OPERATING ENGINEERS LOCAL #49
HEALTH AND WELFARE FUND

2022 SUMMARY PLAN DESCRIPTION

Operating Engineers Local #49 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
Health49.org

Board of Trustees (Administrator, as defined by law)	
UNION TRUSTEES	**EMPLOYER**
Ron Boesel Operating Engineers Local #49 2829 Anthony Lane South Minneapolis, MN 55418	**Tony Frattalone** Frattalone Companies 3205 Spruce Street St. Paul, MN 55117
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Alternate Trustee: **Ryan Davies** Operating Engineers Local #49 8381 Enterprise Drive North Virginia, MN 55792	**Alternate Trustee**: **Mary Wawro** Ryan Companies US, Inc. – Retired 533 South 3rd Street, Suite 100 Minneapolis, MN 55415

FUND ADMINISTRATOR
Wilson-McShane Corporation

FUND COUNSEL
Reinhart Boerner Van Deuren s.c.

FUND CONSULTANT
Segal

FUND AUDITOR
Legacy Professionals, LLP

CONTACT INFORMATION

If you need…	*Contact…*
Information about claims, eligibility or Plan benefits for all claims, or to contact the Board of Trustees	Wilson-McShane Corporation 952-854-0795 or toll free: 800-535-6373 health49.org
Preauthorization for admission to a Hospital outside of the state of Minnesota	Blue Cross and Blue Shield of Minnesota 866-938-9741 bluecrossmn.com/
To speak with a doctor online regarding a non-Emergency Medical Condition	Doctor On Demand doctorondemand.com
To speak with a patient advocate, to speak with an EAP counselor, or if you need a referral for a mental health or substance abuse issue	TEAM 651-642-0182 or 800-634-7710 team-mn.com
To schedule a physical examination	Health Dynamics 866-443-0164 healthdynamics.com
To find a network medical provider or to learn more about other medical programs offered	Blue Cross and Blue Shield of Minnesota 866-489-6948, 8 am - 4:30 pm CT bluecrossmn.com/
To schedule imaging and/or radiology testing	RAYUS Radiology 866-765-7138 rayusradiology.com/
To find a network pharmacy	OptumRx 866-795-6816 optumrx.com
To have a prescription filled for a specialty medication	Optum Specialty Pharmacy 855-427-4682
To find a network dentist	Delta Dental Plan of Minnesota 651-406-5916 or toll free: 800-553-9536 deltadentalmn.org

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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, 2022.

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 or
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 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, 2022. 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. The Trustees are the sole fact-finders with respect to all determinations affecting the Plan. Eligibility or participation in the Plan does not guarantee benefits. The benefits under the Plan are not vested.

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 Administrator, who coordinates the activities of the Board and service vendors. In addition, the Board contracts with experts to provide members and their families with 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, pre-Medicare retirees, Medicare retirees, and their Eligible Dependents; however, not all benefits are available to all participants. The benefits that are available to each group are:

- **Active employees and their Eligible Dependents**:
  1. Active employees only:
     - Death Benefit
     - Accidental Death and Dismemberment Benefit
     - Accident and Sickness Weekly Benefit
  2. Active employees and their Eligible Dependents:
     - Support Programs
     - Comprehensive Major Medical Expense Benefit (medical and prescription drug coverage)
     - Dental Benefits
     - Vision Care Benefits
     - Health Reimbursement Arrangement
- **Pre-Medicare retirees and pre-Medicare Dependents of pre-Medicare and Medicare Retirees**:
  1. Retiree only:
     - Death Benefit
     - Accidental Death and Dismemberment Benefit
  2. Retirees and their Eligible Dependents:
     - Support Programs
     - Comprehensive Major Medical Expense Benefit (medical and prescription drug coverage)
     - Dental Benefits
     - Vision Care Benefits
- **Medicare retirees and their Medicare Dependents**: Generally, your benefits are provided through the Fund's fully-insured Medicare program.

The Fund contracts with a third party administrator (TPA), Wilson-McShane Corporation, to process medical, dental, vision, and other 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.

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

- **Fully covered physical examinations** through Health Dynamics and network providers.
- **A Patient Advocacy program** through TEAM, which helps you find an appropriate medical treatment facility and needed resources for second opinions and 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.
- **An Employee Assistance Program through** TEAM, which provides you and your family members with short-term counseling services either over the phone or in a face-to-face setting.
- **Doctor On Demand,** a Blue Cross and Blue Shield of Minnesota program, 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 by downloading the free Doctor On Demand app.
- **Radiology** services through RAYUS Radiology.
- **Pharmacy network services** through OptumRx, and **specialty drug pharmacy services** through Optum Specialty Pharmacy.
- Additional **savings on dental care** through Delta Dental Plan of Minnesota.

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, refer to the *Contact Information* section.

SCHEDULE OF BENEFITS[1]

BENEFIT MAXIMUMS, CALENDAR YEAR DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS & COPAYMENTS—APPLIES TO THE COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS FOR ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES– (*NOT APPLICABLE FOR WEST RIVER PARTICIPANTS IN SOUTH DAKOTA*)

Calendar Year Deductible (Hourly Actives)

Per Covered Person……..... $500

Per Family……..... $1,000

Calendar Year Deductible (All Other Participants)

Per Covered Person..... $750

Per Family..... $1,500

If you (and/or your spouse, if applicable) have a Health Dynamics comprehensive physical performed December 1st through November 30th, your deductible will be waived for the next calendar year.

Out-of-Pocket Maximum After Deductible Has Been Satisfied

Per Covered Person..... ……$2,500

Per Family..... $6,000

The out-of-pocket maximum does not include the deductible. Copayments, including those for office visits and lab Expenses, will apply to the out-of-pocket maximum.

Coinsurance After Deductible Has Been Satisfied For Hospital Expenses

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 Expenses

	Plan Pays	**You Pay**
Office visits, including lab Expenses to participating providers	The balance of the participating provider Expenses after your $25 copayment.	$25
Office visits, including lab Expenses to non-participating providers	70%	30%
Services provided (or billed by) participating providers	80%	20%
Services provided (or billed by) non-participating providers	70%	30%
Inpatient services at non-participating facilities (except during an emergency)	0%	100%
Emergency services	80%	20%

Prescription Drug Benefits

Coinsurance 20%

Annual Out-of-Pocket Limit

Per Covered Person $2,500

Per Family $5,900

Per Family for Specialty Drugs $1,800

The specialty drug out-of-pocket maximum is in addition to the Plan's $2,500/$5,900 prescription drug out-of-pocket maximum.

All specialty drugs must be obtained through Optum's specialty pharmacy. There is no coverage for specialty drugs obtained elsewhere. There is no coverage for drugs that are not included in the Formulary.

Erectile Dysfunction Coinsurance (for 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 Expense Benefit, subject to the deductible and the 80%/20% coinsurance structure. However, the prescription must be Medically Necessary and medical evidence must demonstrate that no reasonable alternative treatment exists.

BENEFIT MAXIMUMS, CALENDAR YEAR DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS & COPAYMENT AMOUNTS—APPLIES TO THE COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS FOR ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES – (*APPLICABLE FOR WEST RIVER PARTICIPANTS IN SOUTH DAKOTA*)

Calendar Year Deductible

Per Covered Person..... $800

Per Family..... $1,600

If you (and/or your spouse, if applicable) have a Health Dynamics comprehensive physical performed December 1st through November 30th of the following year, your deductible will be waived for the next calendar year.

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

Out-of-Pocket Maximum After Deductible Has Been Satisfied

Per Covered Person $3,550

Per Family..... $7,100

The out-of-pocket maximum does not include the deductible. Copayments, including those for office visits and lab Expenses, will apply to the out-of-pocket maximum.

Coinsurance After Deductible Has Been Satisfied For Hospital Expenses

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 Expenses

	Plan Pays	You Pay
Office visits, including lab Expenses to participating providers	The balance of the participating provider Expenses after your $15 copayment.	$15
Office visits, including lab Expenses to non-participating providers	70%	30%
Services provided (or billed by) participating providers	80%	20%
Services provided (or billed by) non-participating providers	70%	30%
Inpatient stays at non-participating facilities (except during an emergency)	0%	100%
Emergency services	80%	20%

Prescription Drug Benefits

Coinsurance 20%

Annual Out-of-Pocket Limit

Per Covered Person $2,500

Per Family $5,000

Per Family for Specialty Drugs $1,800

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SUPPORT PROGRAMS (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

Physical Exam and Routine Immunizations

Plan Pays

Participating Provider 100%

Non-Participating Provider..... 80%

Health Dynamics Comprehensive Physical Exam Program: Participants and their Eligible Dependent spouses who participate in a comprehensive Health Dynamics physical will have their calendar year deductible waived in the calendar year following the 12-month period (December – November) in which the comprehensive physical is completed. For example, the employee and/or spouse who participates in a comprehensive Health Dynamics physical between December 2020 and November 2021 will have their 2022 calendar year deductible waived. In addition, each individual may elect to receive either a $20 per month gym/health club membership reimbursement for up to 12 months ($240 maximum for member and $240 maximum for spouse) OR have $240 reimbursed to him/her per year for copayments, deductibles and coinsurance amounts paid under the medical plan.

Health Dynamics Primary MD Program: Participants and spouses who prefer to see their own Physician for their annual physical examination versus participating in the Health Dynamics Comprehensive Physical Exam Program may participate in the Health Dynamics Primary MD (Primary MD) program. Primary MD allows participants and spouses to visit their own Physician and have their Physician fill out a questionnaire, which includes clinical data to be supplied back to Health Dynamics for wellness consultation and coaching purposes with the participant and/or spouse. Participants and their spouses who utilize the Primary MD program **are each eligible for either** a $20 per month gym/health club membership reimbursement for up to 12 months ($240 maximum for member and $240 maximum for spouse) OR have $240 reimbursed to him/her per year for copayments and coinsurance amounts paid under the medical plan. Participants and/or spouses participating in the Primary MD program are **not** eligible for waiver of the following year's deductible.

Routine Immunizations

Plan Pays..... 100%

Chiropractic/Acupuncture Treatment

Plan Pays..... 100%

Maximum Visits (chiropractic and acupuncture combined).....19 visits per year

Example: The Plan will cover a participant who visits a chiropractor 16 times and an acupuncturist 3 times in 12 months (19 visits in total). A 20th visit will not be covered, regardless of whether it is a chiropractic visit or an acupuncture visit.

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

SUPPORT PROGRAMS (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES, AND MEDICARE RETIREES)

Employee Assistance Program (TEAM)

Plan Pays..... 100%

Visit Limitations .....None

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

Diagnostic Imaging, Laboratory and Radiology Testing – performed by RAYUS Radiology

Plan Pays..... 100%

Preventive Care – performed by a Health Dynamics or Blue Cross and Blue Shield of Minnesota PPO Health Care Provider

Plan Pays..... 100%

FDA-Approved Vaccines for COVID-19

Plan Pays..... 100%

FDA-approved COVID-19 vaccines will be covered with no out-of-pocket cost and no deductible, regardless of where the vaccine is administered.

Testing for COVID-19

Plan Pays..... 100% during national emergency; then covered 80%

Online or Televisits Unrelated to COVID-19

Plan Pays..... Same as an office visit

Out-of-Network .....Subject to deductible and coinsurance

In-Network Phone Consultations (West River) .....$25/$15 copayment

Patient Advocacy Program

Plan Pays..... 100%

Doctor On Demand Televisits

Plan Pays..... 100%

Minute Clinic – or Any Other Freestanding Clinic Found in a Retail Setting

Plan Pays.....100%, up to $25

Plan Maximum Payment per Visit $25

Prescription Drugs

Plan Pays..... 80%

Smoking Cessation Products

Over-the-Counter Products

When Enrolled in the Plan's Smoking Cessation Program……..... 100%

Prescription Products

When Enrolled in the Plan's Smoking Cessation Program ……..... 80%

Medicare retirees, refer to the booklet from your Medicare supplement carrier for details about your Prescription Drug Benefits.

Ambulance

Plan Pays..... 80%

Limited to travel to nearest appropriate facility for treatment, as Medically Necessary. Air ambulance covered only in an emergency.

Skilled Nursing Care

Maximum Number of Days ..... 2 days for each day of Hospital confinement up to 60 days

Plan Pays..... 80%

Home Health Care

Maximum Number of Visits per Calendar Year..... 90

Plan Pays..... 80%

Hospice Care

Maximum Number of Days 180

Plan Pays..... 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 .....$2,000 once in 5 calendar years

The 5 calendar year period begins the calendar year following the date the first hearing aid is purchased. For example, if a hearing aid is purchased September 1, 2019, then the $2,000 benefit is not available again until January 1, 2025.

Cochlear Implants

The Plan will pay for initial installation and Medically Necessary upgrades, subject to deductible and coinsurance.

