from an accident; or
2. oral surgery for repositioning muscle attachments or for removal of a tumor, cyst, torus or redundant tissue; and
3. the replacement or alteration is completed within 12 months after such surgery.

o. The replacement of a full denture, which is necessary because of:

1. structural change within the mouth, but only if more than five years has elapsed since the initial placement;
2. the initial placement of an opposing full denture; or
3. the prior installation of an immediate temporary denture, but only within 12 months of the installation of the temporary.

p. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, but only if:

1. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture or bridgework was installed; or
2. the existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

q. The replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement.

r. Inlays, gold fillings, crowns, including precision attachments for dentures.

s. Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures.

t. Appliances for treatment of Temporomandibular Joint Syndrome (TMJ) up to the maximum shown in the Schedule of Benefits. Only appliances for non-movement of teeth are covered.

u. Implants.

v. Orthodontia treatment for dependent children only or when part of a Medically Necessary covered treatment for oral surgery, cleft palate repair, or accidental injury to teeth, up to the maximum shown in the Schedule of Benefits.

EXCLUSIONS AND LIMITATIONS

In addition to the Exclusions and Limitations to the Comprehensive Major Medical Expense Benefit, benefits will not be paid under these Dental Benefits for:

a. Expenses incurred after termination of eligibility, except for prosthetic devices which were fitted and ordered prior to termination and which were delivered to an eligible Covered Person within 30 days after the date of termination;

b. Denture rebasing or relining less than six months from the date of initial placement and not more often than once in any two-year period;

d. Replacement of lost or stolen prosthetics;

e. Replacement of prosthetics less than five years after placement, except as specifically provided;

f. Treatment on or to the teeth or gums for cosmetic purposes (including realignment of teeth);

g. The application of dental sealants after the Eligible Dependent's 16th birthday; or

h. Extractions of impacted wisdom teeth that are deemed Medically Necessary by the Patient Advocacy vendor. These are covered under the Comprehensive Major Medical Expense Benefit (see page 51).

VISION CARE PROGRAM - (ACTIVES, RETIREES, AND DEPENDENTS)

Vision Care Benefits will be paid for eye examinations, including dilation of pupils and/or relaxing of focusing muscles by drops, refraction for vision, and examination for pathology, performed by a legally qualified ophthalmologist or optometrist, and the frames and lenses (including contact lenses) that are prescribed. The maximum amount payable for vision services for each Covered Person per calendar year is shown in the Schedule of Benefits. If you are a Medicare retiree, you must exhaust the benefit available under the Plan's Medicare program before you can apply for benefits under this Plan.

The Plan pays higher benefits for services performed by in-network providers. The EyeMed network includes many retailers. To locate an EyeMed provider near you, either visit www.eyemedvisioncare.com and choose Select Network, or call the EyeMed Customer Care Center at 1-866-723-0514 (Monday – Saturday 7:30 am to 11:00 pm Eastern and Sunday 11:00 am to 8:00 pm Eastern).

An Expense is considered to be incurred on the date on which the service or materials are provided or obtained.

Exclusions And Limitations

No payment will be made under this **Vision Care Program** for Expenses incurred for the following:

a. Any vision services or vision materials provided as a result of a Workers' Compensation or occupational disease law; or

b. Any vision service or vision materials for which no charge is made, or that are furnished by or payable under any plan or law of any federal or state government or any political subdivision; or

c. Sunglasses and safety glasses, which do not require a prescription to purchase.

d. Treatment of Keratoconus (covered under Comprehensive Major Medical).

e. Eye exercises and vision training.

GENERAL EXCLUSIONS AND LIMITATIONS

Plan Benefits will **not** be payable for Expenses incurred for, or resulting from:

a. Injury, Sickness or dental treatment for which Workers' Compensation benefits are paid or which arises out of or in the course of any occupation or employment for wage or profit even if Workers' Compensation coverage was not actually elected by the person who could have done so (even if that person was not the Covered Person).

b. An act of declared or undeclared war or armed aggression or while on active duty in the Armed Forces, National Guard or Reserves of any state or country

c. Expenses arising from the maintenance or use of an automobile where (i) the Covered Person fails to maintain the statutory minimum of no-fault automobile medical insurance protection in the jurisdiction in which they reside (this exclusion will apply only up to the amount of no-fault automobile insurance so required); (ii) the Covered Person fails to apply for any available no-fault automobile insurance; (iii) the no-fault insurer has determined that charges are not Medically Necessary, Reasonable or Customary; or (iv) in states without a no-fault statue, the Covered Person does not first exhaust any medical payment coverage on the vehicle(s) involved in the accident.

d. Services or supplies that are:

   1. not recommended by a Health Care Provider, or
   2. not Medically Necessary, or
   3. not provided in accordance with generally accepted professional medical standards, or
   4. Investigative or Experimental treatment s, except for routine expenses for items and services that would be covered if the patient were not participating in a trial for expenses associated with participating in an approved clinical trial for cancer or other life-threatening conditions.

e. Expenses incurred after eligibility terminates.

f. Expenses in excess of the Allowable Charges or Reasonable and Customary Charges

g. Behavioral problems or social maladjustment that are not specifically the result of mental illness.

h. Expenses incurred for the diagnosis and treatment of learning disabilities.

i. Treatment and diagnosis relating to the following diagnosis codes taken from ICD-9-Cm (International Classification of Diseases. 9th Review Clinical Modification)

   1. 302.5 Trans-sexualism;
   2. 302.6 Disorders of psychosexual identity;
   3. 302.7 Psychosexual dysfunction;
   4. 302.8 Other psychosexual disorders;
   5. Diagnosis codes that start with V for conditions not attributable to a mental disorder that are a focus of attention or treatment are not covered (except V61.10 Marital problem).

j. Orthodontia (aligning crooked teeth) services for the purposes of cosmetics, abrasions, erosion, restoring or altering vertical dimension, replacing or stabilizing tooth structure loss by attrition, realigning of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ), except as provided under Dental Benefits and in the Schedule of Benefits.

