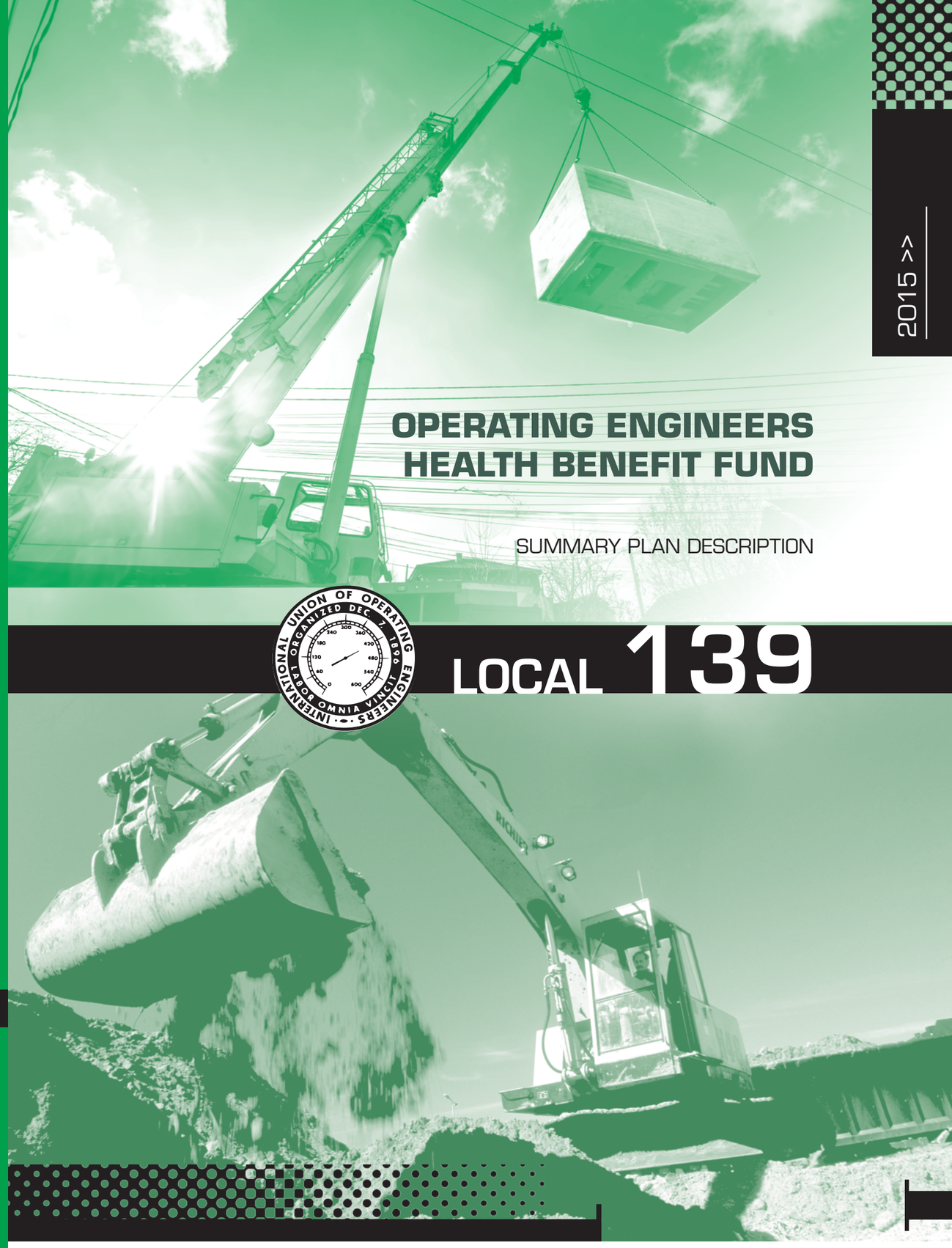

2015 >>

OPERATING ENGINEERS HEALTH BENEFIT FUND

SUMMARY PLAN DESCRIPTION

LOCAL 139

458

OPERATING ENGINEERS LOCAL 139 HEALTH BENEFIT FUND

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P.O. Box 160
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800-242-7018
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INTRODUCTION

The Operating Engineers Local 139 Health Benefit Fund (the "Fund" or "Plan") is a welfare benefit plan that offers you and your family protection when you need:

- Medical care, including prescribed medications;
- Transplant benefits;
- Dental care; and
- Vision care.

The Fund also provides benefits to you or your beneficiaries in the event of your:

- Loss of time from work due to a non-work related short-term Disability;
- Accidental dismemberment; or
- Death.

The Board of Trustees (the "Trustees") determines the benefits provided in accordance with all Plan provisions. Benefits provided to different classes of Participants may vary. In addition, any required self-payment contributions may vary depending on the benefits provided and other factors.

All benefits are provided by the Health Benefit Program and paid from the Operating Engineers Local 139 Health Benefit Fund.

The Trustees retain the right, by written amendment to this Summary Plan Description (SPD)/Plan Document, to change, add, or delete benefits, self-payment contribution rates, eligibility rules, or any other provisions relating to the operation of the Fund. The Trustees also reserve the right to amend, modify, or terminate the Plan at any time and to retain the exclusive right to interpret coverage and benefit provisions of the Fund.

About This Booklet

We are pleased to provide you with this new SPD/Plan Document, which outlines the benefits provided on behalf of you and your eligible Dependents under the Plan. This new SPD/Plan Document reflects changes to the Plan made in accordance with the Mental Health Parity Addiction Equity Act (MHPAEA) and the Patient Protection and Affordable Care Act (the "Affordable Care Act").

This booklet is intended to give you an understanding of the benefits provided by the Fund, effective as of June 1, 2015, and provide you with information on how the Plan operates. We have tried to organize the information in a way that will be useful to you. This booklet includes several sections including:

- An **eligibility** section that tells you how you become a member of the Plan, who in your family is eligible for coverage, what you need to do to continue to be eligible, when coverage under the Plan ends, and what you need to do to reinstate your coverage.
- A **life events** section designed to show you how your benefits are affected by the different events that can occur in your life and how your benefits work, including information about what you need to do when those events occur.
- Several sections that provide **detailed information** about each of the different types of coverage provided through the Plan, including medical, prescription drug, transplant, dental, vision, loss of time (short-term disability), and death and dismemberment benefits, as well as what is not covered under the Plan.
- A **how-to** section on filing claims, including what you need to do if a claim is denied.
- An **administrative information** section that includes general Plan information and details your rights as a Participant in the Plan.
- A **glossary** that defines important words that are used throughout this booklet.
- A back pocket that includes:
  - » A list that provides **important contact information** – so when you need to call someone, you'll know where to look for the phone number; and
  - » A **Summary of Benefits** (effective June 1, 2015), which gives you a brief overview of all of the benefits available to you through the Fund.

GLOSSARY

If you are not familiar with the terms used in this booklet, please check the glossary at the back. Generally, terms defined in the glossary are capitalized throughout this booklet

This booklet replaces and supersedes all prior SPD/Plan Documents and announcements provided before June 1, 2015.

We recommend that you keep this booklet with your important papers so you can refer to it when needed. In the future, as your benefits change, we will send you information that you can store in the back pocket, so you can keep the most up-to-date information on all your health and welfare benefits in the same place.

The Trustees of the Operating Engineers Local 139 Health and Benefit Fund have determined that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the Affordable Care Act was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 262-549-9190 or 800-242-7018. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

We urge you to read this booklet thoroughly and, if you are married, share it with your spouse.

Sincerely,
Board of Trustees

ACTIVE ELIGIBILITY AND COVERAGE

The information contained in this section relates to eligibility for Active employees and their eligible Dependents. Eligibility information for retired and Disabled employees, and their surviving Dependents, can be found on pages 9-11.

BECOMING ELIGIBLE

This section describes the eligibility rules for Active employees and their eligible Dependents. For eligibility information for retired and Disabled employees, and surviving Dependents, see pages 9-11.

You

You may become eligible for benefits if the Fund receives (or received) employer contributions for your hours worked. You must satisfy certain eligibility requirements relating to contributions made on your behalf for hours of work. In addition, you must work (or have worked) for an employer that has entered into a collective bargaining agreement or a participation agreement with the Fund.

Your Dependents

Your Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an eligible Dependent. However, if you do not notify the Fund Office within 30 days of when your new Dependent becomes eligible, your Dependent's coverage may not begin until the first day of the month ***after*** you complete and return an Enrollment Form to the Fund Office adding the Dependent.

In general, your Dependents are your legal spouse and your children under age 26.

Your Dependent child(ren) is covered up to the day of his or her 26th birthday. However, coverage for your unmarried disabled child may be continued beyond his or her 26th birthday if your child meets the requirements listed in the definition of Dependent shown in the ***Glossary*** beginning on page 87.

When Your Spouse Is Eligible For Other Coverage

If your spouse is employed and eligible for medical and/or Prescription drug coverage through his or her employer, your spouse must enroll for that coverage even if there is a charge to do so. If your spouse does not enroll for that coverage, he or she will not be covered under this Plan. Therefore, it is essential that your spouse enroll for such other coverage as soon as possible. Once your spouse is covered under the other plan, your spouse will be covered under this Plan. Your spouse's other plan will be his or her primary plan, which means that plan will pay benefits first. Costs not covered under the other plan may then be submitted to this Plan. That means your spouse may receive more benefits than if he or she were covered under only one plan.

If your spouse's coverage is a high deductible plan with a Health Savings Account (HSA) component, the IRS does not allow this Plan to coordinate benefits and provide secondary coverage. Your spouse will still be required to take his/her employer's coverage.

When you are first eligible, you must:

- Complete an Enrollment Form and return it to the Fund Office, which provides information about your Dependents. You must also provide birth certificates and/or marriage certificates for your eligible Dependents and indicate on the Enrollment Form whether your spouse (if applicable) is employed and has health coverage available through his or her employer.
- If your spouse is employed, but does not have health plan coverage available from his or her employer, you must include a letter from your spouse's employer stating that no other coverage is available.
- If your spouse is not employed, complete and return an Enrollment Form, signed by both of you, stating that your spouse is not employed.

If the Fund Office learns that your spouse is eligible for other coverage but has refused it, your spouse's coverage under the Fund will be terminated immediately. Written notice will be sent to you if and when the coverage under this Plan ends.

Your coverage and your other Dependent's coverage is not affected by your spouse's other health plan coverage, regardless of whether or not you are covered under your spouse's plan. However, if you or your Dependent child(ren) are also covered under your spouse's plan, benefits will be coordinated in accordance with the Plan's Coordination of Benefits provisions (see page 72).

Special Enrollment Rights

Federal law requires that you also be eligible to enroll if:

- You and/or your Dependents decline coverage under this Plan because you have other health coverage and then you and/or your Dependents later lose the other health coverage; or
- You acquire a Dependent through marriage, birth, adoption, or placement for adoption.

For enrollment due to loss of other coverage, you or your Dependent must:

- Otherwise be eligible for Plan coverage; and
- Have been covered under another group health plan or other health insurance when coverage under this Plan was declined, and enrollment must have been declined due to such other coverage.

If the other health coverage is COBRA Continuation Coverage, a special enrollment is only available after the COBRA Continuation Coverage has been exhausted. If the other coverage is not COBRA Continuation Coverage, a special enrollment is available if you or your Dependent is no longer eligible for coverage or the employer contributions for the other coverage.

To enroll yourself and/or your Dependent, you will need to complete, sign, and submit an Enrollment Form to the Fund Office. You will also need to provide proof of Dependent status if applicable. Coverage will become effective once the Fund Office approves the Enrollment Form and any requested documentation of Dependent status.

If you are enrolling yourself and/or your Dependents (including your spouse) after your other health coverage ends, coverage will become effective on the date you and/or your Dependents lose the other health coverage if you (or your Dependents) enroll within 30 days after the date you and/or your Dependents lose the other health coverage. If enrollment occurs more than 30 days after the date you and/or your Dependents lose the other health coverage, your coverage becomes effective on the first of the month following the date the Fund Office receives the completed Enrollment Form and proof of Dependent status acceptable to the Fund Office.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation.

THE QUARTERS SYSTEM

The Health Benefit Fund is designed to pay benefits based on a "Quarters System," which determines your eligibility to receive benefits. The Fund has two kinds of quarters that affect your benefits. They are:

- Work Quarters; and
- Eligibility Quarters.

It is important for you to understand the difference between these two types of quarters and how they relate to each other.

During a Work Quarter, you establish your eligibility for benefits for a later time period. A Work Quarter is a calendar quarter that represents a period of three work months during which your employer makes contributions to the Fund on your behalf. An Eligibility Quarter is the period of time you are eligible for benefits.

In short, you earn a right to benefits during a Work Quarter. As you work, you build a "bank of hours." This bank holds all your reported hours for the current and three prior Work Quarters.

Work Performed During This Work Quarter	Bank of Hours	Determines Your Eligibility For This Eligibility Quarter
January, February, March	Prior April – Current March	June, July, August
April, May, June	Prior July – Current June	September, October, November
July, August, September	Prior October – Current September	December, January, February
October, November, December	Prior January – Current December	March, April, May

How Eligibility Quarters Are Earned

You have sufficient credit for an Eligibility Quarter if the Fund has received contributions from an employer(s) on your behalf of:

- 300 or more hours in the current Work Quarter; or
- 1,200 or more hours in the current and three prior Work Quarters.

You earn credit for hours if you are receiving Loss of Time Benefits from the Fund or if you notify the Fund Office, in writing, that you are receiving Workers' Compensation benefits. You must include a letter from either your employer or the Workers' Compensation carrier (or a copy of your Workers' Compensation check). In either case, you will receive credit for up to 25 hours of contributions each week, not to exceed 100 hours per month, for up to a maximum of:

- 24 months if you are receiving Workers' Compensation benefits; or
- 26 weeks if you are receiving Loss of Time Benefits.

INITIAL ELIGIBILITY

If You Are A Bargaining Unit Employee Or An Alumni Participant

You become eligible to receive benefits on the first of the month after a Work Quarter in which the Fund receives at least 300 hours of employer contributions on your behalf.

When you are initially eligible, you must complete and sign an Enrollment Form.

Generally, the eligibility rules provide that Initial Eligibility cannot be established as a result of reciprocity hours transferred from another Fund. However, reciprocity hours can count toward Initial Eligibility if you earned the hours while you were working for a contributing employer to this Fund.

The initial period of eligibility is five months. This means that once you are eligible for benefits during your first Eligibility Quarter, you are also eligible for the two months prior to the Eligibility Quarter. If you were previously covered under the Plan, but you have not been eligible for benefits under the Plan for 36 months (from the last date you were eligible), you are considered a newly eligible Participant.

EXAMPLE: INITIAL ELIGIBILITY FOR BENEFITS

Mike started working as an Operating Engineer on May 1 and worked 350 hours in May and June. The Work Quarter during which he started working consists of the months of April, May, and June. The Fund received employer contributions for the 350 hours that Mike worked; therefore, he satisfied the Initial Eligibility requirements and is eligible for coverage during the corresponding Eligibility Quarter of September, October, and November. Also, since Mike is a new employee, he is covered by the Fund for the months of July and August.

Notification from the Fund Office of Initial Eligibility occurs after the contributions are received from the contributing employer and processed

If You Are A Bargaining Unit Employee Receiving Workers' Compensation Benefits

If you are a Bargaining Unit Participant and a Disability prevents you from working after you become eligible, you will be given credit for 25 hours per week, up to 100 hours per month, for up to eight Work Quarters, to help maintain your eligibility for benefits.

This subsection does not apply to Non-Bargaining Unit or Alumni Participants.

You will receive the Disability hours credit if:

- You are receiving temporary total or permanent total Disability weekly benefits from Workers' Compensation as a result of your Injury or Sickness;

- Your Disability was due to employment with an employer for which employer contributions are payable to the Fund;
- You submit proof to the Fund Office that you are receiving temporary total or permanent total Disability weekly benefits from Workers' Compensation; and
- You provide medical evidence satisfactory to the Trustees, upon request.

You will not receive the credit if you are receiving temporary partial Disability or total partial Disability benefits from Workers' Compensation.

If any Injury or Sickness for which Workers' Compensation Benefits are paid allows you to return to work but later requires additional treatment, Disability hours can be credited while you are receiving additional treatment, for up to a total of eight Work Quarters or a maximum of 2,400 hours.

If You Are A Non-Bargaining Unit Participant

If You Are A Fund-Related Non-Bargaining Unit Participant

You are considered a Fund-Related Non-Bargaining Unit Participant if you are an employee of the Union, the Associations, a peripheral Fund, or the Administrative Manager. You are subject to the same eligibility rules as all active participating bargaining unit Operating Engineers. However, you are not allowed to make self-payment contributions unless you are also an Operating Engineer available for work.

If You Are A Regular Non-Bargaining Unit Participant

You are a regular Non-Bargaining Unit Participant if you do not perform work under a collective bargaining agreement, but your employer is signatory to a Non-Bargaining Unit Agreement with the Trustees of the Fund that allows for your participation.

Your eligibility begins on the first day of the third month of employment, provided your employer has made contributions on your behalf and has:

- Chosen this Fund's coverage for employees who are not Operating Engineers; and
- Signed a "Non-Bargaining Unit Participation Agreement" that has been accepted by the Trustees.

Your eligibility continues on a month-to-month basis during the remainder of your employment as long as your employer:

- Makes the required contributions on your behalf; and
- Complies with the non-discrimination rule requirements of the Agreement; and
- The bargaining unit contributions for the company that are due to the Fund are current.

As a regular Non-Bargaining Unit Participant, you are not eligible to make self-payment contributions for coverage, and you can only make COBRA Continuation Coverage payments if your employment terminates.

If You Are A Newly Organized Employer Participant

If you are employed by a newly organized employer, your Initial Eligibility begins on the first day of the month following the period in which you work 160 hours for which contributions are made to the Fund on your behalf. You must provide proof to the Fund that you had other group health plan coverage for the 12-month period immediately before the date your Initial Eligibility begins. In the event that you cannot provide proof of a prior 12-month period of group health plan coverage, you must meet the Plan's Initial Eligibility requirements. Once you have met the eligibility requirements, you will remain eligible until the beginning of the next Eligibility Quarter.

However, if the hours you worked were worked in the first or the last month of the Work Quarter, you will be eligible for benefits the beginning of the next month and through the end of the next Eligibility Quarter.

CONTINUING ELIGIBILITY

Once you earn your Initial Eligibility, you continue to earn **three-month** periods of eligibility, called Eligibility Quarters. You stay eligible as long as you work at least 300 hours per Work Quarter and the Fund receives employer contributions for those hours. If you do not work at least 300 hours in a Work Quarter, you can still be eligible if at least 1,200 hours of employer contributions have been made on your behalf in the current and three prior Work Quarters. The Fund always looks at your current and three prior Work Quarters, which continually change (see the following example).

Bank Of Hours

As you work, you build a "bank of hours." This bank holds all your reported hours for the **current and three prior Work Quarters**. The hours accumulated in your bank help you keep your eligibility. If you do not have the required 300 hours in a Work Quarter, you will keep your eligibility as long as you have at least 1,200 hours in your bank. **Your bank of hours changes at the end of each Work Quarter because only hours from your current and three prior Work Quarters are counted**.

EXAMPLE: CONTINUING YOUR ELIGIBILITY

As a new employee starting on May 1, Mike earned Initial Eligibility for July, August, September, October, and November because his employer made 350 hours' worth of contributions on his behalf for May and June.

After meeting the Initial Eligibility requirements, Mike worked over 300 hours in each of his first three Work Quarters, so his eligibility continued. In his fourth Work Quarter, Mike worked only 230 hours for which his employer made contributions. Mike's eligibility will continue because over his current and three prior Work Quarters, he built a "bank of hours" sufficient to continue his coverage.

The bank holds the total of all hours for his current and three prior Work Quarters. Mike had 1,300 hours in his bank at the end of the Work Quarter that he worked only 230 hours. This is more than the minimum of 1,200—so his eligibility continues.

Work Quarter:	Reported Hours:	Bank of Hours:	Bank of Hours:	Earns Eligibility For Eligibility Quarter:
April, May, June	350	Prior July–Current June	350	September, October, November
July, August, September	350	Prior October–Current Sept	350+350=700	December, January, February
October, November, December	370	Prior January–Current Dec	370+700=1,070	March, April, May
January, February, March	230	Prior April–Current March	230+1,070=1,300	June, July, August

However, in the next Work Quarter (April, May, June), Mike again works only 240 hours for which his Employer made contributions. His eligibility will not continue because his total hours worked over the current and three prior Work Quarters is only 1,190 (350 + 370 + 230 + 240), which is less than the 1,200 minimum.

Quarterly Status Report

If you do not agree with the hours reported on your Quarterly Status Report, return the report to the Fund Office, along with any payroll check stubs or other supporting documentation.

If you are eligible for benefits prior to the beginning month of each Eligibility Quarter (March, June, September, and December), you will receive a Quarterly Status Report. This report contains the name of the contractor(s), the month(s) worked, and the number of hours reported to the Fund on your behalf during the most recent Work Quarter. It also indicates the total number of hours you had reported on your behalf for the current and three prior Work Quarters. It also provides your HRA balance as of the date the report was printed. The balance can change daily based upon HRA contributions received and HRA claims paid. Refer to the section beginning on page 24 for information regarding your HRA.

When you first become eligible for benefits, you receive two ID cards that can be used as identification when you are requesting medical, dental, and/or vision services. Keep one and, if you are married, give the other to your spouse. Use your ID card to receive your Prescriptions at discounted prices when you go to a Preferred Provider pharmacy.

LOSING ELIGIBILITY

The Health Benefit Fund is designed to provide benefits for all eligible Participants and their eligible Dependents. However, it is possible for you and/or your Dependents to lose eligibility for coverage.

You

You will lose eligibility for coverage if:

- You have fewer than:
  - » 300 hours of employer contributions are received on your behalf in a Work Quarter; or
  - » 1,200 hours of employer contributions are received on your behalf in the current and three prior Work Quarters;
- You have made the maximum of six consecutive quarterly self-payment contributions (if eligible, see page 19);
- You are a bargaining unit employee and you work for a non-participating employer in the construction industry;
- You do not make the required self-payment contributions on time;
- You are inducted into the Armed Forces (see page 17); or
- There is a written amendment to this SPD that affects eligibility.

If you work for a non-participating employer in the construction industry, the Fund Office will notify you that your benefit coverage (and your Dependents' benefit coverage) will end on the first day of the month following the notice or, if later, 20 days following the notice. You will not be permitted to make self-payment contributions to continue your eligibility. However, you may be eligible for COBRA Continuation Coverage, see page 21.

Your Dependents

If you lose eligibility for coverage for any reason, your spouse and eligible Dependent children will also lose eligibility.

However, in the event of a divorce, your spouse and stepchildren's eligibility ends on the date the divorce is final. Your spouse and stepchildren may be eligible to continue coverage by electing COBRA Continuation Coverage (see page 21).

In addition, your eligible Dependent child loses eligibility on his or her 26th birthday, unless your child is mentally or physically handicapped (see the definition of Dependent on page 89).

REINSTATING ELIGIBILITY

If you lose your eligibility for coverage, you can become eligible for coverage again if you have 300 hours of contributions made on your behalf within a Work Quarter. However, unlike when you are initially eligible, when coverage is reinstated, your coverage begins on the first day of the Eligibility Quarter and consists of just that three-month Eligibility Quarter. As stated on page 5, when you are initially eligible, your eligibility begins on the first of the month following the end of the Work Quarter and consists of five months.

EXAMPLE: REINSTATING ELIGIBILITY

Mike earned Initial Eligibility in July, based on 300 hours in April, May, and June, and stayed eligible through November. Mike did not work in July, August, and September, and did not make self-payment contributions, so he was no longer eligible for December, January, and February. If Mike works more than 300 hours in October, November, and December, he will be reinstated and eligible for coverage in the following March, April, and May. He does not get five months of eligibility.

If you lose eligibility because you enter the Armed Forces, the Initial Eligibility and/or Reinstating Eligibility rules may be waived. See page 17 for more information regarding coverage when you enter the Armed Forces.

If you lose your eligibility due to full-time employment with the International Union, you can reinstate your status in the Fund provided:

- You were eligible for benefit coverage from the Fund immediately preceding your full-time employment with the International Union; and
- Upon termination of such employment with the International Union:
  - » You immediately begin employment under a contract requiring contributions to the Fund; or
  - » You immediately apply for retiree coverage or postponement of retiree coverage under the Plan.

If You Are A Reinstated Participant Of A Newly Organized Employer

If you are employed by a newly organized employer, your Initial Eligibility begins on the first day of the month following the period in which you work 160 hours for which contributions are made to the Fund on your behalf. You must provide proof to the Fund that you had other group health plan coverage for the 12-month period immediately preceding the date your Initial Eligibility begins. If you cannot provide proof of a prior 12-month period of group health plan coverage, you will be required to meet the Initial Eligibility rules on page 5 of this booklet. Once you have met the Fund's eligibility requirements, you will remain eligible until the beginning of the next Eligibility Quarter.