LASIK Eye Surgery

Plan Pays..... 100%

Maximum Payment per Eye..... $500

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.

Medical Foods

Calendar Year Maximum……$5,000

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

Lifetime Maximum $20,000

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 Age 5 and Under

Maximum Visits per Calendar Year 52

Restorative Speech Therapy if After Accident or Illness (like stroke) 80%

Speech Therapy for Participants with Cochlear Implants

Maximum Visits per Calendar Year 10

Orthodontia (Medically Necessary Treatment for Oral Surgery, Pierre Robin Sequence Treatment, Cleft Palate Repair, or Accidental Injury to Teeth)

Lifetime Maximum (payable under Medical Plan and subject to deductible) $2,000

BENEFITS FOR MEDICARE RETIREES AND THEIR MEDICARE DEPENDENTS

Patient Advocacy Program

Plan Pays..... 100%

Hearing Aids

Maximum Payment .....$2,000 once in 5 calendar years

The 5 calendar year period begins the calendar year following the date the first hearing aid is purchased. For example, if a hearing aid is purchased September 1, 2019, then the $2,000 benefit is not available again until January 1, 2025.

DENTAL BENEFITS (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS ONLY)

Maximum Payment per Calendar Year $2,000

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

Plan Pays (Diagnostic and Preventive Services 100%

(Routine dental exams and cleanings are covered two times per calendar year.)

Plan Pays (all other services)..... 80%

TMJ

Maximum Payment per Lifetime..... $800

Plan Pays 80%

Orthodontia (for Eligible Dependent children only)

Lifetime Maximum..... $1,000

Retirees should contact the Fund Office for information regarding dental benefits.

VISION BENEFITS (ALL PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS)

Maximum Allowance per Participant (for two consecutive calendar years)..... $500

The Maximum Allowance does not apply to exams for children under age 18. Any remaining (unspent) balance of the $500 at the end of any two consecutive calendar years will not carry over. Instead, the full $500 will be replenished for your use during the next consecutive two calendar years. **T**he allowance will be replenished to $500 on the first day of every even year.

DEATH BENEFITS (ACTIVE EMPLOYEES AND RETIREES ONLY)

Active Employees..... $8,000

Retirees $2,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (ACTIVE EMPLOYEES AND RETIREES ONLY)

Principal Sum

Active Employees $8,000

Retirees $2,000

ACCIDENT AND SICKNESS WEEKLY BENEFITS (ACTIVE EMPLOYEES ONLY)

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 Illness

If you have not met the initial eligibility requirements for coverage, Accident and Sickness Weekly Benefits will not begin until you are available for active employment.

1 The descriptions of coverage throughout the *Schedule of Benefits* is general. Specific limitations or exclusions in this Plan control in any conflict with the general coverage description.

DEFINITIONS

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010.

Allowable Expense: A specific dollar amount corresponding to a specific item or service that the Plan will use, in combination with other information, to determine the amount of benefits that are payable with respect to the specific item or service.

No benefits are payable with respect to any amount billed for any item or service that exceeds the Allowable Expense amount. No benefits will be paid for any item or service in an amount that exceeds the Allowable Expense. The Allowable Expense amount is not determined by reference to or intended to reflect any usual, customary or reasonable charge. The Plan will determine benefits by reference to the Allowable Expense amount that is determined by the applicable procedure set forth below. The determination of the Allowable Expense amount is subject to the policies and procedures of the applicable claims administrator. The claims administrator may bundle services, take multiple procedure discounts or other reductions as a result of the procedures performed and billed on the claim.

For in-network provider expenses, the Allowable Expense amount is the negotiated amount that the provider has agreed to accept as full payment for the applicable item or service at the time your claim is processed. The claims administrator periodically may adjust the negotiated amount at the time your claim is processed as a result of expected settlements or other factors. The negotiated amount with in-network providers for certain items and services may not be based on a specified charge. Through annual or other global settlements, rebates, prospective payments or other methods, the claims administrator may adjust the negotiated amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in your out-of-pocket amount. If the negotiated amount is decreased, the amount of the decrease is credited to the Plan. If the negotiated amount is increased, the Plan pays that cost on your behalf and you are not required to pay anything further out-of-pocket.

For out-of-network provider expenses within Minnesota, the Allowable Expense amount will be 180% of the Medicare allowed charge for the same or similar service or, if Medicare does not have an applicable allowed charge, 40% of the billed charge. For out-of-network provider expenses outside of Minnesota, the Allowable Expense amount will be the be the out-of-network amount determined by the procedures of the Blue Cross or Blue Shield Plan in the state where the expenses were incurred, or, if there is no such amount, 30% of the billed charge.

Under certain circumstances, the Plan may be required by law to provide benefits based on an Allowable Expense amount that exceeds the amount determined by the procedures described above. In such cases, the Allowable Expense amount is the amount determined by law.

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 and 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 Expense: An expense with respect to which benefits may be payable under the Plan. Only the Allowable Expense for a Medically Necessary service or supply that is not excluded under the Plan and that is recommended by a Health Care Provider for the diagnosis or treatment of an Injury or Illness is a Covered Expense. No benefits are payable under the Plan in connection with expenses that are not Covered Expenses.

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.

Dollar Bank: The accumulated posted contributions for an employee, less any amount used for eligibility or forfeited according to the eligibility rules for this Plan. A Dollar Bank may be credited with a maximum of six months of the required contribution amount. Any excess amount(s) will be credited to a Health Reimbursement Arrangement (HRA). The Dollar Bank is a notional account. It cannot be converted to cash or used for any purpose other than as expressly stated in this Plan. The Dollar Bank is not vested – it may be reduced or eliminated at any time and for any reason.

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. the child is required to be covered by virtue of a court order; or

    5. the child 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 covered as an Eligible 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.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another Hospital before delivery; or

b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Expense: The charge incurred for a covered item or service. 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 Allowable Expense for such services or supplies; or

c. Is Experimental/Investigative.

d. Is otherwise excluded under this Plan.

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. Lack of government approval (when required), generally or for the specific intended use, renders an item or service Experimental/Investigative.

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 Illness or the likelihood that the service or treatment will measurably improve the person's Illness 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 license.

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 that required a Hospital confinement of at least three days. 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.

Illness (Sickness): Any bodily Illness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician. Illness also includes pregnancy.

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 that:

a. Is appropriate, in terms of type, frequency, extent, site and duration, and consistent with the diagnosis and considered effective, all in accordance with accepted standards of practice;

b. Is not primarily for the convenience of the patient or Health Care Provider,

c. Could not have been omitted without adversely affecting the person's condition or the quality of medical care; and

d. Is not more costly than an alternative that is likely to produce reasonably equivalent therapeutic or diagnostic results.

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 Covered 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.

Service Credit: The amount of Covered Employment used to determine your Contribution Allowance.

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 two years of disability. The ability for an employee to return to light duty, non-collectively-bargained work will not disqualify the employee from being deemed Totally Disabled. After the first two 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 (ACTIVE EMPLOYEES)

INITIAL ELIGIBILITY (ACTIVE HOURLY BARGAINED EMPLOYEES)

For eligibility rules for Retired Employees, refer to the next section.

You initially become eligible on the first day of the first calendar month immediately following the month in which employer contributions in your Dollar Bank equal or exceed the required contribution amount. A Dollar Bank may be credited with a maximum of six months of the required contribution amount. Any excess amount(s) will be credited to a Health Reimbursement Arrangement (HRA).

Employer contributions made to the Fund on your behalf to your Dollar Bank are posted on the last day of the month following the work month they were accrued. The amount required to receive a month of eligibility will be subtracted from the Dollar Bank on the first day of any month for which eligibility is granted.

Example of Initial Eligibility

John was hired on January 1, 2021 and his employer made contributions to his Dollar Bank in February 2021, which equaled or exceeded the required contribution amount. His employer's contributions were posted on the last day of February 2021. Therefore, John became eligible on March 1, 2021.

Individuals who are eligible for coverage as your "Eligible Dependents" are listed in the Definitions section. Generally, they include an individual who is your lawful spouse under Minnesota or any other state law, a child under age 26 who is your natural-born child, legally adopted child or child placed with you for adoption, a stepchild, foster child, grandchild or stepchild, and a child under age 26 who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Board of Trustees.

INITIAL ELIGIBILITY (ACTIVE MONTHLY BARGAINING AND NON-BARGAINING UNIT EMPLOYEES)

If you are an active monthly bargaining unit employee, you will be eligible for all benefits. If you are a monthly non-bargaining unit employee, you will be eligible for all benefits except Accident and Sickness Benefits and Death Benefits, under certain circumstances, once contributions have been paid into the Fund on your behalf. (Refer to the *Accident and Sickness Weekly Benefit* section 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 applicable bargaining premium or non-bargaining unit employee participating agreement and is provided at the discretion of the Board of Trustees.

You 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.

FORFEITURE OF DOLLAR BANK AND HRA

Any amount in a Dollar Bank that is attributable to posted contributions more than six months old for an Employee who is not yet eligible, will be forfeited.

The hours will be also 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.

DEPENDENT OPT-OUT PROVISION FOR HSA COVERAGE

An Eligible Dependent of an Eligible Employee or eligible retiree may elect to opt-out of coverage under this Plan if they are eligible for a health plan offered by their employer that is a high deductible health plan with a Health Savings Account (HSA). The Eligible Dependent and Eligible Employee or eligible retiree must complete a Waiver of Coverage form to opt-out of coverage under the Plan. The Waiver of Coverage form can be obtained from the Fund Office. The Eligible Dependent must indicate the date upon which the waiver of coverage will be effective.

The Eligible Dependent and Eligible Employee or eligible retiree understands that by electing to opt-out of coverage under the Plan, the Eligible Dependent will:

- Not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, dental benefits, extended coverage options under federal law, or retiree benefits;
- Have no right or claim to any contributions made to the Plan for the purposes of funding the Eligible Dependent's eligibility for coverage;
- Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the Eligible Dependent's employer; and
- Have no right to return to coverage under the Plan until such time as:
    1. the Eligible Dependent's employer ceases to make the HSA and high-deductible health plan available to its employees or the dependent loses his or her coverage due to retirement, termination of employment, reduction in work hours, or by becoming eligible for Medicare, and
    2. the Eligible Dependent otherwise meets the eligibility requirements of the Plan, and
    3. the Eligible Dependent provides written notice to the Trustees of the desire to once again become covered by the Plan and submits documentation of the loss of the HSA and high-deductible health plan coverage.

CONTINUED ELIGIBILITY

Eligibility will continue for each month as long as you have at least the required contribution amount in your Dollar Bank on the last day of the preceding month.

In the event you have an amount less than the required contribution in your Dollar Bank, eligibility for benefits is subject to termination unless eligibility is continued as the result of:

- Self-contributions or COBRA premium payments from the Plan's Health Reimbursement Arrangement (HRA), if applicable and available;
- Self-contributions;
- Payment of a COBRA premium; or
- Credited posted contributions due to a total disability for which you are receiving Weekly Disability benefits or a total disability caused by an on-the-job Injury or occupational Illness while you were an Eligible Employee.

In the event of your death, coverage for your Eligible Dependents will continue according to the Continued Eligibility for Survivors of Eligible Employees section below.

Continued Eligibility Through Self-Contribution

If you do not have at least the required contribution amount in your Dollar Bank on the last day of a month, you may self-contribute according to the following rules:

- You may make unlimited consecutive self-contributions as long as the amount in your Dollar Bank is greater than zero;
- The amount of the self-contribution must equal the difference between the balance in your Dollar Bank and the required contribution amount; and
- Self-contributions are due by the due date listed on the self-contribution notice. Failure to make self-contributions by the due date will result in termination of coverage.

Continued Eligibility During Disability

If you are unable to work because of a certified disability, you will be credited with contributions toward continued eligibility, for each week or partial week of disability for which certified weekly disability benefits, as defined below, are received, to a maximum of the required contribution subtracted each month. Posted contributions will be at a weekly rate equal to the required contribution in effect multiplied by 12 and divided by 52. However, in no event will more than 26 consecutive weeks of contributions be credited for each disabling Illness or Injury. After maxing out 26 consecutive weeks of eligibility, you can self-pay.

A certified disability is one for which you:

- Are receiving disability benefits from the Fund each week for Accident and Sickness Weekly Benefits; or
- Submit evidence that you are receiving disability benefits from Workers' Compensation because of a disability that occurred while you were working in the jurisdiction of Local Union #49.

Refer to the *Life Events* section for more information about coverage during a disability.

Continued Eligibility During a Family and Medical Leave

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 1/20th of the required contribution amount per day for the extension of FMLA coverage.

Refer to the *Life Events* section for more information about FMLA.

Continued Eligibility While Serving 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.