k. Eye exercises, vision training, refractions, glasses and contact lenses, except as provided under the Vision Care Program and in the Schedule of Benefits.

l. Failure to appear for an appointment as scheduled.

m. Completion of claim forms.

n. Sex transformation.

o. Participation in a riot or in the commission of a felony, except that the Plan will cover injuries or illnesses arising from acts of domestic violence.

p. Supplies or equipment for personal hygiene, comfort or convenience such as air conditioning, humidifiers, physical fitness and exercise equipment, home traction units or waterbeds.

q. Special home construction to accommodate a disabled individual.

r. Speech therapy, except as specifically stated as a covered Expense.

s. Custodial Care.

t. Treatment of infertility or any promotion of pregnancy by artificial means.

u. Vasectomy reversal and tubal ligation reversal.

v. Elective abortions; however, the Plan covers complications of abortion.

w. Acupuncture.

x. Wigs.

y. Detoxification unless part of a treatment program.

z. Smoking cessation programs or aids such as Nicorette gum or patches if not enrolled in the Blue Cross Blue Shield of Minnesota *Quit Coach Program*.

aa. Educational services and materials.

bb. Services for which the Covered Person is not required to pay.

cc. Charges made by a provider for phone consultations.

dd. Expenses for medical or Surgical treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof, except as specifically provided by the Plan.

ee. Expenses for medical or Surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, EXCEPT in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight of more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables used by the Plan.

ff. Cosmetic or reconstructive surgery, except:

1. for injuries;
2. for repair of congenital defects of newborn children;
3. for repair of defects, which result from surgery;
4. for Cosmetic or non-emergency Reconstructive Surgery for which preauthorization has been received from the Fund;
5. for Reconstructive Surgery as required by the Women's Health and Cancer Rights Act of 1998, and

6. except as otherwise specifically covered under the Comprehensive Major Medical Expense Benefit.

gg. The following therapeutic drug classifications are not covered, regardless of dosage, if there is an Over-the-Counter (OTC) drug with the same active ingredients:

1. Non-Sedating Antihistamines (NSA), including, but not limited to Claritin and Clarinex;
2. Proton Pump Inhibitors (PPI) including, but not limited to Nexium and Prilosec; and
3. H2 Antagonists including, but not limited to Tagament and Zantac.

hh. The travel benefit will not cover the following items:

1. Patient personal needs Expenses such as alcohol or cigarettes;
2. Recreational activities while at or during travel to the Quaternary Medical Facility; and
3. Insurance co-payments (assistance may be available through resources outside the Plan for patients with a variety of conditions, who are insured but unable to pay their co-payments).

Additionally, the travel benefit is not intended to cover air or ambulance travel. Free air travel is generally available through other resources outside the Plan for a patient and a family member.

ii. Birth control pills and drugs for the treatment of erectile dysfunction that are prescribed to treat other conditions when not considered Medically Necessary and when medical evidence is unable to demonstrate that no reasonable alternative treatment exists.

jj. Maternity charges incurred by a covered person who is acting as a surrogate mother. A surrogate mother is a pregnant woman who agrees to carry and deliver the child for another couple or person. The child of a surrogate mother is not considered a dependent under the Plan of the woman or her spouse if she has entered into a contract or other understanding that she relinquishes the child after its birth.

kk. Charges for on-line consultations, except OnlineCareAnywhereMN.com.

ll. Expenses associated with substance abuse treatment for wilderness programs, half-way/quarter-way houses, boarding schools, foster home/care and group homes.

mm. Expenses associated with residential facilities that do not qualify as hospitals, skilled nursing facilities, or hospice care facilities, as defined by the Plan.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Trustees have established this HRA Plan so that eligible participants may obtain reimbursement for certain Qualified Medical Care Expenses incurred on a non-taxable basis. This HRA is intended to qualify as an employer-provided medical reimbursement plan under the Internal Revenue Code (IRC) of 1986 (the Code), as amended, Code §105 and §106 and regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45.

The Qualified Medical Care Expenses reimbursed under this HRA Plan are intended to be eligible for exclusion from an eligible participant's gross income under Code §105(b). Reimbursements to highly compensated individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Plan Administrator.

Participation

When a member becomes eligible for the Plan, an HRA Account is opened and maintained in the member's name. Contributions are credited to the account and reimbursements debited from the account.

Employer contributions fund the benefits under the Welfare Fund, of which the HRA is a part. No employee contributions are allowed to be credited to the HRA Account and under no circumstances are benefits funded with salary reduction contributions. The Plan does not create a separate fund for the HRA Plan or otherwise segregate assets for this purpose.

There is no maximum dollar amount that may be credited to an HRA Account. Unused amounts may be carried over from year-to-year, without limitation. Active participants must maintain a minimum account balance of $25. Retired participants may use all of their account balance.

Your eligibility for the HRA ends upon the earlier of the termination of the HRA or your exhaustion of the balance in your account with no additional contributions being made to the account in the following six-month period.

Qualified Medical Care Expenses

A Qualified Medical Care Expense is incurred at the time the medical care or service is furnished, and not when you are formally billed for, charged for, or pay for the medical care. In addition, expenses payable from your HRA Account must be substantiated. Expenses for your Eligible Dependents can be reimbursed from your HRA Account as well.

The following expenses are eligible for reimbursement in accordance with the rules and procedures in this HRA Plan. However, this is not intended to be an all-inclusive list. Other expenses not listed here may be reimbursable.