However, if the hours you worked were worked in the first or the last month of the Work Quarter, you will be eligible for coverage the beginning of the next month and through the end of the next Eligibility Quarter.

RESCISSION OF COVERAGE

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

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

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

CHANGE OF ELIGIBILITY RULES AND BENEFITS

Over time, it may be necessary to change the eligibility rules and the benefits provided by the Health Benefit Fund, including benefits provided to retirees. The Trustees, at their discretion, have the right to interpret, change, modify or discontinue all or part of the eligibility rules or benefits provided, at any time, by written amendment to this SPD.

Whenever policies (such as self-payment contribution rates, benefits provided, etc.) change, you will be notified of the changes and copies of the changes will be on file at the Fund Office. If you have any questions about these policies, contact the Fund Office.

RETIREE ELIGIBILITY AND COVERAGE

The Trustees may change self-payment contribution rates and change or discontinue benefits for retirees at any time.

As of the date of your retirement (not on the date on which your active bank of hours runs out), you and any of your Dependents who are eligible for Medicare Parts A and B **must** enroll for that coverage. Eligibility for enrollment in Medicare Parts A and B generally occurs at age 65 but could be earlier for anyone who has been granted a Social Security Disability award.

SERVICE CREDITS

You are awarded service credits based on your employer contribution hours each Calendar Year. See page 10 for more information.

If you do not have 10 or more service credits but otherwise meet the eligibility requirements for retiree coverage, you are still eligible for retiree coverage. However, you are required to pay the full cost for that coverage (as determined by the Trustees).

When you are no longer actively employed due to retirement or Disability and you are eligible for retiree coverage, you must enroll for such coverage. In addition, in the event of your death, your surviving spouse may enroll for retiree coverage.

ELIGIBILITY

At retirement, you are awarded service credits based on your prior employer contribution hours. The service credits are used to determine your eligibility for retiree coverage, as well as the amount of your self-payment contributions for such coverage (refer to page 10).

You are eligible for retiree coverage if you are retired, as defined by the Plan. For Plan purposes, retired means:

- ***Normal Retired:*** You are at least age 62 with 10 or more service credits;
- ***Early Retired:*** You are between the ages of 55 and 62 with 10 or more service credits;
- ***Surviving Spouses:*** You are the surviving spouse of a Participant that had 10 or more service credits; and
- ***Disabled Retired:*** You have provided proof of a Social Security Disability award at any age with 10 or more service credits.

If you are a Bargaining Unit, Alumni, or Fund-Related Non-Bargaining Unit Participant, to be eligible for retiree coverage, you must:

- Be and remain a member in good standing of or maintain continuous payment of a service fee to Local 139 (this does not apply to Fund-Related Non-Bargaining Unit Participants);
- Be eligible for coverage through the Fund at the time of your retirement (or Disability); and
- Have been credited with employer contributions to the Health Benefit Fund for at least:
  - » 3,000 hours in the three consecutive Calendar Years immediately preceding retirement, or immediately preceding the onset of Disability for Disabled Participants; or
  - » 4,000 hours in the four consecutive Calendar Years immediately preceding retirement, or immediately preceding the onset of Disability for Disabled Participants; or
  - » 5,000 hours in the five consecutive Calendar Years immediately preceding retirement, or immediately preceding the onset of Disability for Disabled Participants.

For retirements that occur from June 6, 2011 through December 31, 2015: If the above hours requirement is not met, you can be eligible to participate in the retiree plan provided you have at least 20 prefunding credits and at least 20 years of Health Fund contributions.

Hours for which you make self-payment contributions, as well as Disability credits and worker's compensation credits, are not included toward meeting the previous hour requirements.

If you are a Non-Bargaining Unit Employee, you must:

- Be receiving Social Security retirement benefits; or
- Not be receiving wages subject to Social Security taxes from any contributing employer (you will be required to provide a copy of your federal and state income tax returns to the Fund Office).

For purposes of determining eligibility for retiree coverage, if you are employed full-time with the International Union, you will be credited as if you remained continuously eligible provided:

- You were eligible for benefit coverage through the Fund immediately preceding your full-time employment with the International Union; and
- Upon termination of such employment by the International Union, you immediately:
  - » Begin employment under a contract requiring contributions to the Fund; or
  - » Apply for retiree coverage by contacting the Fund Office.

Service Credit

Service credits are awarded for your hours of employer contributions each Calendar Year, including hours worked under a reciprocal agreement. You can earn up to a maximum of 42 service credits. Service credits are used to determine your eligibility for retiree coverage as well as to determine the amount of your self-payment contributions for retiree coverage.

> Self-payment hours are not considered hours of employer contributions for earning service credits.

Service credits are awarded based on your hours of employer contributions each Calendar Year as follows:

Hours Of Employer Contributions In A Calendar Year*	Service Credit Earned For That Calendar Year
2,400 hours or more	1.40
2,100 – 2,399 hours	1.30
1,800 – 2,099 hours	1.20
1,500 – 1,799 hours	1.10
1,250 – 1,499 hours	1.00
1,000 – 1,249 hours	0.75
750 – 999 hours	0.50
500 – 749 hours	0.25
0 – 499 hours	0.00

** Any hours for which you make self-payment contributions to continue coverage or for which you are credited during a period of Disability for which you are receiving Loss of Time or Workers' Compensation Benefits are not counted in determining your hours of employer contributions.*

From January 1, 1971 through January 1, 1975, the Fund Office does not have employer contribution information available. However, you will receive one full credit for each year you were a Local Union No. 139 member in good standing, as verified by Local Union No. 139 records. If you were not a Local Union No. 139 member for any year during that time, no credit will be awarded for that year.

When looking at hours of employer contributions made on your behalf, the Fund includes reciprocal hours of employer contributions made on your behalf. However, these hours are prorated, using the contribution rate as the base rate. Contact the Fund Office for more information about reciprocal hours.

RETIREE IN-AND-OUT PROGRAM

When you retire (or if you are already retired), you may continue coverage for yourself and your Dependents under the retiree plan. However, you may delay participation in or opt out of the retiree plan **one time**, at any time, if you have medical coverage available through another group plan, such as one offered through your spouse's employer.

Under the provisions of the Retiree In-and-Out Program, you and your spouse may postpone coverage or opt out of coverage one time only and maintain your eligibility to participate in the retiree program at a later date. During the period in which you opt out of coverage, the Plan will freeze your HRA balance. When you opt back in to retiree coverage, your HRA balance will be restored for use by you and your Dependents. Refer to page 24 through 30 for information on the Plan's HRA offering.

You must file a written notice of your decision to delay retiree coverage with the Fund Office. You may request a Retiree In-and-Out Program Participation Form from the Fund Office.

If you choose to opt out in order to enroll for a Medicare Advantage Plan (Part C and Part D), the Fund will continue to provide you and your eligible Dependents, who have also enrolled in a Medicare Advantage Plan, with dental and vision benefits for a maximum of 12 months. You will also be eligible for the Fund's Death Benefit for up to 12 months. There is no cost to you for these benefits during that year. However, at the end of that time, you must either resume the Fund's coverage or the dental, vision and death benefits will terminate and you will not again, at any time in the future, be allowed to re-enroll in this Plan. You and your Dependents will continue to be eligible for reimbursement of eligible expenses under the HRA that are incurred during this same 12-month period.

Note that only Dependents eligible for Medicare in their own right (due to attaining age 65 or being awarded Social Security Disability) can be covered under Medicare.

Once your other coverage ends, you will need to:

- File a written application with the Fund Office within 60 days following the date your other coverage ends;
- Provide proof that you were continuously covered by another plan since the date you elected to delay your coverage under this Plan; and
- Make the required self-payment contribution for coverage.

Once you retire and begin making retiree self-payment contributions, the full monthly self-payment contribution is required unless you reestablish eligibility as an active Participant, as described on page 8.

RETIREE COVERAGE

When you are eligible for retiree coverage, Dependent coverage is available for any of your Dependents who were eligible for coverage at the time you retired, provided they still meet the Plan's eligibility requirements. If you are married when your retiree coverage begins, your spouse is also eligible for coverage. If your spouse dies and you subsequently remarry, your new spouse is also eligible for coverage under the Plan.

Since the Fund coordinates benefits with Medicare, you and any of your eligible Dependents must enroll in Medicare Parts A and B as soon as you are eligible.

However, if you are eligible for retiree coverage as a surviving spouse and you remarry, your new spouse is not eligible for coverage under the Plan. In addition, if you are under age 65 at the time of your remarriage, you will no longer be eligible for coverage under the Plan**.**

Once you are no longer considered "Active," you and any of your Dependents who are Eligible for Medicare or who may become eligible for Medicare must enroll in Medicare Parts A and B. The Fund coordinates benefits with Medicare when you are eligible. Please review the "Coordination of Benefits with Medicare" section on page 74.

The amount of the retiree self-payment contribution is set by the Trustees. In addition, the Trustees determine the benefits provided to retirees, which will not be the same as those provided to active Participants.

Self-Payment Contributions For Retiree Coverage

Self-payment contributions are required for retiree coverage under the Plan. Health care costs continue to increase each year, and retiree usage of health care services generally increases each year. To ensure that the Fund can provide retiree benefits now and in the future and that your self-payment contributions are kept as low as possible, the Trustees of the Plan continually evaluate how to fund retiree benefits.

The Plan uses two methods to fund retiree benefits – the pre-funded method and the funded method. The amount of the self-payment contribution and how it is determined is different under each method.

The Fund adopted the pre-funded method as of January 1, 2003. In general, this method applies to Participants retiring on or after January 1, 2003. However, individual employers must elect to participate in the pre-funded program. If you do not have the necessary credits under the pre-funded program, your self-payment contributions will be determined under the funded program method, as described beginning on page 13.

Pre-Funded Program Self-Payment Contributions

The amount of your self-payment contribution will depend on:

- The cost of providing coverage;
- The number of service credits you have earned; and
- Your age at retirement.

SERVICE CREDIT

You are awarded service credits based on your employer contribution hours each Calendar Year, up to a maximum of 42 service credits (see page 10).

Your self-payment contribution amount will be the cost of retiree coverage reduced by your service credit amount. The Fund Office will calculate your self-payment contribution amount when you apply for retiree coverage and as costs or rates change. If the cost of retiree coverage increases due to inflation and/or utilization, your self-payment contribution will also increase.

The cost of retiree coverage will be reviewed annually and adjusted to reflect the actual cost of providing retiree coverage. Contact the Fund Office for the most-up-to date cost information.

If you work for a non-participating employer in the construction industry or are expelled from the Union, your accumulated service credits under the Pre-Funded Program will be cancelled. If your eligibility is later reinstated, you may earn new service credits but any cancelled service credits (that were previously lost) will not be restored.

At the time of your retirement, Disability, or death, each service credit you have earned will be applied a service credit rate (as set by the Trustees and subject to change from time to time). The service credit rate will vary depending on your age at retirement and whether you are younger than age 65 or older. The younger you are when you retire, the lower the service credit rate is because you will be benefitting from the program for a longer period of time than a Participant who retires at an older age. In addition, the service credit rate is lower once you reach age 65 because when you reach age 65, you become Eligible for Medicare and Medicare will pay benefits first, before the Plan.

Past service credits were offered on a one-time only basis to Participants who had Pre-Funding contributions made on their behalf immediately following June 2002 and to Non-Bargaining Unit and Alumni Participants whose employers chose to participate in the program as of June 2002.

When you multiply your total service credits by the applicable service credit rate, the resulting amount is your service credit amount. Your self-payment contribution amount for retiree coverage will be the cost of retiree coverage reduced by your service credit amount.

The following service credit rates were adopted June 1, 2015 and still apply:

Age At Retirement	Service Credit Rate Before Age 65*	Service Credit Rate At Age 65 and Older*
55	$21.30	$10.76
56	$22.11	$11.17
57	$22.92	$11.58
58	$23.72	$11.99
59	$24.53	$12.39
60	$25.34	$12.80
61	$26.15	$13.21
62 or older	$26.96	$13.62

** Service credit rates are subject to change.*

If you are a retiree with 39 or more service credits and you reach age 65 and become Eligible for Medicare, you may remain covered under the program. You can continue to pay the same pre-Medicare monthly contribution rate, if the Medicare monthly self-pay contribution rate is higher.

Service Credits for Married Employees

Generally, your service credit rate is determined as of your age when you initially retire. However, if you subsequently return to work and have 1,000 or more hours of employer contributions within one Calendar Year, your service credit rate may be adjusted by age when you subsequently retire. You may only have your service credit rate adjusted once.

In the event that two employees covered by the Plan are married to each other, service credits will be determined as follows:

The total career hours of both employees will be accumulated on a per family basis, and will be counted together in calculating the service credits to be awarded to the family, up to a combined total of 42 service credits.

Only one self-payment will be assessed to the family, and the cost of coverage will be the self-payment amount minus the combined credits. No rebates will be provided if the combined credits exceed the self-payment amount.

Upon the death of one of these spouses, the surviving member spouse will continue to be entitled to use combined service credits for the self-payment.

If these member spouses divorce, then the full combined total of the service credits will be allocated to each of them, and they will be treated as separate retirees with separate coverage and each will be assessed the appropriate self-payment for coverage.

Disabled Retired Participants

In the event that you are retired due to a Disability (as defined by the Plan), you will receive retiree coverage under the Plan. Your self-payment contribution amount is calculated the same as for retiree coverage, based on your age at the time of your Disability. However, if you are not yet age 55 at the time of your Disability, the service credit rate applied to your service credits will be the age 55 rate.

Surviving Spouses

If your surviving spouse is eligible for retiree coverage, his or her self-payment contribution amount is calculated in the same way as it would be for you. However, the amount will be based on your age. For the cost of retiree coverage, the Plan looks at the age the Participant would have been if he or she were still living. For service credits, the Plan looks at the Participant's age at the time of his or her retirement or death, if earlier.

EXAMPLE: SURVIVING SPOUSE SELF-PAYMENT CONTRIBUTION

Pat retires at age 55 on June 1, 2015. Since Pat is younger than age 65, the monthly cost of his retiree coverage is $1,320 and his service credit rate is $21.30. In the event of Pat's death before age 65, his surviving spouse's self-payment contribution will continue at the pre-age 65 rates until Pat would have reached age 65. Then, when Pat would have reached age 65, the amount will be adjusted to the monthly cost of retiree coverage for age 65 and older and a service credit rate of $10.76.

Funded Program Self-Payment Contributions

If you are a Participant who retired before January 1, 2003, or you work for an employer that does not participate in the pre-funded program, your monthly self-payment contribution amount is determined under the funded program. The amount of the retiree self-payment contribution is determined by the Trustees and is based on the cost of providing coverage. The cost of providing coverage for Participants Eligible for Medicare is less since Medicare pays benefits first, before the Fund and, therefore, the Plan's payments are less. The Fund will look at both the retiree and the retiree's spouse to determine the amount of the monthly self-payment contribution. Once you or your spouse becomes Eligible for Medicare, be sure to notify the Fund Office.

Automatic payments are:

- Convenient since you do not have to write a check and pay postage each month. Plus, if self-payment contribution rates change, the new amount will automatically be deducted. However, the Fund Office will inform you before any change in rates occurs.
- Cost effective because the transaction is electronic, which means there is a minimal amount of manual intervention. Plus, the Fund saves additional money by not having to produce and send payment coupon books.

Making Your Retiree Coverage Self-Payment Contributions

Self-payment contributions are required for retiree coverage under the Plan, regardless of how your retiree coverage is funded. If you do not make your self-payment contributions in a timely manner, you will lose eligibility for coverage, **which you can then only reinstate by** returning to full-time active employment and meeting the Fund's reinstatement rules.

To assist you in making your self-payment contributions in a timely and consistent manner, the Fund allows automatic payments. When you are eligible for retiree coverage, you **must enroll** to have your monthly self-payment contributions automatically withdrawn from your checking or savings account. Withdrawals will be made near the fourth of each month so that you can continue to be eligible for coverage that month.

If you have money in your HRA account at retirement, you can use that money to offset the monthly retiree self-payment that you are required to make. When the HRA balance is depleted, you will then have to make the required monthly self-payments.

If you are currently making monthly self-payment contributions using Self-Payment Coupons, you may receive a discount on your monthly amount if you:

- Elect to have your monthly self-payment contributions automatically withdrawn from your checking or savings account; or
- Make, in advance, one self-payment contribution for an entire year of retiree coverage.

When you begin making self-payment contributions as a retiree, Disabled Participant, or surviving spouse, you will be sent a benefit Eligibility ID card. Keep it with you and give one to your spouse. If either of you are also Eligible for Medicare Parts A and B, make sure to show providers your Medicare card in addition to the Health Fund card.

LIFE EVENTS

Refer to the HRA section, beginning on page 24, for information about how you can use your HRA funds as a means of reimbursement when certain life events occur.

When you are first eligible, you must complete, sign, and date an Enrollment Form. You must also provide birth and/or marriage certificates for your eligible Dependents.

KEEP YOUR FUND OFFICE RECORDS UP-TO-DATE

It is important that you keep the Fund Office advised of your current address ***at all times*** to ensure that you receive all information regarding your benefits. To update your records, contact the Fund Office and they will send you the appropriate form.

Your benefits are designed to adapt to your needs at different stages of your life. However, certain life events, such as marriage, divorce, birth of a child, death, or retirement, can affect your benefit coverage. This section describes how your coverage is affected when different life events occur.

WHEN YOU ARE INITIALLY ELIGIBLE

When you first become eligible for benefits from the Plan, you must fill out an Enrollment Form and provide birth certificates and/or marriage certificates for your eligible Dependents. The information is needed by the Fund Office to provide benefits to you. No benefits will be processed by the Fund Office without this information.

The Enrollment Form also includes your beneficiary designation for the Death Benefit provided through the Fund.

It is important to keep this information up to date. It is your responsibility to notify the Fund Office of any changes, including any change in your:

- Marital status (if you marry, separate, or divorce);
- Spouse's employment and/or insurance coverage (including Medicare eligibility);
- Dependents (provide the name, Social Security number, and birth date of your newborn or adopted child, or a child placed with you for adoption. Also provide copies of adoption papers, if applicable);
- Address; or
- Beneficiary designation.

If any of the above changes occur, contact the Fund Office for an Enrollment Form.

GETTING MARRIED

If you get married, your spouse is automatically eligible for coverage effective as of the date of your marriage. However, no benefits will be processed by the Fund Office until you have provided any required information. **In addition, if your spouse is eligible for other medical and/or Prescription drug coverage and does not enroll for that coverage, he or she will not be covered under this Plan**.

Please notify the Fund Office as early as possible after your marriage. You will be required to provide a marriage certificate in order for your spouse to be enrolled in the Plan. Until your spouse is enrolled in the Plan, no claims will be paid. **Remember, if a claim is not filed**

within 24 months of the date the expense related to the service is incurred, the claim may not be accepted and may be denied.

If you get married, you may want to consider updating your beneficiary information.

GETTING DIVORCED

If you and your spouse get divorced, your spouse will no longer be eligible for coverage as a Dependent under the Plan effective as of the date the divorce is final. However, your spouse may elect to continue coverage under COBRA Continuation Coverage for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the divorce date for your spouse to obtain COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation under the Plan. In general, once you are divorced, stepchildren from your former marriage are no longer eligible to be covered under the Plan, but may be eligible for COBRA Continuation Coverage, see page 21.

If your spouse and/or Dependent(s) are covered under another group medical or dental plan, you must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with such other coverage. **In addition, if your spouse is eligible for other medical and/or Prescription drug coverage and does not enroll for that coverage, he or she will not be covered under this Plan.**

The Fund Office may require you to submit supporting documentation such as a copy of your divorce decree or a copy of any Qualified Domestic Relations Order (QDRO) and/or Qualified Medical Child Support Order (QMCSO), if applicable. A QDRO and/or QMCSO may affect your benefit coverage or elections. Contact the Fund Office for a free copy of the Fund's procedures for handling such orders.

If you get divorced and you want to change your beneficiary, you need to complete a new Enrollment Form.

ADDING A CHILD

You can add eligible Dependent children at any time. However, you should contact the Fund Office for the necessary forms immediately after a child is born, becomes your legal responsibility, or adoption proceedings have begun, to assure coverage when needed. Claims will be honored for up to only a 24-month period prior to the child being enrolled.

In general, your natural born child will be eligible for coverage on the date of birth. If you adopt a child or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a Dependent child. Stepchildren are eligible for coverage on the date of your marriage. In order for the Fund Office to determine a Dependent's eligibility, you must provide legal documentation, such as a birth certificate, adoption papers, marriage certificate, guardianship documents, divorce decree, or paternity order, as well as other coverage information from natural parents. Receipt of a valid QMCSO by the Fund Office will automatically result in the enrollment of that person.

Covered Dependents **do not** include your grandchildren, unless the Participant is the legal guardian, has legally adopted them, or the child is placed with you for adoption.

CHILD LOSING ELIGIBILITY

You should notify the Fund Office within 60 days of when your child is no longer eligible for coverage. Your child may elect to continue coverage under COBRA for up to 36 months.

In general, your child is no longer eligible for coverage when he/she reaches age 26. However, if your child is not capable of self-sustaining employment upon attaining age 26 because he/she is permanently and totally Disabled, you may continue coverage for that child for as long as your own coverage continues and the child depends on you for more than one-half of his or her support. To qualify, your child's permanent and total Disability must begin before he/she reaches age 26 and his or her coverage would otherwise end. You must submit proof of the Disability to the Trustees within 31 days of the date your Dependent child's coverage would otherwise end or within 31 days after your Dependent child initially becomes eligible for benefits from the Fund.

In addition, if your parental rights are voluntarily or involuntarily terminated, your child(ren) will no longer be eligible for coverage. You must notify the Fund Office within 30 days of such an occurrence. Failure to timely notify the Fund will cause you to be personally responsible for any claims paid after the change.

For information regarding Dependent eligibility status, refer to the definition in the ***Glossary*** on page 89.

WORKING FOR A NON-PARTICIPATING EMPLOYER

If you work for a non-participating employer in the construction industry, your eligibility under this Plan is terminated and your bank of hours is forfeited.

You may again become eligible under the Plan by meeting the Plan's Initial Eligibility requirements or reinstatement requirements (see page 8).

WORKING OUTSIDE THE FUND'S JURISDICTION – RECIPROCITY

The Fund has made arrangements with other Operating Engineers health funds for transfer of employer contributions to a Participant's home fund. The Trustees allow reciprocity hours to count toward Initial Eligibility provided the hours are earned while working for a contributing employer to this Fund.

If you are working outside Local 139's jurisdiction, the Fund Office will provide a Transfer Authorization Form that you should complete and sign. No hours will be transferred unless this form is completed. Do not risk losing your eligibility—sign the form and return it to the Fund Office immediately.

Initial Eligibility can be established by having 300 hours of contributions reported by a contributing employer for hours worked during a calendar quarter. Hours may be prorated depending on contribution rates of out-of-state funds.

EXAMPLE: RECIPROCITY

On June 1, 2014, the Fund's contribution rate was $9.30 per hour for active employees. Jake worked 300 hours in a state where the rate was $11.25. He received eligibility credit for 362.90 hours under the Fund, even though he only worked 300 hours, because the rate was 21% higher in the other state. If the other state had a $6.75 per hour contribution rate, Jake would only have received credit for 217.74 hours under this Fund.

You should contact the Fund Office immediately if you accept work as an Operating Engineer outside of the state of Wisconsin.

TAKING A LEAVE OF ABSENCE

Under the Family and Medical Leave Act of 1993, as amended, (FMLA), eligibility for benefits must be extended to active employees and their Dependents if the active employee is eligible for and has been granted leave by his or her employer pursuant to FMLA, and if the employee's employer makes the required contributions to the Fund.

FMLA Provisions

If you qualify, FMLA allows you to take up to 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

1. The birth, adoption, or placement with you for adoption of a child;
2. To care for a seriously ill spouse, parent or child;
3. You are unable to work because of a serious Illness; or
4. You have a qualifying exigency because your spouse, child, or parent is on active duty or notified of an impending call to active duty status in support of a contingency military operation as either a member of the Reserves component of the Armed Forces of the U.S. or as a retired member of the regular U.S. Armed Forces.

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

If the need for qualifying exigency leave is foreseeable, you must provide your employer with notice that is "reasonable and practicable."

You may be eligible for up to 26 weeks of leave within a single 12-month period to care for a spouse, child, parent or next of kin who is a covered service member suffering from a serious Illness or Injury sustained in the line of duty, and which renders him or her unfit to perform the duties of his or her office, grade, rank, or rating.

A "covered service member" is a current member of the U.S. Armed Forces (including the National Guard) who is undergoing medical treatment, recuperation or therapy, and is being treated as an outpatient or is on temporary Disability.

Maintenance of Plan Benefits

During your leave, you will continue to receive medical coverage through the Fund if you properly notify your employer of your leave and your employer continues to make contributions to the Fund on your behalf. You are eligible for a leave under FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within a 75-mile radius.