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.

Refer to the *Life Events* section for more information about USERRA.

Continued Eligibility for Survivors of Eligible Employees

If you die while eligible for benefits, your surviving spouse and other Eligible Dependents may remain eligible for benefits by applying the unused portion of your Dollar Bank (including yet-to-be posted contributions due for work prior to your death) to the required contribution necessary to maintain eligibility for benefits. If at any point the Dollar Bank does not have the full amount of the required contribution for a month, your surviving spouse may use your HRA, if available, to continue eligibility for benefits. Otherwise, your surviving spouse may make one self-contribution to bring the Dollar Bank up to the required contribution amount to continue eligibility for benefits for only that month. After eligibility for benefits has terminated, your surviving spouse or any Eligible Dependent may make the required premium payment for COBRA continuation coverage. If your surviving spouse or Eligible Dependent is a Qualified Beneficiary, they will have to waive COBRA coverage to participate in the retiree program.

If your surviving spouse is employed and covered under a group benefits plan through his or her employer, coverage through this Plan will not be available.

Dependents covered for benefits will continue to remain covered under the provisions of the Plan so long as your surviving spouse remains eligible and as long as your dependents continue to be Eligible Dependents as defined by the Plan (refer to the *Definitions* section). If your spouse dies prior to the end of COBRA continuation coverage, your Eligible Dependents may elect to continue COBRA coverage. Refer to the *COBRA Continuation Coverage* section for more information about continuing coverage.

If you have no surviving spouse or if your surviving spouse dies before the Dollar Bank balance is exhausted, the remaining amount in your Dollar Bank will be forfeited.

Special Continuation Rules

If you are involuntarily terminated from employment by any contributing employer, you may make self-payments to continue coverage. Coverage may be continued until the earlier of:

- The date you become eligible for other employer-sponsored health care coverage, or health care coverage under a group policy, contract or plan; or
- The date you again meet the initial eligibility rules.

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 month for which self-payment was due. **It is your responsibility as the employee to keep the Fund notified of your current address and your Eligible Dependents' current address so this contact can be made.**

Self-payments must be made monthly. If your eligibility terminates because you do not make the required self-payment, you lose the right to make future self-payments until you return to work and meet the initial eligibility rules.

TERMINATION OF ELIGIBILITY

Coverage for you and your Eligible 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.

Eligibility will terminate upon the earliest of the following:

- The date the Plan terminates;
- The last day of the month that you do not have the required contribution in your Dollar Bank or HRA, and eligibility is not continued according to continuation of eligibility rules;
- The date you or your Eligible Dependent enters military service (subject to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)); or
- The date a Covered Individual ceases to be an Eligible Dependent.

Amounts in your Dollar Bank may also be forfeited under certain circumstances. Refer back to the subsection titled *Forfeiture of Dollar Bank and HRA.*

The Board of Trustees reserves the right to terminate the Fund and provide for the distribution of the Fund's assets, including the HRA accounts, for the benefit of you and your eligible beneficiaries. The Board intends to continue the Fund indefinitely. However, it is difficult to predict the future, so the Board of Trustees reserves the right to modify or terminate the Fund at any time should it become necessary at the sole discretion of the Board of Trustees.

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:

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

ELIGIBILITY (RETIRED EMPLOYEES)

RETIRED BARGAINING EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

You are required to meet certain eligibility requirements in order to be eligible for retiree coverage. Once you become Medicare-eligible, you will be covered separately under the fully-insured Medicare retiree program.

In order to participate in the Plan as a retiree, you must meet the following requirements:

a. 1. be at least 55, eligible for 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. be at least 62 and have been covered for at least 10 consecutive years under this Fund immediately prior to retirement; or
   3. be at least 65 and have been covered for at least 5 consecutive years under this Fund immediately prior to retirement.

b. Be at least age 55 with at least 10 consecutive years of employment, or age 65 with 5 consecutive years of employment with the same contributing public sector employer (i.e. city, county or other municipality) to the Fund on your last day of work prior to retirement.

c. Be eligible for active coverage at the time of retirement, death, or disablement.

d. You must also pay the required self-payment.

Note that in order for a pre-retired surviving spouse to receive benefits under the retiree program, you must have had 10 Service Credits.

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 retire and you are Totally Disabled, you will receive 26 weeks of disability credits before you need to participate in the retiree program. 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 retiree coverage.

Refer to the *Schedule of Benefits* for specifics on benefit coverage during retirement.

RETIRED NON-BARGAINING EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

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 program if:

- The employee is age 55 or older and has at least 10 consecutive years of employment with one or more participating employers; and
- 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 (refer to the next section for information regarding the Retiree Contribution Allowance program).

You must elect to participate in the retiree program within 30 days of either of the following dates:

- Receipt of initial payment from the Central Pension Fund of Operating Engineers; or
- The last day of the sixth consecutive month of full self-payment.

Failure to enroll in the retiree program within the above-described timeline will disqualify you from future enrollment in the retiree program.

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.

RETURNING TO ACTIVE EMPLOYMENT

If you are a retired employee and you return to active employment, you will again become eligible on the first day of the first calendar month immediately following the month in which employer contributions in your Dollar Bank equal or exceed the required contribution amount.

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

ONE-TIME OPT OUT PROVISION

This provision allows you and your Eligible Dependents to opt out of the retiree program if you have group health coverage elsewhere. You and your Eligible 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 or her employer, if your spouse's coverage is available to Eligible Dependents, that coverage may be less expensive for your family than the retiree program (refer to the next section for information regarding the Retiree Contribution Allowance program). Once this other coverage ends, you may return to the retiree program. The following describes the rules related to the opt out provision and Plan reenrollment.

Eligibility for Opt Out

To be eligible to opt out of the fully-insured Medicare retiree program, you and your Eligible Dependents must:

- Be eligible to enroll in other group health coverage (including coverage under the Veterans' Administration); and
- Have exhausted all of the funds in your Dollar Bank and must not be making self-contributions or COBRA payments.

You must provide the Fund Office with:

- Documentation of the other group health insurance coverage, with the effective dates and who is eligible for coverage; and
- 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 reenroll in the Fund, provided you meet the following conditions:

- You and your Eligible Dependents lose the coverage due to retirement, termination of employment, reduction in work hours, or by becoming eligible for Medicare; or
- 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 reenroll in the Fund.

To reenroll, 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 reenroll with the appropriate documentation. If you or your Eligible Dependents lose the other coverage and do not reenroll in the Fund, you and all of your Eligible Dependents will lose the right to reenroll 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 reenroll, along with the required documentation. For example, if the Fund Office receives your notice of intent to reenroll on March 10, coverage will begin on April 1.

About Medicare

When you reach age 65, retire, and are eligible for Medicare, you must apply for both Medicare Parts A and B. Then, you will be transitioned to the Fund's fully-insured Medicare program. Contact Wilson-McShane for information regarding the fully-insured Medicare program and the benefits that will be available to you and your Medicare-Eligible Dependents. Note that:

- Once you enroll in the fully-insured Medicare program, your non-Medicare-Eligible Dependents will continue to be covered by the Fund at the Fund's non-Medicare retiree level of benefits. If and when they become eligible for Medicare, they will also be eligible for coverage under the fully-insured Medicare program.
- The Fund will continue to provide certain benefits for you even while you are covered under the fully-insured Medicare program. Refer to the *Schedule of Benefits*.
- The Fund allows Medicare participants, who have been confined to a nursing home that does not accept payments from the Fund's Medicare carrier, to opt out of the Fund's fully-insured Medicare program. The Fund will allow nursing home confined Medicare participants to opt back into the Fund's fully-insured Medicare program if the participant's nursing home changes its position and accepts payment from the Medicare carrier.
- 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

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 you die while you are a retired employee, your 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 month for which self-payment was due. Otherwise coverage will end on the earliest of:

- The day the surviving spouse remarries; or
- The day coverage would otherwise terminate for Eligible Dependents.

If an Eligible Dependent's coverage ends because of failure to make self-payments, his/her right to make future self-payments will be forfeited.

Continued Coverage—Dependents of Deceased Active Employees Who Are Eligible for Retiree Coverage

In the event that you die while you are an active employee eligible for retirement coverage, your surviving Eligible Dependents will be eligible to continue their coverage through the Retiree Contribution Allowance program (refer to the next section, as well as the *Life Events* section).

RETIREE CONTRIBUTION ALLOWANCE PROGRAM

The Retiree Contribution Allowance program 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.

Note: If you are a West River retired employee, you can receive retiree coverage upon meeting the eligibility requirements. However, you will not receive any contribution allowance and you will need to pay for the entire cost of coverage.

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 for retirees (noted in the prior section), you will not be eligible for the retiree program offered by the Health and Welfare Fund. In addition, if you retired, became disabled or were a surviving spouse before March 1, 1999, the Retiree Contribution Allowance program does not apply to you.

If you earn Service Credits under the Retiree Contribution Allowance program, the amount of each credit will not change if/when you subsequently retire and reenroll in the retiree program. You will be treated as an active employee once you meet the initial eligibility rules. In addition, you will not earn any additional Service Credits when you return to active employment unless you work 1,600 hours. The amount of any new Service Credits earned will be the amount that Service Credits are worth when you return to the retiree program.

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 self-pay the entire cost of coverage.

Dollar Bank

You will stay on active coverage until all of the funds in your Dollar Bank are 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 Dollar Bank funds were totally depleted. You may also forfeit your partial month self-payment and commence participation in the Retiree Contribution Allowance program immediately.

SELF-PAY RATES AND SERVICE CREDITS

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 retired before 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 work 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

- 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.

- For service after March 1, 1999, cumulative contribution hours under the Health and Welfare Fund are divided by 1,600.
- You will receive one Service Credit if/when you work 1,600 hours. The amount of any new Service Credits earned will be worth the amount they were worth when you accrued the credits.
- Service Credits are provided for employer contribution hours only. Self-pay hours do not count.
- Posted contributions will be at a weekly rate equal to the required contribution in effect, multiplied by 12 and divided by 52. However, in no event will more than 26 consecutive weeks of contributions be credited for each disabling Illness or Injury.
- 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.
- A non-bargaining unit participant will be credited with 1 year of service for each calendar year he/she was covered by the Health and Welfare Fund.
- A bargaining unit premium participant will be credited with 1.2 years of service for each calendar year he/she was covered by the Health and Welfare Fund as a bargaining unit premium participant.
- Effective January 1, 2018, accumulated Service Credits will be frozen for non-bargaining unit employees of public sector employers currently participating in the Local 49 Health and Welfare Fund.
- Employees of public sector employers that signed a Participation Agreement with the Health and Welfare Fund before November 1, 2016 may accrue, at most, one (1) additional year of Service Credit for 2017 work hours.
- Non-bargaining unit employees of public sector employers that sign a Participation Agreement with the Health and Welfare Fund on or after November 1, 2016, will not be eligible to accumulate Service Credits under the Retiree Contribution Allowance program.

All current and future non-bargaining unit employees of public sector employers, and their Eligible Dependents, participating under their employer's Participation Agreement in the Local 49 Health and Welfare Fund will continue to be eligible for the Fund's retiree program.

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 by the applicable "Multiplier."

Note: 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 preceded age 62. For all participants who entered the retiree program prior to January 1, 2018, Service Credits will be capped at 30 total Service Credits. However, for all participants who retire and enter the retiree program on or after January 1, 2018, the maximum of 30 total Service Credits will not apply. The total number of potential Service Credits will be unlimited.

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 and the applicable Multiplier. 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 following chart:

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.

Elimination of the 30 total Service Credit cap for those who retire on or after January 1, 2018 may give rise to situations where a participant's Contribution Allowance exceeds their required self-pay rate. Retirees whose Contribution Allowance exceeds their required self-pay rate will not have a monthly self-pay due. However, in no event will a retiree receive additional credit for unused or excess Contribution Allowances. Further, should the required self-pay rate be increased through Trustee action to an amount that exceeds the retiree's Contribution Allowance, the retiree will be required to make self-payments going forward.

The following is an example that compares the Contribution Allowance calculation for a retiree with 56,000 hours of employment who entered the retiree program prior to January 1, 2018 versus on or after January 1, 2018:

Years of Service	Pre-65 Service Credits— $30 Per Year Contribution Allowance		Post-65 Service Credits— $12 Per Year Contribution Allowance	
56,000 hours/1,600 = 35 Service Credits (uncapped) **And** = 30 Service Credits (capped)	Retirement **prior to** January 1, 2018 (Service Credits capped at 30)	Retirement **on or after** January 1, 2018 (no Service Credit cap)	Retirement **prior to** January 1, 2018 (Service Credits capped at 30)	Retirement **on or after** January 1, 2018 (no Service Credit cap)
	$900 per month* (30 Service Credits times $30 Multiplier)	**$1,050 per month*** (35 Service Credits times $30 Multiplier)	**$360 per month*** (30 Service Credits times $12 Multiplier)	**$420 per month*** (35 Service Credits times $12 Multiplier)

* **Note**: Contribution Allowance amounts shown reduce a retiree's self-pay rate requirement.