- Acupuncture
- Alcoholism (the treatment of)
- Ambulance
- Annual Physical Examination
- Artificial Limb
- Bandages
- Birth Control Pills
- Braille Books and Magazines
- Breast Reconstruction Surgery
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures

- Diagnostic Devices
- Drug Addiction (the treatment of)
- Eyeglasses
- Eye Surgery
- Fertility Enhancement
- Guide Dog
- Gum Treatment
- Gynecologist
- Hearing Aids and Batteries
- Hospital Bills
- Hydrotherapy
- Insulin Treatments
- Insurance Premiums for COBRA or Medicare plans offered through the Local 49 Health & Welfare Fund
- Lab Tests
- Lead Paint Removal
- Lodging (away from home for outpatient care)
- Metabolism Tests
- Neurologist Services
- Nursing Services
- Obstetrician Services
- Operating Room Costs
- Ophthalmologist Services
- Optician Services
- Optometrist Services
- Oral Surgery
- Organ Transplants (including donor's expenses)
- Orthopedic Shoes
- Orthopedist Services
- Osteopath Services
- Over-the-Counter Medications (if prescribed by a Health Care Provider, doctor or surgeon)
- Oxygen and Oxygen Equipment
- Pediatrician Services
- Health Care Provider Services
- Physiotherapist Services
- Podiatrist Services
- Postnatal Treatments
- Practical Nurse Medical Services
- Pregnancy Test Kit
- Prenatal Care
- Prescription Medicines
- Prosthesis
- Psychiatrist Services
- Psychoanalyst Services
- Psychologist Services
- Psychotherapy
- Qualified Long-Term Care Insurance Premiums (up to certain limits)
- Registered Nurse Services
- Self-payment contributions to the Plan
- Special School Costs for the Handicapped
- Splints
- Sterilization
- Stop Smoking Programs
- Surgeon Services
- Telephone or TV Equipment to Assist the Hard-of-Hearing
- Therapy Equipment
- Transportation Expenses (relative to health care)
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Weight-Loss Program
- Wig
- Wheelchair
- X-rays

Non-Reimbursable Expenses

Qualified Medical Care Expenses can only be reimbursed when they have not already been reimbursed by another insurance plan, or any other accident plan or health plan, including a Health Flexible Spending Account (FSA). If a portion of a Qualified Medical Care Expense has been reimbursed elsewhere (e.g., because the health insurance plan imposes copayment or deductible limitations), you can be reimbursed for the remaining portion of such an expense (e.g., the deductible or copay) through your HRA Account if the expense otherwise meets the requirements of a Qualified Medical Care Expense.

"Qualified Medical Care Expenses" will not include the following expenses (not an exhaustive list):

- Athletic, Fitness, or Health Club Membership
- Automobile Insurance Premium (allocable to medical coverage)
- Boarding School Fees
- Bottled Water
- Commuting Expenses of a Disabled Person
- Cosmetic Surgery and Procedures
- Cosmetics, Hygiene Products, and Similar Items
- Diaper Service
- Domestic Help
- Funeral, Cremation, or Burial Expenses
- Health Programs offered by Resort Hotels, Health Clubs, and Gyms
- Illegal Operations and Treatments
- Illegally Procured Drugs
- Massage Therapy (unless prescribed)
- Maternity Clothes
- Premiums for health insurance for individual or group policies other than the Welfare Plan
- Scientology Counseling
- Social Activities
- Special Foods or Beverages
- Specially Designed Car for the Handicapped (other than an autoette or special equipment)
- Swimming Pool
- Travel (for general health improvement)
- Tuition and Travel Expenses (for a problem child to a particular school)
- Voluntary Abortion Expenses
- Weight Loss Programs (for general health)
- Any Item not considered "Medical Care" under IRC Section 213

Reimbursement Procedures

Wilson-McShane will use your HRA account to pay for deductibles and coinsurance automatically, unless you elect otherwise. To stop these automatic payments, call Wilson-McShane to request an election form to stop automatic payments. Once your completed form is received, Wilson-McShane will only reimburse eligible expenses when you submit a completed HRA reimbursement form.

You must submit a paper claim to Wilson-McShane Corporation. Please call Wilson-McShane to request an HRA reimbursement form. If you need to use paper forms or if you need to provide substantiating documentation that is not available electronically, you must send an invoice for the expense for which you are seeking reimbursement, a proof of payment of those expenses, and a completed reimbursement form to Wilson-McShane.

Reimbursements must be for at least $25 and you must maintain at least $25 in your account. (If you are retired, you may use your entire account balance.) You will need to accumulate expenses until you have at least $25 to be reimbursed. If your account is low on funds, you must wait until additional contributions are made and submit HRA claims when you have a sufficient balance.

You must have a prescription for over-the-counter medicine to be reimbursed for that medicine through your HRA Account.

You must provide one of the following to the Fund Office when you submit a claim for reimbursement of prescribed medicine:

a. A receipt from a pharmacy which identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
b. A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.

Coordination of Benefits

Benefits under this HRA Plan are intended to pay solely for Qualified Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Qualified Medical Care Expense is covered or reimbursable from another source, that other source must pay or reimburse instead of this HRA Plan. This HRA Plan may then reimburse for unpaid balances.

Unused Amounts in Your HRA Account

Your HRA Account will be debited during each calendar year for any reimbursement of Qualified Medical Care Expenses and any administrative expenses (as determined by the Trustees) charged to the account. In no event will benefits ever be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for eligible Qualified Medical Care Expenses.

Any unused amounts in your HRA Account can be carried over from one calendar year to the next.

Tax Status

If you submit an expense for reimbursement under the HRA Plan, you cannot deduct that expense on your tax return. Contributions credited to your HRA Account are not taxable income when made and generally are not taxable when paid out as benefits. However, certain actions may cause your HRA to be taxable. For instance, when you receive reimbursement from your HRA Account for contributions for health coverage that could have been paid pre-tax from an IRC Section 125 plan, your reimbursement may be taxable.

Nondiscrimination

Reimbursements to highly compensated individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Plan Administrator in its sole discretion.