The Fund will maintain your prior eligibility until the end of the leave, provided your employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

You may be required to provide:

- 30-day advance notice of the leave, if possible;
- Medical certifications supporting the need for a leave; and
- Second or third medical opinions and periodic recertification (at your employer's expense) and periodic reports during the leave regarding your status and intent to return to work.

If you and your employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

How FMLA Works With COBRA

Taking a family or medical leave is not in itself considered a COBRA Continuation Coverage qualifying event. If you return from leave within 12 or 26 weeks, as applicable, you will not experience a loss of coverage.

However, if you do not return from leave and lose coverage because you do not return to work, that will be considered a qualifying event under COBRA Continuation Coverage. In such an instance, you will have up to 12 weeks (or 26 weeks, if applicable) of maintained health care coverage during FMLA leave and an additional 18 months of continued coverage if you elect COBRA, which requires a self-payment.

TAKING A MILITARY LEAVE

The Fund provides coverage to members returning from active service when coverage through the military (Tri-Care coverage) ends.

If you enter the Armed Forces, you should notify the Fund Office, in writing. Your status will be frozen for the length of your service or five years, whichever is less. Upon your return, you may regain your eligibility status.

If you enter military service (active duty or inactive duty training) for up to 31 days, your health care coverage will continue if you make the required self-payment contributions. If you enter military service for more than 31 days, you may continue your coverage by making the required self-payment contributions for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

REEMPLOYMENT

Following your discharge from military service, you may be eligible to apply for reemployment with your former employer in accord with USERRA. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your employer.

How USERRA Works With COBRA

Continuation Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as that for COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described for COBRA, except that only you (the employee) have the right to elect USERRA coverage for yourself and your Dependents.

Your coverage under USERRA will continue until the earlier of:

1. The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
2. 24 consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

1. Your coverage would otherwise end as described directly above;
2. You lose your rights under USERRA (for instance, for a dishonorable discharge);
3. Your self-payment contribution is due and unpaid; or
4. You again become covered under the Plan.

If You Do Not Continue Coverage Under USERRA

If you do not elect to continue coverage under USERRA, your coverage will end 31 days after you enter active military service, or if you are eligible because your bank of hours is sufficient and you choose to use those hours for coverage, your coverage will end when your bank of hours is no longer sufficient. Your Dependents will have the opportunity to elect COBRA Continuation Coverage for themselves.

Upon your discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered by that employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service. If you chose not to use your bank of hours to continue coverage when you entered military service and you have a balance of hours in your bank that is sufficient for coverage, you will not have to contribute for coverage. However, if you do not have a bank of hours sufficient to continue coverage, you will be required to pay the cost of your coverage until you accumulate sufficient hours in your bank.

The following information outlines the deadlines applicable to your rights to reemployment and reinstatement of health care coverage. When you are discharged or released from military service that lasted:

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

When you are discharged, if you are hospitalized or recovering from a Sickness or Injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover (up to an additional two years) to return to work for a contributing employer.

If your employer reports your return to the Fund Office during the USERRA required time period, your eligibility and your Dependents' eligibility will be reinstated on the day you return to work.

If you are seeking work in the jurisdiction of the Fund, but are unable to find work, be sure to notify the Fund Office within the USERRA required time period after your discharge or release from military service. You may be allowed to make self-payment contributions for coverage.

The Fund will maintain your prior eligibility status until the end of the leave, provided your employer properly grants the leave under the federal law and you make the required notification to the Fund.

WHEN YOU ARE OUT OF WORK DUE TO A DISABILITY

Temporary Disability

If you are out of work due to a non-work related Disability, you may receive Loss of Time Benefits. You should notify your employer and the Fund Office of the reason for your absence from work.

> Loss of Time Benefits are not available to salaried Alumni or Non-Bargaining Unit Participants.

If you are out of work due to a work-related Disability, you may be eligible for Workers' Compensation. Contact your local or state Workers' Compensation office. You must provide the Fund Office with a letter from either your employer or the Workers' Compensation carrier (or provide a copy of your Workers' Compensation check).

Your benefits may continue and you may continue to earn credit for hours if you are out of work and receiving Loss of Time Benefits from the Fund or Workers' Compensation benefits. You will receive credit for up to 25 hours of contributions each week, not to exceed 100 hours per month, up to a maximum of:

- 26 weeks, if you are receiving Loss of Time Benefits; or
- 24 months, if you are receiving Workers' Compensation benefits.

The Fund Office may require initial proof or subsequent proof of Disability, upon request from the Trustees. The Trustees also have the right to require you to submit to a medical examination.

Permanent Disability

If you are permanently Disabled, you may be eligible for retiree coverage under the Plan, see page 9. The Trustees determine the benefits provided under retiree coverage, which may not necessarily be the same as those provided to active Participants.

To continue your eligibility for retiree coverage as a Disabled Participant, you must:

- Be eligible for coverage at the time of your Disability; and
- Have been credited with employer contributions to the Health Benefit Fund for at least:
  - » 3,000 hours in the three consecutive Calendar Years immediately preceding your Disability; or
  - » 4,000 hours in the four consecutive Calendar Years immediately preceding your Disability; or
  - » 5,000 hours in the five consecutive Calendar Years immediately preceding your Disability.

> If you become Disabled due to an Injury that is covered by the AD&D Benefit, you may also be eligible for an AD&D Benefit. Refer to page 61 for information regarding the Plan's AD&D Benefit.

In addition, if you are a Non-Bargaining Unit Employee, you must not be receiving wages subject to Social Security taxes from any contributing employer (to be indicated on a form provided by the Fund Office).

You are considered Disabled by the Fund if you are receiving either a:

- Disability benefit from the Central Pension Fund; or
- Social Security Disability award.

You or any of your Dependents who are eligible **must** enroll for Medicare Parts A and B. If you meet these conditions, you can continue your eligibility for coverage by making self-payment contributions.

IN THE EVENT OF YOUR DEATH

If you die while eligible for coverage under the Plan, your beneficiary will receive a Death Benefit (and an AD&D Benefit if your death is caused by an Accident). See page 61 for more information about the Death and AD&D Benefits provided by the Plan.

In addition, your Dependents' eligibility for coverage will continue until your bank of hours runs out. At that time, your surviving spouse can elect to continue eligibility for benefits by making self-payment contributions for retiree coverage (see page 9).

> Survivor coverage is available for your Dependents that were eligible for coverage at the time of your death.

If your spouse is under age 65 at the time of your death, your spouse's eligibility can be continued until he or she remarries or until your spouse becomes eligible under another group insurance plan (other than Medicare). If your spouse is age 65 or older at the time of your death, his or her eligibility will continue as long as your surviving spouse makes the required self-payment contributions. Your spouse's eligibility is subject to all the rules of retiree coverage (see page 9).

Your Dependent children will also continue to be eligible for medical benefits until age 26, as long as your surviving spouse makes the required self-payment contributions.

Instead of electing retiree coverage, your spouse and Dependent children may continue coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary self-payments for such coverage (see page 21).

WHEN YOU RETIRE

When you retire, you may be eligible to continue retiree coverage under the Plan. See page 9 for more information on continuing coverage as a retiree.

> At the time you retire (or change to Disability status), you or any of your Dependents who are eligible must enroll for Medicare Parts A and B.

CONTINUING COVERAGE

Generally, there are three ways to continue coverage under the Plan once you do not meet the Plan's eligibility rules:

- Self-payment contributions to continue eligibility for active coverage (only available to bargaining unit Participants and Fund-Related Operating Engineers who are available for full-time employment within the jurisdiction of the Fund);
- Retiree self-payment contributions to continue eligibility for retiree coverage (see page 9); or
- COBRA Continuation Coverage.

This section describes how to make self-payment contributions to continue eligibility for active coverage and how to make self-payments for COBRA Continuation Coverage. For more information on continuing coverage under the retiree program, see page 9.

Continuing eligibility for coverage by making self-payment contributions is only available to:

- Bargaining unit Participants; and
- Fund-Related operating engineers who are available for full-time employment within the jurisdiction of the Fund.

SELF-PAYMENT CONTRIBUTIONS FOR ACTIVE COVERAGE

If you are a bargaining unit Participant or Fund-Related Operating Engineer who is available for full-time employment within the jurisdiction of the Fund, it is possible that there will be Work Quarters in which you have less than 300 hours and where you have less than 1,200 hours in the last four Work Quarters. If this happens to you, **you will lose your eligibility** for coverage.

However, you may be eligible to continue your coverage by making self-payment contributions **or** electing COBRA Continuation Coverage. You choose the method you prefer. This section describes how to make self-payments to continue your eligibility for coverage. ***If you choose to make self-payment contributions to the Fund, you waive your right to COBRA***. See page 21 for more information on COBRA Continuation Coverage.

You may make a personal payment to the Fund to continue your eligibility for benefits. These personal payments are called self-payment contributions, and you may make these contributions for up to six consecutive Work Quarters. The self-payment contribution amount depends on the number of hours that you were short of the minimum required and also on the self-payment contribution rate. This rate is set periodically by the Trustees.

You may make self-payment contributions to continue your eligibility as long as you are:

- Immediately available for full-time work as an Operating Engineer for a participating employer;
- Registered in the "out-of-work book" with Local 139;
- Available to accept a referral for which you are qualified; and
- Not suspended or on a withdrawal card from Local 139.

If you work for a non-participating employer in the construction industry, you are not allowed to make self-payment contributions and you will lose your eligibility for coverage. However, you may be eligible to elect COBRA Continuation Coverage, as described on page 21.

Self-Payment Notice

If you do not have sufficient hours to continue your eligibility for coverage, the Fund Office will mail you a Self-Payment Notice before the beginning of March, June, September, or December. The Self-Payment Notice contains the name of the contractor(s), the month(s) worked, and the number of hours reported to the Fund on your behalf for the most recent Work Quarter. It also indicates the total number of hours you had reported on your behalf for the current and three prior Work Quarters.

The amount due is stated on the Self-Payment Notice. Before returning the Notice and the self-payment contribution to the Fund Office, be sure to complete the Notice and sign it. If you do not sign the Self-Payment Notice, it will be returned to you for your signature and your eligibility may be delayed. The payment is due within 15 days from the date of the Notice.

If you do not agree with the hours reported on your Self-Payment Notice, return the notice, along with any payroll check stubs or other supporting documentation to the Fund Office with your payment.

When the Fund Office receives your self-payment contribution, your ID cards will be activated to show your eligibility.

The Rules

Self-payment contributions are limited in nature and there are rules that apply to them, as follows.

- You may make self-payment contributions to continue your eligibility only if you are immediately available for full-time employment as an Operating Engineer with a participating employer. The Fund will assume that you are not available for work if you have withdrawn from, are suspended from, or are not registered in the "out-of-work book" with Local 139.
- Self-payment contributions must be made on time—this means within 15 days of the date on the Self-Payment Notice. The Fund Office mails these Notices quarterly – before the beginning of March, June, September, and December.
- If you **do not** make your self-payment contribution on time, you are not eligible for further self-payment contributions. However, you may be eligible to continue your coverage by electing COBRA Continuation Coverage, as described on page 21.

EXAMPLE: SELF-PAYMENT CONTRIBUTION

Sam elects to make self-payment contributions to the Fund to continue his eligibility for coverage under the Plan. However, after making a quarterly self-payment contribution for coverage, Sam begins working for a non-participating employer and, therefore, is no longer eligible to make self-payments.

- The choice between self-payment contributions and COBRA Continuation Coverage is given only when the first self-payment contribution is required. As explained on page 21, you have 60 days to elect to continue your coverage through COBRA.
- If you do not receive either a Quarterly Status Report or a Self-Payment Notice by the first day of the first month of the Eligibility Quarter (March, June, September, December), **it is your responsibility** to contact the Fund Office. You must contact the Fund Office within 15 days of the date on which a self-payment contribution is required, **or you may lose eligibility from the first day of the Eligibility Quarter.**

Amount Of Self-Payment Contributions For Active Coverage

The cost of self-payment contributions is determined by the Trustees based on the actual cost to provide coverage. The amount is subject to change.

You may make installment payments if the amount shown on your Self-Payment Notice exceeds one-half of the maximum self-payment contribution. As indicated on the Self-Payment Notice, the first installment is due within 15 days of the date on the Notice. The balance, which is the amount listed on the second Self-Payment Form, is due exactly one month later.

If you choose the two-installment plan, your Eligibility ID card will be activated after **both** payments have been received by the Fund Office. If the Fund Office is contacted by telephone to verify your eligibility for benefits, the person calling will be advised that a payment is due and has not yet been received.

If you or a member of your family requires Prescription drugs, you may purchase your Prescription drugs at the pharmacy of your choice and submit the paid receipt to the Fund Office for processing. However, please note that you will not receive your Prescription at discounted prices from Preferred Provider pharmacies until you make the required self-payment contribution for coverage. The Fund will not reimburse you (make benefit payment) until the full self-payment amount that is due has been received.

COBRA CONTINUATION COVERAGE

When you or your Dependents are no longer eligible for coverage, you may be able to continue coverage at your own cost through COBRA Continuation Coverage if you experience a qualifying event.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985

The choice between making self-payment contributions to the Fund to continue your coverage and electing to make self-payment contributions for COBRA Continuation Coverage is given only when the first self-payment contribution is required. Choosing one form of continuation coverage constitutes a waiver of the other form of continuation coverage. Once you receive a COBRA notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. You may elect COBRA on behalf of yourself and your family members or they can each elect their own COBRA Coverage. Parents may elect COBRA Coverage for their children.

You are eligible to continue coverage by electing COBRA Continuation Coverage if you experience a qualifying event.

You or your Dependents must complete the election form and send it back to the Fund Office to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents.
2. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to such coverage, your Dependents (including your spouse and your Dependent children) have the right to elect COBRA Continuation Coverage for themselves.
3. The person electing COBRA Continuation Coverage has 60 days after the election notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed form. An election of COBRA Continuation Coverage is considered to be made on the date the election form is mailed back to the Fund Office. A person also has the right to waive a previous election and make a new election within the 60-day period.
4. If the election form is not mailed back to the Fund Office within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

After the COBRA Continuation Coverage election period has passed, you are not able to choose COBRA Continuation Coverage instead of making the Fund's self-payment contributions.

Under COBRA, you or your Dependents may continue health care coverage past the date coverage would normally end. Under certain circumstances, you or your Dependents may make self-payments to continue:

- Medical benefits; or
- Medical, dental, and vision benefits.

COBRA Continuation Coverage will be identical to the coverage you had under the Plan before the COBRA qualifying event; with the exception that you are ***not*** eligible to continue coverage for Loss of Time, Death, HRA, Pre-funding, and AD&D Benefits (or dental and vision benefits if you elect medical benefits only).

If you acquire a new child that meets the Plan's definition of an eligible Dependent (for example, have a newborn child, adopt a child or have a child placed with you for adoption) while your COBRA Continuation Coverage is in effect, you may add the child to your coverage. To have this child added to your coverage, you must provide written notification and legal documentation to the Fund Office immediately after the birth, adoption, or placement of a child with you for adoption.

Children born, adopted, or placed for adoption as described above, have the same COBRA rights as a Dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, such child's continued coverage depends on timely and uninterrupted self-payment contributions having been received by the Fund on their behalf.

Qualifying Events

It's important to notify the Fund Office of a qualifying event to maintain your COBRA rights.

You do not have to show that you are insurable for COBRA Continuation Coverage. It is offered to you and/or your Dependents if you lose coverage as a result of a qualifying event. Qualifying events include your loss of coverage caused by your:

- Termination of employment;
- Reduction in hours;
- Death;
- Entitlement to (eligibility for and enrollment in) Medicare;
- Divorce/legal separation; and
- Your child losing Dependent status under the Plan.

Notifying The Fund Office

If you do not notify the Fund Office within 60 days of your divorce or legal separation or the loss of your child's Dependent status, you will lose your right to elect COBRA Continuation Coverage.

You or your Dependent must inform the Fund Office of a divorce or a child losing Dependent status under the Plan within 60 days of the qualifying event. If you do not notify the Fund Office within 60 days of such an event, you and/or your Dependents will lose your right to elect COBRA Continuation Coverage.

Your employer must notify the Fund Office of your termination of employment, reduction in hours, or death. However, you should also notify the Fund Office of these events as well as of your entitlement to Medicare coverage, divorce, or child losing Dependent status. To help ensure that you do not suffer a gap in coverage, you or your family should notify the Fund Office of qualifying events as soon as they occur. If you do not notify the Fund Office within 60 days of a qualifying event, you will lose your right to elect COBRA Continuation Coverage.

When the Fund Office is notified that one of these events has occurred, you and your Dependents will be notified as to whether or not you are eligible to elect COBRA Continuation Coverage. Once you receive a COBRA Continuation Coverage notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. Your Dependents have the option to elect coverage independently from you.

Periods of Coverage

Coverage continues for 18 months if your coverage ends due to your termination of employment or your reduction in hours.

Coverage continues for 29 months if you or one of your Dependents are determined to be Disabled by the Social Security Administration when your coverage ends or if you become Disabled within 60 days of the date your coverage ends. To continue coverage for up to 29 months, you must notify the Fund Office of your determination of Disability by the Social Security Administration. If the Social Security Administration subsequently determines that you are not (or are no longer) Disabled, you must notify the Fund Office within 60 days of such determination.

Coverage continues for 36 months if your spouse or other Dependent's coverage ends because of your:

- Entitlement to Medicare;
- Death;
- Divorce/legal separation; or
- Dependent child no longer meets the definition of an eligible Dependent under the Plan.

Loss of Continued Coverage

The period of COBRA Continuation Coverage for you or your Dependents may end if:

- You or your Dependents do not make the required COBRA contributions on a timely basis;
- You or your Dependents become covered under any other group health care plan, including Medicare, after electing COBRA Continuation Coverage; or
- The Fund ceases to provide any group health benefits.

Be sure to notify the Fund Office of any address changes.

If you lose coverage before the expiration of your maximum period of COBRA Continuation Coverage, the Fund Office will notify you. Your Dependents may be eligible to continue coverage. Once your COBRA Continuation Coverage ends, it cannot be reinstated.

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage is determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage. The cost for extended Disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your Dependents' coverage under the Plan ended. The first payment is due 45 days after the date of your election of COBRA coverage. You may contact the Fund Office for the amount of the first payment. Subsequent payments are due the first of the month. However, you have a grace period of 30 days from the due date for subsequent payments. Coverage will end if the payment is not made within 30 days of the due date.

A COMPARISON FOR ACTIVE PARTICIPANTS

Here is a comparison of your coverage continuation options:

	Self-Payment Contribution	COBRA Continuation Coverage
Eligibility Ends	August 31, 2013	August 31, 2013
Payment Privileges Continue Until	February 28, 2015	February 28, 2015
Coverages	Medical, dental, vision, death, HRA, and loss of time benefits	Medical, dental, and vision benefits or Medical only
Cost	Current contribution rate times number of hours short of eligibility	Cost plus 2%
Election Period	Self-Payment Notice must be signed and returned to the Fund Office with payment within 15 days of date on Notice.	COBRA Enrollment Form must be submitted to the Fund Office within 60 days of receipt.

A Reminder: You May Choose Only One Form of Continuation Coverage

Remember, once you receive a COBRA Continuation Coverage notice, you have 60 days to respond to elect COBRA Continuation Coverage. However, if you choose the Fund's self-payment contribution program, you waive your right to elect COBRA and after 60 days you cannot change your mind and elect COBRA Continuation Coverage instead. And if you do not make the Fund's **first** self-payment contribution within 15 days, you are not eligible to make further self-payment contributions.

THE HEALTH REIMBURSEMENT ACCOUNT (HRA)

Realizing that Participants have various types of health care expenses, the Fund offers a Health Reimbursement Account (HRA), which gives you the financial flexibility to use the Plan in the way that best meets your and your family's needs.

HRA HIGHLIGHTS

The HRA is designed to provide reimbursement of certain health care expenses on a tax-free basis. Here's how the HRA works:

- You work for a contributing employer that contributes to the Fund on your behalf.
- For each hour of contributions made on your behalf, a portion of the hourly contribution rate is credited to your HRA.
- You determine how you want to use the money in your HRA. You can use it as you incur eligible health care expenses or save up and use the funds for future health care expenses.
- In order to promote wellness and early detection, if you are an eligible actively working Participant, the Fund credits money into the HRA account that you can use when you receive an annual physical exam. If you are married, both you and your spouse must receive annual physicals in order to qualify for this benefit. In addition, you must complete a simple form, an **HRA Bonus Request Form**, to receive the benefit. You may obtain the form from the Fund Office or print it from the Fund's website.

An HRA may only be used to pay for eligible health care expenses as defined by the Plan (see page 28). However, a wide range of eligible expenses are covered, such as:

- Payments for coverage—including self-payment contributions to continue coverage when you are not working enough hours, COBRA Continuation Coverage self-payments, retiree coverage self-payment contributions, and post-tax premiums your spouse pays for other coverage.
- Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance.
- Health care expenses not covered under the Plan, or only partially covered under the Plan, such as LASIK surgery, contact lenses, Prescription smoking cessation products, Prescription drugs, and expenses that exceed benefit maximums.

We encourage you to read this section carefully to help you understand how your HRA works and how it can benefit you.

ELIGIBILITY

You are eligible for the HRA if you are eligible for coverage under the Plan. All eligibility provisions are the same as listed elsewhere in this Summary Plan Description. This applies to all eligible Participants, including:

- Bargaining Unit Participants;
- Alumni Participants;
- Non-bargaining Unit Participants; and
- Retired Participants.

You may use your HRA for reimbursement of eligible expenses incurred by your spouse and eligible Dependents.

While contributions are only made on your behalf while you are working for a contributing employer, you don't have to be an active Participant to use your HRA. Your HRA balance is available when you're not working enough hours and after retirement, which means as long as you, your spouse, or eligible Dependents are self-paying to continue coverage under the Plan, you may continue to use your HRA. In addition, your HRA balance is available to your surviving spouse and/or eligible Dependents in the event of your death.

The more you work, the more contributions are made to your HRA—and the more your HRA grows, tax-free.

Plus, money in your HRA and amounts reimbursed for eligible expenses are not included in your income, which means you aren't taxed on this money.

Continued Eligibility

Your eligibility for the HRA is based on your eligibility for Plan coverage. Once you are eligible, your eligibility continues on a quarter-to-quarter basis, provided the required contributions are made on your behalf.

Your HRA balance is available to you as long as you are eligible for coverage, whether your eligibility is based on hours of contributions made on your behalf, self-payment contributions you make to continue coverage, or self-payments you make for COBRA Continuation Coverage.

Under the HRA, you may continue to be reimbursed for any premiums you pay toward group health, disability or long-term insurance, as long as you make contributions to continue coverage under the Plan. However, premiums for individual market coverage or insurance plans purchased from a state or the federal Marketplace are not considered expenses eligible for reimbursement through the HRA.

Freezing Your HRA Balance During Retiree In-and-Out Period

You may freeze your HRA balance if you opt out of the Plan's coverage because you have coverage available through another group plan, such as through your spouse's employer. To be eligible to freeze your HRA balance during the time you have opted out of coverage, you must follow the Plan's formal process to opt out of coverage (see the ***Retiree In-and-Out Program*** section on page 11). When you opt back in to retiree coverage, your HRA balance will be restored for use by you and your Dependents, unless you have permanently opted out of the Plan's HRA coverage under the next section.

If You Elect To Purchase Individual Insurance Coverage Through the State or Federal Marketplace

If you seek to purchase individual insurance coverage through the state or federal marketplace, having an HRA account balance will affect your eligibility for government issued subsidies. Therefore, if you have an HRA account balance but wish to purchase individual insurance coverage through the state or federal marketplace, you are allowed, at least annually, to permanently opt out of the Plan's HRA coverage and waive future reimbursements from your HRA account.

If you terminate your employment, you may elect, effective on the date you terminate your employment, to forfeit your HRA account balance. If you opt out of your HRA coverage and forfeit your account balance upon termination, and you later become eligible for Plan coverage again, you may begin accruing new HRA benefits upon becoming eligible again. However, any HRA balance that you forfeited will not be restored.

When Eligibility Ends

As long as you are eligible for Plan coverage, you are eligible to use your HRA, including when you are eligible to continue coverage by making self-payments.

Once your eligibility for Plan coverage ends, so too does your eligibility for the HRA.

If eligibility ends because of a COBRA qualifying event, you will be given the opportunity to continue the same coverage that you had the day before the qualifying event for the periods determined by COBRA (subject to all conditions and limitations of COBRA). This also applies to your HRA.

The Trustees reserve the right to discontinue crediting contributions to your HRA at any time.

If you are a public employee and are due to lose eligibility for coverage as soon as your municipality provides coverage through a different source, you will continue to have access to your HRA and be able to use your HRA balance for a period of 36 months after your eligibility under this Fund ends.

Once you lose eligibility for coverage for a 36-month period, any unused credit in your HRA will be forfeited. In addition, if you are self-paying for COBRA Continuation Coverage, you will forfeit any unused amount in your HRA if you do not make the required

monthly self-payment or at the end of your COBRA Continuation Coverage period. Any forfeited amounts revert to the Plan's general assets and are used for administrative expenses. In no event will forfeited amounts be paid to you or your Dependents in cash.

