OPERATING ENGINEERS LOCAL NO. 965
HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

AND PLAN DOCUMENT

JANUARY 2017 EDITION

PN: 36-6121856 EIN: 501

Important Information

CONTACT INFORMATION

Fund Office

Operating Engineers Local No. 965 Health Benefit Plan
1520 Kensington Road, Suite 200
Oak Brook, IL 60523
Phone: 1-866-384-0965

Blue Cross Blue Shield of IL (Medical PPO)

Website: www.bcbsil.com Phone: 1-800-571-1043

Medical Cost Management (Utilization Review and Precertification)

Phone: 1-800-367-9938

Envision Rx (Prescription Drug Program Manager)

Website: www.envisionrx.com Phone: 1-800-361-4542

Mail-order pharmacy (Orchard): www.orchardrx.com Phone: 1-877-437-9012

HMC Healthworks (WELL4LIFE Wellness Program)

Phone: 1-855-867-0477

ARE YOU TAKING ADVANTAGE OF OUR WEBSITE?

The third party Fund Administrator, BMGI, has established a website to provide you with online access for tracking your fringe benefits. For example, you can obtain:

- Claim forms – medical and HRA
- Your work history and eligibility status
- Contribution detail for the Local 965 Annuity Plan
- Your HRA balance
- The SPD (this booklet)

The website address is **https://bmgiweb.com/965**

You will be prompted to create a user account on your first visit. Select "**New User? Click here to create an account**." The system will guide you through the simple steps of creating a user I.D. and password. After that, you can enter your I.D. and password to log into your account.

The Fund Administrator will maintain the website by keeping your work and contribution history updated. The website will also contain the most up-to-date Plan provisions.

Please contact the Fund Office (BMGI) if you have any questions regarding the website or this SPD.

INTRODUCTION

To All Participants:

We are pleased to distribute this new Summary Plan Description (SPD) which explains the benefits under your Plan, summarizes the eligibility rules for participation in the Fund and explains your participant rights. Please read this booklet carefully and keep it for future reference.

Please contact the Fund Office at the address and phone number below if you need help understanding anything in this booklet, or if you have questions about your eligibility of claims.

Sincerely,

Board of Trustees

To write to the Board of Trustees, address your correspondence to:

Board of Trustees
Operating Engineers Local No. 965 Health Benefit Plan
c/o Benefits Management Group, Inc.
1520 Kensington Road, Suite 200
Oak Brook, IL 60523

(See page 77 for a complete list of the names and addresses of the Trustees.)

About this Book - This Summary Plan Description booklet is intended to give you an accurate description of the benefits and provisions of your Benefit Plan. It is also the Plan Document. Only the full Board of Trustees is authorized to interpret the Plan described in this book. Its interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined by the reviewing court to be arbitrary and capricious, as that standard was enunciated by the United States Supreme Court in *Firestone Tire & Rubber Company, et al., v. Bruch*, 489 US 101 (1989).

Where to Get Help Understanding this Book - If you need assistance, write to the Administrative Manager at the address in the box above, or call them at 1-866-384-0965 during regular business hours. Only the Administrative Manager is authorized to answer the questions for the Trustees. Matters that are not clear, or that need interpreting, will be referred to the Trustees. No agent, representative, officer or other person from the union or an employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents.

Trustee Authority - The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules or other provisions of the Plan at any time. The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and beneficiaries.

Pronouns Used in this Booklet - To avoid awkward wording, this booklet uses masculine pronouns to refer to employees and retirees. But these masculine pronouns (he, him, his) include the feminine (she, her, hers). For the same reason spouses are usually referred to in the feminine gender, but the masculine gender applies where applicable.

Where the words “you” or “your” are used, it means an eligible employee or eligible retiree.

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YOUR RESPONSIBILITIES

Keep the Fund Office informed about:

1. Where you live. The Fund Office must have a correct address for you on file at the Fund Office at all times so you can receive notices and information that affect your eligibility and benefits. If you move, it is up to you to let us know your new address.

2. Your marital and family status. Provide documentation to the Fund Office within 60 days if you get married, divorced, have a child, adopt a child, etc. "Documentation" means the legal documents that prove the person is your dependent, for example, your marriage license, divorce decree, child's birth certificate, child's support order, etc. A copy of the appropriate documentation must be on file with the Fund Office before any benefits will be payable on behalf of your dependent. It is also your responsibility to inform the Fund Office if a child ceases to meet the definition of a covered dependent.

Provide requested information. Respond to all requests for additional information in a timely manner.

Track Your Hours. It is advisable that you keep a log of your hours worked for each employer. You can check online to track your hours and the contributions employers have made on your behalf, and compare them with the hours of your own records. Every contribution quarter you will receive a statement showing the total number of hours you have worked for various employers who contribute to the Fund. Compare your statement of hours to your own records and notify the Union and Fund Office if your records disagree.

Helpful tips:

- Maintain a record of hours worked for each employer.
- Always retain your check stubs.
- Create a log-in account at bmgiweb.com in order to track your hours/contributions.
- Notify the Fund Office as soon as possible of any discrepancies you find.

Make self-payments on time. If you are short the hours you need to continue your coverage, the Fund Office will send you a statement explaining the number of hours you are short, and the amount you can self-pay to make up the shortage. The self-payment letter will include the due date for your self-payment. It is important that you make the payment on time.

CLASS A SCHEDULE OF BENEFITS

• Class A is for active employees and their dependents. •

Weekly Loss of Time (Disability) Benefit)

Amount of weekly benefit $150

Maximum period payable per disability ..... 13 weeks

Benefits start on the 1st day if disability is due to an accident, and on the 8th day for other disabilities.

Preventive Benefit

For covered services and supplies, as described starting on page 24:

In-network providers 100%

Out-of-network providers ..... not covered

Includes periodic adult wellness exams, well-child visits, and immunizations for adults and children.

Comprehensive Major Medical Benefit

The following provisions apply to the allowable amounts of your covered medical expenses, and are per-person unless stated otherwise.

Deductible per calendar year:

Per child $250

Employees, retirees and spouses:

Per person when WELL4LIFE requirements met $250

Per person when WELL4LIFE requirements are not met $1,000

WELL4LIFE is the Plan's wellness program. Your annual deductible is increased to $1,000 if you do not meet all WELL4LIFE requirements by October 31 of the prior year, and participate in a health education program with a health coach if asked to do so. See page 27 for more information.

Utilization review non-compliance penalty - for failure to precertify an inpatient confinement or a non-emergency surgical procedure ..... $100 per occurrence

Plan payment percentages:

In-network providers 90%

Out-of-network providers 80%

Medical out-of-pocket limit per person per calendar year for Comprehensive Major Medical expenses (excluding deductible)..... $1,200

Your coinsurance amounts apply toward your out-of-pocket limit. (Coinsurance is your 10% or 20% share of covered costs after you have satisfied your deductible.)

Global cost-sharing maximum..... determined by federal regulations

As required by the Affordable Care Act, the Plan keeps track of each person's medical/prescription deductible, coinsurance and co-pays to make sure the total does not exceed a certain maximum. Since the regular patient responsibility amounts are already low under this Plan, reaching this global cost-sharing maximum will be a rare occurrence. For more information, see page 28.

SPECIAL BENEFITS AND LIMITATIONS

Deductible and coinsurance apply.

Chiropractic care - maximum benefit ..... $1,000 per calendar year

Orthotics for the feet (must be custom-fitted) - maximum benefit ..... $300 per calendar year

Vision therapy (orthoptics) - maximum number of visits..... 25 visits per lifetime

See page 33 for the types of conditions for which vision therapy is covered.

Wig due to hair loss caused by medical therapy - maximum benefit ..... $500 per lifetime

Prescription Drug Benefit

You pay the following percentages whether you use a participating retail pharmacy or the mail-order pharmacy. You will usually save money using mail-order due to the lower prices.

You Pay

Generic..... 10%

Formulary (preferred) brands..... 20%

Non-formulary brands and specialty medications..... 30%

Prescription drug out-of-pocket limit per person per calendar year..... $350

Healthcare Reimbursement Accounts (HRA)

You can use your HRA account to be reimbursed for self-payments, deductibles, and many other healthcare-related expenses. See pages 36-39 for more information.

CLASS B SCHEDULE OF BENEFITS

• Class B is for retirees and their dependents without Medicare. •

Preventive Benefit..... same as Class A

Comprehensive Major Medical Benefit..... same as Class A

Prescription Drug Benefit ..... same as Class A

CLASS C SCHEDULE OF BENEFITS

• Class C is for Medicare-eligible retirees and their dependents. •

Medical Benefits:

Medicare Part A and Part B deductibles..... paid at 100%

Medicare Part A and Part B coinsurance..... paid at 100%

Charges not covered by Medicare ..... excluded

Preventive Benefit..... same as Class A
coordinated with Medicare
if Medicare covers

Prescription Drug Benefit ..... same as Class A

ELIGIBILITY

The eligibility rules explained in this section represent the requirements which must be satisfied for you and your dependents to become and to remain eligible for benefits from this Plan. In the event that these requirements are not met, your eligibility and/or your dependent's eligibility will be lost and Plan benefits will not be payable.

The Trustees, in their sole discretion, are empowered to change or amend the Plan's eligibility rules at any time. The Trustees also reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the purposes of the Plan or who does not present a bona fide claim.

Contribution Quarters and Benefit Quarters

A contribution quarter is a period of three consecutive calendar months during which you meet the applicable eligibility requirements necessary to provide benefit coverage during the related benefit quarter.

A benefit quarter is a period of three consecutive calendar months during which you and your dependents are covered under the Plan because you have met the eligibility requirements during the related contribution quarter.

The contribution quarters and benefit quarters are as follows:

Contribution Quarters *Work Performed During...*		**Benefit Quarters** *Determines Eligibility For…*
December, January, February	→	May, June, July
March, April, May	→	August, September, October
June, July, August	→	November, December, January
September, October, November	→	February, March, April

Note that there are two administrative lag months between a contribution quarter and its related benefit quarter. For example, June and July are the lag months between the March-April-May contribution quarter and the August-September-October benefit quarter.

Initial Eligibility for Class A Benefits

Class A benefits are for active employees and their dependents.

General Rule (700-Hour Rule)

Your initial eligibility date is the first day of the calendar month next following the calendar month in which:

- You have been employed by contributing employer(s) who have made contributions to the Fund on your behalf for at least 700 hours; and
- Those 700 hours were worked within a period of no more than twelve (12) consecutive calendar months.

Once you become eligible, you will remain eligible until the end of the benefit quarter in which your initial eligibility date falls. After that, the "Continuation of Eligibility" rules below will apply.

Special Agreements (Non-Construction Agreements)

Initial and continuing eligibility requirements are subject to the terms of the employer's agreement with the Fund. For example, some independent agreements may allow for eligibility beginning on the first of the month after contributions are received. Such agreements generally cover certain Quarries and Shop employees under the Union's jurisdiction. Affected employees will be subject to the regular Continuation of Eligibility rules below after they complete eight consecutive quarters (24 months) of eligibility. The 1,000-hour lookback rule described in the next section will not apply to an affected employee until after 24 months of eligibility. If employment terminates before the affected participant has been covered under this rule for 24 months, his eligibility will terminate immediately.

Dependent Eligibility

The initial eligibility date for any of your family members who meet the Plan's definition of a "dependent" (page 46) will be the same date as yours. If you acquire a dependent after you have become eligible, your new family member's effective date of benefits will be the date that person becomes your dependent. You must notify the Fund Office and submit documentation to establish a dependent's eligibility for coverage.

Continuation of Eligibility

After becoming initially eligible you and your covered dependents will continue to be eligible in each successive benefit quarter as long as employer contributions are made on your behalf totaling at least 250 hours in the related contribution quarter, or an employer has contributed 1,000 hours on your behalf during the current contribution quarter plus the three prior contribution quarters. The 1,000-hour rule is also referred to as the "lookback rule."

The lookback rule works like this:

For Eligibility During These Months:	You need:
February, March, April	1,000 worked and contributed hours for work from December to November
May, June, July	1,000 worked and contributed hours for work from March to February
August, September, October	1,000 worked and contributed hours for work from June to May
November, December, January	1,000 worked and contributed hours for work from September to August

For example, to be eligible for the May, June, July 2017 benefit quarter you need either:

1. **250-Hour Rule -** 250 hours contributed on your behalf by an employer during the contribution months of December 2016, January 2017, and February 2017; OR

2. **Lookback Rule -** 1,000 hours contributed on your behalf by an employer during the contribution months of March 2016 through February 2017.

Short-hours self-payments (see explanation of short-hours self-payments below) do not count towards the 1,000-hour lookback rule. The 1,000 hours have to be for hours you worked and for which an employer contributed.

The lookback provision may not be used if you are not available for work at covered employment in the industry with an employer who participates in this Fund. If you leave covered employment and commence work for an employer who is not a participating employer with this Fund, your eligibility will terminate immediately and any hours accumulated will be forfeited.

Your dependents who meet the Plan's definition of a dependent will continue to be eligible for benefits as long as you are.

Short Hours Self-Payments

After becoming initially eligible, if you do not have sufficient employer contributions to continue your eligibility, you may be entitled to make short-hours self-payments to continue your eligibility.

A full short-hours self-payment amount is equal to 250 hours times the hourly contribution rate in effect for contributing employers. If you have worked some hours, but not 250, during a contribution quarter, you can make a partial self-payment for the hours you are short of 250.

> *Example:* After gaining initial eligibility, you worked 190 hours in the March, April, May contribution quarter. In order to maintain your coverage for the August, September, October benefit quarter, you must make a partial self-pay for 60 hours (250 hours - 190 hours = 60) times the current hourly contribution rate. The current hourly contribution rate may be found in the collective bargaining agreement.

Hours for which you make short-hours self-payments do not count toward your future eligibility.

Rules Governing Short Hours Self-Payments

1. You can make full self-payments (paying for 250 hours) for up to a maximum of four (4) consecutive contribution quarters.

2. You can make an unlimited number of partial self-payments (fewer than 250 hours).

3. Full or partial self-payments must be received by the Fund Office within 14 days of the date on the self-pay notice.

Self-pay notices will be sent to your last known address, so it is important that the Fund Office has your current address.

While the Fund Office will mail a notification to you when a self-payment is due, it is your responsibility to make any required self-payments on time regardless of whether or not you receive a notice from the Fund Office.

The due date is the first day of the applicable benefit quarter.

The Fund charges a NSF fee if your check is returned for non-sufficient funds. The NSF fee is currently $25 per check. The Trustees may increase this fee if they determine it to be insufficient based on the fees being charged by banks.

4. You cannot make a self-payment to gain initial eligibility.

5. Self-payments are for full quarters of coverage. No partial refund will be made if a participant dies or otherwise wants to terminate their coverage before the end of the quarter.

6. You must be available for work in covered employment in the industry with a contributing employer in order to make short-hours self-payments. (This does not apply to employees making self-payments due to total disability.)

The Board of Trustees may elect, in their sole discretion, to temporarily extend the 4-quarter maximum self-payment period if the industry is experiencing a period of widespread unemployment.

Eligibility During Disability

Short-Term Disability

If you become totally disabled while you are eligible under this Plan, and if you meet the qualifications explained below, you will be credited with disability hours during your period of disability in order to help you maintain your eligibility.

To qualify under for short-term disability credit under the "Eligibility During Disability" provision, you must:

1. Be eligible under the Plan when your disability begins due to actual hours worked (not self-paid);

2. Be unable to perform covered employment due to your disability;

3. Be eligible for Weekly Loss of Time Benefits, OR submit evidence satisfactory to the Trustees that you are eligible for weekly workers' compensation disability benefits.

The Trustees reserve the right to have you medically examined by a doctor of their choice, at the Plan's expense, to determine whether a disability qualifies under the Plan's rules.

If you do not meet all these requirements, you will not be credited with disability hours. However, you may be entitled to make self-payments for COBRA Coverage to continue your coverage (see pages 18-21).

How Disability Hours Are Credited

1. If you qualify for disability hours, said disability hours will be credited to your work record at a rate of 19.5 hours for each full week of a disability. You may receive up to a maximum of 500 disability hours for any single period of disability (or during any continuous twelve (12)-month period).

2. Disability hours will be counted towards your future eligibility the same as regular work hours.

3. All disability absences will be considered a single disability unless you return to active covered employment for at least:

    a. One day, provided you submit evidence satisfactory to the Trustees that the cause of the latest disability absence cannot be connected with the cause of any prior disability absences; or

    b. Two weeks, even though a connection can be established between the causes of two successive disability absences.

Long-Term Disability

If you remain disabled after you have been credited with 500 disability hours during a period of total disability, you may be eligible to make self-contributions for continued coverage under the Plan.

If Your Disability Is Permanent

You can make self-payments to continue your Plan coverage for up to 30 months if:

1. You are totally and permanently disabled and unable to perform any work for remuneration or profit on the date you would otherwise lose eligibility under the Plan;

2. You were eligible under this Plan for at least five years (60 months) prior to your disability; and

3. You submit a copy of your Social Security Administration disability award within 12 months of the date your eligibility would otherwise terminate (within 12 months of your 30-month self-pay extension).