COORDINATION OF BENEFITS

The purpose of this Plan is to help Covered Persons meet the cost of needed medical care or treatment. It is not intended that anyone receive benefits greater than actual Expenses incurred. Benefits payable by this Plan and any other group medical plans will not exceed 100% of **Allowable Expenses**. In no event will payment under this Plan exceed the amount that would have been allowed if no other plan were involved. All medical benefits provided under this Plan are subject to these rules.

Definitions

Plan means any plan providing benefits or services for or by reason of medical, dental, or vision care or treatment under:

a. group blanket or franchise insurance coverage;

b. group , PPO (Preferred Provider Organizations), PBMs (Prescription Benefits Managers) and other group prepayment coverage, including HMOs (Health Maintenance Organizations);

c. labor-management trustee plans, or employee benefit organization plans;

d. governmental programs, or coverage required or provided by any statute;

e. any group coverage of a child sponsored by, or provided through any educational institution;

f. group arrangements for members of associations of individuals;

g. group or individual automobile No-Fault coverage; and

h. premise liability/homeowners insurance.

The term **plan** is construed separately as to each policy, contract, or other arrangement for benefits or services, and separately as to any part of a plan which may consider benefits or services of other plans in determining its benefits and any part which does not.

An **Allowable Expense** means any necessary, reasonable, and customary item of expense, at least a part of which is covered under one of the plans covering the person for whom claim is made. For those plans that include a network of providers, the Allowable Expense is the contracted amount for a specific service or supply. For non-network providers, the Allowable Expense is set by the Board of Trustees.

Effect On Benefits

If a Covered Person is covered by another plan or plans, the benefits under this Plan and the other plans will be coordinated. This means one plan pays its full benefits first, then the other plan pays.

a. The primary plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this rule.

b. The secondary plan (the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed 100% of the **Allowable Expense**.

This plan is always secondary to no-fault and premise liability insurance. For all other types of plans, if a Covered Person is eligible under another plan, there are rules that determine the order in which benefits are paid:

a. When the other plan does not have Coordination of Benefits rules (COB rules), that plan is primary and must determine benefits first.

b. When another plan does have COB rules, the first of the following rules to apply governs:

   1. If one of the plans covers the claimant as a member or non-dependent, then that plan will be primary.
   2. If a Covered Dependent child whose married or unmarried parents live together, the plan of the parent whose birthday anniversary is earlier in the calendar year will pay for **Allowable Expenses** incurred first; except:

      a) if both parents' birthdays are on the same day, the plan that covered the Covered Dependent child (or the parent) longest will be primary and determine benefits first.

      b) if the other plan does not include this COB rule based on the parents' birthdays, but instead has another rule, then that plan's COB rule will determine the order of benefit payment.

   3. If an eligible dependent child whose unmarried parents are not living together, then the following rules apply:

      a) The plan that covers the parent who must provide health coverage by court decree, will be primary and determine benefits first. If a parent fails to provide court ordered health benefits, this Plan will **not** pay any benefits.

      b) When there is no court decree that requires a parent to provide health coverage to a dependent child, the following rules will apply:

         1. When the parent who has custody of the child has not remarried, the custodial parent's plan will be primary and determine benefits first.

         2. When the parent who has custody of the child has remarried, then the custodial parent's plan will be primary and determine benefits first, the step-parent's plan will determine benefits second and the non-custodial parent's plan will determine benefits third.

   4. If none of the above rules apply, the plan that has covered the claimant for the longest period of time will pay its benefits first; except when:

      a) one plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and

      b) the other plan includes this COB rule for laid-off or retired employees (or is issued in a state that requires this COB rule by law).

      In this case, the plan that covers the claimant as other than a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of the plan coordinates benefits and a part does not, each part will be treated like a separate plan.

COORDINATION OF BENEFITS WITH MEDICARE AND MEDICAID

There is no coordination of benefits with Medicaid.

A Covered Person does not need to retire and begin receiving Social Security retirement benefits to be eligible for Medicare. Most people are automatically eligible for Medicare at age 65 even if they are still employed. Some people become eligible for Medicare before age 65, such as people who are disabled as defined by Social Security or people with end stage renal disease (ESRD).

There are different parts of Medicare. Part A covers Hospital Expenses and is generally free. Part B covers other medical expenses and requires a monthly premium. Part D covers prescription drugs and requires a monthly premium. Medicare Advantage plans, also known as Medicare Part C (Medicare +Choice) may offer a combination of benefits that include Part A, B and D benefits and are similar to health maintenance organization (HMO) plans. **This Plan automatically considers you to be insured under both Part A and Part B if you are eligible for them, whether or not you have actually enrolled. Benefits will be paid as though you were enrolled under both Part A and Part B of Medicare. Therefore, it is very important that you enroll in Medicare as soon as you become eligible.**

Services provided by a Health Care Provider who directly contracts with Medicare beneficiaries, and therefore opts out of Medicare, will not be covered by the Plan.

This Plan will be primary over Medicare if you:

a. are at least age 65, eligible for Medicare because of age and actively employed by an ADEA employer who pays all or part of the required contributions for eligibility.

b. are considered disabled by the Social Security Administration, but are still considered active by an ADEA employer.

c. have end stage renal disease (ESRD) but have not completed the required waiting period prior to Medicare becoming primary.

Medicare will be primary over the Plan if you:

a. are over age 65 and not actively employed by an ADEA employer who pays all or part of the required premium.

b. are at least age 65 and retired. (However, if you become entitled to Medicare due to ESRD prior to becoming eligible for Medicare due to age or another disability, this Plan will be primary for the required waiting period.)

c. are disabled, have completed the 24-month waiting period, and are not actively employed by an ADEA employer who pays all or part of the required premium.

If Medicare is primary for you and you enroll for Medicare Part D, you will not be eligible for prescription drug coverage under this Plan.

Following are definitions for purposes of this section:

Medicare Benefits: Benefits for services and supplies, which the Covered Person receives or is entitled to receive under Medicare.

Age 65: The age attained at 12:01 a.m. on the first day of the month in which the Covered Person's 65th birthday occurs.