In addition, Bargaining Premium participants who enter the retiree program on or after January 1, 2018 will be credited with 1.2 Service Credits for each calendar year he or she was covered by the Health and Welfare Fund. The following example compares the Contribution Allowance calculations for a retiree who entered the retiree program prior to January 1, 2018 versus on or after January 1, 2018 with 35 years of Bargaining Premium service:

	Pre-65 Service Credits— $30 Per Year Contribution Allowance		**Post-65 Service Credits— $12 Per Year Contribution Allowance**	
Years of Service	Retirement **prior to** January 1, 2018 (1.0 Service Credits per year capped at 30)	Retirement **on or after** January 1, 2018 (1.2 Service Credits per year; no cap)	Retirement **prior to** January 1, 2018 (1.0 Service Credits per year capped at 30)	Retirement **on or after** January 1, 2018 (1.2 Service Credits per year; no cap)
35	**$900 per month**	**$1,260 per month**	**$360 per month**	**$504 per month**

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 participate in the retiree program.

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.

IF YOU MOVE

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.

IF YOU GET 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. You must notify the Fund Office within 90 days of the date of your marriage in order for your spouse's coverage to begin on the date of your marriage. If you do not notify the Fund Office within 90 days, coverage for your spouse will not commence until the date that you notify us. You also may want to update your beneficiary information for your Life and AD&D Insurance.

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 an Eligible Dependent. Stepchildren are eligible for coverage on the date of your marriage. Adopted children or children placed for adoption with you will be eligible on the actual date of adoption or placement. Foster children are also eligible on the date they are placed with you.

Note, however, that in order for the date of coverage to begin as previously specified, you must notify the Fund Office within 90 days of the date of the event (i.e., birth, adoption, or placement for adoption). If you do not notify the Fund Office within 90 days, coverage will not commence until the date that you notify us.

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.

IF YOU LEGALLY DIVORCE

If you and your spouse get a divorce, your spouse will no longer be eligible for coverage as an Eligible 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.

IF YOU LOSE PLAN ELIGIBILITY

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. When your coverage ends, you may be eligible to continue coverage by making monthly self-payments for self-pay continuation coverage, or self-paying for COBRA continuation coverage.

IF YOUR CHILD BECOMES INELIGIBLE

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.

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.

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. You will be credited with contributions, which will be at a weekly rate equal to the required contribution in effect multiplied by 12 and divided by 52. However, in no event will more than 26 consecutive weeks of contributions be credited for each disabling Illness or Injury. After maxing out 26 consecutive weeks of eligibility, you can self-pay.

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.

IF YOU SERVE 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 Serve in the Military:
- 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.

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.

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 Eligible 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.

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.

Note that 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

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 FMLA 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 FMLA states that if you take a family or medical leave, you may not lose any benefits that you had accrued before the leave.

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

Eligibility

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.

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.

If you believe you are entitled to FMLA benefits, 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 considered a COBRA qualifying event. If you return from leave within 12 weeks (or 26 weeks, if applicable), you will not lose coverage.

Not returning from leave 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 program if you meet the eligibility requirements. In general, benefits under the retiree program are the same as those for active employees. 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 ends and you start working again for an employer who contributes to the Fund, or if you return to work following a military leave of absence, your coverage will be reinstated.

Retirees

Your retiree coverage under the Plan will end when you return to employment and you become eligible for active coverage.

IN THE EVENT OF YOUR DEATH

In the event of your death, your beneficiary may be eligible for a Death Benefit. If your death is accidental, your beneficiary may be eligible for an additional Accidental Death and Dismemberment Benefit.

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 Eligible 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 continue until your Dollar Bank is depleted. Then, coverage may be continued under the retiree program if you qualified prior to your death. If you do not qualify for the retiree program, your spouse and Eligible Dependents may continue health care coverage for up to 36 months by electing COBRA continuation coverage (see the following section). Your Eligible Dependents must waive COBRA continuation coverage if they elect coverage under the retiree program.

Retirees

Coverage for your Eligible Dependents will continue until the last day of the month in which you die. Your surviving Eligible Dependents can continue coverage through self-payments. If the self-payments are discontinued for any month, or if your Eligible Dependents do not elect to make self-payments when first eligible, they will not be eligible to continue coverage by making self-payments. Your Eligible 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 your child added to your coverage. Children born, adopted, or placed for adoption as described above have the same COBRA rights as a spouse or Eligible 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 Eligible 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 Eligible 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 Eligible 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 becomes a qualified beneficiary if you 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 Eligible Dependent children become qualified beneficiaries if they lose 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 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 an Eligible Dependent child.

If an employee's Eligible Dependent child is covered by a Qualified Medical Child Support Order (QMCSO), the child will be offered the same COBRA rights as other Eligible Dependents if coverage ends for any of the above reasons. Notices will be sent to the Eligible Dependent child in care of the custodial parent once the Fund Office receives notification that a qualifying event has occurred.

If you or an Eligible 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 Eligible Dependent may 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, your spouse, or both of you may elect COBRA continuation coverage. Parents may elect to continue coverage on behalf of their Eligible 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 at any time until that date.

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 60 days of any of the events.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or an Eligible Dependent child's loss of coverage), 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 an Eligible 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 60 days of the date that the Social Security Administration determines that you or your Eligible Dependent is no longer disabled. You must send this notice to the Fund Office.

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 Eligible 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 Fund Office within 60 days of the event. This extension is available to the spouse and Eligible 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 child stops being eligible under the Plan as an Eligible Dependent.

The extension is available only if the event would have caused the spouse or Eligible 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.

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 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 each subsequent month of coverage. Under the Plan, these periodic payments are due on the first day of the month for which you receive COBRA continuation coverage. 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 always due within 45 days of election of COBRA continuation coverage. 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. 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.

Coverage Through the Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs would be before you decide to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful; if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If You Have Questions

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa (addresses and phone numbers are available through EBSA's website).

SUPPORT PROGRAMS

The Fund provides access to several support programs. However, not all of the benefits and programs are offered for Medicare retirees, as is noted in this section. You can refer to the *Schedule of Benefits* for any limits on these benefits.

HEALTH DYNAMICS COMPREHENSIVE PHYSICAL EXAM PROGRAM (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

You, and your eligible spouse, if applicable, can have a complete and thorough annual physical exam performed through the Health Dynamics Comprehensive Physical Exam Program, which will be covered in full with no copayment. When you do, your calendar year deductible will be waived in the calendar year following the 12-month period (December – November) in which the comprehensive physical is completed. For example, if you and/or your spouse participate in a comprehensive Health Dynamics physical between December 2020 and November 2021, your 2022 calendar year deductible will be waived. In addition, each of you can elect to receive either:

- A $20 per month gym/health club membership reimbursement for up to 12 months ($240 maximum for you and $240 maximum for your spouse); or
- Have $240 reimbursed to each of you per year for copayments, deductibles and coinsurance amounts you pay under the medical plan.

Health Dynamics Primary MD program ("Primary MD")—If you, and your spouse, if applicable, prefer to see your own Physician for your annual physical examination versus participating in the Health Dynamics Comprehensive Physical Exam Program, you may participate in the Health Dynamics Primary MD program (Primary MD). Primary MD allows you and your spouse, if applicable, to visit your own Physician and have your Physician fill out a questionnaire, including clinical data, to be supplied back to Health Dynamics for Health Dynamics' wellness consultant for coaching purposes with you and your spouse. When you, and your spouse, if applicable, use the Primary MD program you can elect to receive either:

- A $20 per month gym/health club membership reimbursement for up to 12 months ($240 maximum for you and $240 maximum for your spouse); or
- Have $240 reimbursed to each of you per year for copayments and coinsurance amounts you pay 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 and coinsurance amounts.

Note: You and/or your spouse participating in the Primary MD program are **not** eligible for waiver of the following year's deductible.

Eligibility Requirements

You must be a member or Eligible 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 an annual physical exam 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 Expense 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 Expense Benefit, subject to the deductible and coinsurance.

You should check with the Fund Office for eligibility and current plan provisions about the above physical exam programs.

Health Dynamics' services are paid at 100%. For a list of services available from Health Dynamics, view its website. The website address is located in the chart at the beginning of this booklet.

HEARING AID PROGRAM (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, AND ALL RETIREES AND THEIR ELIGIBLE DEPENDENTS)

The Fund will pay 100% of the Allowable Expense 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 include 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:

- Hearing aids not prescribed by an audiologist, otologist or otolaryngologist, or one certified to dispense hearing aids;
- Expenses made by a speech pathologist or any Expenses for speech therapy, speech readings or lessons in lip reading;
- Expenses for rental of or purchase of amplifiers; or
- Hearing aid batteries.

CHIROPRACTIC SERVICES PROGRAM (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

The Fund will cover chiropractic 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. Visit limitations for chiropractic treatment are combined with those for acupuncture treatment.

ACUPUNCTURE SERVICES PROGRAM (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

The Fund will cover Medically Necessary chiropractic services up to the limits shown in the *Schedule of Benefits*. Visit limitations for acupuncture treatment are combined with those for chiropractic care.

- Acupuncture (manual or electroacupuncture) may be considered Medically Necessary and appropriate for the following indications:
    1. treatment of chronic pain (defined as duration of at least six months) when the following criteria have been met prior to the beginning of acupuncture treatment:
        - a comprehensive history and physical evaluation of the patient has been completed to document etiology of the pain; and

- conservative forms of multidisciplinary therapy (e.g. pharmacologic therapy, physical therapy, psychotherapy) have been tried, and have failed to alleviate the pain.

2. prevention and treatment of nausea associated with surgery, chemotherapy, and pregnancy.
3. maintenance therapy when:
   - patient meets medical necessity; and
   - acupuncture treatment has resulted in positive clinical response demonstrated by one of the following:
     - decreased use of pain medication; or
     - objectively measured improvement in function (e.g. Neck Disability Index, Oswestry Disability Index, Pain Disability Index, and Rolan Morris Back Pain Disability Questionnaire); or
     - improvement in function or stabilization of functional decline indicated by measures at the onset of acupuncture and measures at subsequent follow-up maintenance treatments.

   Maintenance therapy is not considered Medically Necessary and appropriate in all other situations.

- Needle acupuncture is considered Experimental/Investigative for all other conditions including but not limited to the following due to a lack of clinical evidence demonstrating an impact on improved health outcomes:
  1. substance-related disorders;
  2. behavioral health conditions;
  3. infertility;
  4. obesity/weight loss;
  5. fatigue;
  6. allergic rhinitis;
  7. asthma;
  8. acne;
  9. sexual dysfunction; and
  10. nausea due to conditions other than surgery, pregnancy, or chemotherapy
- Electrical stimulation of auricular acupuncture points is considered Experimental/Investigative due to a lack of evidence demonstrating an impact on improved health outcomes.

You and your eligible family members may contact the patient advocacy program vendor, TEAM, at 651-642-0182 or toll free at 800-634-7710, to receive assistance in identifying the highest quality acupuncturists.

TELEHEALTH VISITS AND PHONE CONSULTATIONS (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

You have access to Doctor On Demand, a Blue Cross and Blue Shield of Minnesota 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 reach out to a Doctor On Demand (DoD) doctor 24/7 and receive the attention you need. The services are provided at no cost to you—there is no copay—and DoD has US-based, board-certified Physicians and licensed psychiatrists, psychologists and therapists ready to assist you.

Doctor On Demand providers treat urgent care, behavioral health, preventive health and chronic care issues. They can help with and/or treat colds and flu, skin conditions, women's and men's health issues, allergies, headaches, anxiety, depression, postpartum issues, relationship problems, trauma and loss, and more. You can even get a free mental health assessment.

You'll need to download the Doctor On Demand app from the Apple App Store, Google Play, or via doctorondemand.com. The app works with any smartphone, tablet or computer with a front-facing camera. For use on a desktop, the only supported browsers are Google Chrome and Firefox. To create an account, go to doctorondemand.com, click Join Now and fill in the information requested on the screen.

Note the following regarding online and telehealth visits:

- Visits with out-of-network telehealth providers (other than Doctor on Demand) are covered subject to applicable deductible and coinsurance.
- A copay applies for all in-network phone consultations.
- Out-of-network phone consultations provided outside of DoD are subject to applicable deductible and coinsurance.

EMPLOYEE ASSISTANCE PROGRAM (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, AND ALL RETIREES AND THEIR ELIGIBLE DEPENDENTS)

The Fund contracts with the TEAM Corporation in order to offer you and your family short-term counseling services either over the phone or in a face-to-face setting. TEAM services are provided to you without cost and there are no visit limitations.