Your 30-month self-pay period will consist of 12 months of short-hours self-payments, followed by 18 months of COBRA self-payments.

If Your Disability Is NOT Expected to be Permanent

If your disability is not expected to last long enough to qualify for a Social Security disability award, or if you do not qualify for Social Security disability benefits, you can make full short-hours self-payments for 12 months, and then COBRA self-payments. Your loss of eligibility due to disability will entitle you to an 18-month COBRA coverage period, but your COBRA period runs consecutively with your short-hours self-pay period. So, if you make 12 months of short-hours self-pays, you can pay for another six (6) months of COBRA.

> *Example:* If you have a qualifying long-term disability that starts on November 15, 2016, but were working steadily prior to become disabled, your eligibility will be continued as follows:
>
> - For the first six months you will be credited with 500 disability hours. You should reach the 500-hour maximum in the middle of May 2017.
> - Your disability hours will continue your eligibility until July 31, 2017. At that point, you will need to make a partial short-hours self-payment (for about two weeks of missed work) to extend your eligibility. (You need 250 hours in the March-April-May 2017 contribution quarter to continue your eligibility in the August-September-October benefit quarter. But because you reached the 500-hour limit before the end of the March-April-May contribution quarter, your disability hours will provide you somewhat fewer than 250.)
> - Assuming you make the partial self-payment for the March-April-May 2017 contribution quarter, you can then make four full self-payments to continue your eligibility for another year—through October 31, 2018.
> - If you remain disabled, you can make COBRA self-payments for another three (3) months. This is because the maximum disability self-pay period for all types of self-pays is 18 months, and you previously made short-hours self-pays for 15 months (five quarters).

Benefits During a Period of Disability

If you are maintaining coverage for yourself and your dependents under the Plan by making self-payments during your total disability, you and your dependents will be eligible for the benefits for employees and their dependents specified on the Class A Schedule of Benefits (beginning on page 3), except that you will not be eligible for the Weekly Loss of Time Benefits.

Termination of Eligibility During Disability

If you are making self-payments for continued coverage during your total disability, you and your dependents' coverage under the Plan will terminate on the first to occur of the following dates:

1. The date you become eligible under any other group health care plan.
2. The date you are no longer totally disabled.
3. The date you become eligible for Medicare.
4. The date on which you fail to make a timely and correct self-payment.
5. The end of the maximum self-pay period to which you are entitled.

If your eligibility terminates for the reasons listed above, and before you have made 18 months of self-payments, you may be able to make COBRA self-payments for the duration of your 18-month COBRA maximum self-pay period.

Reinstatement After Disability

After your disability ends, and after you have exhausted any extended eligibility provided by these eligibility requirements during disability, your future eligibility will be governed by the Plan's regular eligibility rules.

Special Circumstances Affecting Eligibility

Change in Employment

Changes in your employment may have an effect on employer contributions paid on your behalf. For example, employer contributions end in the event that you:

1. Change job classifications from covered to non-covered employment, even if that employment is with the same employer; or
2. Change employment from a contributing to a non-contributing employer.

You or your dependents may request from the Union Office information on a particular employer and whether that employer is required to pay contributions to the Fund.

Military Service

If you enter service in the uniformed services of the United States for 31 days or more, you have three different options with respect to eligibility for coverage during your military leave:

- **Option 1 -** Your accumulated eligibility is frozen so that neither you nor your dependents will be covered during your military leave. Your accumulated eligibility will be reinstated later if you return to

covered employment under circumstances entitling you to re-employment under federal law. This is the default option that will apply if you take no action.

- **Option 2 -** Eligibility is frozen, but you make self-payments to keep your coverage in force during your military leave. You will not need health coverage for yourself because you will be covered by the military's health care plan, but the self-payments will continue coverage for your dependents. The maximum self-payment period during a military leave is 24 months. You must make payments for continuing coverage within the same timeframes provided for continuing coverage under COBRA. Your self-pay coverage will run concurrently with COBRA coverage and will be administered in the same manner as COBRA. When you return to covered employment, the eligibility you accumulated before your military leave will be reinstated.

- **Option 3 -** Eligibility is not frozen and you run out your accumulated eligibility credit during your military leave. Once your eligibility credit is exhausted, you may choose to self-pay to keep your dependents covered during the balance of your military leave, for up to 24 months. Or, alternatively, after exhaustion of your eligibility credit, you may choose not to make self-payments, and your coverage will stop.

When you return to work, if your unfrozen eligibility credit is insufficient to reinstate coverage immediately, you can make self-payments until you re-establish eligibility under the regular rules, subject to the 24-month self-pay period limit. According to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guidelines, reemployment and reinstatement deadlines are based on your length of military service. If you do not return to work with an employer within the time required by applicable federal law or if your length of absence exceeds the maximum period prescribed by USERRA (five (5) years), you will be considered as a new employee and required to meet the initial eligibility requirements listed in the Initial Eligibility section.

If you choose to make self-payments under the above rules, the amount of your payment will be the same as the Plan's COBRA rate. The Fund charges a NSF fee (currently $25) if a check is returned for non-sufficient funds.

You will be required to provide documentation of your military service call-up and discharge dates.

The provisions described above are merely a summary, and other rules may apply depending on your circumstances. If you are called to active military duty, you should call the Fund Office as soon as possible so that they can explain these options to you in more detail. The eligibility freeze without self-payments (Option 1) will be automatic unless you request otherwise in a timely manner. If you would like more information about your rights during a military call-up, contact VETS at 1-866-4-USA-DOL or visit the government's website at www.dol.gov.vets. In the event of a conflict between USERRA and the Plan's provisions, USERRA's provisions will apply.

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to you and your dependents if:

1. You are an eligible active employee;

2. You have been granted leave by your employer under FMLA; and

3. Your employer makes the required contributions to the Fund.

If you have been granted FMLA leave, your employer must notify the Fund Office to prevent your loss of eligibility. You must contact both the Union and the Fund Office if when you are granted FMLA leave. Your employer must complete forms to verify your eligibility for benefits during your leave. Your employer must make the applicable contributions to the Fund for your extended eligibility before the Fund will provide benefits.

Your eligibility for a FMLA leave is between you and your employer. The Trustees will not resolve any disputes. FMLA requires your employer to inform you of your rights and obligations under this law. Contact your employer for more information. Not all employers, and not all circumstances entitle an employee to an FMLA leave.

Dropping a Spouse's Coverage

This Plan's coverage is family coverage. When an employee is eligible for benefits, so are all his family members who meet the Plan's definition of a dependent. The Fund does not charge more to cover your spouse or children. However, there are circumstances in which you may want to remove a spouse from your coverage. For example, your spouse may start working for a company that has a flexible spending account plan that requires participants to have no other coverage.

How to Drop Your Spouse's Coverage - If you want this Plan's coverage to terminate for your spouse, you must contact the Fund Office and explain the circumstances involved. You will be asked to sign a coverage waiver stating that you understand the Plan's rules.

How to Reinstate Your Spouse's Coverage - You will have one (and only one) opportunity to reinstate your spouse's coverage under this Plan, except as may be allowed by law. That opportunity is a 30-day window, beginning immediately after he or she is no longer eligible to maintain the other coverage. "No longer eligible" means that the other coverage is no longer available, for example, because of a termination of employment or because the other coverage was under COBRA and terminated because the maximum coverage term ended. "No longer eligible" does not include a loss of coverage for failure to pay a premium, or any other termination that is voluntary. You must provide proof of the effective date and loss of eligibility date for the other group coverage. You may only reinstate your spouse's coverage if he/she still meets the definition of a dependent, and only if you yourself are eligible under the Plan.

Failure to satisfy the reinstatement requirements above will result in your spouse's termination of coverage.

Surviving Dependent Eligibility in the Event of Your Death

If you, the employee, die while eligible for Plan benefits, your covered dependents' eligibility may be continued according to the following rules.

Automatic Continuation

Eligibility for your surviving dependents will continue automatically and without self-payment, provided they continue to meet the definition of a dependent, until the later of the end of the benefit quarter for which you had previously earned eligibility as an active employee, or, the last day of the benefit quarter in which your death occurred.

No self-payments are required for this extended coverage, and your surviving dependents will be eligible for the benefits for which they were eligible at the time of your death.

Self-Payments for Extended Survivor Coverage

After the automatic continuation period described above, qualifying surviving dependents may continue their eligibility by making survivor self-payments, subject to the rules explained below.

1. Your dependents will be eligible to make survivor self-payments if you were eligible at the time of your death, and if you had been continuously eligible for Plan benefits during the *20 consecutive benefit quarters (five years) immediately preceding your death*.

2. The amount your survivor(s) are required to pay for each quarter of coverage is as follows:

Covered Survivor(s)	Quarterly Payment Amount
Spouse only	210 hours times the current contribution rate
Child only	210 hours times the current contribution rate
Two or more survivors	390 hours times the current contribution rate

3. Self-payments must be paid quarterly, and must be received by the Fund Office before the first day of the benefit quarter for which payment is being made. Late payments will not be accepted. The Fund charges a NSF fee (currently $25) if a check is returned for non-sufficient funds.

4. Surviving dependents must elect and pay for survivor coverage when first entitled to do so, and coverage must be continuous. There can be no lapse in coverage.

5. A surviving child of yours can make survivor self-payments on his own if your legal spouse preceded you in death, or dies while making survivor self-payments. If self-payments are being made for more than one child, the self-payment amount will be the 390-hour rate. Only children who meet and continue to meet the Plan's definition of an eligible dependent are eligible for Plan coverage.

6. Surviving dependents who become eligible for Medicare will automatically be moved to Class C, the Plan's supplement to Medicare. (Survivor coverage will always be secondary to Medicare.)

7. Self-payments are for full quarters of coverage. No partial refund will be made if a survivor dies or otherwise wants to terminate their coverage before the end of the quarter.

Termination of Survivor Coverage

A survivor can continue making self-payments to remain covered until the earliest following dates:

1. The date your surviving spouse remarries;

2. The date your surviving child no longer meets the Plan's definition of a dependent;

3. The date your surviving dependent becomes covered under any other group health care plan;

4. The date your surviving dependent relocates outside of the United States;

5. The date a correct and on-time self-payment is not made by or on behalf of a surviving dependent.

If a surviving dependent's eligibility terminates before she has made 36 months of self-payments, she may be able to make COBRA self-payments for the duration of her 36-month maximum COBRA self-pay period, if applicable.

Termination of Eligibility

Employees

You will cease to be eligible for benefits on the first to occur of the following dates unless you are entitled to elect COBRA coverage and an on-time COBRA election and self-payment is made by you or on your behalf:

1. The last day of the last benefit quarter for which:
    a. You had 250 credited hours during the corresponding contribution quarter;
    b. You had 1,000 hours during the corresponding contribution quarter plus the three preceding contribution quarters; or
    c. You made a correct and timely short-hours self-payment.
2. If your benefits are being continued under the "Eligibility During Disability" rules, the date on which you fail to meet the requirements of those rules.
3. If you are making short-hours self-payments, at the end of the last day of the benefit quarter for which a correct and on-time self-payment was made, or at the end of the maximum allowable full self-payment period.
4. If you are making COBRA self-payments, at the end of the last day of the last month for which a correct self-payment was made, or on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" on page 21, whichever occurs first.
5. The date you enter the armed forces of any country on a full-time basis.
6. The date of your death.
7. The date the Trustees terminate this Plan of Benefits.

Dependents

A dependent of yours will cease to be eligible for benefits on the first to occur of the following dates unless the dependent is entitled to COBRA coverage and an on-time COBRA election and self-payment is made by or on behalf of the dependent:

1. The date the person ceases to meet the Plan's definition of a dependent.
2. With respect to a spouse, the date the spouse enters the armed forces of any country on a full-time basis.
3. With respect to a child, the date the child becomes covered under this Plan as an employee.
4. The date on which the employee ceases to be eligible for coverage under the Plan for reasons other than his death.
5. In the event of the employee's death:
    a. The date your surviving spouse remarries;
    b. The date your surviving child no longer meets the Plan's definition of a dependent;
    c. The date your surviving dependent becomes covered under any other group health care plan;

d. The date your surviving dependent relocates outside of the United States;

e. The date a correct and on-time self-payment is not made by or on behalf of a surviving dependent.

6. The date the Trustees terminate Plan benefits for dependents.

7. If COBRA Self-Payments are being made by or on behalf of the dependent, at the end of the last day of the last month for which a correct self-payment was made, or on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" on page 21, whichever occurs first.

Reinstatement of Eligibility

If you lose eligibility under the Plan, you may be reinstated by meeting the requirements under "Continuation of Eligibility" if you have been ineligible no more than twelve (12) consecutive months. If you remain ineligible for more than 12 consecutive months, you must meet the initial eligibility requirements (700 hours).

RETIREE PROGRAM

The following eligibility rules represent the requirements which must be satisfied in order for you and your dependents to become and remain eligible for benefits under the Retiree Program of this Plan. In the event that the requirements specified in this section are not satisfied, the retiree's eligibility, and the eligibility of his dependents, will be lost and benefits will not be payable. The Trustees reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the purpose of the Plan or who does not present a bona fide claim.

The privilege of making retiree self-payments to maintain eligibility for retiree benefits is not an "accrued benefit." The Trustees reserve the right to increase the amount of the retiree self-payment rate or to reduce or completely terminate retiree coverage at any time and at their sole discretion.

Eligibility

You, a normal or early retired employee, may continue coverage for yourself and your dependents under the Retiree Program, provided you meet all of the following requirements:

1. You are at least 55 years of age;
2. You have been continuously eligible in this Plan during the ten (10) consecutive calendar years immediately preceding your retirement; and
3. You are eligible under the Plan at the time of your retirement.

You must elect to participate in the Retiree Program when you are first eligible to do so. If you choose not to participate at that time, you will not be entitled to begin participation later.

Dependent Eligibility

Your Retiree Program benefits will cover any of your family members who meet the definition of a dependent when you retire, provided you make the required self-payments for their coverage. You must elect coverage for your dependents when you are first entitled to do so. If you initially decline coverage for a dependent, you cannot enroll them at a later date.

Only persons who are your eligible dependents when your Retiree Program benefits start can be covered under this program. You cannot add a spouse or child later, even if the person is your newly acquired dependent.

Classes of Benefits

You and your dependents will be eligible for either Class B or Class C benefits. You may be in one class, and your spouse and/or dependents in the other.

Class B - For a retiree or dependent who is NOT eligible for Medicare.

Class C - For a retiree or dependent who is eligible for Medicare.

The benefits for these classes are specified on the applicable Schedule of Benefits.

Retiree Self-Payments

Amount of Self-Payments

Retiree self-pay amounts are based on years of service. The following table shows the rates for retirees whose age plus years of services is 90 or more. Retirees whose retirement age plus years of service is less than 90 will pay more. Contact the Fund Office for more information.

Coverage for	Quarterly Payment Amount (If Retirement Age + Years of Service = 90 or More)
CLASS B (Pre-Medicare)	
Retiree only	235 hours times the current contribution rate
Spouse only	210 hours times the current contribution rate
Retiree and spouse (includes eligible children)	390 hours times the current contribution rate
CLASS C (Medicare-Eligible)	
Retiree only	96 hours times the current contribution rate
Spouse only	96 hours times the current contribution rate
Retiree and spouse (no children)	192 hours times the current contribution rate
Dependent child (age 0-25)	Additional 150 hours per child per quarter

Rules Governing Retiree Self-Payments

1. If a person's status changes (such as a retiree becoming eligible for Medicare), his retiree self-payment amount will change effective on the first day of the benefit quarter coincident with, or next following, the date the change in status occurs.

2. Retiree self-payments are made on a quarterly basis. Each payment must be received by the Fund Office before the first day of the benefit quarter for which payment is being made.

3. Retirees and their dependents must elect to continue coverage under the Retiree Program when first entitled to do so.

4. Coverage must be continuous. Failure to make a timely and correct self-payment will cause retiree coverage to terminate. No further retiree self-payments will be allowed.

5. If an employer makes contributions on your behalf after you retiree, your retiree self-payment amount will NOT be reduced by the amount of the employer contribution. In order to regain coverage as an active employee, you must satisfy the initial eligibility requirements specified on page 4.

6. Retiree self-payments are for full quarters of coverage. The Plan will not issue a partial refund if a participant dies or otherwise wants to terminate coverage before the end of the quarter.

7. The Fund charges a NSF fee if your check is returned for non-sufficient funds. The NSF fee is currently $25 per check.

Termination of Eligibility

Retiree

Your eligibility for Plan benefits will terminate on the first to occur of the following dates:

1. The last day of the benefit quarter for which a correct and on-time retiree self-payment was made to the Fund.
2. The date the Trustees terminate benefits for retirees.
3. The date the Trustees terminate this Plan.

Dependents

Eligibility will terminate for a dependent of yours on the first to occur of the following dates:

1. The date the retiree's coverage terminates.
2. The last day of the benefit quarter for which a correct and on-time retiree self-payment was made to the Fund for the dependent's coverage.
3. The date the person no longer meets the Plan's definition of a dependent, unless she is entitled to COBRA coverage and makes a timely election and self-payment for that coverage
4. The date the Trustees terminate benefits for dependents of retirees.