ADEA Employer: An Employer who:

a. is subject to the U.S. Age Discrimination in Employment Act (ADEA); and

b. has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

PROCEDURE FOR FILING A CLAIM

This section describes the procedure for filing claims for Fund benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the denial.

Written notice of a claim must be received by the Fund Office within 90 days of the date the loss first arises or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Fund Office, with sufficient information to identify the Covered Person, will be deemed to be notice to the Plan.

Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than 25 months from the time proof is otherwise required.

Medical benefits, except vision care, will be paid directly to the provider.

If any benefits of the Plan will be payable to a person who is a minor or otherwise not competent to give a valid release, the Fund Office may pay such indemnity up to an amount not to exceed $1,000.00 to any relative by blood or connection by marriage of the Covered Person who is considered by the Fund Office to be entitled. Any payment made by the Fund Office in good faith and pursuant to this section will fully discharge the Plan to the extent of such payment.

The Fund Office, through its Physician, has the right to examine the Covered Person, whose Injury or Sickness is the basis of a claim or request an autopsy in case of death. Such examination may be required as often as may be reasonable.

HOW TO FILE A CLAIM

A “claim for benefits” is a request for Fund benefits made in accordance with the Fund’s reasonable claims procedures. A claim form must be completed and signed once a year. A claim form may be obtained from the Fund Office by calling (800) 535-6373 or (952) 854-0795. If you use a Participating Provider Organization provider, the provider will file the claim for you. It is recommended that a plan for dental treatment be submitted before work is done so you will know in advance what benefits the Plan will pay. Also, contact the Fund Office about how to file a claim for a Death Benefit and Accidental Death and Dismemberment Benefits.

Inquiries or phone calls about the Fund’s provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, your request for prior approval of a benefit that does not require prior approval by the Fund is not a claim for benefits.

THE FOLLOWING INFORMATION MUST BE COMPLETED IN ORDER FOR YOUR REQUEST FOR BENEFITS TO BE A CLAIM, AND FOR THE FUND OFFICE TO BE ABLE TO DECIDE YOUR CLAIM:

1. Participant name;
2. Patient name;
3. Patient date of birth;
4. Social Security Number of participant or retiree or other identifying number that is adopted by the Plan;
5. Date of service;
6. CPT-4 (the code for Health Care Provider services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
7. ICD-10 (the diagnosis code found in the International Classification of Diseases, 10th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
8. Billed charge;
9. Number of Units (for anesthesia and certain other claims);
10. Federal taxpayer identification number (TIN) of the provider;
11. Billing name and address; and
12. If treatment is due to an accident, accident details.

Where Claims Must Be Filed

Your claim will be considered filed as soon as it is received at the Fund Office. You should file your claims with the Fund at the following address:

Operating Engineers Local #49 Health and Welfare Fund
c/o: Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. You can obtain a form from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

Types of Claims

- **Health Care Claims.** Health care claims include medical, prescription drug, vision and dental claims. Health care claims are divided into four basic types of claims:
  - ***Urgent Care***, which is a claim for care or treatment, as determined by the Plan, that would:
    - Seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or
    - Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Health Care Provider with knowledge of your condition.

    Urgent care claims are considered pre-service claims.
  - ***Pre-Service***, which is a claim for benefits where precertification/notification is required before you obtain care. However, the Plan will not deny benefits for these services if it is not possible for you to obtain precertification/notification or if the process would jeopardize your life or health.

  Concurrent Care, which is a claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits or a termination of benefits.

  Post-Service, which is a claim for benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services for which the claim is being submitted.

- **Death Benefit Claim.**
- **Accidental Death and Dismemberment (AD&D) Benefit Claim.**
- **Accident and Sickness Weekly Benefit Claim.**

Claim Decisions

When you submit a claim for benefits, the Plan will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly, when complete claim information is received. The Plan will make an initial determination within certain timeframes, as follows:

Health Care Claims. Generally, health care determinations will be made as soon as administratively possible, as follows:

- ***Urgent Care Claims.*** The Plan will notify you of its determination as soon as possible, and no later than 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 48 hours to respond. The Plan will notify you of its determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.

- ***Pre-Service Claims.*** The Plan will notify you of its initial determination within 15 days from receipt of your claim. If additional time is necessary, up to 15 additional days, due to matters beyond the control of the Plan, you will be informed of the extension within this 15-day deadline. If additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will notify you of its determination within 15 days.

  If you do not follow the required procedures for filing a pre-service claim, the Plan will notify you within five days of receipt of the claim.

- ***Concurrent Care Claims*.** The Plan will notify you as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment. If a concurrent care claim does not involve urgent care treatment or is filed less than 24 hours before the expiration of the previously approved time period or number of treatments, the Plan will respond according to the type of claim involved.

- ***Post-Service Claims*.** The Plan will notify you of its initial determination within 30 days from receipt of your claim. If additional time is necessary, due to matters beyond the control of the Plan, the Plan may take an additional 15 days to notify you, and you will be informed of the 15-day extension within the initial 30-day deadline. If additional information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will notify you of its determination within 15 days.

  If a claim for concurrent care or post-service is approved, payment will be made and the payment will be considered notice that the claim was approved.

Death and AD&D Benefit Claims. Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this 90-day deadline. The Plan may extend this 90-day period up to an additional 90 days maximum.

Accident and Sickness Weekly Benefit (Loss of Time) Claims. For Accident and Sickness Weekly Benefit (Loss of Time) claims, the Fund will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within 30 days.

If circumstances require an extension of time for making a determination on your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. Once the Fund makes payment on a claim, no further payment will be made.