Reimbursements After Eligibility Ends

When you are no longer eligible for coverage, and before your HRA is forfeited, you may submit expenses for eligible expenses that are incurred **before** your eligibility ended.

> You should file a written claim for reimbursement with the Fund Office as soon as possible. If your claim is not filed within 24 months of the date of the expense, your claim will not be accepted and may be denied.

Life Events

- **If You Do Not Work Enough Hours.** If you do not work enough hours to continue eligibility for coverage, you may use your HRA to make self-payments to continue your coverage. You must contact the Fund Office and complete any necessary paperwork to use your HRA balance towards any required self-payment amounts.
- **Family and Medical Leave Act (FMLA).** During an FMLA leave, your HRA will be maintained if you properly notify your employer of your leave and your employer continues to make contributions on your behalf. The Fund will also maintain your eligibility until the end of the leave.

  Generally, an FMLA leave ends on the earlier of your return to work or after 12 weeks (or 26 weeks, if applicable). If you do not return to work within 12 weeks (or 26 weeks, if applicable) of the date your leave begins, you may be eligible for COBRA Continuation Coverage.

  > **YOUR HRA AND COBRA CONTINUATION COVERAGE**
  >
  > When you, your spouse, and/or eligible Dependents are eligible for COBRA Continuation Coverage, your HRA balance may be used for self-payments to continue this coverage.

- **Military Leave.** If you enter the armed forces for less than 31 days, your HRA will be maintained if your employer contributes on your behalf as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If your military service lasts 31 days or longer, you have two options:
  - You can continue your coverage by making self-payments or electing COBRA Continuation Coverage, at which time your HRA balance will be available for use; or
  - You can notify the Fund Office of your entry into the military, in writing, in which case your HRA balance will be frozen for the lesser of your length of service or five years. Your HRA balance will be available upon your reinstatement of eligibility for coverage, in accordance with the rules listed on page 8.
- **When You Retire. No new contributions will be credited to your HRA after you retire.** Self-payment contributions are required for retiree coverage. When you retire, you may use the balance in your HRA to make self-payment contributions for retiree coverage. In addition, as long as you are eligible for retiree coverage, you may also use your HRA to pay for eligible expenses (see page 28 for more information).

  > If you have no surviving spouse and/or other eligible Dependents at the time of your death, any balance in your HRA will be forfeited and become a part of the Plan's general assets.

- **In the Event of Your Death.** Your HRA balance will be available to your surviving spouse and/or eligible Dependents after your death, and they can use the funds to pay for eligible expenses (including expenses you incurred before your death). They can also use the remaining funds to make self-payments to continue coverage under the Plan.

  While your surviving spouse and/or eligible Dependents may continue to use your HRA as long as they are eligible to make self-payments for coverage, no further contributions will be made to the HRA. In addition, under no circumstances will the balance in your HRA be paid to your beneficiaries in cash.

YOUR ACCOUNT

When you are initially eligible for Plan coverage and employer contributions are received on your behalf, your HRA is established and a portion of the employer contributions made on your behalf is credited to that account. While contributions are only made to your HRA while you are an active employee, you can use your HRA in retirement and submit claims for health care expenses incurred by you, your spouse, and any other eligible Dependents. While you are an active employee, employer contributions made on your behalf continue to be credited to your HRA.

> The Plan will establish and maintain an HRA for each eligible Participant but will not create a separate fund or otherwise segregate assets for this purpose. HRAs are recordkeeping accounts only, and are used to keep track of contributions and available reimbursement amounts.

Contributions

On June 1, 2014, the hourly contribution rate was $9.30 per hour, including pre-funding. For each hour of contributions made on your behalf (on and after June 1, 2014), $1.00 of the hourly contribution rate is credited to your HRA.

EXAMPLE: CONTRIBUTIONS

Wayne has 350 hours of contributions made on his behalf for the July, August, September Work Quarter, which earns him eligibility for the December, January, February Eligibility Quarter. Of the $3,255 ($9.30 x 350 hours) of contributions made on his behalf, $350.00 ($1.00 x 350 hours) will be credited to his HRA.

When looking at hours of contributions made on your behalf, the Fund includes reciprocal hours of contributions made on your behalf. However, these hours are prorated, using the contribution rate as the base rate. Contact the Fund Office for more information about reciprocal hours.

All contributions credited to your HRA are assets of the Fund; you are not vested in the contributions made on your behalf and you may use your HRA only for the purposes stated.

Your HRA Balance

Your HRA balance is the total of employer contributions made on your behalf for the HRA minus any reimbursements you request from your HRA.

Any unused amount in your account at the end of a Calendar Year carries forward, even into retirement. After termination of eligibility, your HRA may be carried forward up to 36 consecutive months (12 calendar quarters) without forfeiture. After retirement, your HRA balance will be carried forward until no balance remains or until you are no longer eligible for coverage.

> If money remains in your HRA at the end of a year, it just rolls over into the next year, allowing you to save for future eligible expenses.

In the event you should seek to purchase individual insurance coverage on the state or federal marketplace, having an HRA account balance will affect your eligibility for government issued subsidies. Therefore, if you have an HRA account balance you will be allowed, at least annually, to permanently opt out of HRA coverage and waive future reimbursements from your HRA account. If you terminate employment, you may elect, effective on the date you terminate employment, to forfeit your HRA account balance. If you opt out of your HRA coverage and forfeit your account balance upon termination of coverage, and you later become initially eligible for Plan coverage again, you may begin accruing new HRA benefits upon becoming eligible again. However, any HRA balance that you forfeited will not be restored.

Quarterly Status Report

When you are eligible for benefits, you receive a quarterly status report before the beginning of each Eligibility Quarter (March, June, September, or December). In addition to reporting the name of the contractor(s), the month(s) worked, and the number of hours reported to the Fund on your behalf during the most recent work quarter, this report will also include your HRA balance.

Self-Payment Notice

If you do not have sufficient hours to continue your eligibility for coverage, you may self-pay to continue coverage. You will receive a self-payment notice before the beginning of each eligibility quarter (March, June, September, or December) that includes the amount of any self-payment due. This notice will also contain information on your HRA balance and give you the option to use your HRA balance toward your self-payment.

> The amount available for reimbursement of eligible expenses is the amount credited to your HRA. Your HRA is funded exclusively through contributions made by your employer to the Fund on your behalf in accordance with the collective bargaining agreement or participation agreement applicable to you. Contributions made on your behalf are due by the 15th of the month but will not be credited to your HRA until they are received by the Fund. Therefore, there will be a lag between the time contributions are required on your behalf and when they are available for you to use. If money remains in your HRA at the end of a year, it just rolls over into the next year, allowing you to save for future eligible expenses.

TAX STATUS

Contributions credited to your HRA are pre-tax (not taxable income when made) and generally are not taxable when paid out as benefits.

Tax Consequences

The Fund makes no guarantee that any amounts paid for you, your spouse, or your eligible Dependents under the HRA will be excludable from your gross income for federal, state, or local income tax purposes. It is your responsibility to determine whether payments under the HRA are excludable, and to notify the Fund if you have any reason to believe that such payment is not excludable.

> If you submit an expense for reimbursement under the Plan's HRA, you cannot deduct that expense on your tax return.

If you receive reimbursement under the HRA on a tax-free basis, and the payment does not qualify for tax-free treatment under the Internal Revenue Code, you will be required to indemnify and reimburse the Fund for any liability incurred for failure to withhold federal income taxes, Social Security taxes, or other taxes.

ELIGIBLE HEALTH CARE EXPENSES

As you incur eligible health care expenses, you can use the money in your HRA to pay for eligible expenses incurred by you, your spouse, and/or your eligible Dependents. Eligible expenses, as defined by the Plan, include (but are not limited to):

- Coverage costs, including self-payment contributions or premiums:
  - » To continue Plan coverage when you are not working enough hours;
  - » For COBRA Continuation Coverage;
  - » For retiree coverage; and
  - » Those that you and/or your spouse pay for other coverage (such as employer insurance, group policy insurance, or Medicare, provided it is not paid on a pre-tax basis); and
- Health care expenses, including:
  - » Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance; or
  - » Expenses not covered, or only partially covered, under the Plan, such as LASIK surgery, contact lenses, Prescription smoking cessation products, and Prescription drugs.

Reimbursable health care expenses may include medical, Prescription drug, dental, and vision expenses.

In general, expenses eligible for reimbursement only include those that:

- Are incurred when you are eligible for Plan coverage;
- You, your spouse, and/or your eligible Dependents are required to pay;
- Are not reimbursed by insurance or any other source; and
- You, your spouse, and/or your eligible Dependents have not taken (or will not take) as a tax deduction.

The HRA is intended to qualify as a medical reimbursement plan under §105 and §106 of the Internal Revenue Code of 1986, as amended, and related regulations, and as a health reimbursement arrangement, as defined under IRS Notice 2002-45, the PPACA and IRS Notice 2013-54. Eligible HRA Expenses reimbursed under the HRA are intended to be eligible for exclusion from your gross income under §105(b) of the Internal Revenue Code of 1986, as amended.

Dependent Expenses

If your spouse and/or your other Dependents meet the Plan's definition of Dependent, you may submit their expenses for reimbursement from your HRA, even if they are not enrolled in the Plan. For example, if your spouse has other coverage and this Plan is not your spouse's primary plan, you may submit eligible expenses that your spouse incurs.

HRA Eligible Expenses Not Otherwise Covered by the Fund

Expenses not otherwise covered by the Fund are eligible for reimbursement from your HRA if they are included as eligible expenses under Internal Revenue Code Section 105 and Section 213(d), unless otherwise listed in the Expenses Not Eligible for Reimbursement section on page 29. See IRS Publication 502 for further details. Such expenses must not be reimbursed or reimbursable from another source and include, but are not limited to the following:

- Acupuncture (excluding remedies and treatment prescribed by an acupuncturist).
- Alcoholism and chemical dependency treatment.
- Ambulance.
- Artificial limbs/teeth.
- Chiropractic treatment.
- Christian Science practitioner's fees.
- Contact lenses and solution.
- Copayments.
- Crutches.
- Custom orthopedic devices.
- Dental fees.
- Diagnostic fees.
- Eye examination fees.
- Fertility Enhancements
- Hearing exams, devices and batteries.
- Home improvements or installation of equipment if the main purpose is medical care.
- Hospital bills.
- Insulin.
- Laboratory fees.
- Long term care insurance premiums.
- Marriage and family counseling.
- Medications and medical supplies (e.g., syringes, needles, etc.).
- Obstetrical expenses.
- Oral surgery.
- Orthodontic fees.
- Over-the-counter medications that are obtained with a prescription from your Physician.
- Oxygen.

You will only be reimbursed for eligible expenses up to the unused amount in your HRA.

If you have any questions as to whether an expense is eligible for reimbursement, contact the Fund Office.

- Physician fees.
- Payments for coverage, including self-payment contributions to continue coverage when you are not working enough hours, COBRA Continuation Coverage self-payments, and retiree self-payments.
- Prescription eyeglasses.
- Prescription medications from the United States or Canada.
- Psychiatric care.
- Psychologist's fees.
- Routine physicals and other non-diagnostic services or treatments.
- Special Education. Tuition and certain other expenses for children who have learning disabilities caused by mental or physical impairments.
- Surgical fees.
- Transportation expenses that are primarily for, and essential to, medical care.
- Weight-Loss Program if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This does not include the cost of food or beverages.
- Wheelchairs.
- Wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease.
- X-rays.

In addition to the above, HRA eligible expenses also cover the following expenses that are not Covered Expenses under the Health Benefit Fund:

- After-tax premiums your spouse pays for other coverage.
- Contributions a spouse is required to pay for employer-sponsored group health coverage (provided the contributions are paid on an after-tax basis).
- Contributions or premiums for qualified, employer-sponsored health coverage.
- Deductibles.
- Expenses applied to the out-of-pocket maximum.
- Eye surgery, including laser eye surgery (e.g., cataracts, LASIK, radial keratotomy, etc.)
- Massage therapy provided by a state licensed massage therapist.
- Premiums paid for group health, Disability or long-term care insurance, unless the premium is paid or could have been paid pre-tax from another source.
- Prescription smoking-cessation programs.

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Expenses that are not eligible for reimbursement from the HRA include, but are not limited to, items that do not constitute "medical care," as defined in Internal Revenue Code §213d. Examples of such ineligible medical expenses include:

- Automobile insurance.
- Automotive improvements
- Bottled water.
- Controlled substances (such as marijuana) that are in violation of federal laws.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an Accident or trauma, or disfiguring disease. Cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not fully promote the proper function of the body or prevent or treat Illness or disease.
- Cosmetics, toiletries, toothpaste, etc.
- Custodial care.
- Dental bleaching.
- Diapers or diaper service.
- Expenses incurred before eligible to participate in the Plan.
- Funeral or burial expenses.
- Health club or fitness program dues, even if necessary to alleviate a specific medical condition (such as obesity).
- Household and domestic help.
- Long-term care services.
- Maternity clothes.
- Nurse expenses to care for a healthy newborn at home.
- Over-the-counter items, drugs, or medications, except that such items obtained with a prescription from your Physician are covered.
- Prescription medications received outside the United States or Canada (such as from Mexico).
- Social activities (such as dance lessons).
- Uniforms or special clothing (such as maternity clothing).
- Weight loss programs for general health or appearance.
- Premiums for individual market coverage or insurance plans purchased from a state or federal marketplace.

Note that this list is subject to change based on the Internal Revenue Services' definition of what is or is not an eligible expense for reimbursement.

CLAIMS AND REIMBURSEMENTS

You must submit a claim for reimbursement of any eligible expense and back-up documentation in accordance with the procedures described in the ***Claims Information*** section on page 65.

Unfortunately, many HRA claims that are submitted to the Fund have to be returned to the claimants because they don't provide the necessary information. Here are a couple of tips to follow so that your HRA reimbursement is not delayed:

- Make sure your claim totals at least $250.
- Check and make sure that the item or service is an eligible expense.
- If you are submitting a large number of claims, submit one HRA claim form for each family member.
- Date and sign each claim form to comply with IRS regulations.
- Save your Explanation of Benefits (EOBs)—do not throw them away. You will need them if you want reimbursement of your coinsurance. Remember, you can access and print copies of your EOBs through the Fund's website, **www.iuoe139.org**.
- Do not send balance due notices or statements from doctors or clinics—they will be returned to you.
- Do not expect a reimbursement if there are no funds in your HRA. You will not have more money in your account until more contributions are made on your behalf.

Reimbursement is paid directly to you; you are responsible for paying any providers.

While requests for reimbursement can be made at any time, to limit administrative expenses, the Fund requires that any requests for reimbursement be for a minimum of $250. Therefore, you may have to hold your requests for reimbursement until you have a total of at least $250 in eligible expenses.

COMPREHENSIVE MEDICAL BENEFITS

The Plan's Comprehensive Medical Benefits offer you financial protection in case an unexpected medical expense should arise, and makes comprehensive health care possible for you and your family, without putting a strain on your budget.

All active and retired Participants who have satisfied the eligibility requirements of the Fund, and their covered Dependents, are eligible for benefits under the Plan's Comprehensive Medical Benefits program. However, there are some limitations on coverage:

- Maternity and obstetrical care are covered only for active and retired Participants and their spouses; and
- Treatment for autism is not covered, but such treatment is an eligible expense under the HRA.

Comprehensive Medical Benefits are designed to provide coverage only for care that is Medically Necessary in the treatment of an Illness or Injury. Therefore, medical treatment for elective Cosmetic Surgery or similar non-Medically Necessary treatment is not covered. If you have any questions, please contact the Fund Office.

The Plan's medical coverage is designed to be comprehensive. But no medical plan, ours included, is designed to reimburse you in full for every health care expense. For instance, day-to-day medical expenses, such as routinely used vitamins or non-Prescription medicines are your responsibility. Covered items are not paid in full, but a large portion is covered. For more information on what is not covered under the Plan, see page 63.

HOW THE PLAN WORKS

Comprehensive Medical Benefits pay for a wide range of services and supplies, including Hospital charges, Physician charges, diagnostic testing, and surgery. How the Plan works is simple. Each year, the Plan covers medical benefits like this:

- You are responsible for meeting your annual deductible(s) (between June 1 and May 31).
- Once you or your family meets the annual deductible(s), the Plan covers a percentage of Covered Expenses and you pay the rest. This is known as coinsurance. The coinsurance percentage the Plan covers varies depending on whether you use a Preferred or non-Preferred Provider.

- Once the coinsurance amounts you pay for Covered Expenses, **not** including the amounts you paid toward your annual deductibles, reach the annual out-of-pocket maximum, the Plan covers 100% of the charges for Covered Expenses incurred for the remainder of the Calendar Year (January through December).

Note that some benefits and expenses may be covered differently or be subject to benefit maximums. Refer to the ***Summary of Benefits*** insert (in the back pocket of this booklet) and specific benefit descriptions for more information.

Annual Deductibles

The medical annual deductible is the amount of Covered Expenses that you (and your family) pay each year before the Fund begins to pay benefits. The annual deductible amount is listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

An annual deductible is a dollar amount that must be paid each year before the Fund begins paying benefits.

Note: Both an in-network and out-of-network deductible apply. Refer to the Summary of Benefits insert.

Payments toward an individual deductible are limited to a family maximum; so that once payments toward the individual deductible for all family members reach the family maximum, individual deductibles for all family members will automatically be satisfied for that year. It is possible to meet the family maximum without satisfying an individual deductible.

EXAMPLE: ANNUAL DEDUCTIBLE FAMILY MAXIMUM

Dan, his wife Debbie, and each of their two daughters are covered under the Plan. In July 2014, Dan's two daughters each incurred $125 in medical Covered Expenses. In September 2014, Dan and his wife each incurred $175 in medical Covered Expenses. The amounts incurred by each individual were applied to their individual medical deductibles as well as to the family maximum. Although no one in Dan's family had met his or her individual medical deductible, because the family had paid $600 in medical Covered Expenses ($125 + $125 + $175 + $175), Dan's family met the deductible family maximum and no further medical deductibles needed to be paid for the June 1, 2014 through May 31, 2015 Deductible Period.

The amounts you pay toward the annual deductible do not apply toward meeting the Plan's annual out-of-pocket maximum.

Waiver Of Annual Deductibles – For Active Participants Only

Depending on the number of hours you work for which contributions are made to the Fund on your behalf, ***your in-network medical annual deductible, and your spouse's in-network medical annual deductible may be waived***. If between January 1 and December 31, you have contributions made on your behalf for:

- 2,600 or more hours, as of the following June 1st, you will not need to meet your individual in-network medical deductible before Plan coverage begins; or
- 2,900 or more hours, as of the following June 1st, you and your spouse will not need to meet your individual in-network medical deductible before Plan coverage begins for medical services (this only applies to you and your spouse).

That means that if you meet the hours of contributions requirement, your (and your spouse's) in-network deductible will be waived for the following June 1 through May 31– this could lower the amount you pay toward medical benefits.

In addition, the hours of contributions made to the Fund on behalf of married Participants who are both Employees can be combined to grant them the appropriate waiver of deductibles, based upon the combined hours.

Amounts you pay for medical expenses apply toward your annual deductible and your annual out-of-pocket maximum. The following amounts are not used to satisfy your annual deductible or out-of-pocket maximum:

- Dental expenses;
- Vision expenses,
- Expenses in excess of the Allowable Charge;
- Expenses in excess of any limits;
- Non-Covered Expenses; and
- Additional emergency room coinsurance amounts.

Note: An out-of-network annual out-of-pocket maximum also applies. Refer to the ***Summary of Benefits*** insert.

Coinsurance

Coinsurance is the percentage of charges you are responsible for paying for certain covered health services after you meet your annual deductible.

Annual Out-Of-Pocket Maximum

The annual out-of-pocket maximum limits the amount of Comprehensive Medical Benefits Covered Expenses you pay each year. The amount of this maximum is listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). Once you or one of your Dependents meet the per person annual out-of-pocket maximum, 100% of that individual's Comprehensive Medical Benefits' Covered Expenses will be paid for the remainder of the Calendar Year. If your family reaches the family maximum, 100% of your and your eligible Dependents' Comprehensive Medical Benefits Covered Expenses will be paid for the remainder of the Calendar Year.

Remember that if you use an out-of-network provider, the amounts that exceed the Fund's Allowable Charge are not applied to the annual out-of-pocket maximum.

Plan Maximums

The Plan no longer imposes lifetime limits on certain benefits. However, some other Comprehensive Medical Benefits have dollar or treatment maximums, as specified on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

Allowable Charges

The Plan covers costs for services and supplies only to the extent that they are Allowable Charges. With respect to a PPO network provider (defined below), the Allowable Charge is the negotiated fee/rate they have agreed to charge for supplies and services rendered. The Trustees determine the Allowable Charge that will be paid for services and supplies of non-PPO providers.

Medically Necessary

The Plan covers costs only for services and supplies that are Medically Necessary. For a definition of Medically Necessary, see page 91.

Preferred Provider Organization (PPO) Network

It's always a good idea to verify that your provider is still part of the PPO network **before** receiving care. To find out if a provider participates in the Plan's PPO network, call the PPO provider directly or visit its website. See the ***Important Contact Information*** insert (in the back pocket of this booklet) for phone numbers and website address.

To help manage certain health care expenses, the Plan contains a cost management feature – the Preferred Provider Organization (PPO) network. The Fund has contracted with a PPO network to provide benefits to our Participants.

Providers (Physicians, Hospitals, and other professional health care providers) participating in the PPO network have agreed to negotiated, reduced fees. When you use a Preferred Provider, you save money for yourself and the Fund because Preferred Providers have agreed to charge a reduced amount for their services.

The Plan will cover radiologist, pathologist, anesthesiologist, emergency room Physician, and laboratory technician Covered Expenses at the network rate when performed at a network-preferred facility or doctor's office, regardless of whether or not the provider is a Preferred Provider.

The Preferred/non-Preferred Provider Feature

Most provider networks are big enough to provide just about any type of health care service that you and your family will need. However, health care is a very personal issue and sometimes you may wish to seek care from a provider that does not participate in the Plan's PPO network. The Preferred/non-Preferred Provider feature of our Plan accommodates these circumstances. Each time you receive medical care, you can choose whether to use a Preferred Provider or not. You always have the final say about the Physicians and Hospitals you and your family use. However, to encourage you to use Preferred Providers whenever possible, the Plan covers a higher percentage of your health care expenses when you go to a Preferred Provider.

To take advantage of the savings the PPO provides, always check to see if your provider is in the network (providers participating in the network change periodically). You must show your Eligibility ID card at the time that you receive service. If you do not notify your provider of your network coverage within 30 days of the date you receive service, the Fund Office will process your claim as an out-of-network claim.

Finding a Preferred Provider is easy. For the most up-to-date information, you can ask your provider if he or she participates in the PPO network, contact the PPO directly by phone, or visit the PPO's website. There is a link to the PPO's website on the Fund's website. Refer to the ***Important Contact Information*** insert (in the back pocket of this booklet).

PREFERRED OR NETWORK PROVIDER

A network of providers, including Physicians, Hospitals, and other health care professionals, that have agreed to charge negotiated, reduced rates. Since Preferred Providers have agreed to these negotiated rates, you help control health care costs for yourself and the Fund when you use Preferred Providers.

Refer to the *Summary of Benefits* insert (in the back pocket of this booklet) for the coinsurance amounts paid for Preferred Providers and non-Preferred Providers.

Medicare Eligible Participants

Medicare places restrictions on health care providers by determining a Medicare Approved Amount (the maximum amount Medicare will pay). Generally, this amount is the same or less than the amount a PPO provider negotiates with its Preferred Providers.

If you are a retiree Eligible for Medicare, the Plan pays benefits as listed on the *Summary of Benefits* insert (in the back pocket of this booklet), regardless of whether or not you use a Preferred Provider.

Therefore, if you or one of your Dependents are Eligible for Medicare, the Fund pays benefits as listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet), regardless of whether or not you use a Preferred Provider. If you are retired, you and your eligible Dependent(s) must enroll in Medicare Parts A and B, when eligible.

SPECIAL MEDICAL BENEFIT PROVISIONS

Emergency Room Additional Coinsurance

In the event of an emergency, there may be several treatment alternatives available to you, including going to a Physician's office, visiting an urgent care facility, or going to a Hospital emergency room. In many instances when immediate attention is needed, the same level of quality care can be received at a Physician's office or urgent care facility as in a Hospital emergency room – and generally, that care will cost less.

To encourage you to seek the least costly, yet quality care, you will be required to pay an additional emergency room coinsurance amount per visit (as specified in the ***Summary of Benefits*** insert in the back pocket of this booklet) when you go to a Hospital emergency room. This coinsurance amount is in addition to any other coinsurance amount you are responsible for paying and is not applied toward meeting your annual out-of-pocket maximum amount. However, if you are admitted as an inpatient to the Hospital as a result of your emergency room visit, the additional coinsurance will be waived.