COBRA Coverage for Dependents of Retirees - If a dependent loses eligibility because she no longer meets the Plan's definition of a dependent (for example, if you and your spouse divorce, or if a child reaches age 26), she is entitled to elect COBRA coverage for a maximum coverage period of up to 36 months after the date her retiree coverage would otherwise terminate due to the qualifying event.

COBRA COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), gives you and your dependents the right to make self-payments for continued health care coverage if coverage is lost for certain reasons (called "qualifying events"). This continued coverage is called "COBRA coverage."

- You must make self-payments for this coverage.
- COBRA self-payments are for coverage months (you pay for the same month you are eligible for benefits) while short-hours self-payments are for contribution (work) quarters.
- COBRA self-payments do not count toward the initial or continuing eligibility requirements. You do not receive hours credit for a COBRA coverage period.
- Your COBRA coverage period begins after any quarters of eligibility you previously earned under the eligibility rules or by making short-hours self-payments.
- The cost of COBRA coverage under the Plan is the same whether you choose individual coverage or family coverage.

You will be offered COBRA when your coverage terminates, even if your termination is temporary or seasonal.

Other Coverage Options

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

Qualifying Events and Maximum Coverage Periods

1. **You and/or your dependents** are entitled to elect COBRA coverage for up to 18 months after the date coverage would otherwise terminate due to one of the following "qualifying events":

   a. A reduction in your hours.

   b. Your termination of employment (including retirement).

   Eleven (11)-Month Extension Rule - If you or a covered dependent are disabled (as defined by Social Security for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or a covered dependent become so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. Your COBRA payment will be higher for the extra 11 months of coverage.

   You must notify the Fund Office within 60 days of the disability determination by Social Security and before the end of the initial 18-month period. You must also notify the Fund Office within 30 days of the date Social Security determines that you or the dependent are no longer disabled.

(This 11-month extension rule does not apply to dependents during a 36-month COBRA maximum coverage period.)

2. **Your dependents** are entitled to elect COBRA coverage for up to 36 months if any of the qualifying events listed below occurs:

   a. If you are divorced from your spouse.

   b. If a child loses dependent status by failing to meet this Plan's definition of a dependent.

   c. Your death.

3. **Military Service -** If you enter military service for at least 30 days, you are entitled to elect COBRA coverage for up to 24 months. (See "Military Service" on page 9 for more information.)

4. **Multiple Qualifying Events -** If your dependents are covered under an 18-month COBRA period due to one of the qualifying events listed in No. 1 above, their COBRA coverage period may be extended if a second qualifying event (your death, a child's failure to meet the definition of a dependent, or your divorce) occurs during that 18-month period. If a second qualifying event occurs, your spouse and children are entitled to elect COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation. Only a person (spouse or child) who was your covered dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours) is entitled to make an election for this extended coverage when a second qualifying event occurs except as follows: If a child is born to you (the employee), adopted by you or placed with you for adoption during the first 18-month continuation period, that child will have the same election rights when a second qualifying event occurs as a person who was your dependent on the day before the first qualifying event. Also note that if an eligible employee has a newborn child, adopts a child or has a child placed with him for adoption while his COBRA coverage is in effect, he may add that child to his COBRA coverage.

5. **Special Medicare Entitlement Rule -** A special rule provides that if you (the employee) become entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of hours, the period of coverage for your spouse and dependent children will be 36 months measured from the date of your Medicare entitlement, or 18 months from the date you lose coverage because of a reduction in hours or termination of employment, whichever is longer.

   This special extension for dependents applies only if dependent coverage is going to end (due to your termination of employment or reduction in hours) within 18 months after the date of your Medicare entitlement. If your dependents' coverage will end more than 18 months after your Medicare entitlement, they will have 18 months of coverage, the same as you do.

Your Notification Responsibilities

You, your spouse or the child must notify the Fund Office if you get divorced or if a child loses dependent status. The Fund Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. It is also an affected dependent's responsibility to notify the Fund Office within 60 days after a second qualifying event occurs during an 18-month coverage period. If the Fund Office is not notified within the 60-day period, the affected person(s) will lose the right to COBRA coverage. It is your employer's responsibility to notify the Fund Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you should also notify the Fund Office when any type of qualifying event occurs.

Benefits Under COBRA Coverage

A person electing COBRA coverage is entitled to the same class of health care benefits for which he was eligible on the day before the qualifying event, except that Weekly Loss of Time (disability) Benefits are not included.

You can retain access to any remaining funds in your HRA if you maintain your Plan coverage by making COBRA self-payments.

Electing COBRA Coverage

1. When the Fund Office is notified of a qualifying event, you and/or your dependents will be sent an election notice that explains when your coverage will terminate, your right to elect COBRA coverage, the due dates, the amount of the COBRA self-payments, etc. An election form will be sent along with the election notice. This is the form you or a dependent fill in and send back to the Fund Office if you want to elect COBRA coverage.

2. A person has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is personally delivered to the Fund Office or on the date of the postmark on the returned election form. If the election form is not returned to the Fund Office within the allowable time period, you and/or your dependents will not be entitled to elect COBRA coverage.

3. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents. A person does not have to show that he is insurable to elect COBRA coverage.

If you do not elect COBRA coverage for your dependents when they are entitled to COBRA coverage, your dependent spouse has the right to elect COBRA coverage for herself and any children for up to 18 months within the time period that you could have elected the coverage for them.

Making COBRA Payments

1. COBRA self-payments must be made monthly. The amount of the monthly self-payment is determined by the Trustees based on federal regulations. The amount is subject to change.

2. A person has 45 days after the date of election to make the initial COBRA self-payment. The initial payment amount must be sufficient to cover the period from the date COBRA coverage started through the current coverage month. You can contact the Fund Office to find out the amount of this initial payment.

3. The due date for each subsequent COBRA payment is the day before the first day of the month for which coverage is desired. Although COBRA payments are due the day before the first day of the month for which coverage is desired, you will be given a grace period of 30 days to make each COBRA payment.

4. If a COBRA payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. The person may not make up the payment or reinstate coverage by making future payments.

Termination of COBRA Coverage

A person's COBRA coverage will be terminated before the end of the applicable maximum coverage period when the first of the following events occurs:

1. A correct COBRA payment is not received by the Fund.
2. After an election of COBRA coverage, the person becomes entitled to Medicare benefits.
3. After an election of COBRA coverage, the person becomes covered under another group health plan as an employee or otherwise.
4. The person has been receiving extended COBRA coverage for up to an additional eleven months due to his or another family member's disability, and Social Security has determined that he or the other family member is no longer disabled.
5. The Fund no longer provides group health coverage to any employees.

COBRA coverage may also be terminated for any reason the Plan would terminate any other employee or dependent's coverage (such as fraud).

Important Note: If your coverage terminates due to a break in eligibility, you are entitled to elect COBRA coverage and make COBRA self-payments under the COBRA coverage rules. If you continue to work for or begin working again for a contributing employer while you are making COBRA payments, the amount of your COBRA payments will NOT be reduced by any employer contributions. You must once again satisfy the requirements for initial eligibility. You may terminate COBRA coverage by stopping your COBRA payments.

Trade Act of 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA coverage and an Individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA coverage during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA coverage election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA coverage later than six months after your coverage ended under the Plan.

Also under the Trade Act, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA Continuation Coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

For More Information

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a health insurance marketplace, visit www.healthcare.gov. For specific information about this Fund or how to elect COBRA, call the Fund Office at 1-866-384-0965.

WEEKLY LOSS OF TIME BENEFIT

Payment of Benefits

Only employees not continuing their eligibility by making COBRA self-payments are eligible for Weekly Loss of Time Benefits.

Weekly Loss of Time Benefits will be payable if you become totally disabled and unable to work as a result of a non-occupational accident or sickness, provided that you are regularly employed by a contributing employer and are eligible under the Plan on the date the disability begins. Benefits are not payable for any period of time for which a physician (M.D. or D.O.) does not certify your total disability in writing. Disability certifications by any other medical practitioner, including but not limited to a chiropractor, will not be certified.

Amount of Benefit

The amount of the weekly benefit is shown on the Class A Schedule of Benefits starting on page 3. If you are disabled for a part of a week, you will receive one-seventh of your weekly benefit for each day of disability.

Maximum Period that Benefits Are Payable / When Benefits Start

Benefits will begin on the first day of disability due to an accidental injury and will begin on the 8th day of disability due to a sickness.

Weekly benefits are payable for up to 13 weeks while you are totally disabled, but not for more than 13 weeks for any one continuous period of disability.

Successive Periods of Disability

1. All successive periods of disability resulting from the same or related cause(s) will be considered one continuous period of disability unless the second period of disability begins after you have returned to active full-time covered employment for at least two (2) weeks.

2. A successive period of disability that is entirely unrelated in cause or nature to the previous disability will be considered a continuation of the prior period of disability unless the second disability begins after you have returned to active full-time covered employment for one full day.

3. If successive periods of disability are due to injuries received in one accident, only the first period of disability will be considered as having been caused by an accident. Any succeeding periods of disability will be considered as being due to sickness.

Exclusions and Limitations

No payment will be made for any period of total disability:

1. Caused by occupational injury or sickness sustained in the course of, or arising out of, any activity for wage or profit, whether or not covered by a workers' compensation law or occupational diseases law or similar law.

2. After you retire (if you are drawing a pension or retirement benefit, you are considered "retired").

3. Resulting from any accidental injury or sickness for which you are not under the regular care of a physician who is an M.D. or D.O.

PREVENTIVE BENEFIT

The Plan covers a wide range of preventive services for eligible participants and their dependents. Those services are listed below.

All covered preventive services provided by an in-network (PPO) provider will be paid at 100% with no deductible. Out-of-network (non-PPO) services are not covered except in rare cases where an in-network provider is not available. Denied charges do not apply to the global cost-sharing maximum or to the out-of-pocket limit under the Comprehensive Major Medical Benefit.

You must use providers in the PPO network in order to receive these benefits.

Most of the services in these lists are determined by federal agencies. However, this Plan covers many preventive services in addition to the mandated coverages. All items listed are subject to change, and in the event of a conflict between federal law and this Plan, federal law will control.

Services listed below are subject to change based on recommendations made by federal health-related organizations.

Immunizations

Covered Immunization	Frequency
Diphtheria, tetanus and pertussis (DtaP)	As recommended by the Advisory Committee on Immunization Practices (ACIP) and that have been adopted by the Director of the Centers for Disease Control and Prevention, including: • Recommended Immunization Schedule for Persons Aged 0 Through 6 Years • Recommended Immunization Schedule for Persons Aged 7 Through 18 Years • Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind • Recommended Adult Immunization Schedule *Immunizations for travel or work are not covered.*
Hepatitis A (HepA)	
Hepatitis B (HepB)	
Human papillomavirus (HPV)	
Influenza (seasonal)	
Influenza type B (Hib)	
Measles, mumps & rubella (MMR)	
Meningococcal (MCV)	
Pneumococcal (PCV/PPSV)	
Polio (IPV)	
Rotavirus (RV)	
Varicella	
Zoster (shingles)	

Adults (Age 19 or Older Unless Otherwise Stated)

Covered Service or Supply	Frequency
Abdominal aortic aneurysm ultrasound screening (men age 65-75 who smoke(d))	one per lifetime
Alcohol misuse counseling	one visit per lifetime
Blood pressure screening (age 18+)	one per calendar year
Cholesterol abnormality screening (men age 35+, or age 20+ if increased risk; women age 45+, or age 20+ if increased risk)	one per calendar year
Colorectal cancer screening (adults age 50-75), including colorectal exams, flexible sigmoidoscopies, barium enemas, and colonoscopies. Colonoscopy coverage includes medically indicated sedation or anesthesia, pathology and medically appropriate pre-screening specialist consultation.	within the age and frequency guidelines established by the American Cancer Society (age 50 if at average risk)
Depression screening	one per lifetime
Diabetes screening (adults with blood pressure greater than 135/80)	one per calendar year
Diet counseling (adults at increased risk for diet-related chronic disease)	one per lifetime

Hepatitis C screening for adults at high risk	once per calendar year
HIV screening	one per lifetime unless patient is at increased risk for HIV infection
Lung cancer screening with low-dose CT for ages 55+ with history of smoking	once per calendar year
Obesity screening, and if patient is obese, up to 26 face-to-face counseling sessions with a doctor, physician's assistant or advanced practice nurse	26 sessions per calendar year
Sexually transmitted infections counseling (adults at increased risk)	one per lifetime
Syphilis screening (persons at increased risk)	one per calendar year
Tobacco use counseling (age 18+)	two 90-day attempts per calendar year, consisting of four 10-minute counseling sessions
Additional Services Provided by this Fund	
Routine physical exams performed by a doctor for employees and spouses, including any standards tests ordered by the doctor as part of a periodic physical examination. This excludes sports and activity exams.	one per year

ADULT PHARMACY PRODUCTS

Aspirin to prevent cardiovascular disease (men age 45-79; women age 55-79), when prescribed by physician	as prescribed by patient's physician - generics only
Bowel preps for covered colonoscopies	generics and OTCs only
Vitamin D supplements for adults age 65 and over	as prescribed by patient's physician - generics only
Tobacco cessation medications (age 18+)	All physician-prescribed medications (including OTCs) for two 90-day attempts

Females

Covered Service or Supply	**Frequency**
BRCA genetic screening and counseling (women with a family history of BRCA 1 or BRCA 2 risk factors). The genetic counseling must be rendered by a physician, nurse or genetic counselor certified by the American Board of Genetic Counseling.	one per lifetime
Breast cancer counseling (women age 35 and older at high risk)	as determined by physician
Breastfeeding support, supplies (including rental of breast pump), and counseling	as needed; breast pump maximum is $150 per pregnancy
Cervical cancer screening	one per calendar year
Chlamydial infection screening (women age 24 or younger or at increased risk)	one per calendar year
Contraception (non-oral) - FDA-approved contraceptive methods for women (IUDs, Depo Provera, etc.) *prescribed by a physician*, and surgical sterlizations	as prescribed by patient's physician
Contraceptive counseling - Patient education and counseling	as prescribed by patient's physician
Domestic and interpersonal violence screening and counseling	one session per year
Gonorrhea screening (women at increased risk)	one per calendar year
HPV DNA testing	every three years starting at age 30
Mammograms	one per calendar year
Osteoporosis screening (women age 60; age 55 if increased risk of osteoporotic fractures)	one per lifetime
Prenatal care, meaning routine doctor visits. *(Delivery, prenatal lab, ultrasounds, and high-risk pregnancy care services are covered under the regular major medical provisions of the Plan. Maternity care for children is only covered if included in this list – any services, including delivery, not listed are excluded for children.)*	as prescribed by patient's physician
Prenatal screening for gestational diabetes, anemia, bacteriuria, HIV and other infections, Hepatitis B, Rh incompatibility and syphilis	one each per pregnancy
Sexually transmitted disease counseling, and HIV screening and counseling	one per year
Well-woman preventive visits to obtain recommended preventive services that are age and developmentally appropriate	one per year

FEMALE PHARMACY PRODUCTS	
Aspirin for pregnant women at high risk for preeclampsia	as prescribed by patient's physician - generics only
Breast cancer chemoprevention drugs (women age 35 and over at high risk)	as prescribed by patient's physician - generics only
Folic acid supplements (women capable of pregnancy)	0.4 to 0.8 mg (400 - 800 µg) per day
Oral contraceptives - FDA-approved drugs and devices that require a prescription. 100% coverage for oral contraceptives (birth control pills) that are generic (or brand without a generic equivalent)	as prescribed by patient's physician

NOTE: Abortions and abortifacient drugs are excluded for all participants.

Children (Under Age 19)

(Newborn Through Age 18 Years)

Covered Service or Supply	Frequency
Alcohol/drug assessment	as recommended by the American Academy of Pediatrics and Bright Futures
Anticipatory guidance	
Autism screening	
Behavioral assessment	
Cervical dysplasia screening	
Developmental screening	
Dyslipidemia screening	
Health history	
Hemoglobin screening	
Lead screening	
Measurements, including height, weight, BMI, blood pressure, etc.	
Metabolic screening	
Oral health risk assessment	
Physician examination	
Sensory (vision and hearing) screening	
Sexually transmitted disease screening and counseling (adolescents)	
Tuberculin (TB) test	
Depression screening (children age 12-18)	one per lifetime
HIV screening (children age 11 or older at increased risk)	one per lifetime
Newborn screenings for hemoglobinopathies, hearing loss, hypothyroidism, phenylketonuria (PKU), and heritable disorders (as recommended by the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children	one per lifetime
Obesity screening and counseling (children age 6+)	one per lifetime
Skin cancer behavioral counseling	one per lifetime
Tobacco use intervention (education and brief counseling to prevent initiation of tobacco use in school-aged children and adolescents)	one per lifetime
Visual acuity screening (children <5 years)	one per calendar year
Additional Services Provided by this Fund	
Well child exams, excluding sports and activity exams	as recommended by child's pediatrician

CHILDREN'S PHARMACY PRODUCTS	
Iron supplements (children age 6-12 mos. at increased risk for anemia)	as prescribed by child's physician - generics only
Oral fluoride (children 6 months+ if water source deficient in fluoride)	as prescribed through age 5 - generics only
Prophylactic medication for gonorrhea	once per lifetime

COMPREHENSIVE MAJOR MEDICAL BENEFIT

Comprehensive Major Medical Benefits are payable for Class A employees and their dependents and Class B retirees and their dependents. Class C retirees and their dependents are not eligible for these benefits (see page 40 for the benefits payable for Class C retirees and their dependents).