When you call TEAM, a professional counselor will work with you to assess your unique situation and recommend the best path forward. A counselor may determine your needs would be best met through alternative services or providers. In such an instance, TEAM will work with its broad network of quality providers and affiliates to align you with the very best support in your area. TEAM will follow up with you to ensure you are getting the services you need and the outcome desired.

TEAM EAP counselors work with a variety of issues. The most common issues include:

- Alcohol or drug problems
- Depression/anxiety
- Behavioral concerns
- Relationship challenges
- Family/parenting issues
- Grief and loss
- Stress management

- Job-related difficulties

TEAM also provides work-life support services, such as financial counseling, legal consultation, and assistance with childcare needs and eldercare resources.

Whether it's a phone call with a counselor to help you locate a provider, or if you're not quite sure where to start, speaking with someone at TEAM will help you gain a sense of direction. To reach a TEAM counselor, call 651-642-0182 or toll free at 800-634-7710, or visit www.team-mn.com.

PATIENT ADVOCACY PROGRAM (ACTIVES EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, AND ALL RETIREES AND THEIR ELIGIBLE DEPENDENTS)

The Plan uses a patient advocacy program to help you and your family receive the information you need to make informed health care decisions. TEAM is also the patient advocacy program vendor.

MATERNITY MANAGEMENT PROGRAM (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

The Fund contracts with Blue Cross and Blue Shield of Minnesota to provide you with access to its Maternity Management program, which provides services to ensure a healthy start to your baby's life. This program is provided at no charge to you. You'll start with an assessment, then get one-on-one support from a Maternity Nurse Manager who:

- Answers questions and offers advice about pregnancy and staying healthy
- Connects you to online tools (articles, videos and more) about pregnancy and infant care;
- Helps you prepare for the arrival of the new baby;
- Offers personalized support; and
- Provides tips on how to stay happy and healthy after the baby is born.

To learn more about the program, call Blue Cross and Blue Shield of Minnesota at 866-489-6948.

BLUE CROSS AND BLUE SHIELD OF MINNESOTA QUIT COACH PROGRAM (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

The Fund contracts with Blue Cross and Blue Shield of Minnesota to provide you with a tobacco and vaping quitting support program that can help you take the first step to becoming nicotine-free. Here's what you'll receive:

- An initial call to talk about your history of nicotine use and your efforts to quit;
- Four additional calls with a wellness coach at times that work for you;
- A personal quit plan;
- A workbook sent to your home with tips to help you stick with the plan and deal with stress and cravings;
- Two additional calls to support you after you complete the program (30- and 90-day follow-ups); and
- Online tools and resources for support and to track your progress between calls.

To learn more about the program, call Blue Cross and Blue Shield of Minnesota at 888-662-BLUE (2583).

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT - (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES

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

BENEFITS

In general, the Plan will pay 80% of eligible 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*.

DEDUCTIBLE

The deductible is the amount of covered medical Expenses that you and your family pay each calendar year 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 in your family satisfy the deductible, no other deductible will be required by other Covered Persons in your family for the remainder of the calendar year. The family deductible is listed in the *Schedule of Benefits*.

COPAYMENT

You will pay the copayment listed in the *Schedule of Benefits* for office visits. The Plan will pay 100% of the remaining Expenses. 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 to determine your copayment.

OUT-OF-POCKET MAXIMUM

The Plan has imposed an out-of-pocket maximum in order to minimize the amount of money you will pay for medical Expenses during a Plan year. After you have paid the annual out-of-pocket maximum toward covered Expenses, the Plan will pay 100% of those covered Expenses for the remainder of that Plan Year.

Out-of-pocket copayments, including those for office visits and lab Expenses, will apply towards you satisfying the Plan's medical out-of-pocket maximum.

MEDICAL PPO NETWORK

The Plan has an agreement with a medical Preferred 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 Expense 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;** however, you will save money when you use in-network providers. For example, all inpatient Expenses incurred at facilities that **are not** in-network will not be covered. The only exception applies when you are receiving care for an Emergency Medical Condition, as defined in the *Definitions* section.

If you or your Eligible Dependent(s) incur Covered Expenses with an out-of-network Health Care Provider, the Plan will determine the benefits payable by reference to the lesser of the billed amount and the Allowable Expense. You are 100% responsible for paying any portion of a billed charge that exceeds the Allowable Expense. In some cases, the balance of an out-of-network charge (the portion that exceeds

the Allowable Expense) may be tens or even hundreds of thousands of dollars. To avoid balance billing, use in-network Health Care Providers.

If you or your Eligible Dependent are scheduled to be admitted to a Hospital, or any other facility for any reason, or intend to receive treatment for which an overnight stay is anticipated, be sure to confirm with the facility or the Fund Office that the facility is an in-network PPO provider**.**

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.

For Transplants and Certain Types of Surgery

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.

PREAUTHORIZATION

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

- Gastric bypass;
- Xenical weight loss;
- Medically Necessary Cosmetic Surgery or non-emergency Reconstructive Surgery; and
- Transplants.

To receive preauthorization for the above services/procedures, call the Fund Office.

Note: A preadmission notification requirement also applies to in-network Hospital admissions. This notification requirement is fulfilled when you or a Hospital (medical or behavioral) informs Blue Cross and Blue Shield of Minnesota that you or your Eligible Dependent will be admitted for inpatient care for any type of non-emergency admission or partial admission. All Hospitals participating in the PPO network and located in Minnesota are required to perform the preadmission notification on your behalf. If you are planning to be hospitalized outside of the state of Minnesota, make sure that preadmission notification will be performed by the Hospital. You can satisfy the preadmission notification requirement by calling 866-938-9741.

COVERED EXPENSES

Only the Allowable Expenses for Medically Necessary services and supplies that are not excluded under the Plan and that are recommended by a Health Care Provider for the diagnosis or treatment of an Injury or Illness are Covered Expenses. Expenses that are not Covered Expenses are not covered and no benefits are payable in connection with such expenses. The following provides examples of Covered Expenses:

a. **Inpatient and Outpatient Hospital Expenses** - including:

   1. Hospital room and board, up to the average semi-private room rate charged by the Hospital; and
   2. operating room, medicines, drugs, blood and blood plasma (including administration thereof), anesthetic (including administration when billed as part of Hospital Expenses), 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 Expenses.

The Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA), a federal law that protects women who choose to have breast reconstruction in connection with a mastectomy. WHCRA covers women who undergo a mastectomy for any medical reason, not just to treat breast cancer. For women who elect breast reconstruction following a mastectomy, coverage is provided in a manner determined in consultation with the attending Physician and the patient for:

1. all stages of reconstruction of the breast on which the mastectomy is performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of the mastectomy, including lymphedema.

Benefits will be provided subject to the same deductible and copayment requirements as other medical and surgical benefits available through the Plan.

c. Preventive Care

The following mandated preventive services are paid at 100% if you use any Blue Cross and Blue Shield of Minnesota PPO Health Care Provider. You can find an up to date list of all preventive care services at www.healthcare.gov/coverage/preventive-care-benefits/. The following list is updated on an ongoing basis to comply with the requirements of the Affordable Care Act:

1. Well-woman visits (including prenatal care)
2. Screening for gestational diabetes
3. Breast feeding support, supplies and counseling (including equipment rental or purchase)
4. Human papillomavirus (HPV) testing every three years beginning at age 30
5. Counseling for sexually transmitted infections
6. Counseling and screening for HIV (includes testing)
7. Contraceptive methods and counseling for all FDA-approved methods and sterilization (includes barrier and hormonal methods and implanted devices)
8. Services related to follow up and management of side effects from contraceptives, counseling for continued adherence and device removal
9. Over-the-counter (OTC) contraceptives for women if prescribed by a Health Care Provider
10. Screening and counseling for interpersonal and domestic violence
11. Aspirin and other OTC items that are recommended by a Health Care Provider
12. Removal of polyps during a screening colonoscopy
13. BRCA genetic testing
14. 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.

d. **Skilled Nursing Care Facility** - Room and board and miscellaneous Expenses 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 two days for every day the Physician certifies that Hospital confinement would have been required.

e. **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; and
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; or
3. services provided by a person who is part of the patient's family or who lives in the patient's home.

f. **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).

g. **Nursery Care** for newborn Eligible Dependent children.

h. **Office Visits**.

i. **Diagnostic Laboratory and Imaging Expenses**, if recommended by a health care provider.

j. **LASIK Eye Surgery** for active employees and their Dependents, payable only once per eye in a lifetime.

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

1. Injuries;
2. repair of congenital defects of newborn children;
3. repair of defects that result from surgery;
4. for which preauthorization has been received from the Fund; or
5. in connection with a mastectomy, as required by federal law.

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

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; or
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.

m. **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.

n. **Dental Services**:

Orthodontia (aligning crooked teeth) is only a payable benefit under the Comprehensive Major Medical Expense Benefit when it is part of a Medically Necessary, covered treatment for oral surgery, Pierre Robin Sequence treatment, cleft palate repair or accidental Injury to teeth, as determined by the Plan Administrator or its designee.

Orthodontia treatment is also covered when provided within six months after an Injury and must be completed within two years after the Injury. The initial treatment may begin more than six months after the Injury ONLY when Medically Necessary.

Orthodontia services are not payable under the Comprehensive Major Medical Expense Benefit 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). Coverage will be limited to a lifetime maximum as shown on the *Schedule of Benefits*.

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 program vendor, TEAM.

Tooth extractions are covered **only** when such extractions are necessary in order to perform Medically Necessary procedures to treat oral cancer.

Dental implant surgery is covered **only** when performed as part of reconstruction of the mouth after treatment for oral cancer.

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.

The following oral services will also be covered under the Comprehensive Major Medical Expense Benefit:

1. bone surgery - **[dental codes: D4260; D4261]**
2. removal of impacted tooth - **[dental codes: D7220; D7230; D7240; D7241]**
3. removal of residual tooth roots - **[dental code: D7250]**
4. oroantral fistula closure - **[dental code: D7260]**
5. primary closure of a sinus perforation - **[dental code: D7261]**
6. tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth - **[dental code: D7270]**
7. tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization - - **[dental code: D7272]**
8. surgical access of an unerupted tooth - **[dental code: D7280]**
9. biopsy of oral tissue - **[dental codes: D7285; D7286]**
10. surgical repositioning of teeth - **[dental code: D7290]**
11. alveoloplasty – Smoothing of the jawbone - **[dental codes: D7310; D7311; D7320; D7321]**
12. vestibuloplasty - surgical modification of the oral cavity generally increasing the height and width of the gum region in preparation for dentures or oral implants **-[dental codes: D7340; D7350]**
13. excision of lesion - **[dental code: D7410]**
14. excision of cyst, outgrowth or tumor - **[dental codes: D7410; D7411; D7412; D7413; D7414; D7415; D7420; D7430; D7431; D7440; D7441; D7450; D7451; D7460; D7461; D7465; D7470; D7480]**
15. incision and drainage of abscess soft tissue - **[dental codes: D7510; D7520]**
16. removal of foreign body, skin or subcutaneous fiber tissue - **[dental code: D7530]**
17. removal of reaction producing foreign bodies musculoskeletal system - **[dental code: D7540]**
18. maxillary sinusotomy for removal of tooth fragment of foreign body - **[dental code: D7560]**

19. jawbone surgery - **[dental codes: D7610; D7620; D7630; D7640;D7710; D7720; D7730; D7740; D7810; D7820]**

20. malar and/or zygomatic arch open or close reduction - **[dental codes: D7650; D7660; D7750; D7760]**
21. alveolus stabilization of teeth open reduction splinting - **[dental code: D7670; D7770]**
22. facial bones complicated reduction with fixation and multiple surgical approaches - **[dental codes: D7680; D7780]**
23. manipulation under anesthesia - **[dental code: D7830]**
24. condylectomy - **[dental code: D7840]**

o. joint or musculoskeletal reconstruction **[dental codes: D7850; D7852; D7854; D7856; D7858; D7860; D7865; D7870; D7872: D7873; D7874; D7875; D7876; D7877]Emergency Expenses Incurred in a Foreign Country** will be covered the same as any other Expense.

p. **Cochlear Implants -** including an initial installation.

q. **Colonoscopy**.

r. **Ambulance Expenses** - including:

1. Ground vehicle transportation to the nearest appropriate facility as Medically Necessary for treatment of medical emergency, acute Illness or inter health care facility transfer; and
2. Air transportation to the nearest qualified facility in case of any emergency only, and only if the use of ground transport: would place the health of the transported individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; would result in serious impairment to bodily functions; or would result in serious dysfunction of any bodily organ or part.

s. **Human Growth Hormone Injections**.

t. **Gastric Bypass Surgery and Xenical Weight Loss Medication** for morbid obesity are covered only if pre-authorized, up to a lifetime maximum of $20,000, including services related to surgical complications and/or follow up surgery to remove excess skin.

u. **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; and
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 reimburses the participant for 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.