The most important consideration in the event of an emergency is to get medical care, especially in a life-threatening situation. However, to ensure you get the most out of your health care benefits, find out what your Physician's hours and emergency procedures are and locate the urgent care facility nearest you.

Ambulance services and physician services received in connection with emergency room services will be treated as in-network expenses, regardless of the provider's network affiliation.

COORDINATION OF BENEFITS

All Comprehensive Medical Benefits are coordinated with benefits under other health plans, including Medicare. See the explanation on page 72.

BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE

The Fund may make a claim against a third party for Comprehensive Medical Benefits where expenses are paid as a result of an Illness, Injury or death caused by Another Person. See page 79 for a detailed explanation.

Preauthorization Requirement

In order for you to receive Plan coverage for the following services and/or supplies, you must contact the Fund Office and have the service and/or supply pre-authorized:

- Inpatient hospitalizations, including inpatient treatment of mental health and substance disorders, and excluding routine delivery or Cesarean section;
- Discograms;
- Hysterectomies;
- Spinal surgery and treatment, except for chiropractic;
- Radiofrequency ablation;
- Ear/nose/throat surgeries;
- Varicose vein procedures;
- Hand/wrist surgery;
- Sleep disorder diagnostics and treatments;
- Home Health Care;
- Hospice care;
- Speech therapy;
- Durable Medical Equipment for a rental that exceeds three months or at a cost that exceeds $500;
- Specialty (high dollar) drugs; and
- Surgery/treatment/care that could be considered Cosmetic, such as Abdominoplasty, Breast Augmentation/reduction, Birthmarks, Blepharoplasty (eyelid surgery), Botox injections, Panniculectomy, and scar removal/revision.

If you do not call to preauthorize care for the listed services and/or supplies, there will be no penalty applied. However, if it is determined that the procedure/service is not Medically Necessary, it will not be covered under the Plan.

COVERED EXPENSES

The Plan's Comprehensive Medical Benefits cover Allowable Charges for Medically Necessary treatment, services, and supplies, subject to any Plan maximums. See the ***Summary of Benefits*** insert (in the back pocket of this booklet) for the percent payable under the Plan and any specific Plan maximums. The following information describes the specific coverage provided.

The Fund's medical benefits are coordinated with Medicare. If you are eligible for Medicare, unless you are an active Participant or the Dependent of an active Participant, you **must** enroll for both Medicare Parts A and B. In general, this coordination with Medicare provides you with at least the benefit amount you would receive if you had only the Fund's Comprehensive Medical Benefits. See page 73 for a detailed explanation of how the Fund's benefits are coordinated with Medicare.

Hospital Charges

While you or your Dependents are Confined in a Hospital (inpatient), the Plan covers the following Medically Necessary benefits if they are ordered by a Physician for the condition for which you are admitted. Please note that many of the services listed below may also be provided and billed by a Physician. This Plan allows benefit payment based upon who bills for services.

- Inpatient Physician services with a limit of one treatment by a Physician per day for a single diagnosis, or one treatment for multiple diagnoses within the same medical specialty (except for newborns);
- Semiprivate Hospital room and board charges or charges for a private room if Medically Necessary because the patient has a contagious disease or to prevent possible infection after surgery;
- Intensive Care Unit;
- Special diets;
- General nursing services;
- Operating, delivery, and treatment rooms and equipment;
- Federal legend drugs and medications;
- Dressings, ordinary splints, and plaster casts;
- Laboratory and x-ray examinations, including discograms if pre-authorization received;
- Electrocardiograms;
- Basal metabolism tests;
- Physical Therapy;
- Speech Therapy;
- Occupational Therapy;
- Oxygen and its administration;
- Anesthesia and its administration;
- Administration of blood and blood plasma;
- Intravenous injections and solutions;
- X-ray and radium therapy;
- Radioactive isotope therapy;
- Chemotherapy;
- Diagnostic services; and
- Enteral nutritional therapy administered through a feeding tube and parenteral nutritional therapy administered intravenously. The therapy must be ordered by the Participant's Physician and be Medically Necessary. The Participant's condition must require enteral or parenteral therapy to provide sufficient nutrients to maintain weight and strength commensurate with the Participant's overall health status.

Maternity And Obstetrical Benefits

Benefits for maternity care are provided only for you or your eligible spouse (other Dependents are not covered). This Plan complies with the federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section; or requiring a Physician to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. In addition, the Plan covers one pediatrician visit in the Hospital after birth, unless a medical diagnosis is made.

Even though your Dependent female child is not eligible for maternity and obstetrical benefits, the Plan **may** provide benefits for Complications of Pregnancy.

Complications of Pregnancy include:

- Acute nephritis;
- Nephrosis;
- Cardiac decomposition;
- Missed abortion;
- Hyperemesis gravidarum;
- Eclampsia of pregnancy;
- Other pregnancy-related conditions that are as medically severe as the above;
- Ectopic pregnancy; and
- Miscarriage or spontaneous abortion where a live birth is not possible.

The following conditions **are not** considered to be Complications of Pregnancy:

- False labor;
- Occasional spotting;
- Rest during pregnancy, even if prescribed by a Physician;
- Elective Cesarean section or a Cesarean section required because a previous pregnancy was terminated by Cesarean section;
- Similar conditions not medically termed as Complications of Pregnancy; and
- Elective abortions.

Outpatient And Out-of-Hospital Care

You and your eligible Dependents are covered for care you receive outside the Hospital, in an Ambulatory Care Center or from a Hospital as an outpatient. This means you have protection against expenses for sudden and serious medical problems. Coverage includes reasonable Hospital charges that are Medically Necessary for the treatment of an Illness or Injury.

Medically Necessary outpatient and out-of-Hospital services and supplies covered by the Plan include:

- Treatment by a Physician or surgeon;
- Services of a graduate or licensed Registered Nurse (RN) other than assisting at surgery, Certified Registered Nurse Anesthetist (CRNA), Physician Assistant (PA), or Physiotherapist (this does not include a massage therapist, member of your immediate family, or person ordinarily living in your home);
- Surgical dressings, ordinary splints, plaster casts, braces, and crutches, excluding diabetic supplies, which are covered under the Plan's Prescription Drug Benefit;
- Laboratory examinations, chemotherapy, anesthesia and its administration, blood and blood plasma, oxygen and its administration, artificial limbs and eyes (as Medically Necessary), artificial breast(s) following mastectomy, and replacements of artificial breast(s), see page 39;
- Radiology and x-ray, including the services of a radiologist. However, such treatment must be rendered to the Eligible Person in the radiologist's office or in the outpatient department of the Hospital making the charge;
- Medically Necessary ground and air transportation, including charges for local professional ambulance service between Hospitals, as well as to and from the Hospital if transportation is Medically Necessary for proper treatment. Benefits are not payable for transportation or transfer based solely on convenience or personal preference, or for any reason other than Medical Necessity;
- Costs of home care treatment for hemophilia, including blood products and related peripheral materials, such as tourniquets, needles, and syringes (this does not include expenses for a freezer for storage of supplies or for personal service fees for self-infusion);
- Pregnancy tests, when performed by your Physician, for the Participant and spouse only;

The Plan covers immunizations for both children and adults at 100%, no deductible. All immunizations, as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the United States Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA) are covered by the Plan. You can log on to the CDC website at **www.cdc.gov/vaccines/schedules** to see the list of immunizations and the CDC's age and gender recommendations for such immunizations.

Seasonal flu shots are also covered 100% and are not subject to the deductible.

- Immunizations, as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), the United States Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA);
- Treatment for damage to teeth for a period that is based on the developmental time required;
- Orthopedic inserts and shoes that must be modified to be attached to a brace when prescribed by an orthopedist and custom made;
- The initial cost of prosthetics or replacement of prosthetics when Medically Necessary and **only with prior written approval from the Fund**;
- Custom foot orthotics, up to the Calendar Year maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet);
- Diabetic (therapeutic) shoes or inserts for people with diabetes who have severe diabetic foot disease, up to the Calendar Year maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). The Physician who treats your diabetes must certify your need for therapeutic shoes. The shoes must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, or pedorthist;
- Foot care for treatment of flat feet; subluxation of the foot; cutting or removal of corns and calluses when there is a medical condition (although not covered for a routine diagnosis); nail trimming, cutting and debridement when there is a medical condition (although not covered for a routine diagnosis);
- CPAP/BiPAP supplies (when preauthorized as required) as provided on the ***Summary of Benefits*** insert (in the back pocket of this booklet);
- Rental (or purchase if the Fund determines this is more cost efficient) of Durable Medical Equipment such as a wheelchair, Hospital bed, and other prescribed Durable Medical Equipment up to the usual, customary, and reasonable purchase price and **only with prior written approval from the Fund**; and
- Weight loss programs, if supervised by a Physician.

As soon as you know that you may need to use Durable Medical Equipment, call the Fund Office to find out if it is better to buy or rent. Do not wait until after you have already rented or bought the equipment to make the call. Purchases of Durable Medical Equipment must be approved.

Hospice Care Benefits

An alternative type of care for the Terminally Ill, referred to as Hospice care, allows the patient to receive appropriate care in the most comfortable, home-like atmosphere possible. An individual is considered Terminally Ill if he or she has a life expectancy of less than six months, as certified in writing by a Physician. When it is medically determined that an Eligible Person is Terminally Ill, the Eligible Person (or authorized representative, such as a family member) and the Physician may prefer Hospice care as opposed to Hospital Confinement.

Benefits are for the period during which the Eligible Person would otherwise, upon recommendation of his or her Physician, have to be Hospital-Confined. Such benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, or for care in a Hospice unit of a Hospital or a separate Hospice facility.

Covered Hospice services, provided through a Hospice facility, include:

- Physicians' visits;
- Room and board (if care is not provided in your home or a Hospital);
- Care provided by skilled nurses (RNs) and home health care aides;
- Assessment visits by a Hospice Program staff member; and
- Physical, Occupational, Speech, and Respiratory therapy.

Hospice benefits do not include patient or family counseling.

In the event the medical determination is made that the terminal condition is reversed, benefits are payable as provided under other sections of the Plan.

Home Health Care

Home health care recognizes that the use of the patient's own home as an aid in treatment is often beneficial. Home health care is designed for Hospital patients who do not need all Hospital facilities, but would stay hospitalized without home care.

With the agreement of your Physician, you may be discharged from the Hospital sooner than usually would be expected if you have Home Health Care. All of the services you might need in the Hospital are provided in your home. Your Physician always has complete medical supervision of your case.

The Home Health Care agency carries out your Physician's orders, provides general nursing services, gives medications and drugs that otherwise would have been given in the Hospital, reports on your condition and progress, and instructs your family regarding your care.

Routine Physical Examination Benefits

The Plan covers routine physical examinations for you and your eligible Dependents. Benefits for you and your spouse are different from those for your eligible Dependent children, in that adults may receive routine physical examinations from a Health Dynamics provider. Refer to the ***Summary of Benefits*** insert (in the back pocket of this booklet) for the percent paid by the Plan for these benefits.

For You And Your Spouse

The Plan covers an annual physical examination for active Participants and their spouses. You have the choice of going to your own Physician or using the Health Dynamics Program. If the exam is performed by your Physician in his or her office or a Hospital, the Plan covers the exam, laboratory tests, x-rays, mammograms (including digital mammograms), pap smears, and prostate exams (PSA).

The Fund will credit funds into your HRA annually if you (and your spouse if you are married) get a routine physical exam either through Health Dynamics or your regular Physician.

If your annual exam is provided through the Health Dynamics Program, the Plan covers 100% of expenses relating to your physical. You ***cannot*** go to your own Physician and use the Health Dynamics Program; you must choose one or the other. However, you may go to your own Physician for a pap smear and mammogram and use the Health Dynamics Program for a ll other covered services.

EXAMPLE: USING YOUR OWN PHYSICIAN OR THE HEALTH DYNAMICS PROGRAM

In 2014, Ted chose to go to his own Physician for a pulmonary function test and cardiovascular fitness test. For the remainder of the 2014 Plan Year, Ted could not use the Health Dynamics Program. However, in 2015, Ted may decide to have an annual exam provided through the Health Dynamics Program, instead of going to his own Physician.

The Health Dynamics Program physical involves two visits:

- First visit, you'll receive:
  - » Health history review;
  - » Blood chemistry analysis;
  - » Body composition;
  - » Resting blood pressure;
  - » Height and weight measurements;
  - » Pulmonary function test;
  - » Strength evaluation;
  - » Flexibility testing;
  - » 12-lead EKG;
  - » Cardiovascular fitness test;
  - » Physician directed examination;
  - » Urinalysis;
  - » Colorectal cancer screening;
  - » Chest x-ray or mammogram;
  - » Pap smear (upon request); and
  - » PSA test.
- Second visit, you'll receive a:
  - » Results report booklet; and
  - » Personal consultation.

You cannot go to your own Physician and use the Health Dynamics Program; you must choose one or the other.

If you or your spouse choose to receive your exam through the Health Dynamics Program, you can refer to the "Dynamic Health" quarterly newsletter for a listing of provider locations and phone numbers.

Annual Physical HRA Bonus

"Annual" means once per Calendar Year.

In order to promote wellness and early detection, the Fund will credit funds into the HRA account of eligible actively working Participants who receive an annual physical exam. If you are married, then both you and your spouse must receive annual physicals in order to qualify for this benefit. You must complete a simple form, an **HRA Bonus Request Form**, to obtain this benefit. You may obtain the form from the Fund Office or print it from the Fund's website.

If you and/or your spouse choose to have your routine physical exam performed by your personal Physician, then the physical must consist of at least the following components in order to qualify (in all instances, a Health Dynamics physical will meet the following requirements):

- An office visit (coded by the Physician as either "routine" or "annual physical")
- Routine lab tests
- A PSA (prostate specific antigen) test for males over age 40
- A pap smear for females over age 21
- A mammogram for females over age 40

Due to varying guidelines, if your personal Physician recommended that you not have the PSA, pap or mammogram, you will not be required to have it.

This benefit will generally be processed within 30 days to allow time for Health Dynamics or your Physician to submit the claim for these services. A copy of the form will be returned to you indicating the date that the bonus was credited to your HRA account or the reason the claim was denied.

For Your Dependent Children

Physicians recommend periodic office visits for well childcare. During the first 24 months of your child's life, these occur at frequent intervals. The Plan covers routine physical examinations for your Dependent children as specified on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

Please note that the Fund allows for one pediatrician visit in the Hospital after birth. Any additional charges for Physician visits while a well newborn is an inpatient are not covered.

Pap Smear and Mammogram Benefits

You have the option of choosing to go to your own Physician for a pap smear and/or mammogram, or to obtain the tests during your routine annual physical exam through Health Dynamics.

If you obtain the pap smear and mammogram through your own Physician, the Plan covers its coinsurance listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet) for the office visit and pap smear after you pay your deductible and coinsurance. You may still obtain a routine physical examination during the same year, but the pap smear and mammogram will not be covered in that examination.

If you obtain the pap smear and mammogram during your routine physical examination with Health Dynamics, the Plan covers 100% of Covered Expenses as listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

EXAMPLE: USING YOUR OWN PHYSICIAN OR THE HEALTH DYNAMICS PROGRAM

In 2014, Kelly chose to go to her own Physician for a pap smear. After Kelly paid her deductible and coinsurance for the office visit and pap smear, the Plan covered the office visit and pap smear at the coinsurance percentage listed in the Summary of Benefits insert, depending on the type of provider. For the remainder of the 2014 Plan Year, Kelly could use the Health Dynamics Program for all other covered services provided under the Routine Physical Examination Benefit (but not for another pap smear). If Kelly had not gone to her own Physician for the pap smear, she could have had the pap smear test performed during her 2014 annual exam provided through the Health Dynamics Program, paid at 100%, rather than going to her own Physician where she had to pay the deductible and coinsurance. Alternatively, Kelly could have chosen to have the physical exam provided through a non-Health Dynamics provider, for which the Fund would have paid a percentage of the Covered Expenses as shown on the Summary of Benefits insert (in the back pocket of this booklet).

Colorectal Cancer Screening Benefits

If you choose to go to your own Physician for a routine annual physical exam, the Plan covers a percentage of the expenses, subject to the Plan deductible and coinsurance listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). In some instances, limited types of screenings for colorectal cancer may be included in a Physician's exam, such as fecal occult blood testing (FOBT), which the Physician can perform. However, other types of screening procedures normally cannot be provided by the Physician and therefore you must be referred to a specialist. In these instances, the screenings are not covered.

Once you meet your annual deductible, the Plan covers a percentage of covered colorectal cancer screening procedures.

In general, ***for average risk individuals age 50 and older*** the Plan covers one fecal occult blood test (FOBT) each year and:

- One sigmoidoscopy every five years; or
- One double contrast barium enema (DCBE) every five years; or
- One colonoscopy every 10 years.

The Plan also covers:

- Screening with annual FOBT, either alone or in conjunction with sigmoidoscopy, beginning at age 50 years.
- Colorectal cancer screening (tests and frequency as outlined above) beginning at age 40 covered for persons with a single first-degree relative (sibling, parent, or child) with a history of colorectal cancer or an adenomatous polyp.
- Screening with sigmoidoscopy, DCBE, or colonoscopy covered as frequently as every two years for individuals with one or more of the following high risk factors for colorectal cancer:
  - » A first-degree relative (sibling, parent, child) who has had colorectal cancer or an adenomatous polyposis (screening covered beginning at age 40 years);
  - » Family history of familial adenomatous polyposis (screening covered beginning at puberty);
  - » Family history of hereditary nonpolyposis colorectal cancer (HNPCC) (screening covered beginning at age 20 years).
- Colorectal cancer surveillance with colonoscopy, flexible sigmoidoscopy or DCBE covered as frequently as every two years for individuals who meet any of the following criteria:
  - » Patient has inflammatory bowel disease, including ulcerative colitis or Crohn's disease (colorectal cancer surveillance covered as frequently as every two years);
  - » Personal history of adenomatous polyps (surveillance covered as frequently as every two years);
  - » Personal history of colorectal cancer (surveillance covered as frequently as every two years).

Surgical Benefits

Comprehensive Medical Benefits cover Medically Necessary surgical procedures. Operative and cutting procedures performed by Physicians, including usual inpatient pre- and post-operative care are covered. Benefits are paid whether a covered surgery is performed in a Freestanding Surgical Center or in a Hospital.

The Fund pays surgical benefits based on actual fees charged as long as fees are Allowable Charges, and properly submitted. In some cases, Physicians and Hospitals "unbundle" procedures for billing purposes. Unbundling involves separating procedures into several different steps and billing for each one separately to increase the total amount billed.

EXAMPLE: SURGICAL BENEFITS

A total hysterectomy should be billed as one surgery. To inflate the bill, a Physician might bill separately for preparation for surgery, removal of the uterus, removal of the ovaries, removal of the fallopian tubes, follow-up visits, and removing the stitches. The Fund will pay benefits for one surgery.

For surgery, benefit payment is based on:

- 150% of the Allowable Charge for bilateral procedures;
- 10% of the Allowable Charge for a PA assisting in surgery if a resident is not available to assist;
- 20% of the Allowable Charge for an MD assisting in surgery;
- 50% of the Allowable Charges for multiple surgical procedures, other than evaluation and management services, performed at the same time by the same provider;
- 125% of the Allowable Charges, divided equally between co-surgeons. When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report his or her distinct operative work as well as any associated procedures.

Benefits for covered Oral Surgery procedures (defined on page 56) are covered only under the Comprehensive Medical Benefits plan.

Reconstructive Surgery

In accordance with the Women's Health and Cancer Rights Act of 1998, benefits for breast Reconstructive Surgery following a mastectomy are provided on the same basis as other surgical procedures covered by the Plan and include:

- Reconstruction of the breast on which a mastectomy is performed;
- Reconstructive Surgery on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Physical complications of any stage of mastectomy, including lymphedemas.

Gastric Bypass Surgery Provisions

Studies show that millions of adults in the United States are overweight or obese – conditions that substantially increase the risk of other health problems.

To lose weight, it is recommended that individuals alter their diet and increase physical activity, allowing them to lose weight safely over a prolonged period. However, this method alone is not always effective. As a result, individuals may explore other alternative procedures, including dietary therapy approaches such as low-calorie diets and lower-fat diets, altering physical activity, behavior therapy techniques, pharmacotherapy, surgery, and combinations of these techniques.

> Weight loss surgery is only one option for weight reduction, and then only in a limited number of patients with clinically severe obesity. The National Institutes of Health recommends that weight loss surgery be reserved for patients who tried medical therapy, but it failed, and who are at high risk for obesity-associated morbidity or mortality. In addition, an integrated program should be in place to provide guidance on diet, physical activity, and behavioral and social support both before and after the surgery to help the individual maintain a healthy lifestyle, avoiding costly future complications.

While surgical weight loss alternatives, such as gastric bypass surgery, have always been an option under the Plan, currently the only restriction is that such surgery be Medically Necessary. However, these methods can be very costly and without any specific restrictions or guidelines, they are not as effective as they could be, and could in fact be potentially dangerous for the individual. Therefore, to ensure that you get the most out of your Plan benefits, certain requirements and limits have been added for gastric bypass surgery. To be considered a Covered Expense under the Plan, you or your covered Dependent **must**:

- Be between the ages of 18 and 65, since there are increased risks of complications in individuals before age 18 and after age 65;
- Provide documentation by a Physician (other than the Physician that will perform the surgery) that you have exhausted all other weight loss options without success, such as various weight loss and exercise programs. The programs must have occurred within the two years immediately before surgery and must have lasted at least six months; and
- Use a Preferred Provider to perform the gastric bypass surgery at a Preferred Provider facility.

The Plan limits gastric bypass surgery to one course of treatment per person per lifetime, if Medically Necessary. One course of treatment includes the gastric bypass surgery, removal of staples and all corrective follow-up surgery.

Enteral Nutritional Therapy

The Plan covers enteral nutritional therapy administered through a feeding tube and parenteral nutritional therapy administered intravenously. The therapy must be ordered by the Participant's Physician and be Medically Necessary. The Participant's condition must require enteral or parenteral therapy to provide sufficient nutrients to maintain weight and strength commensurate with the Participant's overall health status.

Temporomandibular Joint Disorder (TMJ)

The Plan covers all Usual, Customary, and Reasonable Medically Necessary charges related to or caused by Temporomandibular Joint Disorder (TMJ), up to the lifetime maximum shown on the *Summary of Benefits* insert (in the back pocket of this booklet). There is no maximum amount payable on surgical treatment of TMJ; such care is covered under Surgical Benefits (see previous section). This maximum applies regardless of whether the treatment is rendered by a Physician or a Dentist. Benefits for treatment of TMJ are only covered under Comprehensive Medical Benefits.

Certain Dental Care

Oral Surgery (as defined on page 56) and Medically Necessary dental treatment are covered under Comprehensive Medical Benefits if your teeth are damaged in an Accident. Treatment must be received within six months and end within 12 months of the Accident. Coverage is also provided for treatment of cleft lip and cleft palate conditions. Covered services include Medically Necessary inpatient or outpatient expenses, including Orthodontics, Oral Surgery, otologic, audiological, and speech/language treatment.

Congenital Defect Casting

If a physical defect, existing at birth and affecting an eligible Dependent child, is corrected by a cast, the Plan covers the appropriate portion of the expenses for casting.

Speech Therapy

The Plan provides coverage for speech therapy for a medically proven organic pathology, provided the treatment is:

- Medically Necessary;
- Ordered by a Physician; and
- Provided by a certified therapist.

> Once maximum restoration of function is reached, the Plan discontinues paying for Speech and Physical Therapy.

The certified therapist must be someone other than a spouse, child, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, or a person ordinarily living in your home.

Physical Therapy

The Plan covers Physical Therapy provided in a Hospital, clinic, office, Skilled Nursing Facility, Extended Care Facility, or your home when necessary to restore functions lost or reduced by Illness or Injury.

Physical Therapy must be prescribed and supervised by a licensed Physician and must be administered by a licensed physical therapist. In addition, the therapy must be justified by the Physician's diagnosis and medical recommendation.

Occupational Therapy

The Plan covers Occupational Therapy, including Physical Therapy administered by an occupational therapist. However, outpatient Occupational Therapy is covered only when it meets the Plan's definition of Physical Therapy and is performed by an occupational therapist.

> The Plan provides a combined benefit for Physical and Occupational Therapy as specified on the Summary of Benefits insert (in the back pocket of this booklet).

Kidney And Cornea Transplants

Transplant Benefits

Comprehensive Medical Benefits cover organ transplants for Medically Necessary services.

Covered services include:

- Hospital room and board (semiprivate room);
- Physicians' services and related inpatient services;
- Acquisition, preparation, removal, transportation, and storage of the kidney or cornea;
- Transportation, lodging, and meals for the patient only as medically required pre- and post-surgery, up to the maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet);
- Diagnostic x-ray and laboratory, etc.;
- Private nursing care, up to the maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet); and
- Local ambulance, rental of wheelchair, etc.