Wellness Program (WELL4LIFE)

This Plan provides a wellness program called WELL4LIFE for Class A employees and spouses, and Class B retirees and spouses. WELL4LIFE is administered by HMC HealthWorks, a third party organization specializing in wellness and disease management plans.

To participate, you and your spouse must obtain comprehensive physical exams and biometrics (measurable data about your physical condition) between January 1 and October 31 each year. Following your exam your physician will need to fill out a WELL4LIFE form and submit it to HMC HealthWorks. The deadline for submitting the completed form is October 31. A new physician's form and more detailed information will be sent to you at the beginning of each year.

Individuals with certain medical conditions and biometric markers are then required to speak with a WELL4LIFE program professional about their health conditions and/or risk factors and participate in the health education portion of the program. Failure to participate by either the employee (participant) or their spouse as recommended is considered not meeting the requirements, which will result in the employee and spouse each paying the higher deductible.

Participation is voluntary, but if you and your spouse both participate your deductible will be the lowest deductible rate in the Plan for the next calendar year.

Per employee and spouse when WELL4LIFE requirements met .....Current deductible $250

Per person when WELL4LIFE requirements are not met.....Currently $1,000

Does not apply to children or Class C participants.

Both you and your spouse must meet the requirements of the WELL4LIFE program to have the lowest deductible rate.

Precertification Requirements

When your physician proposes a hospital stay or a non-emergency surgery, you must contact the utilization review provider listed on the inside front cover of this booklet. The utilization review provider will work with you and your physician to make sure you are receiving the necessary care while helping to control the Fund's health care costs.

- **Inpatient Admissions -** You must contact the utilization review provider and obtain a pre-admission certification before you incur any charges in connection with an inpatient stay.

  If you fail to obtain a pre-admission certification when you or any of your dependents are admitted to an inpatient facility (hospital, skilled nursing facility or residential treatment facility), whether or not it

is in the PPO network, an additional **$100 non-compliance penalty** will be applied to the covered expenses incurred for that confinement. This $100 cannot be applied towards satisfaction of the calendar year deductible, nor toward the person's medical out-of-pocket limit or global cost-sharing maximum.

- **Emergency Admissions -** The $100 non-compliance penalty will apply if you do not contact the utilization review provider within two business days after an emergency hospital admission.
- **Transplants -** All transplant procedures require precertification. If the utilization review organization determines that the procedure does not meet the Plan's medical necessity criteria, the procedure will not be covered by the Plan.

The Plan may also utilize the services of the utilization review organization to determine whether or not other types of services are medically necessary and meet the Plan's coverage criteria.

How Major Medical Benefits Are Paid

Calendar Year Deductible

Each year a deductible amount will be subtracted from your covered medical expenses before the Plan will pay its payment percentage for your remaining covered expenses. Each person in your family must meet their deductible separately. As explained in the "Wellness Program (WELL4LIFE)" section above, employees, retirees, and spouses who do not satisfy the WELL4LIFE requirements will be subject to higher deductibles.

Plan Payment Percentages

A Plan co-pay percentage is the percentage of covered medical expenses that the Plan pays for a person during a calendar year after the calendar year deductible has been satisfied and before the person's medical out-of-pocket limit has been reached. The Plan generally pays a 90% for in-network covered medical expenses and 80% for out-of-network covered medical expenses.

The percentage not paid by the Plan is called your "coinsurance."

Medical Out-of-Pocket Limit

The out-of-pocket limit is the maximum amount you are required to pay during a year for your coinsurance share of covered medical expenses. Once your coinsurance share reaches the amount of the $1,200 out-of-pocket limit for a calendar year, the Plan will pay 100% of most covered expenses during the remainder of that calendar year.

Global Cost-Sharing Maximum

The Affordable Care Act requires that the Plan keep track of all the amounts a person is responsible for paying in deductibles, co-pays, and coinsurance during a calendar year. If the sum of those amounts reaches a certain level, the Plan is required to pay the covered expenses incurred during the remainder of that year at 100%. The maximums are determined by federal regulations, and will increase each year based on the medical inflation rate. For 2017 the maximums are $7,150/person and $14,300/family. The Plan will keep track of your cost-sharing amounts as required, but because of the Plan's low cost-sharing requirements, it is unlikely that any one person or family will reach the federal maximums.

Services or supplies that you are required to pay in full due to a Plan provision, limitation or exclusion do NOT apply to your global maximum. Utilization review noncompliance penalties, amounts in excess of the allowable charge, and charges incurred in excess of a Plan maximum or limitation also do NOT apply.

Maximum Benefits and Limitations

The various maximum benefits and limitations are listed in detail on the Schedules of Benefits. Before incurring any expenses, be sure to become familiar with the limitations and maximum benefits on your Schedule of Benefits.

Covered Medical Expenses

Payment of benefits for covered medical expenses is subject to the Plan co-pay percentages, maximum benefits shown on the Schedule of Benefits and to all other limitations and exclusions that apply. Even if a particular charge is considered a covered medical expense, benefits will not be payable in excess of any maximum benefit or other limitation stated in this Summary Plan Description booklet.

Covered medical expenses are the allowable charges that you and your family actually incur for the following medically necessary services and supplies.

1. **Ambulance transportation.** Medically necessary professional local ambulance service to a hospital or between hospitals if necessary for more highly specialized care. Air ambulance or ambulance to convey an individual from one state to another will be covered, if such transport is, in the opinion of the Trustees, medically necessary to the treatment of a life-threatening disease or injury.

2. **Ambulatory surgery center** charges by in-network facilities only.

Out-of-network surgery centers are not covered.

3. **Anesthetics** and its administration by a physician or certified nurse anesthetist. General anesthesia for dental procedures and associated hospital or ambulatory facility charges (in-network only), if the patient is under 6 years of age; or has a medical condition that requires general anesthesia and admission to a hospital or outpatient surgery facility.

4. **Chemotherapy and radiation therapy**.

5. **Chiropractic treatment.** Benefits for office visits, spinal manipulations/adjustments and other therapy are limited to $1,000 per person per calendar year. Benefits for x-rays are not subject to the $1,000 maximum, and are limited to one set of x-rays per year. "Maintenance" visits for a non-active spinal condition are not covered. Acupuncture, massage therapy, dietary supplements and hair analysis are also excluded.

6. **Clinical trials.** The patient costs for a covered person enrolled in an approved clinical trial. An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition that is: (a) federally funded or approved; (b) conducted under an investigational new drug application reviewed by the Food and Drug Administration; or (c) a drug trial that is exempt from having such an investigational new drug application. A "life-threatening condition" is any disease from which the likelihood of death is probable unless the course of the disease is interrupted. "Routine patient costs" include all services and supplies that are typically covered by the Plan for persons not enrolled in clinical trials. Routine patient costs do NOT include: (a) the investigational item, device or service itself; (b) services that are provided solely to satisfy data collection and analysis needs, or (c) services that are clearly inconsistent with the widely accepted and established standards of care.

7. **Dental care and treatment**, but only for services provided by a doctor, dentist or oral surgeon for treatment of a fractured jaw and repair or replacement of natural teeth, provided that the services are provided within six months of the accidental injury. Covered medical expenses will also include charges, including medically necessary hospital charges, for the following types of oral surgery:

   a. The surgical excision of partially or completely unerupted impacted teeth.

   b. The excision of a tooth root without the extraction of the entire tooth, but not root canal therapy.

   c. Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth, such as alveolar abscesses, alveolectomies, apicoectomies (resection of root of tooth), cysts of the jaw, epulis (fibrous tumors of the gums), impacted teeth or periodontal treatment (disease of the gums).

8. **Diagnostic tests**, including x-rays, lab tests and complex imaging (MRIs, PET scans and CT scans), including the fees for interpretation by a pathologist or radiologist.

   Genetic tests are covered only if the result of the test will directly impact the clinical treatment of the covered person's existing medical condition. All other genetic testing, including prenatal screenings are excluded.

9. **Durable medical equipment.** Rental, up to the purchase price, of durable medical equipment such as wheelchairs, hospital beds and other therapeutic mechanical equipment necessary for treatment of the patient's medical condition, provided the equipment is prescribed by a doctor. The Plan will cover either rental or purchase based on the type of equipment and the patient's prognosis. A mobility scooter may be covered in lieu of, but not in addition to, a medically indicated motorized wheelchair.

   Replacement of covered medical equipment may be covered if the original item is no longer serviceable, but not more frequently than once in a period of 60 months.

10. **Home health care** after a hospital confinement as follows:

    a. The care must be for the same or related condition(s) for which the patient was confined in the hospital, and proper treatment of the patient's condition would otherwise require hospital confinement.

    b. The utilization review organization must certify the program of home health care as medically necessary.

    c. The care must be provided by or through an organization which meets the Plan's definition of a "home health agency" (see page 49).

    d. Covered medical expenses will include charges made for the following services and supplies provided to a covered person in his home by or through a home health agency:

       - Part-time or intermittent nursing care provided by an R.N. or L.P.N.
       - Part-time or intermittent home health aide services for patient care.
       - Physical therapy provided by a registered physical therapist.
       - Occupational therapy provided by a registered occupational therapist.
       - Medical supplies, other than drugs and biologicals, and the use of medical appliances.

11. **Hospice care.** Covered expenses include the following services and supplies provided by a hospice (as defined on page 49) or provided through arrangements made by a hospice for care of a terminally ill person:

- Nursing care by an R.N. or L.P.N. and services of home health aides (these services may be furnished on a 24-hour basis during a period of crisis or if the care is necessary to maintain the patient at home).
- Medical social services provided under a doctor's direction; counseling services and/or psychological therapy by a social worker or a psychologist; and chaplaincy.
- Physical and occupational therapy and speech language pathology.
- Non-prescription drugs used for palliative care, medical supplies, bandages and equipment, and drugs and biologicals used for pain and symptom control.
- Skilled nursing facility short-term inpatient care to provide respite care, palliative care, or care in periods of crisis.
- Charges incurred for treatment of a person's terminal condition other than those listed above will be considered for payment the same as charges made for treatment of any other condition.

12. **Hospital** services as follows:

    a. Room and board up to the hospital's semi-private rate unless the private room is deemed medically necessary or if only private rooms are available. The Plan also covers intensive care and coronary care units.

    b. Other medically necessary inpatient services and supplies furnished by a hospital.

    c. Services and supplies furnished in the outpatient department of a hospital.

    d. Emergency treatment provided in a hospital outpatient or emergency department.

    Out-of-network emergency room treatment will be paid at the in-network rate if the treatment is for an "emergency" (as defined on page 48).

13. **Medical supplies** as follows:

    a. *Casts,* splints, trusses, braces and crutches.

    b. *Oxygen* and its administration.

    c. *Whole blood* or blood plasma, including the cost of their administration.

    d. *Wigs* necessitated by hair loss caused by medical therapy. The Plan will cover one wig per lifetime up to a maximum allowable amount of $500.

    e. *Orthotics* that are custom-fitted for the patient and ordered by doctor, up to a maximum allowable amount of $300 per calendar year.

    f. *Orthopedic/diabetic shoes* prescribed by a doctor and custom-fitted for the patient.

14. **Mental/nervous disorders treatment -** Inpatient and outpatient services are covered on the same basis and subject to the same terms, provisions and limitations as medical-surgical treatment when provided by licensed hospitals, doctors, psychologists and clinical counselors (with Masters' degrees or better).

    Residential treatment facility confinements will be covered subject to the following if the facility must meet the Plan's definition of a covered residential treatment facility (on page 50) and the utilization review organization pre-certifies the confinement as medically necessary.

15. **Obesity (bariatric) surgery** for an employee, retiree or spouse if the utilization review organization predetermines the procedures to be medically necessary. Only one surgical procedure will be covered

during a person's lifetime. Lap band adjustments are not considered separate surgical procedures, and are covered when the original lap band placement is covered.

16. **Organ and tissue transplants**, for procedures approved by Medicare. The Plan will also cover the reasonable medically necessary hospital and physician charges of a living donor.

17. **Physicians' services.** Services of a legally qualified physician or surgeon, including the services of a physician for a second surgical opinion and the fees for assistant surgeons.

    Additional Covered Providers

    Although not included in the definition of a "physician," benefits are payable for services provided by the certain licensed providers if payments would have been made by this Plan to a physician for the same services. In addition to the types of providers specifically described in this "Covered Medical Expenses" section, the Plan will also cover the professional medical services rendered by the following providers when the services are within the Plan's normal covered expense provisions and are rendered within the scope of each such individual's license and specialty:

    - A licensed nurse practitioner (L.N.P.) or advanced practice nurse (A.P.N.)
    - A physician's assistant (P.A.)
    - A certified surgical assistant (C.S.A.)
    - A doctor of dentistry (D.D.S.)
    - A podiatrist (D.P.M.)
    - An optometrist (O.D.)

18. **Podiatry.** Medical and surgical treatment by a podiatrist (D.P.M.) for diseases and injuries of the foot.

19. **Pregnancy** and pregnancy-related expenses for a female employee, retiree or spouse, including newborn hospital charges for a covered dependent child while the mother is also confined.

    Note about length of maternity hospitalizations - A federal law requires that a covered person and her newborn infant be entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Cesarean section. Further, a Plan cannot require the provider (hospital or doctor) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. (The attending provider may however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) The Plan will provide benefits for the covered medical expenses incurred by a covered person during the prescribed time periods, subject to all applicable Plan benefit provisions, maximums and limitations.

20. **Prostheses** or appliances to replace physical organs or parts of organs, such as artificial eyes and artificial limbs. Covered expenses include:

    a. The initial contact lens or lens implants which is required in conjunction with the surgical removal of cataracts.

    b. Breast prostheses or reconstructive breast surgery following a mastectomy, including reconstructive surgery on the non-affected breast to achieve a symmetrical appearance.

    Maintenance or replacement of a prosthetic may be covered if the original device is no longer serviceable, but not more frequently than once in a period of 60 months.

21. **Rehabilitative therapy** as follows:

    a. *Physical and occupational therapy* rendered by a licensed physical therapist (P.T.) or licensed occupational therapist (O.T.). Coverage is also provided for therapy rendered by a physical therapist assistant (P.T.A.) or occupational therapist assistant (O.T.A.) if the therapy is rendered under the direct supervision of, and billed by, a P.T. or O.T. The treatment must be recommended by your doctor.

    b. *Speech therapy* (outpatient) rendered by a qualified licensed speech therapist for a person who had normal speech and lost it as a result of sickness or accidental injury.

    c. *Cardiovascular rehabilitation therapy* that is rendered through a supervised medical cardiac rehabilitation program prescribed by a physician within six months after an acute cardiovascular incident for a patient with modifiable coronary risk factors or poor exercise tolerance.

    d. *Vision therapy (orthoptics)* rendered to a child by an optometrist for treatment of amblyopia, strabismus, esotropia, exotropia or a convergence defect. The Plan will cover up to 25 visits per lifetime.

22. Voluntary **sterilization** procedures for employees, retirees and spouses.

23. **Substance abuse treatment -** Inpatient and outpatient services are covered on the same basis and subject to the same terms, provisions and limitations as medical-surgical treatment when provided by licensed hospitals, doctors, psychologists and clinical counselors (with Masters' degrees or better).

    Residential treatment facility confinements will be covered subject to the following if the facility must meet the Plan's definition of a covered residential treatment facility (on page 50) and the utilization review organization pre-certifies the confinement as medically necessary.

24. **Urgent or immediate care** treatment at an urgent care facility.

PRESCRIPTION DRUG PROGRAM

Your Prescription Drug Program is administered by EnvisionRxOptions. New participants are sent an information packet containing prescription drug cards. Your new member kit includes information on how to use Orchard Pharmaceutical Services, Envision's dedicated mail-order and specialty pharmacy. If you need more information or an additional card, contact Envision.

To Contact EnvisionRxOptions
Website: www.envisionrx.com Phone: 1-800-361-4542
Mail-order pharmacy (Orchard): www.orchardrx.com Phone: 1-877-437-9012

Most pharmacies and pharmacy chains are in the Envision network. ***No benefits are payable for prescription drugs purchased outside the pharmacy network***, including prescriptions filled at Veteran's Administration (V.A.) pharmacies.