IF A CLAIM IS DENIED

If your claim is denied in whole or in part, the Fund must provide you with a notice of their initial determination about your claim within certain timeframes after they receive your claim. The notice must provide you with the following information:

a. The specific reason or reasons for the denial of benefits or other adverse benefit determination;

b. A specific reference to the pertinent provisions of the Plan upon which the decision is based;

c. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

d. A copy of the Fund's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA after exhausting the Fund's administrative remedies;

e. A copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request;

f. A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for Medical and Accident and Sickness Weekly Benefit (loss of time) claims that are denied due to:

    1. Medical Necessity;

    2. Experimental treatment; or

    3. Similar exclusion or limit.

Appeal Procedures

The following procedures will apply to appeals from benefit denials or other adverse benefit determinations:

a. You have 180 days (60 days for a life insurance or AD&D claim) following receipt of a benefit denial or other adverse benefit determination within which to appeal the determination, in writing, to the Fund office.

b. You have the opportunity to submit written comments, documents, records, and other information relating to your claim.

c. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

d. All comments, documents, records, and other information submitted by you relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination, will be taken into account.

e. You are entitled to be represented by counsel or other representative of your choosing during this appeal process.

f. The Board of Trustees will not give deference to the initial benefit denial or adverse benefit determination.

g. If the determination is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational or not Medically Necessary or appropriate, a health care professional who has appropriate training and experience in the relevant field of medicine will be consulted.

h. Upon request, the Fund will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim, without regard to whether the advice was relied upon in making the determination.

First Level of Review – Appeal to the Board of Trustees

If you disagree with the determination of your claim, then you may make an appeal to the Fund's Board of Trustees. Ordinarily, decisions on appeals involving Post-Service Medical Claims, Accident and Sickness Weekly Benefits, or Death Benefit Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your claim has been reached by the Board of Trustees, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Appeal Decisions

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made and the decision maker will not defer to the initial decision. An appropriate fiduciary of the Plan, which is the Board of Trustees, will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted. The Plan will notify you, in writing, of the decision on any appeal.

Appeal Decision Timeframes

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as follows:

Health Care Claims:

- ***Urgent Care Claims.*** The Plan will notify you of its determination as soon as possible and no later than 72 hours from receipt of your appeal.

- ***Pre-Service Claims*.** The Plan will notify you of its determination within 30 days from receipt of your appeal.

- ***Concurrent Care Claims.*** The Plan will notify you of its determination before termination of your benefit.

- ***Post-Service Claims*.** A determination will be made at the Trustees' next regularly scheduled quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require an extension of time, you will be notified and a determination will be made no later than the third quarterly meeting following receipt of the appeal. You will be notified of the decision in writing within five (5) days of the date of the meeting at which the decision is made.

Accident and Sickness Weekly Benefits (Loss of Time). A determination will be made at the Trustees' next quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second quarterly meeting following receipt of your appeal. If special circumstances require an extension of time, you will be notified and a determination will be made no later than the third quarterly meeting following receipt of the appeal. You will be notified of the decision in writing within five (5) days of the date of the meeting at which the decision is made.

Death and AD&D Benefits. Generally, you will receive written notice of a decision on your initial claim within 60 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this 60-day deadline. The Plan may extend this 60-day period up to an additional 60 days maximum.

You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision.

Notice of Decision of Appeal

The decision on any appeal of your claim will be given to you in writing. The notice of a denial of a claim on appeal will state:

a. The specific reason(s) for the determination.

b. Reference to the specific Fund provision(s) on which the determination is based.

c. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

d. A statement of your right to bring a civil action under ERISA Section 502(a) after exhausting the Fund's administrative remedies.

If an internal rule, guideline, or protocol was relied upon by the Fund, then you may receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on medical necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, then you may receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

Second Level of Appeal – External Review

For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s)).

If your appeal of a claim, whether pre-service, post-service or urgent care claim, 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.

NOTE that if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the **Plan**, external review is not available.

External Review of Standard Claims

Your request for external review of a standard (not urgent) claim must made, in writing, within four (4) months of the date that you receive notice of an Initial Claim Benefit Determination (Claim) or Adverse Redetermination Decision (rejection of an Internal Appeal). For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them 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 after an Appeal for a Claim Benefit Determinations (Redetermination Decision).

Preliminary Review

a. Within five (5) business days of receipt of your external review request for a standard claim, the Fund Office will complete a preliminary review of the request to determine whether:
    1. 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;
    2. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
    3. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
    4. You have provided all of the information and forms required to process an external review.

b. Within one (1) business day of completing its preliminary review, The Fund Office will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:
    1. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
    2. If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the 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

If the request is complete and eligible, The Fund Office will assign the request to an Independent Review Organization (IRO). The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Fund Office will rotate assignment among IROs with which it contracts.

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

a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).
b. Within five (5) business days after the assignment to the IRO, The Fund Office will provide the IRO with the documents and information it considered in making its Adverse Determination.
c. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Fund Office. Upon receipt of any such information, the Fund Office may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Fund Office will not delay the external review. However, if upon reconsideration, the Fund Office 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.
d. 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 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 requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. 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).

e. The assigned IRO will provide written notice of its final external review decision to you and the Fund Office within 45 days after the IRO receives the request for the external review.
f. The assigned IRO's decision notice will contain:
    1. 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, and the treatment code and its corresponding meaning, and the reason for the previous denial);
    2. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    4. 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;
    5. A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
    6. A statement that judicial review may be available to you; and
    7. Current contact information, including 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:

a. 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
b. You receive an adverse Appeal for a Claim Benefit Determinations (Redetermination Decision) 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.

Review Process

The process is the same as for a standard review, but the timeframes are shorter, as follows:

a. The preliminary review will be made as quickly as possible and notification will be made by phone.
b. If the claim meets the requirements for an external review, the IRO will make its determination 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.

Legal Actions

You may not start a lawsuit until after:

a. you have requested both levels of review and a final decision has been reached, or
b. you have not received a final decision or notice that an extension will be necessary to reach a final decision in the appropriate time frame described above.

The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. Otherwise, you must exhaust the Plan's claims and appeals procedures before bringing any lawsuit or administrative proceeding. Any lawsuit based on the decision of the arbitrator is governed by the applicable statute of limitations.