Mental Health And Substance Abuse Treatment

Comprehensive Medical Benefits cover inpatient and outpatient treatment for mental health and substance abuse disorders in the same manner as other medical and surgical expenses. In addition, the Plan provides mental health and substance abuse treatment through the Employee Assistance Program (see page 47).

Your mental health and substance abuse benefits include treatment for mental, psychoneurotic, personality, nervous, and eating disorders, as well as treatment for alcoholism and drug/chemical abuse. The PPO network provider offers an extensive nationwide network of professional therapists, hospitals, and alternate care facilities (network providers) to ensure that you and your family receive the highest quality mental health and substance abuse treatment services that are available.

You may use a provider that participates in the PPO network or an out-of-network provider and still receive benefits. Treatment for mental health and substance abuse disorders is subject to the maximums and limitations listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

Preauthorization of Mental Health and Substance Abuse Disorders

Before beginning any inpatient treatment for a mental health or substance abuse disorder, your provider must have the treatment preauthorized through the PPO network provider. In addition, your provider must submit claims to the PPO network provider. In the event of an emergency Hospital admission, your provider must call for preauthorization within 48 hours after the admission. If your inpatient treatment for mental health or substance abuse is not preauthorized, there will be no penalty applied because preauthorization can be conducted retroactively. However, if it is determined that the procedure or service is not Medically Necessary, it will not be covered under the Plan.

Infertility Benefits

Infertility benefits are covered under the Plan for you and your eligible spouse only. Benefits include Medically Necessary testing and treatments related to the diagnosis of infertility, up to the maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

Diabetic Self-Management Education Benefits

The Plan provides coverage for diabetic self-management education programs as specified on the ***Summary of Benefits*** insert (in the back pocket of this booklet), provided the program is Medically Necessary and prescribed by a Physician. Covered Expenses include services such as dietary counseling and training on the proper technique for administration of injections.

Chiropractic Therapy

The Plan covers Medically Necessary treatment received from a licensed chiropractor for spinal manipulation, up to the maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). Spinal manipulation is care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body to remove nerve interference and its effect, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. Chiropractic therapy includes therapeutic, supportive, and maintenance care.

Acupuncture Benefits

The Plan covers a percentage of Medically Necessary Covered Expenses for acupuncture provided by a licensed acupuncturist, up to the maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

Hearing Care Benefits

The Fund provides hearing care benefits for eligible Participants. The Plan covers one hearing exam per person per Calendar Year. The Plan covers hearing aids and hearing aid repair up to the maximums listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). The hearing aid benefit may cover the majority of behind the ear, in the ear, and in-the-canal aids that are available. If you opt for advanced technology, such as in-the-canal devices or digitally programmable hearing aids, the Fund's hearing aid benefit allowance may not cover the full cost.

Processors For Cochlear Implants

Replacement of processors for cochlear implants are covered at the same frequency as the hearing benefit and at two-times the maximum hearing benefit payable. The benefit is based on the amount and frequency of the hearing benefit, but is not part of or overlapping the hearing benefit.

Chemotherapy Pills And Injectable Medications (Specialty (high-cost) Drugs)

Specialty medications are covered under the Plan's Prescription Drug Benefits through the retail or mail order program of the Plan's prescription drug provider. However, coverage for oncology medications and injectable medications delivered by your Physician, or at a medical facility, will be covered under the Plan's Comprehensive Medical Benefits and subject to the deductible, coinsurance, and out-of-pocket maximum provisions of the Plan's Comprehensive Medical Benefits.

Prescription Drug Benefits

Prescription drug expenses are rising faster than most other health care expenses, and can be a significant expense for you and your family. Recognizing this, the Fund offers prescription drug benefits to you and your eligible Dependents. Prescription drug benefits are offered through a Pharmacy Benefit Manager, CVS Caremark, which provides a network of participating retail pharmacies (Preferred Provider pharmacies) and a mail order program. While you can go to any retail pharmacy and have your Prescription filled, when you have your Prescription filled at a retail Preferred Provider pharmacy or through the mail order program, you save money for yourself and the Plan.

Please Note: Prescription drug coinsurance amounts do not apply toward the medical annual deductible or out-of-pocket maximum.

When you need a medication for a short time, it may be easier to go to a retail pharmacy. If you are taking a medication on a long-term basis, it may be more convenient to have it filled through the mail order program because you can get a larger supply through the mail order program and pay less than at retail.

Prescription drug benefits are not subject to the Plan's medical annual deductible or out-of-pocket maximum.

Generic Equivalents And Brand Name Medications

Many Prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. On average, generic medications can cost 50% less than brand name medications, but for some medications this savings can be as great as 90%. This can be a significant source of savings for you and the Fund. In general, the savings achieved by using generic medications will help control the cost of health care while providing quality medications.

A generic equivalent is a copy of a brand name medication that is no longer protected by a patent. A generic medication serves the same purpose as the original (brand name) medication and costs less.

You should discuss with your Physician if a generic equivalent is available, and appropriate, for any Prescriptions you need filled. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

Retail Pharmacy Program

The retail pharmacy program is for your short-term Prescription needs, like cold or flu medications. Here's how the retail pharmacy program works:

- When you are eligible for Plan coverage, you receive an ID card that contains the information the pharmacist will need to process your Prescriptions through CVS Caremark.
- You can go to any retail pharmacy you choose to have your Prescription(s) filled (up to a 90-day supply at one time). When you use a CVS Caremark Preferred Provider Pharmacy, you receive your Prescription at preferred prices.
- Show your ID card when you have your Prescription filled.
- Pay the coinsurance amount listed on the Summary of Benefits insert (in the back pocket of this booklet).

The Plan's pharmacy network has thousands of locations nationwide, including most major chain stores. When you go to a Preferred Provider pharmacy and present your Prescription Drug ID card, you receive preferred prices on your medications.

Although your Fund ID card lists only the name of the Participant, the names and information for family members are in the computer system, so all family members will receive the discount. If you need additional cards, contact the Fund Office.

Once you receive your Prescription, the pharmacy will bill the Fund directly for the balance of the Prescription. The Fund will then reimburse the provider the percentage that the Plan covers.

Mail Order Program

You should use the mail order program when you need to have Prescriptions filled for maintenance medications. Maintenance medications are Prescription drugs that are used on an ongoing basis. These Prescriptions can be used to treat chronic Illnesses such as arthritis, diabetes, or high blood pressure. The mail order program provides a safe, convenient way for you to have your medications delivered right to your home.

The mail order program allows you to get up to a three-month supply of a Prescription at one time.

If you use the mail order program, you will need to send your coinsurance amount along with your Prescription when you mail it in. If you are not paying by credit card, you will need to contact the Prescription Benefit Manager for the exact amount of the coinsurance due from you.

If your Physician prescribes a long-term medication for you, follow these steps to have your Prescriptions filled (or refilled) through the mail order program:

Step 1: Ask your Physician for a Prescription for up to a three-month supply, plus refills if appropriate.

Step 2: Complete a mail order form, making sure to include all requested information (some of which can be found on your Prescription Drug ID card). If you need additional order forms, contact the Fund Office or the Prescription Benefit Manager (see the ***Important Contact Information*** insert in the back pocket of this booklet).

Step 3: Complete the health history (it is part of the order form and only needs to be completed the first time you use the mail order program).

Step 4: Send your completed form, along with the written Prescription and your payment, using the pre-addressed, postage paid envelope provided with your order form.

You may charge the full amount of your payment on your VISA, MasterCard, American Express, or Discover credit card or you can pay by check or money order.

It will take approximately 10-14 days from the time you send in your order until you receive your Prescription(s). With each delivery, you will receive a new order form and a pre-addressed, postage paid envelope.

If your written Prescription indicates that refills are available, you will receive a refill number with your Prescription order. You then have several options on refilling your Prescription; you can refill your Prescription online, by phone, or by mail. See the ***Important Contact Information*** insert (in the back pocket of this booklet).

Specialty Medication Program

The Plan covers specialty medications when the prescriptions are filled at a CVS Caremark retail pharmacy or through the mail order program. If you go to a non-preferred provider, your medication will not be covered under the Plan. For Medicare Retirees, you are allowed to obtain specialty drugs from any pharmacy, however the Fund encourages you to use the CVS Specialty Drug pharmacy for preferred pricing arrangements for the Fund.

You will be required to pay the amount listed in the ***Summary of Benefits*** insert (in the back pocket of this booklet). The Prescription drug benefit for specialty medications is not subject to the Plan's medical annual deductible or medical out-of-pocket maximum. Instead, a special out-of-pocket maximum applies to these specialty medications, as shown in the ***Summary of Benefits*** insert (in the back pocket of this booklet).

To receive Plan coverage for specialty medications, you must contact CVS Caremark to have your medication pre-authorized. If it is determined that the medication is not Medically Necessary, it will not be covered under the Plan. You can call the number on the ***Important Contact Information*** insert (in the back pocket of this booklet) to locate a network retail pharmacy in your area, or to obtain information about the mail order program.

Specialty Preferred Drug Step Therapy Program

In an effort to promote cost-effective care and control the Plan's costs associated with specialty medications, the Plan has implemented CVS Caremark's Specialty Preferred Drug Step Therapy Program. The program is designed to help you and your Physician select the most cost effective medications to treat certain conditions. CVS Caremark assesses prescribed specialty medications that fall within the following therapy classes:

- Autoimmune (Rheumatoid Arthritis, Crohn's Disease, Psoriasis);
- Multiple Sclerosis; and
- Infertility.

Because these therapy classes have multiple therapeutically equivalent medications available to treat the same condition, CVS Caremark will recommend that the pharmacist dispense the most cost-effective medication for you. ***If you were taking a non-preferred medication on or before April 1, 2014, CVS Caremark will not require that you change to an alternative preferred medication***.

You must contact CVS Caremark and have the medication pre-authorized. If it is determined that the medication is ***not*** Medically Necessary, it will ***not*** be covered under the Plan.

Covered Prescription Drug Expenses

Generally, the Plan covers federal legend drugs that require a written Prescription from a Physician or Dentist. A licensed pharmacist must dispense these Prescriptions. The Plan also covers other legend drugs available by Prescription such as:

- Compounded medications of which at least one ingredient is a Prescription legend drug (prior authorization required if $300 or more);
- Insulin;
- Insulin syringes/needles and other diabetic supplies such as test strips, test tape, and lancets;
- Fertility agents (for you and your eligible spouse only), such as pergonal and metrodin;
- Prenatal vitamins;
- Immunosuppressant (anti-rejection) drugs;
- AIDS-related drugs;
- Legend meclizine;
- Liquid Zantac for Dependent children;
- Birth control prescribed by your Physician for an FDA-approved birth control method (over-the-counter birth control methods are not covered by the Plan);
- Esomeprazole;
- Generic Omeprazole; and
- Nicotine addiction medications.
- Viagra (or similar medication) is covered under the Plan's Prescription drug benefits if your Physician provides medical documentation that it is necessary to treat a dysfunction that is organic in nature. You must obtain precertification from the Fund Office before you can have your Prescription filled. In addition, each year you must obtain recertification from the Fund Office to continue to have your Prescription covered under the Plan. If you do not obtain precertification (or recertification, as necessary) from the Fund Office, your Prescription is not covered under the Plan.
- The Plan does cover medications related to the treatment of attention deficit disorder. However, if the medication is for an individual over age 14, you must provide medical documentation that the medication is necessary to treat this disorder. If you do not provide this documentation, the Prescription is not covered under the Plan.

You may see or have seen advertisements on television and in the newspapers about Prescription drugs being available from Canadian pharmacies at a cost that is much lower than that of USA pharmacies. Note that it is not legal for the Fund to participate in a program that directly imports Prescription drugs from a foreign country. However, since this Fund's Prescription drug benefit allows reimbursement for Prescriptions that you purchase individually, the Fund will reimburse the applicable benefit toward the cost of Prescription medications covered under the Plan, including those purchased by you from a retail or mail order Canadian pharmacy. Be advised that the Fund has not done any comparison of Prescription drug prices nor has it investigated the safety of any specific Canadian drugs or pharmacies. In addition, if you use a Canadian pharmacy that obtains its drugs from other countries, any medications you purchase from that Canadian pharmacy will not be covered by the Fund.

Medicare Prescription Drug Coverage (Medicare Part D)

If you are Eligible for Medicare, you can compare your current coverage (including which medications are covered) with the coverage and cost of the Medicare plans in your area.

- **Active Participants and Their Dependents:** If you are an active Participant or Dependent of an active Participant and enroll for Medicare Prescription Drug Coverage, you will continue to be eligible for Fund benefits. However, Medicare will coordinate your benefits with the Plan, in accordance with Medicare's and the Plan's coordination provisions.

- **Retired Participants and Their Dependents:** If you are a Medicare-eligible retiree or Medicare-eligible Dependent of a retiree and enroll for Medicare Prescription Drug Coverage, you will no longer receive Prescription drug benefits through the Fund. You will continue to be eligible to receive medical benefits; however, your monthly premium for coverage under the Fund will not be reduced. Also, for most people there is a monthly premium for Medicare Prescription Drug Coverage.

  > If you have enrolled in a Medicare Part D plan, you have no Prescription drug coverage under this Plan.

  If you are a non-Medicare eligible retiree or non-Medicare eligible Dependent of a retiree, you will continue to be eligible for Fund Prescription drug benefits. However, once you become Eligible for Medicare, if you enroll for Medicare Prescription Drug Coverage, you will no longer receive Prescription drug benefits through the Fund, as indicated above.

  If you decide to enroll and later decide to drop Medicare Prescription Drug Coverage, you will be given a one-time opportunity to re-enroll for the Fund's Prescription drug benefits.

IF YOU ARE ELIGIBLE FOR MEDICARE

Active Participants And Their Dependents

At age 65, you generally become Eligible for Medicare benefits. As long as you are actively working and have enough hours or make the required self-payment contributions, you continue to be covered by the Fund's medical benefits. The Fund assumes that our medical benefits are your primary coverage (and your Dependent's if he or she is also Eligible for Medicare). Medicare benefits will be secondary, if you are enrolled for coverage.

As long as you remain actively at work, you should continue to submit your claims to the Fund. After payment, you can submit the expenses to Medicare for possible payment.

> The Plan coordinates all benefits with other coverage. If you or one of your Dependents are eligible for coverage under Medicare, you must enroll in Medicare to receive the maximum coverage possible.

All Other Participants

If you are retired, Disabled, or a surviving spouse, and become Eligible for Medicare, Medicare is your primary coverage. **To receive coverage under this Plan, you and/or your spouse must sign up for both Medicare Part A and Part B** when eligible. This means, if you are retired and your spouse becomes Eligible for Medicare, even if you are not yet eligible, then your spouse must enroll. The Plan covers benefits after Medicare has covered the expense.

For more information on Medicare and how the Plan coordinates benefits with Medicare, see page 74.

COMPREHENSIVE MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

Comprehensive Medical Benefits provide coverage for most medical expenses related to an Illness or Injury. You should be aware that some expenses are not covered by the Plan. In addition to any General Plan Exclusions And Limitations (see page 63), Comprehensive Medical Benefits are not paid for the following expenses.

1. Abortion procedures, except the Plan covers complications of abortion.
2. Blood donor services.
3. Convenience items provided while you are an inpatient.
4. Dental implants (these may be covered under the Plan's dental benefits).
5. Dental treatment, except as specifically described elsewhere in this booklet.
6. Durable Medical Equipment supplies and repairs, except that repairs to wheelchairs and prosthetics are covered.
7. Education, training, and room and board charges while you or your Dependent is Confined in an institution that primarily is a school or other institution for training, a place of rest, a place for the aged, or a nursing home.
8. Maternity services for other than the Participant or legal spouse.
9. Motor vehicles, lifts for wheelchairs, stair lifts, hot tubs, and filtration systems.
10. Non-Prescription medications (also known as over-the-counter medications), including vitamins, nutrients, and food supplements (except Medically Necessary enteral or parenteral therapy formulas administered intravenously or through a feeding tube), even if prescribed by a Physician.
11. Nursing home care.
12. Prescription Drug Benefit Exclusions:
    a. Administration or injection of any drug (however, this may be covered under the Plan's medical benefits).
    b. Medications:
        i. Betaseron.
        ii. Covered Prescription medications that are not administered in a Hospital, long-term care facility or other inpatient setting (except Medically Necessary enteral or parenteral therapy formulas administered intravenously or through a feeding tube). However, you may purchase Prescription medications under the Plan and take them to your Physician to be administered.
        iii. Individually packaged medications purchased through or billed by a nursing home or similar facility.
        iv. Non-legend (over-the-counter) drugs other than insulin.
        v. Topical Minoxidil (Rogaine).

c. Therapeutic supplies, devices, or appliances, including support garments and other non-medical substances (unless listed otherwise).

d. Vitamins, including over-the-counter vitamins, except that pre-natal vitamins are covered.

13. Reconstructive or Cosmetic Surgery, except for Medically Necessary surgery or as specifically listed as covered elsewhere in this booklet.
14. Consultation services related to medical or surgical services when they are rendered by the same Physician during the same Hospital admission, except at the sole discretion of the Plan.
15. Services performed by interns, residents, Physician Assistants, surgical technicians, or registered nurses who are employees of a Hospital, clinic, or Physician, and whose fees are charged by, for, or payable to a Hospital, clinic, Physician, or other institution. However, services performed by Physician Assistants will be covered if no surgical resident is available on staff.
16. Sterilization reversal procedures, if the Fund paid benefits for the sterilization.
17. Surrogate maternity services.
18. Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.
19. Speech Therapy unless you have a medically proven organic pathology.
20. Therapy services, such as recreational, educational, water, horse, music or art therapies, or physical fitness or exercise programs.
21. Topical application form of Minoxidil, Rogaine or their medical equivalent.
22. Transplants, except as specifically listed as covered elsewhere in this booklet.
23. Transportation or travel to or from medical treatment, except as specifically described elsewhere in this booklet.
24. Transsexual/gender reassignment (sex change) operations or any care or services associated with this type of operation.
25. Eye exams or glasses, except as specifically described elsewhere in this booklet.
26. Surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK), Anterior Lens Keratotomy (ALK), and Laser in Situ Keratomileusis (LASIK).
27. Vision therapy and training.
28. Expenses incurred for preventive control programs, such as dietary instruction or educational training, except for diabetic self-management education as described on page 41.
29. Upgraded lenses after cataract surgery that are available to correct refraction. The Plan covers only the standard lenses.
30. Private Hospital room and/or private duty nursing, unless determined to be Medically Necessary and preauthorized.
31. Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disease and Alzheimer's disease.

THE EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP is designed to provide prompt, professional help when you or your Dependents experience personal problems, stress, marital difficulties, and other similar problems. The PPO network provider offers an extensive nationwide network of professional therapists, Hospitals, and alternate care facilities (network providers).

Under the EAP, you and your eligible family members are each entitled to up to five visits per person per incident with a licensed counselor who participates in the EAP network (this does not include MD visits and psychological testing). The EAP is sponsored by the Fund and is free for you and your eligible Dependents. There are no out-of-pocket costs for you or your family. Any information you share with counselors will be kept confidential. To be referred to an EAP counselor, call the service provider and speak with one of its staff members, or obtain information via the website. Refer to the ***Important Contact Information*** insert (in the back pocket of this booklet). When you log onto the website, select "Member Log In" and just enter "OE Local 139" where it asks for your company or program name. Staff members are available 24 hours a day, seven days a week.

After the first five visits, mental health and substance abuse treatments will continue to be covered as explained on page 41.

For answers to your questions about the EAP program, contact the EAP provider at the phone number listed on the ***Important Contact Information*** insert (in the back pocket of this booklet) or log onto the website shown on the insert. For answers to your questions about your mental health and substance abuse benefits, contact the Fund Office.

TRANSPLANT BENEFITS

The Plan does not provide transplant benefits for Medicare-primary Participants or Medicare-primary Dependents. Coverage for these individuals is provided under the Plan's Comprehensive Medical Benefits.

Except Kidney and Cornea

Transplants are very expensive medical procedures. The Fund provides benefits to help you receive the care you need and, at the same time, help manage your costs. This section summarizes your transplant benefits. Kidney only transplants and cornea transplants are covered under Comprehensive Medical Benefits (see page 31).

Coverage under this benefit is subject to change.

The Fund provides transplant benefits for active Participants, non-Medicare eligible retirees, and their eligible Dependents.

If you choose to have a transplant performed at a facility other than one of the Blue Distinction Centers for Transplants facilities, the benefits paid will not exceed the rate that would have been charged had the procedure been performed at a Blue Distinction Centers for Transplants facility.

Retirees and their Dependents who are Medicare-eligible and have Medicare as their primary plan must have their transplant procedure performed by a Medicare-approved facility. After Medicare pays for transplant benefits as the primary plan, the Fund will coordinate payment for such Medicare-approved transplant benefits under the Plan's Comprehensive Medical Benefit, as provided in the ***Coordination of Benefits with Medicare*** section on page 74.

The Plan provides coverage for the following transplant surgeries:

- Liver;
- Heart;
- Heart/lung;
- Lung;
- Pancreas;
- Pancreas/kidney;
- Small intestines; and
- Bone marrow.

The Plan's Transplant Benefits includes:

- Organ Transplants: The Plan covers liver, heart, heart/lung, lung (single and double), pancreas, pancreas/kidney, and small intestines transplants. Kidneys are only covered under the Plan's Transplant Benefits when a combined pancreas and kidney transplant procedure is performed.
- Bone Marrow Transplants: The Plan covers the following bone marrow transplant procedures to treat leukemia, lymphoma, blood and genetic diseases, or solid tumors:
  - » Allogeneic;
  - » Autologous, including autologous bone marrow transplant in breast cancer and testicular cancer;
  - » Syngeneic; and
  - » Peripheral stem cell.
- However, these procedures are not covered if they are used as a treatment for, or used as a method of, immune reconstitution for individuals infected with any human T-cell viruses.

- Circulatory Assist Devices: The Plan covers medical expenses incurred by registered candidates during the circulatory assist device benefit period.
- Hepatic Assist Devices: The Plan covers medical expenses incurred by registered liver candidates during the hepatic assist device benefit period.

BENEFIT PERIOD

Expenses relating to Transplant Benefits are covered during the applicable "benefit period" as follows:

- Organ Transplant Benefit Period: The organ transplant benefit period is 370 continuous days and begins five days before the covered organ transplant procedure.
- Bone Marrow Transplant Benefit Period: The bone marrow transplant benefit period is 395 continuous days and begins 30 days before a covered bone marrow transplant infusion.
- Circulatory Assist Device Benefit Period: The circulatory assist device benefit period begins five days before the circulatory assist device implant and ends on the date of a covered heart or heart/lung transplant procedure. If the procedure is not completed, the circulatory assist device benefit period will end on the date of the intended recipient's death or the date of explant of the circulatory assist device, whichever occurs first.
- Hepatic Assist Device Benefit Period: The hepatic assist device benefit period begins five days before the hepatic assist device implant and ends on the date of a covered liver transplant procedure. If the procedure is not completed, the hepatic assist device benefit period will end on the date of the intended recipient's death or the date of explant of the hepatic assist device, whichever occurs first.

COVERED EXPENSES

Benefits are payable only if two board certified specialists in the field of surgery provide written notice certifying that alternative procedures, services, or courses of treatment would not be effective for the patient's condition.

COORDINATION OF BENEFITS

All Transplant Benefits are coordinated with benefits under other health plans. See the explanation on page 72.

BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE

The Fund may make a claim against a third party for Transplant Benefits where expenses are paid as a result of an Illness, Injury, or death caused by Another Person. See page 79 for a detailed explanation.

Organ donation (e.g., bone marrow) is not covered, because of lack of Medical Necessity. However, if you need a covered organ, the Plan covers your costs and that of the donor. In such circumstances, the donor is covered for only those medical services related to the transplant.

Covered medical expenses are those incurred during the applicable benefit period that:

- Result from or are directly related to the completion of a covered transplant procedure or assist device;
- Are related to the condition, Illness, or disease that necessitated the covered transplant procedure or assist device;
- Are related to complications resulting from the condition, Illness, or disease that necessitated the covered transplant or assist device; and
- Are complications resulting from the covered transplant procedure or assist device itself.