Your Co-Pays

Your prescription drug co-pay amounts are as follows:

Generic	10%
Formulary (preferred) brands	20%
Non-formulary brands and specialty medications	30%
Out-of-pocket limit per person per calendar year	$350

Prescription Drug Out-of-Pocket Limits

A $350 out-of-pocket limit applies to your annual prescription drug co-pays. If your co-pays total that amount in a calendar year, you will not have to pay any additional co-pays for the covered drugs you purchase during the remainder of the year. Only co-pays for covered drugs apply to out-of-pocket limits—the cost of excluded drugs does not apply.

When There Is Other Coverage

Pharmacies are generally able to electronically process prescription drug purchases through both the patient's primary and secondary plans when the drugs are purchased. Persons with dual coverage should make sure the pharmacy has all the information it needs to coordinate coverage between the two benefit plans.

Drugs Covered Under the Prescription Drug Program

This program covers drugs and medicines that require a physician's written prescription in order to be dispensed by a licensed pharmacist.

The Plan also covers certain prescription and over-the-counter-products for active participants and their dependents under the Preventive Benefit. See the list that starts on page 24.

Envision has clinical management programs in place to ensure that patients receive safe, clinically proven and cost-effective medications for their conditions. Because of this, you and/or the prescribing doctor may be required to submit proof of medical necessity for certain drugs or dosages, and in certain cases, alternative medications may be recommended.

You cannot use the Plan's Prescription Drug Program for cosmetic drugs, erectile dysfunction drugs like Viagra, abortifacients or drugs for non-covered products or conditions. See "Exclusions and Limitations" starting on page 41 for more information.

In addition, dispensing limits may apply to certain medications based on the manufacturer's recommended dosage and duration of therapy, common usage, FDA and state recommendations and/or clinical studies.

HRA ACCOUNTS

Healthcare Reimbursement Accounts (HRAs) are individual flexible spending accounts funded by employer contributions. The amount in your HRA account can be used for certain healthcare expenses not payable by the regular healthcare plan. HRA accounts will also be used for self-payments to keep employees from losing eligibility under the Plan.

Amounts contributed to and withdrawn from your HRA account are not considered taxable income to you, allowing you to pay for qualifying healthcare expenses with untaxed income. (Tax laws and regulations change from time to time, so you should contact your tax advisor concerning the taxation of HRA reimbursements.)

Your HRA is a **reimbursement** account. This means you must pay the expense, or make the self-payment, before you can be **reimbursed** from your HRA.

How Medical Reimbursement Accounts Are Funded

For every hour you work in covered employment, your contributing employer will make a contribution to the HRA account established in your name. The hourly contribution amount is determined during the collective bargaining process, and may change from time to time.

You will only have an HRA account if your employer makes HRA contributions to the Fund. Not all employers are currently participating. For example employers with non-construction agreements do not make HRA contributions.

You Must Maintain Qualifying Coverage

Federal regulations require HRA accounts to be integrated with other healthcare coverage that meets all the requirements of the Affordable Care Act (ACA). This means that you cannot use your HRA account unless you are eligible under this Plan or another ACA-compliant plan. Federal law controls this issue, and it is subject to change.

Federal regulations require that you be eligible for this Plan or another qualifying health plan in order to access your HRA funds.

Your eligibility to use your HRA account will terminate when your eligibility under this Plan terminates *unless* you can provide proof that you are covered under another ACA-compliant healthcare plan. For example, if you retire and want to enroll in your spouse's healthcare plan, you should contact the Fund Office as soon as possible to find out how you may prove that your spouse's plan is ACA-compliant.

It is YOUR RESPONSIBILITY to contact the Fund Office when your eligibility terminates to see how and if you can continue using your HRA.

Other Rules and Features

1. There is no limit to the amount that can accumulate in your account. Amounts in your HRA will carry over from year to year in accordance with the provisions of this section.

2. No administrative fees will be charged for using your HRA.

3. No interest will be credited to HRA accounts. (Any interest earned by the Fund will be used to offset the cost of administering the program.)

4. You cannot make self-payments into your account. And, if you make self-payments to maintain your eligibility, no amount of that self-payment will be credited to your HRA.

5. The contributions made on your behalf into your HRA will be reflected on your quarterly statement.

6. You may submit a request for reimbursement at any time, but the minimum amount request should be $100. You can request reimbursement for multiple reimbursable expenses whose total is $100 or more. If you accumulate less than $100 in reimbursable expenses in a year, you may request reimbursement at the end of the year. You will be reimbursed for any covered reimbursable expense, subject to your account balance

7. The contributions made on your behalf into your HRA account will be reflected on your quarterly statement. HRA claims must be submitted within twelve (12) months from the date the claim was incurred.

Covered HRA Expenses

The expenses for which you can be reimbursed are based on Internal Revenue Service rules and may change from time to time. Currently, the expenses for which you can request reimbursement are as follows, but only if the expense is considered a deductible healthcare expense by the IRS, and only if the person incurring the expense (you or your dependent) is eligible under the regular healthcare plan when the expense is incurred.

- Acupuncture.
- Chiropractic treatment.
- Deductibles, coinsurance and co-payments from the regular healthcare plan.
- Dental care.
- Fertility enhancement procedures and medications.
- Guide dogs and service animals, and special telephone and television equipment for hearing impaired persons.
- Hearing aids.
- Lasik surgery.
- Medical and prescription drug expenses that are not covered under the regular healthcare plan, but that are considered deductible medical expenses by the IRS.
- Medically supervised weight loss programs (but not food/supplements).
- Short-hours self-payments for regular healthcare plan coverage.
- Retiree self-payments for retiree coverage under this Plan.
- Certain costs of modifying the home or car of a disabled person
- Certain lodging expenses while accompanying a patient
- Certain transportation expenses for medical treatment
- Qualified special schooling expenses for mentally impaired or physically disabled.
- Vision care.

Non-Covered Expenses

- Burial expenses.
- Charges incurred by a person not covered by the Plan.
- Child and dependent/elder care expenses.
- College tuition/books.
- Cosmetic surgery and treatments.
- Expenses reimbursed by some other source.
- Health club memberships/expenses.
- Household help.
- Long-term care insurance premiums.
- Over-the-counter (OTC) drugs and products, except as required by the Affordable Care Act.

See the most recent issue of IRS Publication 502 for the complete list of IRS-approved HRA covered expenses covered.

- Environmental devices such as, air conditioners, air purifiers, or humidifiers.
- Sales tax, shipping and/or handling fees.

How to File HRA Claims

1. HRA claim forms, called Healthcare Reimbursement Account Payment Request Forms, are available from the Fund Office, Local 965's office or the BMGI website. (You must have set up a log-in for the BMGI site in order to obtain this form.)

2. To file an HRA claim, fill out the claim form and include the following supporting documentation:

   - If the expense was first submitted to the regular healthcare plan, the Explanation of Benefits (EOB) received from the claims office that indicates the amount of your responsibility.
   - For prescription drug co-pays, the bill (statement) from your pharmacist showing your co-pay responsibility.
   - If the patient is covered under another plan, the Explanation of Benefits from that plan.
   - For dental, vision or hearing claims, the itemized bill from the provider.

   Acceptable supporting documentation does NOT include:

   - Cash register receipts
   - Balance-due statements
   - Cancelled checks

3. Submit the claim to the Fund Office at:

   Operating Engineers Local No. 965 Health Benefit Plan
   1520 Kensington Road, Suite 200
   Oak Brook, IL 60523

IRS rules do not allow self-payments to be made by direct withdrawal from an HRA. You must make self-payments by check or money order, and then file a claim to be reimbursed from your HRA.

In the Event of Your Death

If you die, your surviving dependents can use your HRA account for covered HRA expenses as long as they remain covered under this Plan. In addition, if you incurred covered expenses before your death, reimbursement for those expenses may be made to your representative.

HRA accounts are NOT death benefits. The balance will NOT be paid out as a cash benefit or pension in the event of your death.

Forfeiture Rule

If no contributions or withdrawals are made to an HRA during a period of 60 months, that account will be forfeited, and the balance will be used to help defray the cost of administering this program, or, at the Trustees' discretion, transferred to pay claims under the Health Benefit Fund.

Important! This Is Not a Savings Account or a Vested Benefit

Your Healthcare Reimbursement Account is not a savings account from which you can withdraw at will, and no interest will accumulate. In addition, you are not vested in the balance. This means that you do not have a legal right to your HRA balance. The Trustees control all monies in these accounts and have the right to reallocate such money at any time. The Trustees have the right to terminate the HRA program at any time.

CLASS C (MEDICARE SUPPLEMENT)

Class C benefits for retirees and their dependents with primary coverage through Medicare.

Medical Benefits to Supplement Medicare Parts A and B

Class C medical benefits are meant to supplement Medicare Parts A and B. The medical expenses covered by Class C are those that are also covered by Medicare, but for which Medicare makes no payment. For example, this Plan covers the amounts of the Medicare deductibles and the patient's 20% percentage share of the charges for which Medicare pays the remaining 80%. Charges for such services and supplies are covered up to the amounts considered by Medicare to be "allowable expenses."

If you are covered under Class C and use a physician who has opted out of Medicare, this Plan will not the cover charges by that physician. The same applies if you use a provider that is not permitted to participate in Medicare or receive Medicare reimbursements. For example, Medicare does not cover the services of Certified Surgical Assistants (C.S.A.'s); it only covers surgical assistance by M.D.'s and D.O.'s. So if a C.S.A. bills for assisting at your surgery, neither Medicare nor this Fund will cover those expenses. (Your Medicare EOB may say that the C.S.A.'s services should be paid by your secondary plan, but that is not accurate when the secondary plan—like this Plan—is a supplement to Medicare.)

Class C participants must be enrolled in Medicare Part A and Part B.
This Plan's benefits for an eligible person will be determined
as though the person is enrolled in both Part A and Part B,
whether or not the person is actually enrolled in both Parts.

Additional Class C Benefits

Class C provides the following additional benefits:

- Prescription drug benefits; and
- Preventive care, as described in the "Preventive Benefit" section starting on page 24. If the service is also covered by Medicare, the Plan's benefit will be adjusted (reduced) accordingly.

Medicare Prescription Drug Plans

Class C participants have the option of dropping this Plan's prescription drug coverage and enrolling in a Medicare prescription drug (Part D) plan. This Plan will continue to provide the same hospital and physician benefits as before, but will no longer provide you with prescription drug benefits. In addition:

- Your self-payment amount for this Plan's retiree coverage will NOT change if you drop your drug coverage.
- You cannot choose dual coverage.
- If you DO decide to enroll in a Medicare Part D plan, you CANNOT get this Plan's coverage back.
- You and your spouse can be covered under different drug plans.
- You must inform the Fund Office if you or your spouse chooses Part D coverage. If you do not provide timely notification, and if this Plan continues to pay your drug expenses, you will have to repay this Plan for the amount it paid. Your double coverage could also cause problems and overpayment situations with your Part D plan.

EXCLUSIONS AND LIMITATIONS

These exclusions and limitations apply to all of the benefits provided under this Plan. No Plan benefits of any kind are payable for charges incurred for, or loss sustained as a result of, any of the following unless an exception is stated.

1. Voluntary **abortions**, including surgical abortions and chemically induced abortions (including the use of RU-486).

2. **Acupuncture**.

3. **Advanced behavior analysis (ABA)** or similar behavioral modification programs.

4. Any amounts in excess of the **allowable charge** (as defined on page 46).

5. **Alternative, complementary or other non-standard treatments, therapies or services**. For example, the Plan does not cover acupressure, aversion therapy, hair analysis, herbal treatments, holistic treatment, homeopathy, hypnosis, meditation, mind-body stress management, naprapathy, naturopathy, nutritional counseling (unless an exception is specifically stated), relaxation therapy, soft-tissue manipulative therapy, or yoga.

6. **Ambulatory or free-standing surgery centers that are not in the Plan's PPO network**.

7. Services or supplies which are furnished, paid for or otherwise provided for due to past or present service of any person in the **armed forces** of a government.

8. For a **child:**

   a. Services related to pregnancy or a pregnancy-related condition, except as covered under the Preventive Benefit;

   b. Sterilization procedures, except as covered under the Preventive Benefit; or

   c. Obesity surgery.

9. Completing of **claim forms** (or forms required by the Plan for the processing of claims) by a doctor or other provider of medical services or supplies.

10. Education, training, **classes, sessions, or materials** such as booklets or tapes. This exclusion applies to, but is not limited to, classes to learn sign language or Braille or other accommodative skills.

11. **Consultations or sessions with other family members** even if the consultations and sessions are required as part of the psychological or psychiatric treatment of another family member.

12. Any treatment or surgical procedure or service that is of an elective nature, or for any non-emergency plastic or **cosmetic** surgery on the body, including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue.

    Exception: This exclusion does not apply to:

    a. Reconstructive breast surgery following a mastectomy, including reconstructive surgery on the non-affected breast to achieve a symmetrical appearance.

b. Reduction mammoplasty (breast reduction) when pre-certified by the utilization review organization to be medically necessary, and generally requiring that no less than 550 grams of tissue be removed from each breast due to such conditions as severe skin disorder such as rash or ulceration under the breast; or severe musculoskeletal symptoms such as back pain or shoulder disfiguration.

c. Cosmetic surgery which is for the correction of defects incurred as a result of injuries sustained by a person as a result of an accident.

d. The correction of congenital defects.

e. Corrective surgical procedures on organs of the body which perform or function improperly.

f. Voluntary vasectomies and other sterilization procedures performed on you and your spouse.

13. **Court-ordered services**, or those required as a condition of parole or probation.

14. **Custodial care** regardless of what the care is called. This exclusion also applies to care or treatment of a person as an inpatient in an institution which is primarily a place of rest, a place for the aged or a nursing home.

15. **Dental services** and supplies rendered for treatment of the teeth, the gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, including dental prosthetic appliances or any charges made for the fitting of any of these appliances, unless the service or supply was rendered as a result of a non-occupational accidental injury, or as specified as covered in "Covered Medical Expenses."

16. Services related **developmental or educational delays**, learning disabilities, or conduct and antisocial behavior disorders, including but not limited to developmental speech or language delays.

17. Transplant **donor searches or testing** to determine the compatibility of a potential or actual donor.

18. Services, treatments or supplies that are **experimental or investigative** in nature.

19. **Eye refractions, eyeglasses, contact lenses** (except the first pair of contact lenses required following cataract surgery).

20. Services rendered while the person is confined in a hospital or **facility operated by the United States governmen**t or an agency of the United States Government, provided however, that if such charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law such charges shall be considered covered medical expenses to the extent that they would have been considered covered medical expenses had the V.A. not been involved.

21. Bodily injury or sickness sustained as a result of the commission of, or attempt to commit, a **felony** or sustained as the result of the individual's engagement in an illegal occupation.

22. **Fitness expenses**, including, but not limited to, health club memberships, workout or exercise equipment, personal fitness trainers, and spas or saunas, even if recommended by a doctor.

23. **Habilitative** therapy, services or supplies.

24. **Hearing aids**, hearing exams and hearing aid fitting.

25. Charges that would not have been made **if this Plan did not exist**, or any medical care or service which a person would not be legally required to pay or for which no charge is made.

26. **Infertility** treatments, including but not limited to hormone therapy, artificial insemination, embryo transfer or any other direct attempt to induce or facilitate fertility or conception.

27. **Maintenance** or preventive care of a person's well-controlled medical condition.

28. **Marriage or family counseling**.

29. **Massage therapy**, regardless of the type of provider providing or billing for the therapy.

30. Charges incurred by a person during any stated time period for a particular type of care or treatment or for a particular type of condition once the person has already received Plan benefits totaling any specified **maximum benefit** for that type of care.

31. **Medical equipment** or supplies as follows:

    a. Items that primarily serve as a comfort or convenience function for the patient or the patient's caretaker (such as a wheelchair ramp, start lift or a vehicle lift device).

    b. Household items to accommodate a person's disability or create a safe and/or comfortable surrounding. This exclusion applies to, but is not limited to:

    - air conditioners
    - air purifiers
    - blankets
    - dehumidifiers
    - grab bars
    - heating units
    - humidifiers
    - mattresses or mattress covers
    - pillows
    - pools or whirlpools
    - raised toilet seats
    - special bathing systems
    - thermometers
    - water purifiers

    c. Deluxe items or features, upgrades, customizations or add-ons, even if prescribed by a doctor. Only standard equipment, prosthetics and appliances are covered. The participant will be responsible for the cost difference between a standard item and the deluxe, upgraded, enhanced or customized model.

    d. Backup or duplicative items, or items specifically designed for outdoor use, sports or travel.

32. Care or treatment of **mental or nervous disorders** except as specified as covered in "Covered Medical Expenses."

33. Services or supplies received from a **non-covered provider**, including a doctor or hospital which does not meet this Plan's definition of "physician" (page 49) or "hospital" (page 49).

34. Any services, treatment or supplies rendered or furnished while the individual is **not eligible for Plan benefits**, including charges incurred before the date the individual became covered under this Plan or after the individual's coverage has terminated.

35. Services, treatment or supplies that are **not medically necessary** (as defined on page 49).

36. Any condition for which the individual is **not under the regular care of a doctor**, or services or supplies which are not recommended or approved by a legally qualified doctor.