The procedures specified in this section will be the sole and exclusive procedures available to a Covered Person or beneficiary who is dissatisfied with an eligibility determination, benefit award, or who is otherwise adversely affected by an action of the Trustees.

RIGHT OF SUBROGATION (REIMBURSEMENT)

Subrogation is the Plan's right to obtain reimbursement when a third person is legally obligated to pay damages for your Injuries. This subrogation right lowers the cost of the Plan.

The following rules apply to the Plan's right of subrogation and reimbursement:

a. **Subrogation and Reimbursement Rights in Return for Benefits:** In return for the receipt of benefits from the Plan, the Covered Person agrees that the Plan has the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the Covered Person will sign a form acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the Covered Person refuses to sign the acknowledgment. The Plan's subrogation and reimbursement rights to benefits paid prior to the Plan's notice of a subrogation and reimbursement right are not impacted if the Covered Person refuses to sign the acknowledgment.

b. **Constructive Trust or Equitable Lien:** The Plan's subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Covered Person from a third-party, whether by settlement, judgment or otherwise. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the Covered Person fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's subrogation and reimbursement rights, the Plan reserves the right to, among other things, pursue all available equitable action and offset any future benefits payable to the Covered Person under the Plan.

c. **Plan Paid First:** Amounts recovered or recoverable by or on the Covered Person's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Covered Person. The Plan's subrogation and reimbursement right comes first even if the Covered Member is not paid for all of their claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a third-party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the Covered Person may have received or may be entitled to receive from the third-party.

d. **Right to Take Action:** The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any other plan member can bring an action (including in the Covered Person's name) for specific performance, injunction or any other equitable action necessary to protect its rights in the cause of action, right of recovery or recovery by a Covered Person. The Plan will commence any action it deems appropriate against a Covered Person, an attorney or any third-party to protect its subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of eligible dependents covered by the Plan regardless of whether such dependent is legally obligated for expenses of treatment.

e. **Applies to All Rights of Recovery or Causes of Action:** The Plan's subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the Covered Person has or may have against any third-party.

f. **No Assignment:** The Covered Person cannot assign any rights or causes of action they may have against a third-party to recover medical expenses without the express written consent of the Plan.

g. **Full Cooperation:** The Covered Person will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. Benefits will be denied if the Covered Person does not cooperate with the Plan.

h. **Notification to the Plan:** The Covered Person must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the member for their injuries, sickness, or death. Further, the Covered Person must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims.

i. **Third-Party:** Third-party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers' compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for a member's losses, damages, injuries or claims relating in any way to the injury, occurrence, conditions or circumstances leading to the Plan's payment of benefits. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the member, dependent, or participant.

j. **Apportionment, Comparative Fault. Contributory Negligence, Make-Whole and Common-Fund Doctrines Do Not Apply:** The Plan's subrogation and reimbursement rights include all portions of the Covered Person's claims regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium, The Plan's subrogation and reimbursement rights are not affected, reduced or eliminated by comparative fault, contributory negligence, the make-whole and common-fund doctrines or any other equitable defenses.

k. **Attorney's Fees:** The Plan will not be responsible for any attorney's fees or costs incurred by the Covered Person in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorney's fees or costs.

l. **Course and Scope of Employment:** If the Plan has paid benefits for any injury which arises out of and in the course and scope of employment, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by the Covered Person regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney's fees are awarded to the Covered Person's attorney from the Plan's recovery, the Covered Person will reimburse the Plan for the attorney's fees.

m. **Future Claims:** In the event you recover any sums from any third party or any insurance company for claims related to a specific event or health condition as set forth above before making claim against the Plan related to that specific event or health condition, the Plan will be:

    1. responsible to make payments for benefits only in excess of your net recovery (gross amount less actual costs of collection); or

    2. entitled to reimbursement from you for payment of any benefit up to the amount of your net recovery.

Right Of Recovery

Whenever the Plan has made payments in excess of its contractual obligations, the Plan has the right to recover such overpayments from any person or legal entity to or for whom such payments were made, including by making deductions from benefits which may be payable to or on behalf of an eligible person in the future.

IMPORTANT INFORMATION ABOUT THE HEALTH AND WELFARE FUND

The following information is provided to help identify this Welfare Plan and the people who are involved in its operation as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Name Of Plan - The Plan is known as the Operating Engineers Local #49 Health and Welfare Fund.

Type Of Plan - The Fund is maintained for the purpose of providing Death, Loss of Time, Medical, Dental, and Vision Benefits for Eligible Employees and their Eligible Dependents according to the Schedule of Benefits and eligibility rules described in this booklet.

All benefits of this Health and Welfare Fund are provided on a self-funded basis directly from the Fund's assets.

Vendors – The Fund contracts with various vendors for services, as follows:

a. Wilson-McShane Corporation:
    1. Maintain eligibility records;
    2. Accounts for Employer and self-payment contributions;
    3. Answers Participant inquiries; and
    4. Administers claims and other routine administrative functions.
b. See your medical card for PPO information.
c. Delta Dental provides access to the dental network.
d. The Patient Advocacy Program vendor provides patient advocacy and referral services for Centers of Excellence and the Travel Benefit.
e. Blue Cross Blue Shield of Minnesota (BCBSMN) provides Employee Assistance Program benefits and referral services for Mental Health and Substance Abuse.
f. Health Dynamics provides physical examination services.

See *Contacts* on page 10.

Type of Administration – The Board of Trustees have contracted with Wilson-McShane Corporation to provide day-to-day administration of the Plan.

Booklet - This booklet describes the requirements and eligibility for participation, the types of benefits available and the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits.

Agent For Service Of Legal Process – Matt Winkel of Wilson-McShane Corporation is designated as agent for service of legal process. Any legal documents should be served upon Mr. Winkel or any individual Trustee at the Fund Office.