The following Transplant Benefit expenses are covered under the Plan:

- Hospital services, including:
  - » Room, board, and general nursing service in a room with two or more beds or a bed in a special care unit;
  - » Ancillary Hospital services and supplies, including, but not limited to:
    - – Use of operating and treatment rooms;
    - – Prescribed drugs;
    - – Whole blood, administration of blood, and blood processing;
    - – Anesthesia, anesthesia supplies, and services rendered by an employee of the Hospital or facility;
    - – Medical and surgical dressings and supplies;
    - – Diagnostic services; and
    - – Therapy services, such as radiation therapy, chemotherapy, and dialysis treatment.
  - » Outpatient surgery Hospital services and supplies, including removal of sutures, anesthesia, anesthesia supplies, and services rendered by an employee of the Hospital or facility other than the surgeon or assistant at surgery; and
  - » Pre-admission testing, including tests and studies required in connection with admission or outpatient treatment prior to a scheduled admission.
- Surgical and medical services including:
  - » Surgical services performed by a Physician or other professional provider (provided separately for pre- and post-operative services);
  - » Surgical assistant, provided an intern, resident, or house staff member is not available;
  - » Administration of anesthesia ordered by the attending Physician and rendered by a Physician or other professional provider other than the surgeon or assistant surgeon;

- » Second surgical opinions for a consulting opinion and related diagnostic services to confirm the need for recommended surgery, provided the Physician who originally recommended surgery does not provide the second (or third) opinion (a third opinion and directly related diagnostic services are covered in the event the second opinion conflicts with the original recommendation).
- » Inpatient medical services by a Physician or other professional provider for a condition related to the transplant procedure or complication related to the transplant procedure, including inpatient medical care visits, intensive medical care, concurrent care, and consultation.
- » Outpatient medical services rendered by a Physician or other professional provider for a condition directly related to the transplant, including emergency medical care and home, office, and other outpatient visits.

- Outpatient diagnostic services, including:
  - » Radiology, ultrasound and nuclear medicine;
  - » Laboratory and pathology; and
  - » ECG, EEG, other electronic diagnostic medical procedures, and physiological medical testing.
- Outpatient therapy services, including:
  - » Radiation therapy;
  - » Chemotherapy;
  - » Dialysis treatment for 30 days after discharge from the Hospital (in any setting);
  - » Physical Therapy;
  - » Occupational Therapy;
  - » Speech Therapy; and
  - » Respiratory Therapy.
- Psychiatric care services, including:
  - » Inpatient medical services for treatment of mental Illness by a Physician or other professional provider for medical care visits (limited to one visit per day), individual psychotherapy, group psychotherapy, psychological testing, and family counseling; and
  - » Outpatient psychiatric care services when provided for treatment of mental Illness by a Hospital, Physician, or other professional provider.
- Ambulance service providing transportation by means of a specifically designed and equipped vehicle used only for transporting Sick and Injured persons.
- Private duty nursing services of a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) when ordered by a Physician, including inpatient services and home services.
- Skilled Nursing Facility services when Confined as an inpatient. However, no benefits are paid after the maximum level of recovery possible is reached, when Confinement is intended solely to assist with activities of daily living.
- Home health care services provided by a Hospital or Home Health Care Agency when prescribed by the attending Physician prior to discharge from the Hospital or other facility. The individual must be Confined at home and home health care services must be rendered for treatment of the same Illness or Injury for which the individual was Confined, including:
  - » Professional services of an RN, LPN, or LVN;
  - » Physical Therapy;
  - » Medical and surgical supplies provided by the home health care provider;
  - » Prescribed drugs;
  - » Oxygen and its administration;
  - » Medical social service consultations;
  - » Health aide services to an individual receiving covered nursing or therapy services;
  - » Durable Medical Equipment; and
  - » Dialysis treatment for 30 days after discharge from the Hospital.

  No home health care benefits will be provided for dietitian services, homemaker services, maintenance therapy, purchase or rental of dialysis equipment, or food or home delivered meals.
- Durable Medical Equipment rental (not to exceed the total cost of purchase) or purchase when prescribed by a Physician or other professional provided as required for therapeutic use.
- Prosthetic appliances, including the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies that replace all or part of an absent body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ.
- Orthotic devices, including rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.
- Transportation, lodging, and meals (see Benefit Maximums on the next page).

Certain limitations may apply to the above Covered Expenses. In addition, Prescription drugs are covered under the Plan's Prescription drug benefits. Contact the Fund Office for more detailed information or a copy of any insurance contracts governing these benefits.

BENEFIT MAXIMUMS

You and each covered Dependent can receive Transplant Benefits up to the maximums specified on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

All reasonable and necessary transportation, lodging and meal expenses incurred, up to the daily maximum will be reimbursed. The sum of all costs of transportation, lodging, and meals is subject to an overall maximum. The following transportation, lodging, and meal expenses will be reimbursed up to the maximums listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet) for each covered transplant procedure completed:

- If the recipient of the covered transplant procedure is an adult, costs of transportation to and from the site of the covered transplant procedure for the recipient and one other individual will be reimbursed.
- If the recipient of the covered transplant procedure is a minor, costs of transportation to and from the site of the covered transplant procedure for the recipient and two other individuals will be reimbursed.

PROCEDURES SCHEDULED BUT NOT PERFORMED

If a covered transplant procedure is not performed as scheduled, due to the intended Eligible Person's medical condition or death, then benefits are provided for charges directly related to that scheduled transplant (except procurement expenses) that are incurred five days before the scheduled or attempted transplant procedure, including the date of the scheduled or attempted transplant procedure and the following day or the date of death, whichever is earlier. If the transplant would have made use of an organ from a living related donor, procurement expenses will be reimbursed if they occur within five days of the date of the scheduled transplant.

If a bone marrow or stem cell transplant infusion is not performed as scheduled after the high dose portion of the therapy has begun due to the intended Eligible Person's medical condition or death, then benefits are provided for procurement charges directly related to the scheduled transplant procedure that are incurred 30 days before the scheduled transplant procedure, extending to and including the scheduled date of the transplant procedure or extended to and including the date of death, whichever is earlier.

EXTENDED TRANSPLANT BENEFITS

If your coverage under the Plan ends and you have already begun the process of having a transplant, coverage continues for the duration of the applicable benefit period.

TRANSPLANT BENEFIT EXCLUSIONS AND LIMITATIONS

You should be aware that some expenses are not covered under the Plan's Transplant Benefits. In addition to any General Plan Exclusions And Limitations (see page 63), Transplant Benefits are not paid for the following expenses.

1. Care, services, or supplies:
   a. Care, services, or supplies not prescribed by or performed by or upon the direction of a Physician or professional/facility Provider.
   b. Care, services, or supplies rendered by a provider that is a member of the Participants' immediate family.
   c. Care, services, or supplies rendered by Hospitals, Physicians, or other providers that do not meet the Plan's definitions of such providers.
2. Charges:
   a. Charges a Participant would not legally have to pay if there were no insurance.
   b. Charges for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
   c. Charges for telephone consultations, failure to keep a scheduled visit, or for completion of a claim form.
3. Cosmetic: Surgery and any related services intended solely to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process.
4. Custodial: Custodial or long-term Care, domiciliary care, or rest cures.
5. Experimental or Investigative: Treatment that is Experimental or Investigative in nature.
6. Medical Necessity: Services or supplies that are not Medically Necessary.

7. Other Coverage:
   a. Provided, or that would be provided, by any governmental unit, such as Medicare.
   b. Received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
   c. Related to any Illness or bodily Injury that occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This applies whether or not the individual claims the benefits or compensation or recovers losses from the third party.
   d. To the extent payment has been made under Medicare or would have been made if applied for and claimed (i.e., multi-visceral transplants where one organ is payable by Medicare, such as kidney and heart transplant where the kidney transplant is payable by Medicare).
8. Rehabilitation:
   a. Treatment for alcoholism.
   b. Treatment for drug abuse.
9. Transplant:
   a. For a transplant procedure performed after the date coverage ends, including a transplant performed with a benefit period beginning after coverage ends but performed during a continuous Hospital stay that began before coverage ended.
   b. For a transplant procedure performed prior to becoming eligible or for an inpatient admission that began and ended before being covered.
   c. For any Illness or Injury suffered after becoming eligible that is not a direct result of a transplant procedure or complication covered under the Plan.
   d. For any non-human organ transplant.
   e. For donor expenses other than those specifically listed as covered.
   f. For non-transplant related costs.
   g. For recurrence of the disease for which the transplant was performed.

RECOVERY INCENTIVE PROGRAM

Be on the lookout for pricing errors and/or services billed but never received.

The Recovery Incentive Program is intended to encourage you and your family to carefully review your medical bills. Reviewing a health care provider's bill could help lower the cost you and the Fund pay for health care. The program provides you with a cash incentive to discover and arrange for the recovery of overcharges made on your medical bills, including Hospital and Physician bills.

The program allows for payment of 10% of the actual amount of an overcharge that the Hospital or Physician agrees is valid. The maximum the Fund will pay for any individual overcharge is $1,000.

Following is a detailed description of the Recovery Incentive Program, including guidelines to assist you in reviewing the services received at a Hospital. Remember, always request an itemized bill to review the services rendered.

RECOVERY INCENTIVE PROGRAM GUIDELINES

For purposes of the cash incentive, only Hospital and Physician expenses that the Plan covers will be considered in determining the amount payable to you under this program. A cash incentive will not be paid for billing errors of less than $25 or for medical expenses not covered under the Plan's program of benefits (such as telephone bills, television rental, or newspapers while Hospital-Confined). Claims involving coordination of benefits will be eligible only if this Plan is primary.

HOW THE PROGRAM WORKS

- When you receive a bill, review it carefully – look for pricing errors or charges for services never received.
- When an overcharge is discovered, report any overcharges to the provider's billing department and request a corrected bill. If it is clear that an error has been made on your bill, the provider must drop these charges, unless there is evidence in the medical file to the contrary.
- Proof of eligibility for a cash incentive must be submitted to the Fund Office. Send a copy of the initial itemized medical bill and a copy of the adjusted bill showing the reduced billing amount to the Fund Office.
- Upon receipt of proof and verification that the overcharge has been recovered, the Fund will issue a check to you for 10% of the actual amount of the overcharge, up to a maximum of $1,000 per occurrence.

The Trustees and administrative staff of the Fund will not get involved in any differences between you and the provider with respect to disputed charges. You are solely responsible for handling such disputes. The Trustees have the sole right at any time to amend or modify these guidelines or terminate the Recovery Incentive Program.

SUGGESTIONS FOR REVIEWING YOUR ITEMIZED BILLS

- Before leaving the Hospital, make sure the Hospital provides or arranges to send an itemized bill.
- Either during your admission or immediately after discharge, list the events of your stay.
- Match this list against your actual bills to detect any overcharges.
- Check your bill carefully for charges that represent any treatments, services, or supplies that were not received. Follow this or a similar checklist.
  - » Determine if you were billed for the correct number of days; and for the correct type of room occupied (private, semi-private, ward).
  - » If intensive care was required, determine if you were billed for the correct number of days.
  - » Determine if you were charged for the day that you were discharged even though you left before the day's charges began.
  - » Determine if you were charged for only the tests or x-rays that you actually received.
  - » Determine if you were charged for medication, injections, dressings, supplies, etc. that you did not receive or for quantities in excess of what you remember.
  - » Determine if medication ordered by your Physician for a specified period was billed to you for your entire Hospital stay.
  - » If you received any therapy, determine if you were charged for the correct type of treatment, and for the correct number of hours.
  - » If you received a blood transfusion, determine if you were charged for blood that a donor, blood bank, or a Red Cross family or community assurance program replaced.
  - » If admitted to the maternity wing, determine if you were billed for a labor room that may not have been used due to swift delivery.
  - » Ask for an explanation of specific terms used in your bill—for example, miscellaneous charges.

DENTAL BENEFITS

COORDINATION OF BENEFITS

All Dental Benefits are coordinated with benefits under other dental plans. See the explanation on page 72.

BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE

The Fund may make a claim against a third party for Dental Benefits where expenses are paid as a result of an Illness, Injury or death caused by another person. See page 79 for a detailed explanation.

The Fund provides coverage for dental care for active Participants and their eligible Dependents. Coverage is provided to retired Participants (and their eligible Dependents) who are enrolled and make self-payment contributions for this coverage.

COVERED EXPENSES

Dental Benefits are separated into three categories of services, as specified on the ***Summary of Benefits*** insert (in the back pocket of this booklet):

- Diagnostic and Preventive;
- Routine (Restorative, Endodontic, Periodontic, and Prosthetics); and
- Orthodontics (braces—for Dependent children only).

The Plan limits certain expenses paid for Dental Benefits. The per person Calendar Year maximum for routine dental services is listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). This Calendar Year maximum does not apply to diagnostic and Preventive Services or Orthodontic services. However, the Plan has a separate Lifetime maximum for Orthodontic services (see the ***Summary of Benefits*** insert in the back pocket of this booklet), but it does not apply to Dependent children under age 19.

When the charge is higher than the Allowable Charge, you will be informed through the Explanation of Benefits (EOB). You are responsible for paying the difference between the Plan's benefit and the amount charged. To protect yourself against having to pay excessive dental expenses, request that your Dentist submit a Pretreatment Estimate to the Fund Office.

Diagnostic And Preventive Care

Diagnostic and Preventive care services and procedures include:

- Up to two routine oral examinations per Calendar Year, including bitewing xrays;
- Up to two cleanings (prophylaxis) each Calendar Year (these may be done by a Dental Hygienist);
- One full mouth xray every two Calendar Years;
- Sealants twice per Calendar Year; and
- Two topical fluoride treatments per Calendar Year.

Routine Procedures

The Plan covers routine dental expenses, including implants, Restorative, Endodontic, Periodontic, and Prosthodontic (the artificial replacement of missing teeth or a part of a tooth). Dental services and procedures covered under this category include:

- Palliative exams that are related to treatment;
- Restorative services, including restoration with amalgam, synthetic porcelain, and plastic materials. Restorations made with gold are included only if the teeth cannot be restored with the other materials listed previously;
- Endodontic services, including pulpal therapy and root canal filling;
- Periodontic services, including procedures for treating gums and the supporting structures of the teeth. Oral Surgery is not covered under the dental portion of the Plan; however, it may be covered under the Plan's medical benefits;
- Prosthetic services, including bridges, implants, partial and complete dentures, and services related to making existing dentures satisfactory. Replacement of existing dentures is made only if they are unsatisfactory. The replacement of dentures or other prosthetic appliances is allowable only once in a fiveyear period; and
- Procedures to reline and rebase—not within six months of the initial placement and not more than once in any 36-month period for any covered person.

Dental care included in this category is subject to the Calendar Year maximum.

Prosthodontic services that are required specifically as a direct result of oral cancer will not be subject to the dental plan's Calendar Year maximum benefit, which is currently $2,500. Benefits for Prosthodontics will be allowed at 80% of the Plan's Allowable Charge with no maximum benefit limitation.

Orthodontic Services (Braces)

Your eligible Dependent children are covered if they need Orthodontic care. Benefits are paid as specified on the ***Summary of Benefits*** insert (in the back pocket of this booklet) based on the Allowable Charges incurred during an entire period of Orthodontic treatment, provided your Dependent is eligible when the treatment begins and during the entire course of treatment.

> Keep in mind that payment for Orthodontic treatment is subject to a Lifetime maximum for Dependent children who are age 19 and older. The maximum does not apply to Dependent children under age 19.

There is no maximum on benefits payable for Orthodontic treatment for Dependent children under age 19. Benefits payable for Orthodontic treatment for employees and Dependents who are age 19 or older are subject to the Lifetime maximum benefit, which means the aggregate amount payable for all Orthodontic expenses incurred during each Eligible Person's Lifetime.

Eligible dental expenses under this provision are expenses incurred as the result of the initial and subsequent installation of Orthodontic appliances, including all Orthodontic treatment rendered by an orthodontist preceding and subsequent to the installation.

Orthodontic benefits are payable on an itemized basis. When the orthodontist submits itemized statements during a period of Orthodontic treatment, benefits are paid as expenses are incurred and submitted for payment.

DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

You should be aware that some items of dental care are not covered by the Plan. In addition to any General Plan Exclusions And Limitations (see page 63), Dental Benefits are not paid for the following expenses.

1. Prosthetic replacement more than once in a five-year period, unless Medically Necessary.
2. Replacement of a lost or stolen appliance or of duplicate appliances.
3. Services:
   a. Equipment sterilization.
   b. Oral Surgery and Temporomandibular Joint Disorder treatment (both are covered under Comprehensive Medical Benefits).
   c. Preventive control programs, including oral hygiene instruction, plaque control, hydrotherapy, or dietary planning.
   d. Rebase or reline of dentures within six months of initial placement.
4. Temporary procedures.
5. Orthodontic treatment for you or your spouse.
6. Treatment, care, services, or supplies incurred before you or your eligible Dependents were covered under this Plan, including dental treatment furnished for prosthetic services or devices (including crowns and bridges) started before the Eligible Person's effective date (such services are considered started when impressions and fittings have been made).
7. Bleaching or whitening procedures or supplies.

VISION BENEFITS

COORDINATION OF BENEFITS

All Vision Benefits are coordinated with benefits under other health plans and Medicare. See the explanation on page 72.

Eye care is an important part of your overall health. The Trustees recognize this and, as a result, provide Vision Benefits for active Participants and their eligible Dependents. Coverage is also provided to eligible retired Participants and their Dependents who have enrolled and make self-payment contributions for this coverage.

The Plan covers 100% of one vision exam per person each Calendar Year. In addition, the Plan covers 100% of expenses for eligible materials – lenses, frames, and contacts – up to the per person maximum listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). Since the Fund covers eligible material expenses only up to a set amount, it is to your benefit to shop for the most cost-effective materials. Many vision providers offer coupons for discounts on materials, and others run seasonal sales.

COVERED EXPENSES

Vision Benefits covered under the Plan per person per Calendar Year may include:

- A complete eye examination;
- Eyeglass lenses and frames including single vision, bifocal, trifocal, and lenticular lenses); and
- Contact lenses.

Services must be provided by and supplies received from a legally qualified Optician, Optometrist, or Ophthalmologist, acting within the usual scope of his or her practice, to be eligible expenses under the Plan.

VISION BENEFIT EXCLUSIONS AND LIMITATIONS

You should be aware that some items of vision care are not covered by the Plan. In addition to any General Plan Exclusions And Limitations (see page 63), Vision Benefits are not paid for the following expenses.

1. Services, including:
   a. Eye exams required by an employer.
   b. Eye exercises, including remedial reading exercises.
   c. Orthoptics or visual training.
   d. Services performed or supplies furnished by a provider other than an Optician, Optometrist, or Ophthalmologist.
   e. Supplemental services not covered in basic care.

2. Supplies, including:
   a. Aniseikonic lenses (for binocular vision).
   b. Non-Prescription lenses.
   c. Non-Prescription sunglasses.
   d. Subnormal vision aids.
3. Laser surgery and surgical correction of refractive errors and refractive keratoplasty procedures including but not limited to Radial Keratotomy (RK), Anterior Lens Keratotomy (ALK), PRK, and Laser in Situ Keratomileusis (LASIK), and similar surgeries for the correction of vision.
4. Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except as specifically noted elsewhere in this booklet, including vision services rendered after coverage ends, except that lenses and frames ordered before coverage ended will be covered if they are delivered within 31 days.

LOSS OF TIME (SHORT-TERM DISABILITY) BENEFITS

Loss of Time Benefits are for active Participants only. However, Loss of Time Benefits are not available to salaried Alumni or Non-Bargaining Unit Participants.

If you are an active Participant unable to work because of a non-job related Illness or because of an Injury caused by an Accident off the job, and you are under the regular care of a qualified Physician, you are eligible to receive Loss of Time Benefits (short-term Disability benefits).

If you are under the regular care of a qualified Physician, benefits begin on the:

- First day you are off work due to an Accident off the job; or
- Eighth day you are off work due to a non-job related Illness.

Loss of Time Benefits are paid weekly, at the rate listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). Benefits may run for a maximum of 26 weeks for any one Period of Disability.

Successive periods of Disability due to the same or related causes not separated by a return to active employment are considered one Period of Disability.

To be eligible for coverage as an active employee following a Period of Disability, you must have a release from your Physician to return to work and you must work at least 40 hours. If you return to work for at least 40 hours after being released by your Physician, and you have to leave work again because of a Disability, a new Period of Disability will begin. You must return to work and have at least 40 hours of contributions made on your behalf after one Period of Disability to qualify for a second or succeeding Period of Disability and receive Loss of Time Benefits.

You do not have to be Confined to your home to collect benefits, but you must be under the care of a Physician. For a Disability lasting less than one full week, benefits are paid based on the ratio of the number of days of Disability divided by the number of days in the week. In any event, no Disability is considered as beginning before the first visit to a Physician.

While you are receiving Loss of Time Benefits, you continue to receive credit for hours toward eligibility. If you are receiving Workers' Compensation benefits, you will receive credit for hours toward eligibility if you notify the Fund Office, in writing. In either case, you will receive credit for up to 25 hours of contributions each week, not to exceed 100 hours per month, to a maximum of:

- 24 months if you are receiving Workers' Compensation benefits; or
- 26 weeks if you are receiving Loss of Time Benefits.

Loss of Time Benefits are subject to federal income tax, which you can elect to have withheld. Social Security taxes are also withheld. The Fund Office will send you a W2 Form after the end of the year to report this taxable income.

LOSS OF TIME BENEFIT EXCLUSIONS AND LIMITATIONS

In addition to any General Plan Exclusions And Limitations that apply (see page 63), Loss of Time Benefits are not paid for any period of time for which you are:

1. Being treated for mental health, eating disorders, or substance (alcohol or drug) abuse on an outpatient basis.
2. Receiving benefits under Workers' Compensation or occupational disease laws.
3. Receiving wages or salary.

DEATH AND DISMEMBERMENT BENEFITS

Death and AD&D Benefits are for active and retired Participants only; Dependents and surviving spouses are not covered.

All active and retired Participants who have satisfied the eligibility requirements are covered by the Death Benefit and Accidental Death and Dismemberment Benefit programs available through the Metropolitan Life Insurance Company (MetLife). Dependents and surviving spouses are not eligible for coverage.

DEATH BENEFIT

In the event of your death while you are eligible for benefits from the Fund, your designated beneficiary will receive the Death Benefit. A claim, along with proof of your death, must be sent to the Fund Office. Upon receipt, information will be sent to MetLife. Your claim will be reviewed and, if approved, your beneficiary will be paid the amount of the Death Benefit listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet).

You are eligible to receive an "accelerated benefit" of up to 50% of your basic life insurance amount if you become Terminally Ill due to an Injury or Illness. However, the benefit will not exceed $10,000 for active Participants and $5,000 for retirees.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

If you are Injured or die due to an Accident, you (or your beneficiary) will be paid up to the maximum amount of the Accidental Death and Dismemberment (AD&D) Benefit listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). This benefit is paid in addition to the Death Benefit.

The full amount of the AD&D Benefit is paid as follows:

For Loss Of:	Benefit
Life	Full Amount
Both Arms, Both Legs, Speech and Hearing, Paralysis of Both Arms and Both Legs, any combination of Hand, Foot, or Sight in One Eye, or Brain Damage	Full Amount
One Arm, One Leg	Three Quarters of Full Amount
One Hand, One Foot, Sight in One Eye, Speech or Hearing, or Paralysis of Both Legs, Paralysis of the Arm and Leg on either side of the Body	Half of Full Amount
One Thumb and Index Finger of Same Hand, Paralysis of One Arm or Leg	One Quarter of Full Amount

You are also entitled to a monthly benefit of 1% of the full amount of your AD&D benefit if you fall into a Coma within 30 days of the date you sustain an Accidental Injury. Your monthly benefit will begin on the 7th consecutive day of the Coma and continue for the duration of the Coma, up to a maximum of 60 months.

No more than the full amount of the AD&D Benefit will be paid for one Accident.

In the event of your death, the benefit is paid to your beneficiary. In the event of an Accidental Injury for which you are eligible for benefits, the benefit is paid to you.

Additional Benefits

The AD&D policy also includes certain benefits for Injuries you sustain in an automobile Accident, as well as coverage for childcare and education, spouse education, and Hospital Confinement.

AD&D Benefit Exclusions And Limitations

In addition to any General Plan Exclusions And Limitations that apply (see page 63), AD&D Benefits are not paid for any loss caused or contributed to by:

1. Physical or mental Illness or infirmity, or the diagnosis or treatment of such Illness or infirmity;
2. Infection, other than infection occurring in an external Accidental wound;
3. Suicide or attempted suicide;
4. Intentionally self-inflicted Injury;
5. Service in the armed forces of any country or international authority, except the United States National Guard;
6. Any incident related to:
   a. Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
   b. Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   c. Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
   d. Travel in an aircraft or device used:
      – for testing or Experimental purposes;
      – by or for any military authority; or
      – for travel or designed for travel beyond the earth's atmosphere;
7. Committing or attempting to commit a felony;
8. The voluntary intake or use by any means of:
   a. Any drug, medication or sedative, unless it is:
      – taken or used as prescribed by a Physician, or
      – an "over the counter" drug, medication or sedative taken as directed;
   b. Alcohol in combination with any drug, medication, or sedative; or
   c. Poison, gas, or fumes;
9. War, whether declared or undeclared; or act of war, insurrection, rebellion or riot; or
10. Intoxication of the Injured party (or if the intoxicated party is the operator of a vehicle or other device involved in the incident).

BENEFICIARY

The Death Benefit and AD&D Benefit are paid to the beneficiary you designate and who is on record with the Fund Office. You may change your beneficiary at any time. To change beneficiaries, contact the Fund Office. The Fund Office will give you the form needed to make the change. You may also name more than one beneficiary. If your marital status or the number of your Dependents changes, you may want to review your beneficiary designation. Remember—it is your responsibility to keep your beneficiary designation current.