37. **Nutritional counseling**, evaluation or therapy except as specifically covered under the Preventive Benefit.

38. **Nutritional supplements**, food products and formulas, vitamins, minerals, and formulas, except as specifically covered under the Preventive Benefit.

39. **Obesity or overweight** services or treatments except as specifically stated under "Covered Medical Expenses" or the Preventive Benefit. This exclusion applies to exercise programs, special diet or diet supplements, amphetamines or any other form of diet medicating, whether or not recommended or supervised by a doctor.

40. **Over-the-counter** or patent medicines that can be obtained without a doctor's prescription, except as covered under the Preventive Benefit.

41. **Prosthetic or medical equipment replacement,** repair or maintenance more frequently than once in a period of 60 months.

42. Care or treatment of a person if the individual providing the care or treatment is a **relative** in any way to the person receiving the care or ordinarily lives in such person's home.

43. **Reversal** or attempted reversal of a previous elective sterilization.

44. Services, treatments or supplies provided in connection with a **self-inflicted injury** such as attempted suicide (whether sane or insane), unless the injuries resulted from a medical condition (including both physical and mental health conditions).

45. **Sex (gender) transformations or reassignments** whether medical or surgical, regardless of the person's diagnosis, or any complications resulting from such treatments or procedures.

46. Any operation, counseling, physical therapy, supplies or prostheses, including penile prostheses, or treatment provided in connection with **of sexual dysfunction** or inadequacies, including any complications arising from such conditions.

47. **Shoes or shoe inserts** for treatment of the feet, unless prescribed by a doctor and custom-fitted for the patient.

48. **Special education** rendered to any person, regardless of the type of education, the purpose of the education, the recommendation of the attending doctor or the qualifications of the individual rendering the special education.

49. Services, supplies, treatments or procedures which are not rendered for the treatment or correction of, or in connection with, a **specific non-occupational accidental bodily injury or sickness** unless specifically identified as being covered under the Plan.

50. Care or treatment of **substance abuse** except as specified as covered in "Covered Medical Expenses.

51. **Surrogacy or surrogate fees**, including but not limited to medical or other expenses for: (a) a surrogate who carries and delivers a child on behalf of a person covered under this Plan; or (b) a female who is covered under this Plan and who carries and delivers a child that is not her child or that of her husband. Any child born of a person who is covered under this Plan but acting as a surrogate for someone else will not be a covered dependent of the surrogate mother or her spouse.

52. **Taxes, shipping** or handling fees.

53. **Telemedicine** charges.

54. Services, treatment or supplies which are payable or furnished by a **third party**, including services provided through a mutual benefit association, or covered under any policy of insurance or other medical benefit plan or service plan for which the Trustees, directly or indirectly, have paid for all or a portion of the cost.

55. **Transportation,** except for medically necessary emergency transport by professional ambulance. This exclusion applies to medivan transport or any other non-emergency transportation by private or commercial vehicle, even when the patient is disabled and/or the purpose is to receive medical treatment.

56. **Travel**, whether or not recommended by a doctor except as stated in "Covered Medical Expenses."

57. Charges incurred for **vision-correction procedures,** including Lasik and any other procedures performed for the purpose of correcting nearsightedness, farsightedness or astigmatism.

58. Bodily injury or sickness caused by **war or any act of war**, whether war is declared or undeclared; any act of international armed conflict; any conflict involving the armed forces of any international body; insurrection; or riot.

59. **Wigs**, toupees, hairpieces or hair growth products, except as specified in "Covered Medicare Expenses" for a wig after medical therapy.

60. Accidental injury, sickness or disease sustained while the person was performing any act of employment or doing anything pertaining to any occupation or employment for wages or profit or for which benefits are or may be payable in whole or in part under any **workers' compensation** law, employer's liability law, occupational diseases law or similar law. If an individual's claim under worker's compensation law, employer's liability law, occupational diseases law or similar law is denied, the illness or injury will not be considered work related and payment will be made according to the provisions of the Plan.

The preceding list is not an all-inclusive listing of the Plan's limitations and excluded procedures, services or supplies. It is only representative of the types of charges for which benefits are limited or not payable and of the types of situations in which charges are incurred for which benefits are limited or not payable. Basically, benefits are only payable under this Plan for direct treatment of non-occupational accidental injuries and sicknesses.

DEFINITIONS

Allowable Charge

The maximum covered charge for a service rendered or supply furnished by a health care provider that will be considered for payment.

- For *in-network* providers, the allowable charge is the contracted fee.
- For *out-of-network* providers, the allowable charge is the same as the contracted in-network rate.
- If this Plan is *secondary to Medicare*, the allowable charge means only that amount which is an allowable charge under Medicare's benefit rules.

Chiropractic Care

Office visits, x-rays, spinal adjustments and manipulations, diathermy, and other therapeutic physical therapy services that are rendered or prescribed by a chiropractor. Services provided by a medical doctor, osteopath or physical therapists are also considered by the Plan to be "chiropractic care" if the service provided is of the type customarily rendered by a chiropractor.

Covered Expense

The allowable charge incurred by a covered person for a treatment, service or supply that is eligible to be considered for payment under the Plan, subject to all applicable payment provisions of the Plan.

Covered Person

An eligible employee or eligible retiree, and any person in his family or household who meets the Plan's definition of a dependent.

Covered Under the Plan

An individual is eligible to receive benefits under this Plan.

Custodial Care

Care that is designed primarily to assist an individual in meeting the activities of daily living, regardless of what the care is called, including any care intended primarily to help a disabled person meet basic personal needs when there is no plan of active medical treatment to reduce the disability or the plan of active medical treatment cannot reasonably be expected to reduce the disability. "Custodial care" includes any services that can be safely and adequately provided by persons who do not have the technical skills of a health care provider.

Dependent

A "dependent" is any of the following:

1. Your legal spouse;
2. Your child (see "Definition of Child" below) under age 26. (Coverage will continue until the end of the calendar month in which the child's 26th birthday occurs.)

3. Your unmarried child older than age 26 who is totally and permanently disabled due to a disability that began prior to age 26. For purposes of this paragraph, "permanently disabled" means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of twelve (12) months or more. You must furnish proof of the child's incapacity within 31 days after the date coverage for the child would otherwise terminate due to his reaching the limiting age. You will also be required to furnish proof of the child's continued disability from time to time, but not more often than once in a twelve-month period. Coverage will terminate if the Plan determines, based upon medical evidence, that the child is no longer disabled or if the child does not undergo an examination or furnish proof required by the Plan.

Definition of "Child"

For the purposes of this definition, a "child" is any of the following:

1. Your natural child or any child legally adopted by you or placed in your home for the purpose of adoption.

2. Any stepchild of yours (meaning any child of your spouse who was born to your spouse or who was legally adopted by your spouse).

3. Any child of yours who is recognized by the Trustees as an alternate recipient under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order or administrative order relating to child support that provides for a child's coverage under the Plan. If you would like a copy of the Plan's QMCSO procedures, without charge, please call or write the Fund Office.

The Trustees reserve the right to determine whether a child is dependent or not and may require proof of dependency as a condition of allowing or continuing coverage. In the case of divorce, adoption or placement for adoption, the Trustees may require a copy of any court decree or other documentation to determine dependent status.

A "child" under this Plan does NOT include a child born to or fathered by a child of yours, nor will the Plan cover a child delivered by a female other than your legal spouse, unless there is a valid QMCSO stating that you have financial responsible for such child.

Durable Medical Equipment

"Medical equipment" means equipment that meets all of the following requirements: (1) it is primarily and customarily used to serve a medical purpose; (2) it can withstand repeated use; (3) it is generally not useful to a person in the absence of illness or injury; (4) it makes a meaningful contribution to the treatment of the patient's illness or injury or to the improved functioning of a malformed or damaged body part; and (5) it is appropriate for use in the home.

Eligible Employee

An individual who meets the definition of an employee and who has met the eligibility requirements for being eligible to receive the applicable Plan benefits provided for eligible employees.

Eligible Dependent

An individual who meets the definition of a dependent and who is a dependent of a person who has met the requirements for being eligible to receive Plan benefits.

Eligible Retiree

A retired employee who has met the Plan's eligibility requirements for being eligible to receive the Retiree Benefits provided under the Plan.

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 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; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

Employee

Any person employed by an employer, on whose behalf employer contributions are required to be made.

Employer; Contributing Employer

1. Any association or individual employer who has duly executed a collective bargaining agreement with the Union and is thereby required to make contributions to this Fund on behalf of its employees; or

2. Any employer not presently a party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement by executing a participation agreement.

Experimental or Investigational

The use of any of the following is considered to be experimental or investigative:

1. Any treatment, procedure, facility, equipment, drug, device or supply not yet generally accepted among experts as accepted medical practice; or

2. Any treatment, procedure, facility, equipment, drug, device or supply which cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other Federal agency, for which such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized; or

3. Any treatment, procedure, facility, equipment, drug, device or supply which is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses; or if the prevailing opinion among experts regarding the treatment, procedure, facility, equipment, drug, device or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is experimental or investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with medical consultants of their choosing.

Fund

The trust fund formulated and created under the Agreement and Declaration of Trust and any amendments thereto.

Home Health Agency

A licensed public agency or private organization which meets all of the following requirements: (1) it is eligible to participate in Medicare; (2) it is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients; and (3) its services are supervised by a physician or an R.N.

Hospice

A licensed agency, organization or facility primarily engaged in providing a coordinated set of services at home or in outpatient or institutional settings to persons suffering from a terminal medical condition. The agency or organization: (1) must be eligible to participate in Medicare; (2) must have an interdisciplinary group of personnel that includes the services of at least one physician and one R.N.; (3) must maintain clerical records on all patients; and (4) must meet the standards of the National Hospice Organization.

Hospital

An institution which meets all of the following requirements: (1) it maintains permanent and full-time facilities for bed care of five or more resident patients; (2) it has a physician in regular attendance; (3) it continually provides a 24-hour-a-day nursing service by registered nurses; it is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics; and (4) it is operating lawfully in the jurisdiction where it is located.

Medically Necessary; Medical Necessity

A service or supply which, in terms of generally accepted medical standards meets all the following requirements: (1) it is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (2) it could not have been omitted without adversely affecting the patient's condition or the quality of medical care; (3) it is not primarily for the convenience of the patient, the patient's caretaker, or a medical provider; (4) if more than one alternative is available, it is the most cost-effective alternative that can meet the patient's essential health needs; and (5) it could not be omitted without adversely affecting the patient's condition or the quality of medical care.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the expense a covered charge.

Mental/Nervous Disorder

An emotional sickness, including a neurosis, psychoneurosis, psychopathy or psychosis.

Physician; Doctor

An individual who is a legally qualified doctor or surgeon, provided he is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is licensed to practice medicine in all its branches. Such individual must be working within the scope of his/her license.

Plan

The plan of health care benefits provided the Operating Engineers Local No. 965 Health Benefit Plan.

Residential Treatment Facility

A licensed institution that meets all of the following criteria: (1) it is primarily engaged in providing skilled inpatient services for the sub-acute treatment of behavioral and mental health disorders; (2) it provides 24-hour-a-day supervision by one or more physicians; (3) it provides 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N., and it has an R.N. on duty at least eight hours a day; (4) it is accredited by The Joint Commission or it is in the Plan's preferred provider network.

Skilled Nursing Facility

An institution, or a distinct part of an institution, which complies with all licensing and other legal requirements and which meets all of the following criteria: (1) it is recognized as a covered provider by Medicare; (2) it is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services; (3) it provides 24-hour-a-day supervision by one or more physicians; and (4) it provides 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N. who is on duty at least eight (8) hours a day.

Substance Abuse

The abuse of, addiction to, or dependency on the use of drugs, narcotics, alcohol or any other chemical (except nicotine).

Totally Disabled; Total Disability

A medical disability resulting solely from a sickness or accidental injury that prevents an employee from engaging in any occupation or employment for compensation or profit; or prevents a dependent from engaging in substantially all the normal activities of a person of like age and sex in good health.

Trust Agreement or Trust

The Agreement and Declaration of Trust of the Operating Engineers Local No. 965 Health Benefit Plan as amended from time to time.

Trustees

The Board of Trustees or the Trustees designated in the Trust Agreement, as determined by the context, together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

Union

Operating Engineers Local 965 or any local union of operating engineers that has executed a collective bargaining agreement with an employer which requires participation in, and contributions to, the Fund.

Urgent Care Facility

A licensed free-standing facility, by whatever name called (including an "immediate care center"), that is engaged primarily in providing minor emergency and episodic medical care to its patients. A doctor, an R.N. and a licensed x-ray technician must be in attendance at all times that the center is open. The facilities must include x-ray and laboratory equipment and a basic life support system.

OTHER BENEFIT LIMITATIONS

Subrogation and Reimbursement (Third Party Liability)

Subrogation gives the Plan the right to recover all of the benefits, including Weekly Loss of Time Benefits, that it has paid to you or your dependent, or to those who provided your medical treatment, from another payment source or from you if you have received the payment directly. The Plan has the right to recover those payments, whether or not you have been fully paid for your treatment or other expenses from the same Injury.

For instance, if you are in an automobile accident, you may receive payment for your medical treatment from an automobile insurance company or from the person who was at fault for the accident. If the Plan paid for your expenses that the automobile insurance company is responsible for, the Plan has the right to recover those expenses, including Weekly Loss of Time Benefits, from the automobile insurance company or from you if they were paid to you.

The following definitions apply to the terms used in this section:

- **Another Person** or **Entity** means any individual, corporation, municipality, other governmental entity, partnership, association, trust, or any other organization no matter how the person or entity has been identified.
- **Another Source** means someone other than you or the Plan and includes:
  - ~ An insurance company that must pay the claims that result from the acts of Another Person, such as accident coverage, no fault coverage, uninsured or underinsured motorist coverage, personal injury protection, homeowners insurance, or school or athletic insurance;
  - ~ An employee health insurance plan or arrangement;
  - ~ A medical and/or hospital plan; or
  - ~ Another Person or any other entity (such as a company, organization, or corporation) that is responsible for the acts of the person that caused the expenses, such as a homeowner or other property owner.
- **Another Source** does not include another employer group health plan that covers you, for example, through your spouse's employer, if that coverage is subject to the Plan's Coordination of Benefits provisions.
- **Compensable Injury** means any Injury for which you may recover payment from Another Source.
- **Compensated Injury** means any Injury for which your expenses have already been paid by Another Source before this Plan pays benefits toward the same claim.
- **Injury** means either an illness or an injury if caused by the actions of Another Person or Entity. It also includes conditions that you may develop over time, such as from continued exposure to a harmful agent or a prolonged misdiagnosis of your condition.
- **Recovery** means any payment from Another Source due to an Injury. It includes *any* judgment, award, or settlement, whether or not the judgment, award, or settlement specifically includes or excludes medical expenses or payments for disability. This definition applies no matter what the Recovery is called. For example, "loss," "punitive damages," "pain and suffering," "medical expenses," "attorney's fees," "costs," etc. will all be defined as recoveries.

- **Subrogation** means that the Plan has the right to take your place to ensure that any person or entity responsible for your Injury pays for the expenses of your Injury or reimburses the Plan for the amount it has paid on your behalf for that Injury.

Agreement to Reimburse Plan for Other Payments

Whenever you have an Injury expense that may be paid for by Another Person or Entity, you must complete a Reimbursement Agreement to receive benefits from the Plan. Signing the Agreement is not a guarantee of payments by the Plan. If your dependent is a minor or is legally incompetent, you and the person who is legally authorized to act on his or her behalf must complete the Agreement. You must also comply with the following terms:

- You must agree to repay the Plan any benefits the Plan has paid because of your Injury. This provision applies even if the Recovery does not fully pay you for your Injury expenses. The Plan does not recognize the "make whole" doctrine.
- You will only be required to repay the amount of the benefits the Plan paid on the claim, or the amount you have recovered, whichever is less, without regard to attorneys' fees and expenses you paid to obtain the Recovery. The Plan does not recognize the "common-fund" doctrine.
- The Reimbursement Agreement gives the Plan an equitable lien – or claim – on the money you recover from Another Source, both to the full extent of the Plan's Subrogation rights and to the full extent of its right to repayment under the Agreement. The lien is valid whether or not the Agreement or the Plan's Subrogation rights are enforceable.
- You must protect the Plan's right to reimbursement for benefits paid and do everything necessary for the Plan's Recovery of benefits it paid. You must assist and cooperate with Plan representatives and sign all required documents to recover benefits paid by the Plan.
- If you receive a judgment or settlement, you must repay the Plan the lesser of the full amount of benefits paid by the Plan, or the amount of the Recovery. This provision applies, whether or not the source of the Recovery was legally responsible for paying those expenses. If you do not repay the Plan, the Plan may reduce future benefits for your claims until the Plan has recovered the benefits it paid. The Plan's right to reduce future benefits is in addition to any other legal rights the Plan may pursue to recover benefits. If you obtain a Recovery from Another Person or Entity or Another Source, you must hold the Recovery or an amount equal to the total claims and benefits paid by the plan in trust pending reimbursement to the Plan and/or pending resolution of the Plan's lien. Further, it will be considered and deemed to be held in trust for such purpose.
- You, your dependent or your dependent's representative must:
  - ~ Not assign to any other person or entity your right to recover benefits from Another Source;
  - ~ Obtain the Plan's consent before releasing Another Person from liability for any Injury; and
  - ~ Not interfere with the Plan's claim and lien.
- If you attempt to assign your right to Recovery of benefits, the Plan may pursue legal action against you and the person or entity to which you assigned your rights, to cancel your assignment and recover the benefits paid by the Plan.
- The Plan is subrogated to your right to recover from Another Source.
- The Plan will not be responsible for legal fees and expenses you pay to obtain a Recovery from Another Source, unless the Plan has previously agreed to that in writing.