Medical Foods include:

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; and
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. **Medical Supplies**:

1. blood and plasma;
2. artificial limbs and eyes to replace natural limbs and eyes;
3. surgical dressings;
4. casts;
5. splints;
6. trusses;
7. braces;
8. crutches;
9. oxygen and the rental of equipment for its administration; and
10. rental of durable medical equipment prescribed by a Health Care Provider but not to exceed the actual purchase price.

Refer to the next section for more information about prescription drug coverage.

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;
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;
3. women who themselves or have a first or second degree relative with multiple primary or bilateral breast cancers;
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;
5. women with a first or second degree male relative with breast cancer:
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 age 5 and under, up to 52 visits per year; and
3. restorative speech therapy in case of accident or Illness will be paid under the Comprehensive Major Medical Expense Benefit 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**. The participant must enroll in the Blue Cross and Blue Shield of Minnesota *Quit Coach Program* to receive coverage. Contact Blue Cross and Blue Shield of Minnesota for additional information.

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**.

dd. **Limited Trials to Judge Efficacy**. The Plan will occasionally cover Board-approved trial procedures and treatments for a limited number of participants and for a limited duration in order to evaluate the efficacy of certain procedures or treatment programs. Limited trials, which would otherwise be excluded by the Plan, must be expressly adopted by the Board of Trustees. Eligibility to participate in a limited trial is not guaranteed. Eligibility will be determined according to rules adopted by the Board of Trustees. Coverage in connection with a limited trial will be in accordance with this Plan except to the extent that the Board of Trustees expressly adopts a coverage rule that is contrary to the Plan, in which case the limited trial coverage rule will apply.

ee. The Plan will cover services related to the **LINX Reflux Management System** under its Comprehensive Major Medical Expense Benefit, subject to the Plan's medical necessity criteria. Services must be pre-approved by the patient advocacy program vendor, TEAM, in order to be eligible for coverage.

PRESCRIPTION DRUG BENEFITS - (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, PRE-MEDICARE RETIREES, AND PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES)

Prescription drug Expenses are rising faster than most other health care Expenses, and can be a significant cost for you and your family. Recognizing this, the Fund contracts with OptumRx to provide prescription drug benefits to you and your Eligible Dependents. Covered Expenses are only the Allowable Expenses for Medically Necessary drugs that are prescribed by a Health Care Provider for the treatment of an Injury or Illness that is not expressly excluded under the Plan.

RETAIL AND MAIL ORDER

Optum offers both a retail and mail order program. You are also responsible to share in the cost of your medication, so coinsurance applies.

You are free to use any pharmacy that you wish. All you will need to do is pay your applicable coinsurance at the time you purchase your medication.

GENERIC EQUIVALENTS AND BRAND-NAME MEDICATIONS

Generic medications are less costly than brand name medications, so the amount you pay out-of-pocket, as well as the costs that the Plan incurs, will be predicated on whether you purchase a generic medication or a brand name medication.

- **Generic medications** are chemically and therapeutically equivalent to the corresponding name brand drug, but are available at a lower price. A generic equivalent is a copy of a brand name medication that is no longer protected by a patent. A generic medication usually serves the same purpose as the original (brand name) medication and costs less.
- **Brand name medications** are available from specific manufacturers and are advertised and sold under a trade name. A generic equivalent may be available.

When available, generic medications save you (and the Plan) money and should be substituted for brand medications. Therefore, when you or your Eligible Dependent needs a prescription, you may want to ask your Physician whether a generic can be substituted for a brand name medication.

The *Schedule of Benefits* shows the amount of coinsurance you will be required to pay for your medication.

COVERAGE FOR SPECIALTY MEDICATIONS

The Plan has contracted with a specialty drug pharmacy, Optum Specialty Pharmacy, to help save you money.

Specialty medications are prescription drugs that require special handling and close monitoring. They are often considerably more expensive than traditional prescription drugs, partly due to their specialized use and the manner in which they are administered, manufactured, handled, and distributed:

- Specialty drugs are primarily self-injectable medications requiring patient training and education; and
- Their unique manufacturing and distribution process limits the number of pharmacies that are capable of effectively purchasing, storing, and distributing the medications.

The Plan covers specialty medications that are used to treat certain ongoing, complex chronic health conditions like hemophilia, Hepatitis C, Multiple Sclerosis, osteoarthritis, hypertension, or macular degeneration, to name a few. At times, a specialty medication may be prescribed throughout a patient's lifetime.

A separate out-of-pocket per family maximum applies for specialty medications. The out-of-pocket maximum is in addition to the Plan's family prescription drug out-of-pocket maximums, and will apply before the Plan pays benefits. Refer to the *Schedule of Benefits*.

If you need a prescription filled for a specialty medication, it must be filled through Optum Specialty Pharmacy. Before attempting to have your prescription filled, you or your Physician must call Optum Specialty Pharmacy at 855-427-4682.

COVERAGE FOR FLU SHOTS, ROUTINE VACCINATIONS, AND VACCINATIONS FOR COVID-19

Flu shots and other routine adult vaccines administered at a network pharmacy participating in Optum's Vaccine Immunization/Injection Network are covered 100%, with no out-of-pocket expense to you.

Examples of routine vaccines include: Flu (Influenza); Hepatitis A & B (adult and pediatric); Human Papillomavirus (HPV); Measles; Mumps; Rubella; Meningococcal (Meningitis); Pneumococcal (Pneumonia); Tdap (Tetanus, Diphtheria, Pertussis); Varicella (chicken pox); and Shingrix (Shingles).

Visit www.optumrx.com for a more complete list of pharmacies participating in Optum's Vaccine Immunization/Injection Network, or call 866-795-6816.

EXCLUSIONS AND LIMITATIONS

Not all prescription medications are covered under the Plan's Comprehensive Major Medical Expense Benefit. Benefits are not paid for the following expenses:

- Medications that are not legally obtained from a licensed pharmacist;
- Medications that are not prescribed by a licensed Health Care Provider;
- Experimental or Investigational drugs;
- Medications used for cosmetic purposes;
- Certain medications that are deemed excessively overpriced and for which comparable alternatives are available;
- Any medications outside of Optum's formulary; and
- Any medications that are excluded under the Plan's General Exclusions and Limitations.

DENTAL BENEFITS - (ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS ONLY)

Dental Benefits will be paid for covered dental Expenses incurred by eligible active employees and their Eligible Dependents. 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 Expense Benefit will pay first and then Dental Benefits will be considered.

The Fund Office may, at its discretion, request supporting proof of loss such as clinical reports, Expenses 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, any applicable 20% coinsurance that you are required to pay 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; or
- Calling Delta Dental's Customer Service at:

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

COVERED DENTAL CARE

Covered Dental Expenses include the following:

a. Oral examinations, including scaling and cleaning of teeth, two times per year, 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 Eligible Dependent is less than 15 years old;

c. Dental X-rays;

d. Space maintainers;

e. Extractions;

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

g. Fillings (including composite fillings);

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

i. Injection of antibiotic drugs by the attending dentist;

j. 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;

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 and 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; and

v. Orthodontia treatment for Eligible 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*.

Note that orthodontia (aligning crooked teeth) is a payable benefit under the Comprehensive Major Medical Expense Benefit, with certain limitations.

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;

c. Replacement of lost or stolen prosthetics;

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

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

f. The application of dental sealants after the Eligible Dependent's 16th birthday.

DENTAL BENEFITS - (PRE-MEDICARE RETIREES, PRE-MEDICARE DEPENDENTS OF PRE-MEDICARE AND MEDICARE RETIREES, AND MEDICARE RETIREES AND THEIR DEPENDENTS)

Your participation in the fully-insured retiree dental program is optional.

As a retiree, you may begin your (or your spouse's) participation in the program on the dates noted below, following the occurrence of any of the following events:

- The first day of your participation in the retiree program;
- The first of the month following the loss of dental coverage from a spouse's employer's group dental plan; or
- The first day you become eligible for Medicare.

In order to participate in the program, you must request to enroll no later than 30 days following the event by contacting the Fund Administrator at 952-854-0795 or toll free at 800-535-6373.

VISION BENEFITS - (ALL PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS)

Vision benefits are administered by Wilson-McShane. You and each of your Eligible Dependents will be provided with an allowance to use towards vision care. Expenses you incur during a two consecutive calendar period (for example, between January1, 2020 and December 31, 2021). The amount of the allowance is shown in the *Schedule of Benefits*. The allowance will be replenished to $500 on the first day of every even year.

Any remaining (unspent) balance of your allowance at the end of any two consecutive calendar years **will not carry over**. Instead, the full allowance amount will be replenished for your use during the next two-year period. Note that an "Expense" is considered to be incurred on the date on which the service or materials are provided or obtained.

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.

COVERED VISION CARE

You can use your allowance to pay 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.

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;

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

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

d. Treatment of Keratoconus (covered under the Comprehensive Major Medical Expense Benefit);

e. Eye exercises and vision training; or

f. Any vision services that are excluded under the Plan's General Exclusions and Limitations.

DEATH BENEFITS - (ACTIVE 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 must be eligible for the Accident and Sickness Weekly Benefit in order to be eligible for the Death Benefit. **Non-bargaining employees are eligible for this benefit provided**:

- They are not an owner or officer of their employer; and
- They are not receiving accident/sick pay from their employer**.**

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:

- To your surviving spouse;
- Equally to any child and/or children;
- Equally to parents; and then
- To your estate.

If your beneficiary is under age 18, the Fund will distribute the benefit in accordance with the provisions of the applicable Uniform Transfer to Minors Act, which allows a minor to receive gifts without the aid of a guardian or trustees.

Note that generally, death benefits that are self-funded, like ours, will be taxable to the beneficiary. Consult a tax professional for details.

ASSIGNMENT

Death Benefits provided by this Plan are not assignable.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS - (ACTIVE 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:

- The Principal Sum for loss of life; or
- The Principal Sum for loss of:
    1. both hands;
    2. both feet;
    3. both eyes; or
    4. any such two members; or
- 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 BENEFITS - (ACTIVE EMPLOYEES ONLY)

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

- They are not an owner or officer of the employer (including an owner-operator); and
- They are not receiving accident/sick pay from their employer**.**

If you experience an Injury or Illness before becoming eligible for benefits from the Plan, you must return to active employment and attain eligibility before you may be eligible for benefits under the Accident and Sickness Weekly Benefit.

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 an Illness. 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 Illness or accidental Injury for which you are not under the care of a Physician;

b. Disability covered by Workers' Compensation or any occupational Illness law; or

b. Disability due to an occupational Injury that occurred while working for pay or profit; or

c. Disability, which is not certified by a medical doctor; or

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

e. If you are receiving unemployment benefits; or

f. If you are receiving pension benefits from the Central Pension Fund of Operating Engineers.

GENERAL EXCLUSIONS AND LIMITATIONS

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

a. Inpatient hospitalization at Hospitals that are not part of the Blue Cross and Blue Shield of Minnesota network, unless the hospitalization is the result of an Emergency Medical Condition.

   You are experiencing an emergency if the absence of immediate medical attention would be reasonably expected to:

   1. seriously jeopardize your life, health, or ability to regain maximum function; or
   2. subject you to severe and unmanageable pain.

   Specific services that qualify for this exception are those defined by 28 C.F.R. § 2590.715-2719A(b)(4)(ii). Generally, this means a medical screening examination for an Emergency Medical Condition provided by an emergency department of a Hospital and such further medical examination and treatment at the Hospital that is necessary to stabilize the patient.

b. Injury, Illness 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).

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

d. 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 Expenses are not Medically Necessary or in excess of the Allowable Expense; 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.

e. Services or supplies that are:

   1. not recommended by a Health Care Provider;
   2. not Medically Necessary;
   3. prescribed or recommended for a purpose that is not approved by the FDA (commonly called "off-label");
   4. not provided in accordance with generally accepted professional medical standards; or
   5. Investigative or Experimental treatments. Note that the Plan will occasionally cover Board-approved trial procedures and treatments for a limited number of participants, and for a limited duration, in order to evaluate the efficacy of certain procedures or treatment programs.

f. Expenses incurred after eligibility terminates.

g. Expenses in excess of the Allowable Expenses.

h. Behavioral problems or social maladjustments that are not specifically the result of mental Illness.

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

j. Expenses related to transgender treatment and diagnosis.

k. 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).

l. Eye exercises, vision training, refractions, glasses and contact lenses, except as provided under the Vision Care program.

m. Failure to appear for an appointment as scheduled.

n. Completion of claim forms.

o. Sex transformation.

p. 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.