Board Of Trustees - A Board of Trustees is responsible for the operation of this Health and Welfare Fund. The Board of Trustees has the responsibility of determining the eligibility rules for participation by employees in the benefit Plan and for determining the benefits to be offered. The Trustees will exercise complete discretionary authority to construe, interpret, and apply all of the terms of the Plan. Decisions of the Board of Trustees will be given judicial deference in any action in court or administrative proceeding that follows their decision. The Board of Trustees is also responsible for reporting to the government agencies and disclosing to Plan participants and beneficiaries as required by ERISA.

The Board of Trustees intends to continue the Welfare Plan indefinitely. The Board of Trustees retains the right to amend the Plan at any time. Any amendment to the Plan will be binding on all Covered Persons on the effective date of the amendment.

The Board of Trustees also retains the right to terminate the Welfare Plan and Welfare Trust Fund if all contributing employers are no longer obligated through written agreement to make required contributions. In this event, the monies of the Trust Fund will be applied to all existing benefit obligations in effect on the date of termination of the Welfare Plan and Trust. Termination of the Plan will be binding on all Covered Persons who were covered under the Plan prior to termination.

At termination, any balance of the Welfare Trust Fund that cannot be so applied, will be applied to other uses as, in the opinion of the Board of Trustees, will best serve the intentions of the Welfare Plan. Upon the disbursement of the entire Trust, the Trust will then terminate.

The Board of Trustees will amend or terminate the Plan in accordance with the terms of the Trust Agreement and the Employee Retirement Income Security Act of 1974, as amended (ERISA). You will be notified in writing of any amendment to the Plan or of termination of the Plan.

Plan Sponsor And Plan Administrator - The Board of Trustees is both the Plan Sponsor and Plan Administrator of the Health and Welfare Fund. The Board of Trustees consists of an equal number of Union and Employer representatives, selected by the Union and the Associations and employers. You may contact the Board of Trustees at the Fund Office.

Identification Number - The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 41-6187749. The Number assigned to this Plan by the Board of Trustees pursuant to the instructions of IRS is 501.

Contributions - The Operating Engineers Local #49 Health and Welfare Fund receives money from contributing employers in accordance with the Collective Bargaining Agreements of the International Union of Operating Engineers Local #49. Copies of the collective bargaining agreements are available at the Local Unions' Offices and the Fund Office, upon request and without charge. A complete list of contributing employers is available at the Fund Office. You may also request in writing and without charge, a copy of the list of contributing employers or information as to whether a particular employer is a contributing employer.

In addition, Employees and Retirees, if eligible, may self-pay for coverage.

Fund Assets - All assets are presently invested pursuant to guidelines adopted by the Board of Trustees.

Plan Year - The Fund's fiscal year for the purpose of maintaining records and filing various governmental records and reports is the annual period June 1 through May 31.

PRIVACY POLICY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Plan protect the confidentiality and security of your protected health information.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

The Plan will distribute its Privacy Notice periodically, as required by HIPAA rules, or when changes are made to the policies and procedures.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other Plan benefit or employee benefit plan.

The Plan hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates," to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your protected health information include the right to:

- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office.

The Use and Disclosure of Protected Health Information

The Operating Engineers Local #49 Health and Welfare Fund ("Plan") will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

a. *Payment* includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

   1. coordination of benefits;
   2. adjudication of health benefit claims (including appeals and other payment disputes);
   3. subrogation of health benefit claims;
   4. billing, collection activities and related health care data processing;
   5. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
   6. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
   7. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
   8. utilization review;
   9. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
   10. reimbursement to the Plan.

b. *Health Care Operations* include, but are not limited to, the following activities:

   1. quality assessment;
   2. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
   3. rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
   4. underwriting, premium rating 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 (including stop-loss insurance and excess of loss insurance);
   5. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
   6. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
   7. business management and general administrative activities of the Plan, including, but not limited to:
      a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
      b) customer service, including the provision of data analyses for plan sponsors or others; and

c) resolution of internal grievances.

8. The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or Beneficiary.

   With an authorization, the Plan will disclose PHI to other Operating Engineers employee benefit plans (including the Central Pension Fund) for purposes related to administration of these plans.

c. *Certification of Plan Sponsor*

The Plan will disclose PHI to the Board of Trustees of the Operating Engineers Local #49 Health and Welfare Fund ("Plan Sponsor") only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

d. Conditions of Disclosure

The Plan will not disclose PHI to the Plan Sponsor unless the Plan Sponsor agrees to:

1. not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
5. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. make PHI available to an individual in accordance with HIPAA's access requirements;
7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA:
8. make available the information required to provide an accounting of disclosures;
9. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

   a) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction feasible); and

   b) ensure that the adequate separation between the Plan and Plan Sponsor required in 45 CFR §504(f)(2)(iii) is satisfied.

e. *Adequate Separation Between the Plan and the Plan Sponsor*

In accordance with HIPAA, only the Trustees of the Operating Engineers Local #49 Health and Welfare Fund and others allowed by law may be given access to PHI.

f. Limitations Of PHI Access And Disclosure

The persons described in paragraph 6 above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

g. Noncompliance Issues

If the persons described in paragraph 6 above do not comply with these privacy provisions, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

STATEMENT OF ERISA RIGHTS

As a participant in the 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 are entitled to the following rights.

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts, 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 Fund Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description and Plan Document. The Fund Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- 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 Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

You lose coverage under the plan;

- You become entitled to elect COBRA Continuation Coverage; or
- Your COBRA Continuation Coverage ends.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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.

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. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. For instance, if you request a copy of the Summary Plan Description and Plan Document 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 Fund Administrator 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 Fund Administrator.

If you have a claim for benefits that 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 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.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at:

Nearest Regional Office:

Employee Benefits Security Administration
Kansas City Regional Office
1100 Main Street, Suite 1200
Kansas City, MO 64105-5148
Tel 816.426.5131

National Office:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
(866) 444-3272

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their Web site at http://www.dol.gov/pwba.