The Plan may require your attorneys to sign an agreement that they will honor and enforce the terms of the Reimbursement Agreement before they disburse any money received as a Recovery from a Compensable Injury.

Plan's Subrogation Right

Your agreement to repay in the Reimbursement Agreement and the Plan's Subrogation rights are separate and distinct rights and obligations. If either the Agreement or the Plan's Subrogation right fails or is considered invalid in some way, it will not affect the validity of the other.

- The provisions in the previous section, Agreement to Reimburse Plan for Other Payments also apply to the Plan's Subrogation right. If you fail or refuse to sign a Reimbursement Agreement, it does not affect the Plan's Subrogation rights or the Plan's right to claim a lien against and collect benefits from any source of possible Recovery.
- The Plan has the right to intervene and participate in any legal action you bring against Another Source.
- If you fail or refuse to take legal action against Another Source within a reasonable time, the Plan may do so in your name to recover amounts due under the Subrogation provision. If the Plan takes legal action, the Plan has the right to deduct its expenses, costs, and attorney's fees out of any Recovery or settlement. However, the Plan is not required, by this provision, to pursue your claim against Another Person.
- If you recover benefits from Another Source and do not repay the Plan, the Plan may sue you to recover the amount paid. The Plan may also reduce any of your future benefits until the Plan is fully repaid, regardless of whether or not the future claim is related to the Compensated Injury.
- If the Trustees determine that Recovery from Another Source is not possible, the Plan will waive its Subrogation right and will pay its normal benefits for your claim.
- The Trustees, or their authorized representative, have the sole discretion to interpret the Plan's Subrogation provisions and to settle any of the Plan's Subrogation claims and liens.
- The Trustees have the sole discretion to make a determination regarding questions as to whether any benefit payment is related to a Compensable Injury. You must sign any and all necessary documents, releases, and waivers that relate to their determination, upon request.

Compensated Injuries

If Another Source has already paid your expenses toward treatment of your Injury:

- The Plan will not begin paying benefits until the total expenses for your Compensable Injury exceed the total amount you have recovered from the other source.
- Any and all monetary Recovery you receive will first be applied to benefits payable under this Plan.
- The Plan's Subrogation rights are enforceable, regardless of:
  - ~ Who begins the legal action against the person or entity that is responsible for the Injury;
  - ~ Who pays the amount of the Recovery;
  - ~ Whether the Recovery is in the form of a judgment, settlement, or otherwise; or
  - ~ Whether you receive the Recovery as an employee, Dependent, legally competent or incompetent person, or a representative of any such person.
- Nothing in this section will interfere with or limit the Fund's Subrogation right for medical expenses that were incurred and paid before you recovered the expenses from your Injury.

Right of Recovery/Reimbursement of Overpayment and Offset of Future Benefits

Whenever payments have been made by the Trustees with respect to charges in a total amount at any time in excess of the maximum amount of payment required under the provisions of this Plan, the Trustees shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: (1) any persons to or for or with respect to whom such payments were made; (2) any insurance companies; and (3) any other organizations.

Further, in the event you receive an overpayment of benefits, on your behalf or on behalf of your dependent, you are obligated to refund the overpayment to the Fund immediately. In the event you fail to refund any overpayment, then the Fund can offset the overpayment against future benefits until the overpayment is fully recouped, or suspend your benefits until the said overpayment is paid in full. Such offset and/or suspension can be applied to your benefits or your dependents' benefits regardless of whom received the overpayment. The Fund may also initiate an action in a court of competent jurisdiction and obtain any and appropriate relief (including equitable relief).

Coordination of Benefits (C.O.B.)

Benefits are coordinated when both you and your spouse and/or your dependent children are covered by this Plan as well as by another group health plan. Coordination allows benefits to be paid by two or more plans, up to but not to exceed 100% of the allowable expenses on the claim.

General C.O.B. Information

1. Benefits are coordinated on all employee and dependent claims for payment or reimbursement. C.O.B. applies to medical and prescription drug benefits.

2. Benefits are coordinated with other group plans and Medicare. If you are covered under a personal individual plan for which you pay the full premiums, this Plan will not coordinate with that plan but will pay its normal benefits. Benefits are also not coordinated with Medicaid, or, in most cases, TriCare (the health care program provided by the U.S. armed service).

3. You must file a claim for any benefits to which you are entitled from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits to which you are entitled.

4. Benefits are coordinated based on "allowable expenses," which are expenses that are eligible to be considered for reimbursement.

5. This Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses that the other plan denies payment for because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, precertification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim.

6. If a person is covered by two or more plans that provide benefits on the basis of negotiated fees, any amount in excess of the primary plan's negotiated fees is not an allowable expense.

7. A plan that pays "primary" benefits is the plan that is required to pay its benefits first. The plan that pays "secondary" benefits is the plan that pays its benefits after the other plan has paid its benefits.

Order of Benefit Payments

If all plans have a C.O.B. provision, benefits are determined based on the first of the following rules that applies:

1. **Non-dependent or dependent -** The plan that covers the person other than as a dependent, for example as an employee, is primary and the plan that covers the person as a dependent is secondary.

2. **Children -** On claims for dependent children:

   a. When the natural parents are married (and not separated or divorced), or when they are not married but living together, the plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year will pay second. This is known as the "birthday rule."

   b. When the natural parents are separated or divorced, or are not married and not living together, benefits are payable according to any existing court decree. If there is no court decree stating who is responsible for a child's health care, the plan covering the parent with custody pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second and the plan covering the parent without custody pays third.

      The birthday rule will apply if a court decree awards joint custody without specifying that one party has the responsibility to provide health coverage, or in any other situation not addressed in the above rules.

3. **Active or inactive employee -** The plan that covers a person as an active employee is prime over a plan that covers the person as a laid-off or retired employee. The same order applies to the person's dependents.

4. **Continuation (COBRA) coverage -** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation (COBRA) coverage is secondary. However, this rule will not apply if the person is covered as a dependent under one plan and as a non-dependent under the other plan. In that case, the plan covering him as a non-dependent is primary, even if the non-dependent coverage is COBRA coverage.

5. **Longer or shorter length of coverage -** The plan that covered the person as an employee or retiree longer is primary.

6. **Two Plan participants -** If you and your spouse are both covered as employees under this Plan and one of you has a claim, the Plan will pay primary benefits on the claim as the claim of an employee and then pay secondary benefits on the claim as the claim of a dependent. Claims for the dependent children of two Plan employees will be coordinated, subject to rules in No. 2 above.

   Note that if this applies to you, you will still be responsible for the annual medical deductible.

7. **Other situations -** If the preceding rules do not determine the primary plan, this plan will follow the guidelines established by the National Association of Insurance Commissioners (NAIC) to determine the order of payment. If the NAIC guidelines do not apply to a particular situation, the allowable expenses will be shared equally between the plans, but in no case will this plan will pay more than it would have paid had it been primary.

C.O.B. with Medicare

The provisions described below do not apply to Class C participants (retirees with Medicare)—see page 40 for information about Class C and Medicare.

You are responsible for enrolling in Medicare Part A and Part B when first eligible to do so. If Medicare is the person's primary plan, this Plan's benefits will be determined as though the person is enrolled in both Part A and Part B, whether or not the person is actually enrolled in both Parts.

This Plan will always pay secondary to Medicare when it is allowed to do so by law. In such case, the benefits payable by this Plan will be reduced so that the total of this Plan's normal benefits and Medicare's payment will not be more than 100% of covered expenses.

You (and/or your spouse) can decline coverage under this Plan. If you do, Medicare will be your only health care coverage. You will not get any secondary benefits from this Plan. If you and/or your spouse prefer Medicare as your only health care coverage when you are age 65, contact the Fund Office (or your spouse should notify her own plan). Unless you make such a choice, this Plan will usually continue to pay primary benefits for you (and its normal benefits for your spouse) as long as you stay regularly eligible, unless it is legally permitted to pay second.

The Plan does not coordinate benefits with Medicare Part D prescription drug plans.

Medicare-Eligible Persons Under 65 - If any covered person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second.

Employees Continuing to Work After Age 65 - If you continue to work for a contributing employer who has 20 or more employees after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits unless it is legally permitted to pay second. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for her before Medicare pays unless it is legally permitted to pay second. If she is covered under her own plan, her plan will pay first, this Plan will usually pay second, and Medicare will pay last.

If you continue to work for a contributing employer who has less than 20 total employees after you are age 65, this Plan will usually pay benefits for you and your spouse after Medicare pays its benefits unless this Plan is legally required to pay first.

GENERAL PLAN PROVISION AND INFORMATION

How to File a Claim

Medical Claims

Blue Cross Blue Shield hospitals and doctors will file claims for you. Non-participating providers will also usually submit their claims for you. If your non-participating provider will not submit the claim for you, you will have to submit the claim to the Blue Cross affiliate in the state where the service was rendered.

In Illinois, the address is:

BCBSIL
P.O. Box 805107
Chicago, IL 60680-4112

Blue Cross requires that paper claims be on HCFA-1500 or UB-04 claim forms. The provider should be able to furnish a bill on the proper claim form.

HRA Claims

The HRA claim filing rules are on page 38.

All Other Claims

Submit all other claims and correspondence to:

Fund Office Address

Operating Engineers Local No. 965 Health Benefit Plan
c/o Benefits Management Group, Inc.
1520 Kensington Rd, Suite 200
Oak Brook, IL 60523

When Another Plan Is Primary

If another health plan is primary for one of your covered family members, you must submit a copy of the other plan's EOB (Explanation of Benefits) along with the itemized bill to the Fund Office. This Plan will not be able to pay your claim without that information.

Claim Filing Time Limit

Claims must be submitted within one year of the date incurred.

** Important **
All claims, including HRA claims, must be filed within
ONE YEAR of the date the expense is incurred.

Claim Processing and Appeal Procedures

In order for the Plan to pay benefits, a claim must be filed with the Fund Office in accordance with the procedures described above. A claim can be filed by you, your eligible dependent or by someone authorized to act on behalf of you or your eligible dependent.

1. A claim is considered to have been filed on the date it is received at the Fund Office, even if the claim is incomplete. The Fund Office receives claims during regular business hours, Monday through Friday.

2. A "claim" is a request for Plan benefits, normally because the claimant has incurred a healthcare expense. A request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy, whether or not the pharmacy is a prescription network provider.

3. You may designate another person as your authorized representative for purposes of filing a claim. Such designations must be in writing.

    - Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you.

    - A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as your authorized representative.

Claim Processing Time Periods

The amount of time the Plan can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

- A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested.
- A "disability claim" is a claim for Weekly Loss of Time Benefits.
- A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. This is usually referred to a preauthorization. These claims are subject to utilization review/pre-certification.
- An "urgent care claim" is a claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function; or, a claim that in the opinion of a physician with knowledge of your medical condition would subject you to severe pain that cannot be adequately managed without the proposed treatment.

  A physician with knowledge of the claimant's medical condition may determine if a claim is one involving urgent care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.
- A "concurrent care claim" is also a type of pre-service claim. A concurrent care claim is a request to extend a course of treatment beyond the period of time or number of treatments previously approved. In this case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an appeal and obtain a determination prior to the reduction or elimination of benefits. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

If all the information needed to process your claim is provided to the claims office, your claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

- *Post-service claims* - 30 days
- *Disability claims* - 45 days
- *Pre-service claims* - 15 days
- *Urgent care claims* - 72 hours
- *Concurrent care claims* - There is no formal deadline to notify you of a benefit reduction. However, in the case of a benefit reduction, you will be notified sufficiently prior to any scheduled termination of a course of treatment in order for you to appeal.

When Additional Information Is Needed (Claimant Extension)

Generally, if additional information is needed from you, your doctor or the provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown above. It is your responsibility to see that the missing information is provided to the Fund Office. The normal processing period will be extended by the time it takes you to provide the information, and the time period will start to run once the Fund Office has received a response to its request. If you do not provide the missing information within 45 days, the Fund Office will make a decision on your claim without it, and your claim could be denied as a result.

In addition:

- *Urgent Care Claims* - If the Plan receives insufficient information on the claim resulting in an inability to make a determination, or if there is a failure in following the Plan's procedures in filing a claim, you will be notified, either orally or in writing, within 24 hours of receipt of said claim. You must respond within 48 hours to the Plan with the information requested. If the information is not provided within the foregoing timeframe, the claim will be decided on the basis of the information previously submitted. The Plan will make a benefit determination within 48 hours after the Plan receives the requested information from you or within 48 hours after the end of the period in which you have to provide the requested information.
- *Pre-Service Claims* - If the Plan receives insufficient information on a pre-service claim resulting in an inability to make a determination, or if there is a failure in following the Plan's procedures in filing a claim, you will be notified, either orally or in writing, within 15 days after receipt of your claim. You must respond within 45 days to the Plan with the information requested. If the information is not provided within the foregoing timeframe, the claim will be decided on the basis of the information previously submitted. During the time period in which you have to provide the additional information, the normal period for making a decision on the claim will be suspended. The Plan then has 15 days to make a decision on the pre-service claim.
- *Disability Claims* - If, during the review, additional information is required from you, you will be so notified within the required time periods for notice of a decision or extension as detailed above. You will have at least 45 days to provide such information. A written notice of any denial will be issued within 30 days following the date you provide the information or the expiration of the time period for providing such information, unless special circumstances require a second 30-day extension, subject to the same rules.

Plan Extension

The time periods above may be extended if the Fund Office determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information from you or the provider). You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than 15 days for post-service claims or 30 days for disability claims (in special circumstances a second 30-day extension may be needed for a disability claim).

Claim Denials

If all or a part of your claim is denied after the Fund Office has received all other necessary information from you, you will be sent a written notice giving you the reasons for the denial. The notice will state:

- The specific reason or reasons for the adverse benefit determination, including any Plan standards used in denying the claim;
- Reference to the specific Plan provision on which the determination was based;
- A description of any additional material or information necessary to process the claim and an explanation of why such material or information is needed;
- A copy of the Plan's internal appeal procedures and external review processes, time period to appeal your claim, and the information regarding how to initiate an appeal;
- A statement that you have the opportunity to request the diagnosis code and its corresponding meaning as well as the treatment code and its corresponding meaning;
- A statement that you may bring a lawsuit under ERISA Section 502(a) after the appeal of your claim is completed;
- If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criteria, a statement that a copy of such internal rule, guideline, protocol, or similar criteria that was relied on will be provided free of charge to you, upon request;
- If the adverse benefit determination was based on Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit, a statement that a copy of such scientific or clinical judgment for the determination will be provided free of charge to you upon request;
- Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review process; and
- A description of the expedited review process applicable to urgent care claims if the notice is a denial of an urgent care claim.

For urgent care claims and pre-service claims, you will receive notice of the determination even when your claim is approved.

Claim Appeal Procedure

Appealing the Denial of a Claim

If your claim has been denied in whole or in part, you may request a full and fair review (also called an "appeal") by the Board of Trustees by filing a written notice of appeal with the Plan. You may orally request an expedited appeal/review of a denied urgent care claim by calling the Fund Office at 1-866-384-0965 or you may submit your request in writing to the address shown in No. 1 below. You may be notified

of the Board's decision on an urgent care claim by telephone or facsimile. You may also request an expedited appeal/review under external review, if applicable.

1. A notice of appeal must be received at the Fund Office not more than 180 days after you receive the written notice of denial of the claim. Your appeal is considered to have been filed on the date the written notice of appeal is received at the Fund Office. To appeal, write to:

   Board of Trustees
   Operating Engineers Local No. 965 Health Benefit Plan
   c/o Benefits Management Group, Inc.
   1520 Kensington Rd., Suite 200
   Oak Brook, IL 60523

2. The review will not be performed by a person, or a subordinate of the person, who made the original claim denial.

3. If another person claims to be representing you in your appeal, the Board has the right to require that you give the Plan a signed statement, advising the Board that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense. Permission for you to utilize a representative does not provide the representative (particularly a health care provider) with an independent right to payment of benefits in the representative's name, to file or proceed with a review of a claim for benefits in the representative's name or to obtain any rights as a "participant" or "beneficiary" under the Plan. Any appeal can only be brought in the name of yourself or your dependent who are the only entities permitted to be a "participant" or "beneficiary" under this Plan.