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

r. Special home construction to accommodate a disabled individual.

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

t. Custodial Care.

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

v. Vasectomy reversal and tubal ligation reversal.

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

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 and 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. 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.

dd. 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.

ee. Cosmetic or non-emergency Reconstructive Surgery that is deemed medically unnecessary.

ff. 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.

gg. 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.

hh. Maternity Expenses 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 an Eligible 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.

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

jj. Expenses associated with Residential Treatment Facilities that do not qualify as Hospitals, skilled nursing facilities, or hospice care facilities, as defined by the Plan.

kk. Any claim for loss, Expense, or charge submitted to the Plan on behalf of an individual that is fraudulent or involves an intentional misrepresentation of material fact.

ll. An Expense excluded by Blue Cross and Blue Shield of Minnesota's PPO coverage criteria, Optum's coverage criteria, or the coverage criteria of any other administrative entity under direct or indirect contract with the Plan involving the adjudication of claims, except to the extent that such coverage criteria are expressly contrary to this Plan. For purposes of this exclusion, "coverage criteria" are policies adopted by an administrative entity that relate to whether, or to what extent, a claim is payable. Coverage criteria include, without limitation, clinical policies, formularies, policies governing the process or timing of claims administration, and policies pertaining to the development or administration of such policies.

mm. Examinations made for routine check-up purposes.

nn. Dental care or treatment.

oo. Eye refractions.

pp. Therapeutic X-rays.

qq. 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 that is or would be subject to the Plan's Right of Subrogation and Reimbursement before making claim against the Plan related to that specific event or health condition, and you: (1) recovered such sum prior to becoming covered under the Plan; (2) failed to fully comply with the rules of the Plan under Section 2 of the Plan's Right of Subrogation and Reimbursement provision, as determined by the Trustees in their sole discretion; or (3) received a sum from a third party, workers' compensation insurer, or insurance company as compensation for future medical expenses and/or consideration for closing out and resolving any claim for future medical benefits, 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.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) - (ACTIVE EMPLOYEES, RETIREES, AND THEIR ELIGIBLE DEPENDENTS)

The Trustees have established this HRA Plan so that eligible participants may obtain reimbursement for certain Qualified Medical Care Expenses, which are those allowed under Internal Revenue Code (IRC) Section 213.(d), that are 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 you become eligible for the Plan, a notional HRA account is opened and maintained in your name.

TERMINATION

If you are an active employee, your HRA account will terminate once the balance is less than $25.

If you are a retiree, your HRA account will terminate when the balance reaches $0.

Also note that your eligibility to participate in the HRA ends upon the earlier of:

- The termination of the HRA account; or
- The exhaustion of the balance in your account, with no additional contributions being made to the account in the following six-month period.

FUNDING

Contributions are credited to your HRA account. Employer contributions fund 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. On and after January 1, 2021, your HRA account will be credited with the contributions made to your Dollar Bank that exceed six months of the required contribution amount. There is no maximum dollar amount that may be credited to your 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.

Contributions continue until terminated.

INTEGRATION AND OPT-OUT

In order to comply with the Affordable Care Act, its implementing regulations and Internal Revenue Service Notice 2013-54, the following rules apply to the HRA account:

Integration: Coverage under a Group Health Plan

Your Participation. In order for you to obtain reimbursement of HRA reimbursable expenses, the HRA must be "integrated" with a group health plan that provides minimum value coverage, and you must actually be enrolled in the group health plan that provides minimum value coverage. Medical coverage under the Plan for actives, retirees under age 65, and their Eligible Dependents provide minimum value and satisfy the requirement that the HRA be integrated. In addition, coverage under another group health plan not sponsored by the Trustees of the Fund may also satisfy the integration requirement if such coverage provides minimum value coverage and you are enrolled in another group health plan that provides minimum value coverage. To be covered under the HRA, you must meet the eligibility requirements of the Fund, properly waive/opt-out of medical coverage by completing the applicable section of the Enrollment Form and provide the necessary proof of enrollment in other minimum value coverage.

Dependents. In order for your Eligible Dependents to obtain reimbursement of HRA reimbursable expenses, the HRA must be integrated with a group health plan that provides minimum value coverage and your Eligible Dependents must actually be enrolled in the group health plan that provides minimum value coverage. Medical coverage under the Plan for actives, retirees under age 65, and Eligible Dependents provide minimum value and satisfy the requirement that the HRA be integrated. In addition, coverage under another group health plan not sponsored by the Trustees of the Fund may also satisfy the integration requirement if such coverage provides minimum value coverage and the Eligible Dependent(s) is actually enrolled in the other group health plan that provides minimum value coverage. To be covered under the HRA, the dependent(s) must meet the eligibility requirements of the Fund and you must have properly waived medical coverage for your Eligible Dependents by completing the applicable section of the Enrollment Form. The necessary proof of enrollment in other minimum value coverage must be provided.

QUALIFIED MEDICAL CARE EXPENSES

A Qualified Medical Care Expense (which is an Expense defined under Internal Revenue Code (IRC) Section 213.(d)) 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 enrolled 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 treatments
- Alcoholism (the treatment of)
- Ambulance services
- Annual physical examinations
- Artificial limbs
- Bandages
- Birth control pills
- Braille books and magazines
- Breast reconstruction surgery
- Chiropractor services
- Christian Science practitioners
- Contact lenses
- Crutches
- Dental treatments
- Dental X-rays
- Dentures
- Diagnostic devices
- Drug addictions (the treatment of)
- Eyeglasses

- Eye surgeries
- Fertility enhancements
- Guide dogs
- Gum treatments
- Gynecologist services
- 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 kits
- 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
- Sterilizations
- Smoking cessation programs
- Surgeon services
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation Expenses (relative to health care)
- Vaccines
- Vasectomies
- Vitamins (if prescribed)
- Weight-loss programs
- Wigs
- Wheelchairs
- 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

The Fund will use your HRA account to reimburse 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 within 24 months of the date on which the Expense was incurred in order for the Expense to be eligible for reimbursement. 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 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
- 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 may be debited 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.

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:

- Group blanket or franchise insurance coverage;
- Group , PPO (Preferred Provider Organizations), PBMs (Prescription Benefits Managers) and other group prepayment coverage, including HMOs (Health Maintenance Organizations);
- Labor-management trustee plans, or employee benefit organization plans;
- Governmental programs, or coverage required or provided by any statute;
- Any group coverage of a child sponsored by, or provided through any educational institution;
- Group arrangements for members of associations of individuals;
- Group or individual automobile no-fault coverage; and
- 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.

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.

- 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.
- 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 Eligible Dependent child whose married or unmarried parents live together, the plan of the parent whose birthday is earlier in the calendar year will pay for Allowable Expenses incurred first; except:

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

      - 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.
      - When there is no court decree that requires a parent to provide health coverage to a dependent child, the following rules will apply:
        - When the parent who has custody of the child has not remarried, the custodial parent's plan will be primary and determine benefits first.
        - 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 stepparent'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:

      - one plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and
      - 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. If Medicare is considered the primary payor, 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. If Medicare would be the primary payor, 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:

- 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;
- Are considered disabled by the Social Security Administration, but are still considered active by an ADEA employer; and
- 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:

- Are over age 65 and not actively employed by an ADEA employer who pays all or part of the required premium;
- 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.); and
- 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:

- Is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
- 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 Illness 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 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:

- Participant name;
- Patient name;
- Patient date of birth;
- Social Security Number of participant or retiree or other identifying number that is adopted by the Plan;
- Date of service;
- Type of device defined by HCPC, CPT code, ICD-10, NDC, or other nationally recognized codes, including individual Expenses for each;
- Billed Expense;

- Number of units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address;
- Previous balances paid; and
- If treatment is due to an accident, the details of the accident.

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

All vision care Expense receipts should be submitted to the Fund Office, Wilson-McShane Corporation, for reimbursement. All receipts must be submitted with an Operating Engineers Local #49 Health & Welfare Fund Vision Claim Form.

All paper claims for HRA reimbursement must be submitted within 24 months of the date on which the Expense was incurred. Request the HRA form from the Fund Office.

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:

  1. ***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.

  2. ***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.
  3. ***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.
  4. ***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**.
- **Health Reimbursement Arrangement (HRA) 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 claim may be provided to you orally within 72 hours and confirmed in writing within three days of 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 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 of the receipt of your claim. If additional time is necessary, due to matters beyond the control of the Plan, the Plan may extend its determination by up to 15 additional days. 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 will have up to 45 days to provide the requested information. The Plan will notify you of its determination within 15 days of receipt of the information.

  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 60 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 60-day deadline. If additional information is needed to process your claim, you will be notified within 60 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. The opportunity, upon request and without charge, for reasonable access to and copies of all documents, records and other information relevant to the initial claim for benefits;

e. 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;

f. 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;

g. 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.

h. If the claim is a disability claim, the Plan will provide you with a description of the review process applicable to the disability claim and a discussion of the decision, including an explanation, if applicable, of the basis for disagreeing with or not following:

   1. the views presented by your health care and /or vocational professionals;
   2. the views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
   3. your disability determination from the Social Security Administration.

APPEALING A DENIED CLAIM

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 death 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 include:

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; and

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

If the Fund relied upon an internal rule, guideline, or protocol, you may receive a copy of the rule or a statement that a copy 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 such explanation is available upon request at no charge.

If the decision involved disability benefits, you will receive a written explanation providing the basis for disagreeing with or not following:

1. The views presented by your health care and /or vocational professionals;

2. The views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

3. Your disability determination from the Social Security Administration.

Second Level of Appeal – External Review

For purposes of this section, references to "you" or "your" include you, your Eligible Dependent(s), and you and your Eligible 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.

External review is not available for all denied claims. 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. If your claim was denied for a reason that does not involve medical judgment (for example, because the expense at issue is expressly excluded or because the claim was untimely), external review is not available. If you request external review, the IRO will determine whether your claim is eligible for external review.

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 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 determination (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 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 must be brought within the later of (a) one year following the date on which you become, or should by reasonable diligence have become, aware of your claim or (b) one year from the date of a final decision on appeal.

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 AND REIMBURSEMENT

Subrogation is the Plan's right to pursue a third party that caused you or your dependent to suffer an Injury. Reimbursement is the Plan's right to obtain reimbursement directly from you when a third party is legally obligated to pay damages for your Injuries. These rights of subrogation and reimbursement lower the cost of the Plan.

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

Section 1. General

The Plan has first priority subrogation and reimbursement rights if it provides benefits resulting from or related to an Injury, occurrence or condition for which the Subrogee has a right of redress against any third party. For purposes of this Subrogation and Reimbursement section, Subrogee means the participant, employee, dependent, beneficiary, representative (including a trustee in a wrongful death action), an administrator of an estate, or any other person asserting a claim related to the Injury, claim, action or occurrence under this section.

What does first priority right of subrogation and reimbursement mean? It means that if the Plan pays benefits that are, in any way, compensated by a third party, such as an insurance company, the Subrogee agrees that when a recovery is made from that third party, the Plan is fully reimbursed out of that recovery for any benefits the Plan paid or will pay.

For example, the subrogation and reimbursement right may apply if a Subrogee is injured at work, in an automobile accident, at a home or business, in an assault, as a result of medical or other negligence or in any other way for which a third party has or may have responsibility. If a recovery is obtained from a third party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The Subrogee receives payment only after the Plan is fully reimbursed.

The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each Subrogee in recognition of the fact that the value of benefits provided to each employee or Eligible Dependent will be maintained and enhanced by enforcement of these rights.