4. Upon written request, the Fund Office will provide reasonable access to, and copies of, all documents, records or other information relevant to your claim. If the Fund Office obtained an opinion from a medical or vocational expert in connection with your claim, the Fund Office will, on written request, provide you with the name of that expert. You will not be charged for copies of documents you request in connection with an appeal.

5. In deciding your appeal, the Board will consider all comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was previously submitted or relied upon in the initial determination.

6. If an appeal involves a medical judgment, such as whether treatment is medically necessary, the Board will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Committee will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

Notification Following Review

If your appeal is for an urgent care claim, you will be notified of the decision about your appeal as soon as possible, taking into account the circumstances, but not later than 72 hours after receipt of your request for review. In the case of non-urgent pre-service claims, you will be notified no later than 30 days after receipt of your request for review.

A review and determination for disability and post-service claims will be made no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review. The Board meets on a quarterly basis. However, if the request is filed within 30 days preceding the date of such meeting, a determination may be made by no later than the date of the second meeting.

If special circumstances (such as the need to hold a hearing) require a further extension of time, a determination will be made not later than the third meeting of the Trustees. Before the start of the extension, you will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.

You will be informed of the Board's decision, normally within five calendar days of the review. The decision will be in writing unless the appeal was for an urgent care claim and you are advised by telephone or fax. When you receive the written decision, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement of your right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed of your right to receive free of charge upon request the specific internal rule, guideline, protocol or similar criterion relied on to make the decision. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request. If applicable, you will also receive an explanation of the Plan's external review procedures, along with any time limits and information regarding how to initiate an external review.

External Review

For purposes of this section, references to "you" or "your" include you, your covered dependents, and you and your covered dependents' authorized representatives; and references to "Plan" include the Plan and its designees.

This external review process is intended to comply with the external review requirements of the Patient Protection and Affordable Care Act of 2010 (ACA), as set forth in Interim Final Regulations implementing the Act, in Technical Release 2010-01, in an amendment to the Interim Final Regulations issued on June 22, 2011, and in Technical Release 2011-02.

The Plan will charge you a $25 administrative fee per external review that will be refunded to you if your external appeal is successful.

If your appeal of a claim, whether pre-service, post-service or urgent care claim, is denied, and that adverse benefit determination involved a medical judgment or a rescission of coverage, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

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

External Review of Standard Claims

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an initial adverse benefit determination or adverse appeal claim benefit determination, unless extensions under the prior provisions would not allow a request for external review within the four (4) month timeframe. For convenience, these determinations are referred to below as an "adverse determination," unless it is necessary to address them differently.

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

You do not need to exhaust the internal review and appeals process if the Plan fails to follow all of the requirements for internal review. However, this does not apply to the Plan's minor violations of regulatory procedures or actions that are not prejudicial, are attributable to good cause, or are beyond the control of the Plan and made in the context of a good faith exchange of information or are not reflective of a pattern or practice of non-compliance.

Preliminary Review

1. Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The adverse determination concerns a claim involving medical judgment or rescission of coverage;
    c. The adverse determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
    d. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
    e. You have provided all of the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:
    a. 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)).
    b. 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 (IRO)

If the request is complete and eligible, the Plan will assign the request to an 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 Plan will rotate assignment among IROs with which it contracts.

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

1. 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. Such additional information must be submitted within ten (10) business days. Information submitted after ten (10) business days may not be considered by the IRO.

2. Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse determination.

3. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may

reconsider its adverse determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its adverse determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will 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).

5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

6. The assigned IRO's decision notice will contain:

   a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial);

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

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

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

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

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

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

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

Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse initial claim benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for

an expedited internal appeal; or

2. You receive an adverse appeal claim benefit determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse appeal claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in section I.A.1, are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in section I.A.2.

Review by Independent Review Organization

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

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review above. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's 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.

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

After External Review

If the final external review reverses the Plan's adverse determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's adverse determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

Payment of Claims

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or federal law. In addition, such otherwise binding decisions do not preclude the Plan from making payments on the claim or providing benefits to the claimant at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including making

payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, or termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

Lawsuits

In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or its Trustees may be filed until the matter has been submitted for review in accordance with the claim appeal provisions and external review provisions, if applicable, that are set forth in this SPD. Further, in the event a claim has been submitted for review in accordance with such procedures and the claim is denied, no lawsuit or other action against the Plan or its Trustees may be filed after ninety (90) days from the date the participant or beneficiary has exhausted all of their appeal rights.

If this limitation is less than that required by law, such limitation is hereby extended to conform to the minimum period permitted by law

Discretion of Trustees

The Trustees or persons to whom such authority has been delegated by the Trustees, such as a claims review committee, have authority to make adverse benefit determinations regarding any application for benefits and the interpretation of the Plan, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan, unless otherwise stated herein, such as under the external review procedures. If a decision of the Trustees or those acting for the Trustees or under the external review process is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious. The Trustees' decision(s) shall be enforced and upheld to the maximum extent allowed by applicable law.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. *Get a copy of health and claims records*
   - You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
   - We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

2. *Ask us to correct health and claims records*
    - You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
    - We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. *Request confidential communications*
    - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
    - We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
4. *Ask us to limit what we use or share*
    - You can ask us not to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say "no" if it would affect your care.
5. *Get a list of those with whom we've shared information*
    - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
    - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. *Get a copy of this privacy notice* - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
7. *Choose someone to act for you*
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
    - We will make sure the person has this authority and can act for you before we take any action.
8. *File a complaint if you feel your rights are violated*
    - You can complain if you feel we have violated your rights by contacting our Privacy Official (see the last page of this notice).
    - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
    - We will not retaliate against you for filing a complaint.

Your Choices - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to (1) share information with your family, close friends, or others involved in payment for your care, and (2) share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and

share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We *never* share your information for marketing purposes. We *never* sell your information.

Our Uses and Disclosures - We typically use or share your health information in the following ways.

1. *Help manage the health care treatment you receive* – we can use your health information and share it with professionals who are treating you.

   Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

2. *Run our organization* - We can use and disclose your information to run our organization and contact you when necessary.

   We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

   Example: We use health information about you to develop better services for you.

3. *Pay for your health services* - We can use and disclose your health information as we pay for your health services.

4. *Administer your plan* - We may disclose your health information to your health plan sponsor (the Trustees) for plan administration.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

1. *Help with public health and safety issues* - We can share health information about you for certain situations such as:
   - Preventing disease
   - Helping with product recalls
   - Reporting adverse reactions to medications
   - Reporting suspected abuse, neglect, or domestic violence
   - Preventing or reducing a serious threat to anyone's health or safety

2. *Do research* - We can, but do not, use or share your information for health research.

3. *Comply with the law* - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

4. *Respond to organ and tissue donation requests* and work with a medical examiner or funeral director - We can share health information about you with organ procurement organizations.

5. *We can share health information with a coroner*, medical examiner, or funeral director when an individual dies.

6. *Address workers' compensation, law enforcement, and other government requests* - We can use or share

health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

7. *For special government functions* such as military, national security, and presidential protective services

8. *Respond to lawsuits and legal actions* - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities - We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person - The Fund has designated Benefits Management Group, Inc. (BMGI) as its Privacy Official. BMGI is the contact person for all issues regarding patient privacy and your privacy rights. You may contact BMGI at Operating Engineers Local No. 965 Health Benefit Plan, 1520 Kensington Road, Suite 200, Oak Brook, IL 60523, telephone 1-866-384-0965.

Effective Date - This Notice is effective May 1, 2016.

OTHER GENERAL PLAN PROVISIONS

Things You Should Know About Your Plan

Benefit Rights Not Vested

No one has a vested (that is, non-forfeitable) right to future coverage under the Plan or to the continuation of any given benefit under the Plan. The Trustees have the right to modify or discontinue any benefit or any component of the Plan, such as coverage for retirees.

Trustee Authority and Right

Under the Trust Agreement creating the Fund and under the Plan of Benefits, the Trustees or persons acting for them, such as a claim review committee, have sole authority to make final determinations regarding any application for benefits. The Trustees also have sole authority over the interpretation of the Plan, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if the Board of Trustees or persons delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to trust that the Trustees' decision is to be upheld unless it is determined to be arbitrary or capricious.

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them. The Trustees have the authority to increase, decrease or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted you under the Plan are legally enforceable.

Plan Termination

The Trustees have the right and the authority to terminate this Plan of Benefits under certain circumstances, for example, if future collective bargaining agreements and participation agreements do not require employer contributions to the Plan.

If the Plan is terminated, benefits for covered expenses incurred before the termination date fixed by the Trustees will be paid to covered persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Payment of Benefits

Benefits are payable individually for you and each of your dependents up to but not to exceed the benefits shown on the Schedule of Benefits for each class. Benefits are payable when the required forms have been provided to the Fund Office.

Medical benefits are payable to the provider unless proof is submitted showing that the bill has been paid in full. Blue Cross Blue Shield of Illinois (BCBSIL) pays the doctor or hospital on the Plan's behalf. After BCBSIL has made the payment, the doctor or hospital will bill you for any remaining charges. It is your

responsibility to pay the balance directly to the hospital or doctor—do not file a claim for the remaining amount with the Fund Office.

All other benefit payments will be made to you (even if the claim is for one of your dependents) unless you assign benefits. However, if a person who is your dependent is not a member of your household, benefits for treatment of such dependent may be payable to the dependent or, if the dependent is a minor, to the adult who has custody and care of the minor, unless benefits are assigned.

If the Trustees decide that a person is not physically, mentally or otherwise capable of handling his business affairs, and no guardian has been appointed for him, the Trustees may make payment to the individual (or individuals) who has assumed the care and principal support of that person. If the person dies before all amounts that are due have been paid, the Trustees may make payment to the executor or administrator of the person's estate, to his surviving spouse, child or children, parent, or to any individual who, in their opinion, is entitled to the benefits.

A charge for any service or supply will be considered to have been incurred on the date that the service was rendered or the supply was provided.

Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of this Plan or the similar terms of any other plan, the Fund may, without consent or notice to any eligible person, release to or obtain from any insurance company or other organization or individual, any information, with respect to any eligible person, which the Fund deems to be necessary for such purposes. Any eligible person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Examinations

The Trustees have the right to have a physician of their choice examine a claimant when and as often as they may reasonably require while a claim is being processed. The Trustees also have the right to examine any and all hospital or medical records relating to a claim and to ask for an autopsy in the case of a death, provided an autopsy is not forbidden by law.

Governing Law

All questions pertaining to the validity or interpretation of the Trust Agreement, the Plan, or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Plan will be determined under federal law, where applicable federal law exists.

Free Choice of Physician

You will have free choice of any physician who meets the Plan's definition of a physician.

Workers' Compensation Not Affected

This Plan is not in lieu of any workers' compensation law or occupational diseases law or similar law. This Plan does not affect any requirement for coverage under any workers' compensation law or occupational diseases law or similar law.

Your ERISA Statement of Rights

As a participant in the Operating Engineers Local No. 965 Health Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office (the Fund Office) and at other specified locations, such as union halls, all documents governing the Plan, including 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 Pension and Welfare Benefit Administration.

2. Upon written request to the Fund Office, obtain copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. A reasonable charge may be made for the copies.

3. Receive a summary of the Plan's annual financial report. The Fund Office is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

In certain cases, you can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Office 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 Office. 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 plan 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 Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material

You can read the material listed in the above section by making an appointment at the Fund Office during normal business hours. Also, copies of the material will be mailed to you if you send a written request to the Fund Office. There may be a small charge for copying some of the material, so call the Fund Office to find out the cost before requesting material. If a charge is made, your check must be attached to your written request for the material.

NONDISCRIMINATION STATEMENT

The Operating Engineers Local No. 965 Health Benefit Plan (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

The Plan

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ~ Qualified sign language interpreters
  - ~ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - ~ Qualified interpreters
  - ~ Information written in other languages

If you need these services, contact Mr. Chris Krzysko, the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Civil Rights Coordinator by mail, telephone, email or in person at Operating Engineers Local No. 965 Health Benefit Plan, c/o Benefits Management Group, Inc., 1520 Kensington Road, Suite 200, Oak Brook, IL 60523, telephone 1-866-384-0965, email operators@comcast.net. If you need help filing a grievance, Fund Office personnel are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Depart-

ment of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

* * *

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-384-0965.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-384-0965.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-384-0965

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-384-0965 (번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-384-0965.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-384-0965 (رقم هاتف الصم والبكم: 1-866-384-0965).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-384-0965.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-384-0965.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-384-0965.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-384-0965.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-384-0965.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-384-0965 (पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-384-0965.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-384-0965.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-384-0965.

Other Disclosures Required Under ERISA

Name of Plan

The name of this Plan is the Operating Engineers Local No. 965 Health Benefit Plan.

Plan Sponsorship and Administration

The Plan is sponsored and administered by a joint labor-management Board of Trustees. The Board of Trustees is divided equally between Trustees appointed by the Union and Trustees appointed by employers contributing to the Fund. The Board of Trustees is the Plan Administrator. The legal address and telephone number of the Board of Trustees is 3520 E. Cook Street, Springfield, IL 62703 and 1-217-528-9659, and the names and addresses of the individual Trustees are shown on page 77.

The Board is assisted in its administration of the Fund by a salaried contract administrator (Administrative Manager) who is an employee of the Fund. The Administrative Manager's name and address are on page 78.

Service of Legal Process

The name and address of the agent whom the Trustees have appointed for service of legal process is shown on page 78. Service of legal process may also be made on any Trustee or on the Administrative Manager.

Parties to the Collective Bargaining Agreement

The Fund is established and maintained under the terms of a collective bargaining agreement, sometimes referred to as a labor contract, between employers and the Operating Engineers Local No. 965. This agreement sets forth the conditions under which participating employers are required to contribute to the Fund. A copy of the collective bargaining agreement may be obtained upon written request to the Administrative Manager, may be examined at the Fund Office during normal business hours, or may be obtained from the Local 965 office.

Currently, the parties to the collective bargaining agreement are: Local Union No. 965 International Union of Operating Engineers, AFL-CIO Associated General Contractors of Illinois, Central Illinois Builders Association and those employers which execute an individual collective bargaining or non-bargaining participation agreement with the Local Union. A complete list of all employers who have made, or are making contributions, is available for review at the Fund Office during normal business hours. If you wish to have a copy of that list, you may submit a written request to the Administrative Manager or the Local 965 office. Upon written request to the Administrative Manager, participants and beneficiaries may also obtain information as to the address of a particular employer and whether that employer has made, or is making, contributions to the Plan.

Source of Contributions

The Fund receives contributions from employers who have entered into a collective bargaining agreement with the Union or participation agreements with the Trustees. Contributions are also received from employees, dependents and retirees for the purpose of maintaining coverage in accordance with the self-payment rules. You are entitled to participate in this Plan if you work under one of the collective bargaining agreements or participation agreements and if your employer makes the required contributions to the Fund for you. Other persons entitled to participate in this Plan are permanent employees of the Fund. The Fund may also receive refunds or fees from its prescription benefit manager.

Type of Plan, Accumulation of Assets

The Operating Engineers Local No. 965 Health Benefit Plan is classified as a health and welfare benefit plan. Employer contributions and participant self-payments are received and held in trust by the Board of Trustees pending the payment of benefits and administrative expenses. Income is also realized from invested assets. The Fund provides hospital, medical, prescription drug, HRA and disability benefits on a

self-funded basis. When benefits are self-funded, benefits are paid directly from the Fund by the Board of Trustees to the employee or beneficiary. The Fund's custodial bank is JP Morgan Chase Bank.

Plan Year

The Plan's financial records are maintained on a twelve-month fiscal year basis, beginning November 1 and ending October 31.

Plan Identification Numbers

The Employer Identification number (EIN) assigned to this Plan is 36-6121856. The Plan Number (PN) assigned to this Plan is 501.

BOARD OF TRUSTEES

Union Trustees

Dennis Minick, Fund Chairman
Operating Engineers Local 965
3520 E. Cook St.
Springfield, IL 62703

Bret Scaggs
Operating Engineers Local 965
3520 E. Cook St.
Springfield, IL 62703

Kent Campbell
Operating Engineers Local 965
3520 E. Cook St.
Springfield, IL 62703

Employer Trustees

David Mifflin, Fund Secretary/Treasurer
United Contractors Midwest
P.O. Box 13420
Springfield, IL 62791

Bob Bruner
United Contractors Midwest
P.O. Box 13420
Springfield, IL 62791

Steve Halverson
Halverson Construction Co. Inc.
620 N. 19th St.
Springfield, IL 62702

PLAN PROFESSIONALS

Administrative Manager

Benefits Management Group, Inc.
1520 Kensington Rd, Suite 200
Oak Brook, IL 60523
1-866-384-0965

Fund Consultant

Foster & Foster, Inc.
One Oak Brook Terrace, Suite 720
Oak Brook Terrace, IL 60181

Fund Counsel

Cavanagh & O'Hara
2319 W. Jefferson Street
Springfield, IL 62702-8000

Agent for Service of Legal Process

Cavanagh & O'Hara
2319 W. Jefferson Street
Springfield, IL 62702-8000

Service may also be made on any Trustee or the Administrative Manager.