Section 2. Rules for the Plan

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

a. Acknowledgment of the Plan's Subrogation and Reimbursement Rights: The Subrogee agrees that the Plan has the first priority rights of subrogation and reimbursement as described in this subrogation and reimbursement section. The Subrogee and his or her attorney will sign a Subrogation and Reimbursement Acknowledgment Form acknowledging the Plan's subrogation and reimbursement rights prior to payment or further payment of benefits. In the event the Subrogee and/or his or her attorney refuse to sign the Form, the Plan will deny all claims relating to the Injury, occurrence or condition for which the Subrogee has a right of redress against any third party or insurer. The Plan's subrogation and reimbursement rights relating to benefits paid prior to the execution of the form are not impacted if the Subrogee and his or her attorney refuse to sign the form. The Plan will take any and all action necessary to protect its subrogation and reimbursement rights, including denying the claims, offsetting any future benefits payable under the Plan, and/or recouping any benefits previously paid.

b. Plan Granted 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 Subrogee from a third party, whether by settlement, judgment or otherwise and in consideration for the payment of benefits, the aforementioned individual(s) agree to the same. 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 Subrogee 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, and at the discretion of the Trustees, pursue all available equitable remedies, pursue all available legal remedies, offset any benefits payable under the Plan, recoup any benefits previously paid, suspend all benefits available under the Plan, deny all claims related to the incident in which a recovery was received in addition to non-related claims submitted by the Subrogee.

c. Subrogee Constructive Trust and/or Equitable Lien Duties: The Subrogee is required to use his or her best efforts to preserve the Plan's right of subrogation and reimbursement. This includes, but is not limited to, the Subrogee's causing of the Plan's subrogation or reimbursement interest to be paid to the Plan, advising their legal counsel to segregate the Plan's subrogation or reimbursement interest to be held in such legal counsel's trust account until the Plan's interest is agreed to or completely adjudicated, and not allowing any other disbursement from any settlement or judgment proceeds to Subrogee, Subrogee's attorney, or any other third party, prior to complete disbursement to the Plan.

d. Plan Paid First: Amounts recovered or recoverable by or on the Subrogee'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 Subrogee. The Plan's subrogation and reimbursement right comes first even if the Subrogee 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 Subrogee may have received or may be entitled to receive from the third party.

e. 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 can bring an action (including in the Subrogee's name) for, breach of contract, 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 Subrogee. The Plan will commence any action it deems appropriate against a Subrogee, 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 Eligible Dependent is legally obligated for Expenses of treatment.

f. 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 Subrogee has or may have against any third party, regardless of whether such person or entity has the right, legal or otherwise, to recover the medical Expenses paid by the Plan.

g. No Assignment: The Subrogee 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.

h. Full Cooperation: The Subrogee 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 or recouped if the Subrogee does not cooperate with the Plan. This includes, but is not limited to, responding to any Plan request for information and updates.

i. Notification to the Plan: The Subrogee must promptly advise the Plan Administrator, in writing, of any claim or demand he or she makes against any person or entity related to an Injury, occurrence, or condition for which the Subrogee has a right or potential right of redress against any third party. Further, the Subrogee must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims. The Subrogee must promptly provide the Plan Administrator, in writing, with the name, address and telephone number of his or her attorney in the event a claim is pursued.

j. 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, pay or are liable for a Subrogee'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 Subrogee.

k. 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 Subrogee'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.

l. Attorney's Fees: The Plan will not be responsible for any attorney's fees or costs incurred by the Subrogee 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. The Plan will not pay the Subrogee's attorney any portion of the amounts it is entitled to for subrogation and reimbursement.

m. Course and Scope of Employment: If the Plan has paid benefits for any Injury which may have arisen 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 Subrogee 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 Subrogee's attorney from the Plan's recovery, the Subrogee will reimburse the Plan for the attorney's fees.

n. Future related claims: Future related claims will be denied in accordance with the provisions found under the General Exclusions and Limitations section.

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 Plan is an employee welfare benefit plan 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. maintains eligibility records;
    2. accounts for employer and self-payment contributions;
    3. answers Participant inquiries; and
    4. administers claims and vision benefits, and performs other routine administrative functions.
b. Blue Cross and Blue Shield of Minnesota provides access to the medical network and performs preauthorization.
c. Delta Dental provides access to the dental network.
d. TEAM provides patient advocacy and referral services for Centers of Excellence, an Employee Assistance Program, and referral services for mental health and substance abuse issues.
e. Health Dynamics provides physical examination services.
f. OptumRx provides the pharmacy network.
g. Optum Specialty Pharmacy provides specialty medications.
h. Doctor On Demand provides telehealth services.
i. RAYUS Radiology for scheduling of imaging and/or radiology testing.

For contact information, refer to the *Contact Information* section of this booklet.

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 – Pamela Nissen at Reinhart Boerner Van Deuren, s.c. is designated as the agent for service of legal process at 80 South Eighth Street, Suite 900, Minneapolis, MN 55402. Any legal documents should be served upon Pamela Nissen 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, to determine

all facts relevant to administering the Plan, and to make all decisions, determinations, and take all actions necessary or appropriate to the administration of the Plan. Decisions, determinations, and actions of the Board of Trustees will be given the maximum judicial deference permitted under the law. 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, prospectively or retroactively. 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.

You are not vested in any of the benefits described in this booklet. 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, or 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 address of the Board is under "Fund Office" in the "Contact Information" section of this booklet. 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 23-7015120. 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 – Assets to pay benefits are accumulated in the Operating Engineers Local #49 Health and Welfare Fund, a trust established under Minnesota law.

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.

Genetic Information Nondiscrimination Act - Generally, the Plan will not require you or your family members to provide genetic information or undergo genetic testing. However, the Plan may condition coverage of certain items or services on whether you have the appropriate genetic makeup. If you request coverage of such items or services, the Plan will request the relevant genetic information. Any genetic information the Plan receives will be used or disclosed by the Plan only as permitted by the Plan's Privacy Practices. If you decline to provide the information, the Plan will deny coverage.

Section 1557 of the Affordable Care Act - Section 1557 prohibits certain discrimination. However, health plans that do not receive federal financial assistance are not required to comply with Section 1557. The Plan does not receive or intend to begin accepting federal financial assistance as defined in 45 C.F.R. § 92.4. Therefore, the Plan is not subject to Section 1557.

Section 2706 of the Affordable Care Act - To the extent required to comply with 42 U.S.C. § 300gg–5, the Plan will not discriminate against any Healthcare Provider who is acting within the scope of that provider's license or certification under applicable State law.

Section 2709 of the Affordable Care Act - To the extent necessary to comply with 42 U.S.C. § 300gg–8, routine patient costs for a qualified individual to participate in an approved clinical trial with respect to the treatment of a cancer or other life-threatening disease or condition are will not be considered not "Experimental or Investigative".

Section 1302(c) of the Affordable Care Act - Notwithstanding anything to the contrary, the annual cost-sharing requirements under this Plan will not exceed the limits established in 42 U.S.C. § 18022(c).

PRIVACY NOTICE

Under the federal Medical Data Privacy Regulations, or "Privacy Regulations," the Plan is required to give you this NOTICE OF PRIVACY PRACTICES which tells you about how the Plan protects the privacy of your health information and your rights under the new Privacy Regulations. (The Privacy Regulations can be found at 45 Code of Federal Regulations Parts 160 and 164.)

The Privacy Regulations govern the use and disclosure of your individually identifiable health information that is transmitted or maintained by the Plan. This is called "Protected Health Information" or "PHI" under the Regulations.

1. When the Plan Uses and Discloses Your PHI

a. Uses and Disclosures Required by the Privacy Regulations

The Plan is required to give you access to certain PHI, if you ask, so you can inspect and copy it.

The Plan is required to release your PHI to the Secretary of the federal Department of Health and Human Services to review the Plan's compliance with the Privacy Regulations.

b. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Plan and its "business associates" have the right to and will use PHI without your consent, authorization or opportunity to agree or object so the Plan can carry out "treatment, payment and health care operations." The Plan can also disclose PHI to the Board of Trustees and to certain agents of the Board of Trustees (such as Union business agents and the Trustees' office staffs) for purposes related to treatment, payment and health care operations. This Summary Plan Description has been amended to protect your PHI as required by federal law.

Treatment includes providing, coordinating or managing health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may release your PHI to a treating doctor so that the doctor may obtain information concerning your treatment from your prior treating doctor.

Payment includes determining coverage and paying benefits (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the doctor's bill for your visit to the doctor will be paid by the Plan.

Health care operations includes quality assessment and improvement, reviewing competence or qualifications of health care professionals, determining the appropriate contribution rates to the Plan, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts or determining the appropriate contribution rates for the Plan.

It also includes disease management, case management, conducting or arranging for medical review; legal services and auditing functions, including fraud and abuse compliance programs; planning and development, Plan management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

c. Uses and Disclosures that Require Your Written Authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist.

Your authorization will also generally be obtained before the Plan will release your PHI to persons not specifically authorized to receive the information under the Privacy Regulations, such as your spouse. When your authorization is required for a release of your PHI, you will also have the right to revoke the authorization at any time.

d. Uses and Disclosures that Require You Have an Opportunity to Agree or Disagree before the Information is Used or Released

The Plan can disclose your PHI to family members, other relatives and your close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for that care; and you have either agreed to the disclosures or have been given an opportunity to object and have not objected.

e. Other Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

The Plan can use and disclose your PHI without your consent, authorization or request under the following circumstances; however, as a general rule the Plan will release PHI in these situations only when necessary to protect a person's health or safety:

l . when required by law, such as releases to the Secretary of Health and Human Services;

2. when permitted for purposes of public health activities, including when necessary to report if you have been exposed to a communicable disease or are at risk of spreading a disease or condition;

3. to report information about abuse, neglect or domestic violence to public authorities;

4. to a public health oversight agency for oversight activities such as civil, administrative or criminal investigations; inspections; licensing or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud);

5. when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request;

6. when required for law enforcement purposes (for example, to report certain types of wounds);

7. for other law enforcement purposes, including identifying or locating a suspect, fugitive, material witness or missing person;

8. to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Disclosure is also permitted to funeral directors, as necessary, to carry out their duties with respect to the decedent;

9. for research, subject to certain conditions;

10. to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat; or

11. when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

2. Your Rights

a. Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

These requests should be made to the Plan's "Contact Person" listed at the end of this notice.

b. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

Designated Record Set includes your medical records and billing records maintained by or for a covered Health Care Provider; enrollment, payment, billing, claims adjudication and case management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan's Contact Person.

If the Plan denies you access, you or your personal representative will be provided with a written denial stating the basis for the denial, a description of how you can exercise those review rights and a description of how you can complain to the Secretary of the U.S. Department of Health and Human Services.

c. Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set as long as the PHI is maintained in the designated record set. The request must be made in writing and must provide your reasons supporting your request.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan cannot comply with the deadline. If the request is denied in whole or part, the Plan will provide you with a written denial that explains the basis for the denial. You or your personal representative can then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests to amend your PHI in a designated record set should be made to the Plan's Contact Person at the Plan Administrator's office. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

d. The Right to Receive on Accounting of PHI Disclosures

At your request, the Plan will also give you an accounting of the Plan's disclosures of your PHI during the six years prior to the date of your request. However, the accounting need not include PHI disclosures made (l) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Plan gives you a written statement about the reasons for the delay and the date by which accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost based fee for each additional accounting.

To the extent the Plan uses or maintains an electronic health record as defined by HITECH with respect to your PHI, you will have the right to obtain from the Plan a copy of such information in an electronic format and, if you so choose, direct the Plan to transmit such copy directly to any entity or person you chose, provided you have specifically identified to the Plan to whom the electronic health record should be sent. Further, to the extent the Plan uses or maintains your PHI in the form of an electronic health record as defined by HITECH, you will have a right to receive an accounting of any disclosures of that PHI made by the Plan in the three years prior to the date on which you request an accounting.

e. The Right to Receive a Paper Copy of This Notice upon Request

Please contact the Plan's Contact Person at the Plan Administrator's office to receive a paper copy of this notice.

f. Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of this authority may take one of the following forms: (1) a power of attorney for health care purposes notarized by a notary public; (2) a court order of appointment of the person as the conservator or guardian of the individual; or (3) an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. The Plan, however, reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan before that date. If a privacy practice is changed, a revised version of this notice will be provided by mail to all past and present Covered Persons for whom the Plan still maintains PHI.

If your PHI is acquired, used or disclosed in a manner that is not permitted by the HIPAA Privacy Rule and such acquisition, use or disclosure poses a significant risk of financial, reputational, or other harm to you (defined as a "breach"), the Plan will provide you with notice of the breach without unreasonable delay and in no case later than 60 days after the discovery of the breach by the Plan. The breach notification will advise you of the breach, what PHI was involved in the breach, any steps you should take to protect yourself from potential harm, a description of what the Plan is doing to investigate the breach and mitigate any harm to you and contact procedures for you to learn more about the breach.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

a. Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

This minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a Health Care Provider for treatment;
2. disclosures mode to the Secretary of the U.S. Department of Health and Human Services;
3. uses or disclosures that are required by law; and
4. uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe the information can be used to identify an individual. In other words, if the information is de-identified, it is not individually identifiable health information and, therefore, not PHI.

The Plan can also use or disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals and from which identifying information has been deleted in accordance with the Privacy Regulations.

4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan's Contact Person at the Plan Administrator's office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

5. Who to Contact for More Information

If you have any questions, please contact the Plan's Contact Person at the Plan Administrator's office. The address is 3001 Metro Drive, Suite 500, Bloomington, MN 55425, and the telephone number is 952-854-0795 or 800-535-6373.

Conclusion

PHI uses and disclosures by the Plan are regulated by the federal HIPAA law. This notice attempts to summarize the Privacy Regulations. The Privacy Regulations will supersede any discrepancy between the information in this notice and the regulations.

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 bill 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, your spouse, or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible 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.

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
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 website at http://www.dol.gov/pwba.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.