If any designated beneficiary dies before you, that beneficiary's right to the Death Benefit or the AD&D Benefit terminates. If there is no beneficiary designation on file, your Death Benefit is paid to your surviving:

- Spouse; or if none,
- Children in equal shares; or if none,
- Parents in equal shares; or if none,
- Brothers and sisters in equal shares; or if none,
- Estate.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

Custodial Care, which is not covered under the Plan, includes expenses incurred for accommodations (including room and board and other institutional services) and nursing services, due to age or a mental or physical condition, primarily to assist a patient in daily living activities.

The Plan provides coverage for many Medical, Prescription Drug, Transplant, Dental, Vision, Disability, and Death benefits. In addition to any specific exclusions and limitations listed throughout this booklet, Plan benefits are not paid for the following.

1. Charges:
   a. For completion of claim forms or failure to keep any appointment.
   b. Above the Allowable Charges of the Plan.
   c. Related to interest on expenses or sales tax.
2. Cosmetic: Treatment, surgery, and any related services intended solely for Cosmetic purposes or to improve appearance, except when necessitated by mastectomy or congenital malformations but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process, including, but not limited to:
   a. Cosmetic reconstruction of the nose;
   b. Electrolysis;
   c. Keloids;
   d. Removal of wrinkles or excess skin;
   e. Revision of previous elective procedures;
   f. Treatment of male pattern baldness; and
   g. Wigs.
3. Custodial:
   a. Any charges for Custodial Care, domiciliary care, or rest cures. The fact that a Participant is also receiving medical services that are merely maintenance care that cannot reasonably be expected to substantially improve a medical condition does not prevent this limitation from applying.
   b. Medical supplies and Durable Medical Equipment used only for a Participant's comfort, personal hygiene, or convenience, including, but not limited to: air conditioners, air cleaners, humidifiers, dehumidifiers, purifiers, physical fitness equipment, Physician's equipment, disposable supplies other than colostomy supplies, self-help devices not medical in nature, hot tubs, filtration systems, heating pads, ice bags, cooling units or cold therapy units, and similar equipment.
4. Experimental/Investigative: Treatment, care, service, or a supply (including Prescription medications) of any kind that is Experimental or Investigative in nature or not generally accepted practice by the medical (or applicable) community.

5. Governmental: Any treatment, care, services, or supplies furnished by or payable under any plan or law through any municipal, state, or federal government or any political subdivision (this applies whether or not the Eligible Person claims the benefits or compensation and whether or not the Eligible Person recovers losses from a third party), except for:
   a. The Veterans Administration, when services are provided to a veteran for a Disability that is not service connected;
   b. A military Hospital or facility, when services are provided to a retiree (or Dependent of a retiree) from the armed services; or
   c. A group health plan established by a government for its own civilian employees and their Dependents.
6. Other Coverage: Any treatment, care, services, or supplies for which you or your eligible Dependents have received or are entitled to receive benefits under a Workers' Compensation, occupational disease law, employers' liability law, or similar law, or that arise out of or in the course of any occupation or employment (regardless of whether or not the Eligible Person is paid in cash). This applies whether or not the Eligible Person claims the benefits or compensation, whether or not the Eligible Person recovers losses from a third party, and whether or not the Eligible Person is not eligible due to non-payment of premiums by an employer. However, if you or your eligible Dependents have been denied Workers' Compensation, occupational disease benefits, employer liability laws, or government benefits, and have filed an appeal with the appropriate state agency, you and your attorney must execute an agreement stating that you agree to repay/reimburse the Fund for all benefits paid by the Fund on behalf of the Eligible Person for said services and treatments out of **any** Recovery proceeds, whether by settlement or otherwise.
7. Pre-Eligibility: Expenses related to treatment, care, services, or supplies incurred on or after you or your eligible Dependents become covered under this Plan, including:
   a. Dental treatment furnished for prosthetic services or devices (including crowns and bridges) started before the Eligible Person's effective date (such services are considered started when impressions and fittings have been made); and
   b. Transplant procedures performed prior to an Eligible Person's effective date or during an inpatient admission that began before the Eligible Person's effective date.
8. Post-Eligibility: Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except as specifically noted elsewhere in this booklet, including:
   a. Vision services rendered after coverage ends, except that lenses and frames ordered before coverage ended will be covered if they are delivered within 31 days; and
   b. Transplant procedures performed with a transplant benefit period beginning on the termination date of an Eligible Person's coverage but performed during a continuous Hospital stay, which began before that termination date;
9. Treatment, Care, Services, or Supplies:
   a. For which no charge is made or incurred, or for which you would not be required to pay if you did not have coverage (unless otherwise required by applicable federal law).
   b. Not Medically Necessary for the treatment of an Illness or Injury, including those not prescribed by or performed by or upon the direction of a Physician or other professional/facility provider.
   c. Other than those specifically listed as Covered Expenses.
   d. Provided through a medical department, clinic, or similar facility provided or maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
   e. Rendered by a person who ordinarily resides in your home or who is a member of the Eligible Person's immediate family.
   f. Required while incarcerated in a federal, state, or local penal institution, or required while in custody of federal, state or local law enforcement authorities.
   g. Resulting from any Injury sustained or Illness contracted while on duty with any military, naval, or air force of any country or international organization or the result of an act of declared or undeclared war (including resistance to armed aggression).
   h. For hygienic and preventive maintenance foot care, including cleaning and soaking the feet, applying skin creams in order to maintain skin tone, and other services that are performed when there is not a localized Illness, Injury or symptom involving the foot.
10. Damage to the facility of an in-network or out-of-network provider caused by an Eligible Person. The actual cost of such damage may be billed directly to the Eligible Person.
11. Treatment of mental retardation, other than the initial diagnosis.
12. Treatment of obesity, except for counseling related to a mental health or addiction issue; other treatment of obesity is covered under the Plan's Gastric Bypass Surgery Provisions.
13. Court-ordered testing and treatment, if not Medically Necessary.
14. Ancillary services such as vocational rehabilitation, behavior training, sleep therapy, and employment counseling, training, or educational therapy for learning disabilities or other educational services.
15. Prescription and non-Prescription drugs, except for medications prescribed by a Physician in connection with treatment as an inpatient at a Hospital or prescribed medications covered under the Plan's Prescription Drug Benefits.
16. Inpatient services, treatment, or supplies rendered without preauthorization, except in the event of an emergency.
17. Non-emergency care when traveling outside the United States.

CLAIMS INFORMATION

Generally, medical Preferred Providers will file a claim for you. However, you will be required to submit a claim for reimbursement of any eligible HRA expenses, as well as Loss of Time and AD&D benefits, as later explained.

If you or an Eligible Dependent has coverage under more than one health care plan, benefits are coordinated (see page 72).

This section describes how to file a claim, when claims are paid and what to do if a claim is denied. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees.

FILING A CLAIM – GENERAL PROCEDURES

Generally, medical Preferred Providers will file a claim for you. If you need to file a claim, you should file a written claim with the Fund Office within 30 days of incurring covered charges (you may use a standard form that is used by most providers). Late claims are difficult for the Fund Office to process. Therefore, if you do not file your claim within 24 months of the date the expenses related to the service are incurred, your claim may not be accepted and will be denied.

To take advantage of the savings the PPO provides, always check to see if your provider is in the network (providers participating in the network change periodically). You must show your Eligibility ID card at the time that you receive service. If you do not notify your provider of your network coverage within 30 days of the date you receive service, the Fund Office will process your claim as an out-of-network claim.

You will need to file a claim for reimbursement of HRA expenses and for certain eligible Prescription drug expenses. However, when you use a medical Preferred Provider or if you use the Fund ID card to obtain Prescriptions through CVS Caremark, the provider will generally file the claim for you. Most medical Preferred Providers will also file a claim for you, but if they do not, you should send an itemized bill of the service(s) rendered to the Fund Office at the following address:

Operating Engineers Local 139
Health Benefit Fund
P.O. Box 160
Pewaukee, Wisconsin 53072-0160

Itemized Bills

An itemized bill should show:

- Your name and Social Security number or unique identification number (shown on your ID card?), OEF_ _ _ _ _ _;
- The patient's name;
- The Physician's name;
- The Physician's tax identification number;
- The dates of treatment or purchase;
- The type of services (Physician's office visit, Hospital, lab tests, etc.);
- The charge made for each service;
- The condition for which the charge was incurred (the diagnosis); and
- If due to an Injury, indicate how, when, and where the Injury occurred.

If your bills clearly show all the above information, it may not be necessary to submit a claim form.

Provide All Necessary Information

If you need to file a claim, you can avoid unnecessary delays in processing your claims by providing all the necessary information. A main reason for delays in processing of benefits is failure on the part of the providers furnishing supplies or services, and the person filing for benefits, to provide all the information needed to determine benefits.

Failure to supply complete information requires the Fund Office to send a request for additional information. This causes delays in processing your benefits.

Information most often omitted by Participants in filing for benefits includes:

- Coverage under other group health plans provided through employment of other family members;
- How, when, and where an Injury occurred, and a complete description of the circumstances; and
- Whether the Injury was employment-related.

If you are submitting claims yourself, be sure to double check that you have included all the necessary information before you send them in.

> Most likely, you will not know if your Physician omits information; however, a reminder to the receptionist or nurse in the Physician's office that such information is important may help.

Information most often omitted by Physicians in completing their portion of claim forms includes:

- Diagnosis of the condition for which the patient received treatment;
- The Physician's tax identification number; and
- Correct itemization for charges.

Remember, all claims, whether submitted by you or your provider, should be mailed or submitted directly to the address listed on your Eligibility ID card.

FILING SPECIFIC BENEFIT CLAIMS

The following sections provide information for filing specific benefit claims.

Health Care Claims

> Contact the Fund Office for information about filing transplant expense benefit claims.

Many health care providers will submit claims for you. Health care claims include medical, transplant, dental, vision, and hearing care benefits. Be sure to show your ID card to the health care provider so the provider knows where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so.

Types Of Health Care Claims

There are four basic types of health care claims:

- **Urgent Care.** An urgent care claim, which is a type of pre-service claim, is a claim for medical care or treatment that:
  - » Would seriously jeopardize your life, health, or ability to regain maximum function if normal pre-service standards were applied; or
  - » Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

- **Pre-Service**. A pre-service claim is a claim for treatment where the Plan requires that you obtain preauthorization for all inpatient and certain outpatient treatments. The Plan will not deny benefits for these procedures or services if:
  - » It is not possible for you to obtain preauthorization; or
  - » The preauthorization process would jeopardize your life or health.
- **Post-Service.** A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.
- **Concurrent Care.** A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of a Hospital stay) and the reconsideration results in:
  - » Reduced benefits; or
  - » A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, the Plan Administrator will notify you as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Fund Office will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment

Coverage Under More Than One Plan

If you or an Eligible Dependent has coverage under two or more health plans, be sure to include the name of the other health plan(s) on your claim form. In addition, if you are also covered by Medicare and/or another plan, attach a copy of the itemized bill relating to the health service provided and a copy of any Explanation of Benefits (EOB). Both the bill and EOB must be submitted.

If Medicare is your or your Dependents' primary payor, ask your provider to bill Medicare for you. When Medicare makes its payment, you will receive an EOB from Medicare.

> When you or a Dependent are covered under Medicare, with Medicare as the primary payor, you must submit a copy of Medicare's EOB with your claim.

You must submit a copy of the Medicare EOB, along with an itemized statement from your provider, to the Fund Office so benefits can be coordinated with payment from Medicare (as described on page 73).

Please do not forward the itemized statement to the Fund until you have the Medicare EOB. If you do, the Fund Office will send you a letter requesting the Medicare EOB before your claim will be processed.

Assignment Of Benefits

The Plan prohibits you, as a Participant or beneficiary, from assigning any right under the Plan to a provider of services or supplies. This means that you cannot assign to any provider the right:

- To receive benefits;
- To claim benefits in accordance with Plan procedures and/or federal law;
- To commence legal action against the Plan, Trustees, Fund, its agents or employees;
- To request Plan documents or other instruments under which the Plan is established or operated; or
- To request any other information that a Participant or beneficiary is entitled to receive upon written request to the Plan administrator.

This new provision does not prohibit the Administrative Manager or the Trustees from mailing payment of benefits directly to a provider of services or supplies.

Pretreatment Estimates

If you wish to know, in advance, if the charges of your provider are considered Allowable Charges by the Fund or if a series of dental treatments is expected to cost more than $100, it may be to your advantage to ask your provider to submit a request for a Pretreatment Estimate to the Fund Office. This will ensure that you know which services and materials are covered and how much will be paid.

Caution: It is in your best interest not to sign any form that says you will accept responsibility for any part of the charges not paid by your insurance. Benefit payments are based on Allowable Charges. If the provider charges an amount over the Allowable Charge, and you have signed the form indicating you are responsible for any amount the Plan does not cover, you have no recourse and will be required to pay the balance.

Prescription Drug Claims

If you need to file a claim for Prescription drug benefits that you purchased from Canada or without using your ID card at a CVS Caremark participating pharmacy, you must provide a pharmacy receipt (not a cash register receipt) and include the following information:

- Your name and Social Security number or unique identification number;
- The patient's name;
- The Physician's name;
- Prescription number;
- Name of the medicine; and
- Cost of Prescription.

HRA Claims

You must submit a claim for reimbursement of any eligible expense. If you, your spouse, and/or your eligible Dependents are eligible for other coverage, you must include a copy of the Explanation of Benefits (EOB) from the other coverage as well as any EOB from this Plan. Only expenses that are covered, but not reimbursed as shown on the EOB form, will be considered eligible for reimbursement.

> The claim form is available on the Fund's website.

You may submit eligible expenses for reimbursement at any time. While requests for reimbursement can be made at any time, to limit administrative expenses, the Plan requires that any requests for reimbursement be for a minimum of $250. Therefore, you will have to hold your requests for reimbursement until you have at least $250 in eligible expenses. In addition, the amount reimbursed for any eligible expense will not exceed your HRA balance at the time reimbursement is requested. However, in the event your Plan coverage ends, you may submit eligible expenses totaling less than $250 to close out your Account.

> If you need a claim form, please contact the Benefits Office. It's a good idea to make a copy of all materials you submit for your records. Materials you submit will not be returned to you.

To receive reimbursement for eligible expenses, you must submit a written claim form to the Fund Office within 24 months of the date of the expense. Reimbursement requests must be accompanied by a properly completed claim form, which can be obtained from the Fund Office or downloaded from the Fund's website. The claim form will include a statement that you must sign verifying that the eligible expenses:

- Have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source;
- Have not been paid on a pre-tax basis; and
- Have not been taken, nor intend to be taken, as a tax deduction.

Along with the form, you must provide any of the following, as applicable:

- An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.
- An EOB from any coverage (including any EOB from this Plan) when requesting reimbursement of the balance of charges for which coverage is available.
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums.
- A receipt and proof of purchase or rental for covered items (such as crutches or wheelchairs).
- Any additional documentation requested by the Fund Office.

It's a good idea to make a copy of all material you submit for your records. Materials you submit will not be returned to you.

Claims for Mental Health and Substance Abuse Treatment Services

Your provider must submit your claims for mental health and substance abuse treatment services to Anthem at the address shown on your ID card.

Loss Of Time Claims

Request a claim form from the Fund Office and fill out items 1 through 6 on the form.

If you are Disabled and unable to work, be sure the Physician fills out the complete "Attending Physician's Statement." The Physician should be as specific as possible about when you will be able to return to work; indefinite is too vague an answer. The Fund needs this information to know when your Disability began and when it is expected to end.

When the form is completed, return it to the Fund Office.

Supplementary Report For Loss Of Time Benefits

Loss of Time Benefits are paid based on your Physician's estimate of when you can return to work. At any time, the Fund Office may require that your Physician complete a "Supplementary Report For Loss of Time Benefits" if there is any question regarding your Disability or if you are unable to return to work after the initial estimated return date that your Physician indicated.

Death And Dismemberment Claims

Call or write the Fund Office and explain the type of claim you are filing. The Fund Office will send you the proper claim form.

To file a claim for AD&D benefits, notify the Fund Office or MetLife of your loss within 20 days of the date of the loss. If you request a form from MetLife, you should receive it within 15 days of the date you contact MetLife. Fill out the claim form and send it back to MetLife with any proof requested within 90 days of the date of the loss.

For death claims, a certified copy of the death certificate will also need to be included.

CLAIM DECISIONS AND PAYMENT OF CLAIMS

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly by the Fund Office, when complete claim information is received. For any loss for which recurrent payments are provided, benefit amounts are paid as they accrue, but not less often than monthly (or not less often than quarterly for Orthodontic benefits).

LEGAL ACTIONS

No attempt to recover from the Fund through legal action may be made until 60 days after a complete claim has been filed and you have followed the claim appeal procedures (see page 65).

The Fund reserves the right to have the patient examined, at its own expense, as often as is reasonably necessary while a claim is pending to determine the proper benefit. The Fund may also have an autopsy performed, unless forbidden by law.

If payment of a claim is made to you on behalf of one of your covered Dependents (for example, if your ex-spouse or Dependent child submit a claim and payment is made to you), you are responsible for payment to the provider on behalf of that individual. Once the Fund makes payment on a claim, no further payment will be made.

Health Care Claims

Generally, once all required information is provided, health care benefits will be paid within 30 days after the claim is received (or as otherwise described below). The Fund Office will notify you of its initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Fund Office will give you written notice of its decision about your claim.

The deadlines differ for the different types of claims as shown in the following information:

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on you urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. The notice will state the special circumstances and the date the Fund expects to make a decision. You will then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received, if sooner.
- **Pre-Service and Post-Service Claims.** An initial determination will be made within 15 calendar days from receipt of your pre-service claim and within 30 calendar days from receipt of your post-service claim. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan, you will be informed of the extension within this initial day deadline. In addition, if additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. The notice will state the special circumstances and the date the Fund expects to make a decision. After 45 days or, if sooner, after the information is received, the Fund will make a determination within 15 days.

Generally, when Preferred Providers submit the claims, payment is made directly to the provider. Preferred Providers handle all the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the provider.

Loss Of Time Benefit Claims

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The Fund may extend this 45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary. The notice will state the special circumstances and the date the Fund expects to make a decision.

In some instances the Fund may require additional information to process and make a determination on your claim. If such information is required, the Fund Office will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, then your claim may be denied.

Death And Dismemberment Benefit Claims

Generally, you will receive written notice on a decision on your claim within 90 days after the Fund Office or MetLife receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Fund expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

IF A CLAIM IS DENIED

If your claim is denied (in whole or in part), the Fund Office will:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes as previously described.

> In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

Information Requirements

When the Fund Office notifies you of its initial denial on your claim, it will provide:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim.

In addition, for health care and Loss of Time Benefit claims the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit.

If your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

APPEALING A DENIED CLAIM

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Trustees at the Fund Office as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days from the date of a decision for ***health care*** or ***Loss of Time Benefit*** claims; or
- 60 days from the date proof is filed for ***life insurance*** claims and three years after the date proof is required for ***AD&D*** claims.

> All mental health and/or substance abuse appeals will be processed in the same manner as appeals on other medical claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative. A health care professional that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents; and
- Request to review all relevant information (free of charge).

In addition, if your claim is for ***health care*** or ***Loss of Time Benefits*** and is denied based on:

- An internal rule, guideline, protocol, or other similar criteria, you have the right to request a free copy of such information; and
- A Medical Necessity, Experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment used for the determination.

You may request an opportunity to appear before the Trustees (or an authorized committee of the Board) in person or by representative. If you don't request to appear before the Trustees, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing of the date, time, and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Make your written request for a claim appeal and submit any written comments to:

Board of Trustees
Operating Engineers Local 139 Health Benefit Fund
Office of the Administrative Manager
N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160

APPEAL DECISIONS

If you file your appeal on time and follow any applicable required procedures, a new, full, and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Fund will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Fund Office will notify you, in writing, of the decision on any appeal within the timeframes noted in the next subsection. However, oral notice of a determination on your urgent care claims may be provided to you sooner.

Appeal Timeframes

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

- Health Care Claims:
  - ***Urgent Care Claims.*** A determination will be made as soon as possible, but no later than 72 hours from receipt of your appeal.
  - ***Pre-Service Claims.*** A determination will be made within 30 calendar days from receipt of your appeal. If the appeal process has two levels, the determination will be made within 15 calendar days from receipt of your appeal for each level.
  - ***Post-Service Claims.*** A determination will be made by the Trustees at their next regularly scheduled meeting (at least quarterly) that follows the receipt of the request for review. However, if the request is filed within 30 days of the date of the meeting, the determination may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances exist (such as the need to hold a hearing), the appeal decision can be made at the third meeting following the appeal request. However, the Fund Office will notify you of this extension prior to the extension time. You will be notified of the decision within five days of the date of the meeting at which the Trustees make a determination on your claim.
  - ***Concurrent Care Claims.*** A determination will be made before termination of your benefit.
- **Loss of Time Benefits.** A determination will be made within the same timeframe as for post-service claims.
- **Death or Dismemberment Benefits.** A determination will be made within 60 calendar days from receipt of your appeal.

If your request is filed within 30 days of the date of a Trustees meeting, the Fund may make its determination no later than the date of the second meeting following the receipt of the request for review. If special circumstances exist (such as the need to hold a hearing), the appeal decision can be made at the third meeting following the appeal request. However, the Fund Office will notify you of this extension prior to the extension time.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Fund will consult with a health care professional whom:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity of any medical experts consulted in making a determination of your appeal.

Information Requirements

When the Fund notifies you of its determination on your appeal, it will provide:

- The specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records, and relevant information; and
- A statement that you may bring a civil action suit under ERISA, if you have exhausted the Plan's claims and appeal procedures.

In addition, for ***health care*** and ***Loss of Time Benefit*** claims, the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

Under the documents creating the Benefit Fund (and the terms of the Plan), the Trustees have sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Trustees, or persons to whom such decision making authority has been delegated by the Trustees, in their

sole discretion, decide the Participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters will be accorded judicial deference and are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan.

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain your benefits. You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the review procedures described in this section. You may, at your own expense, have legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

HRA Reimbursements

Reimbursements available under the HRA are intended to be solely for eligible expenses not previously reimbursed or reimbursable elsewhere. To the extent an eligible expense is payable or reimbursable from another source, that other source must pay or reimburse before reimbursement from the HRA.

If you, your spouse, and/or your eligible Dependents have other coverage, you must first submit any claim for reimbursement of eligible health care expenses to the other plan before submitting it for reimbursement from your HRA. Any portion of your eligible expenses that is not reimbursed after submission to the other plan can be submitted for reimbursement from the HRA.

If the expense can be reimbursed from a Flexible Spending Account (FSA) such as through a spouse's plan, for example, it must first be reimbursed from the FSA, then the HRA. The HRA pays secondary.

COORDINATION OF BENEFITS

Your and your Dependents' benefits are coordinated with other group health plans or prepaid group health care plans. When the benefits from all plans are added together, you will receive no more than 100% of the expenses incurred.

In no event will this Plan's payment be more than what would have been paid if there were no other plan involved. Benefits payable under another plan include any benefits that would have been payable, even though you may not actually have filed a claim.

Order Of Payment

The Plan's Coordination of Benefits provisions determine which plan is primary (pays benefits first) and which plan is secondary.

The Fund pays regular benefits when this Plan is the primary plan. When this Plan is the secondary plan, benefits the Fund pays will be no more than the total percentage of costs that the Fund would have paid had this Plan been the primary plan. Remember that the Fund will not pay an amount that is greater than, when added to other amounts paid or payable, the actual expenses incurred.

In general, here's how benefits are coordinated:

- If another plan covering an Eligible Person does not have a Coordination of Benefits provision, then that plan is primary.
- If a plan covers an individual as an active employee, then that plan is primary over a plan that covers an individual as a Dependent or laid-off or retired employee (or as a Dependent of a laid-off or retired employee). An active employee is someone who is actively working in employment, not laid off or retired.
- If you and your spouse are both covered as active eligible Employees under this Plan and one of you has a claim, the Fund will pay primary benefits on the claims as the claim of an Employee and then pay secondary benefits on the claim as the claim of a Dependent. This does not apply if one spouse is not eligible for benefits under the Plan.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an active employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan.
- If a person who is covered as a Dependent under this Plan is covered as a spouse under another plan, then the plan covering the Dependent as a spouse is the primary plan and the plan covering the Dependent as other than a spouse is the secondary plan.
- In the event that the individual covered under more than one plan is a Dependent child and none of the above rules apply, then the following rules determine which plan is primary:
  - » If the Dependent child does not have coverage through the above rules, then the Dependent child is covered through the Dependent child's parents and if the parents are not divorced or separated:
    - – The plan of the parent whose birthday is earlier in the year (excluding the year of birth) is primary;

      EXAMPLE: BIRTHDAY RULE

      Jeff's mother's birthday is March 3rd and his father's birthday is August 20th. His mother's plan is primary because her birthday is earlier than his father's. This is called the "birthday rule."

    - – If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary;

- If a plan does not follow the birthday rule, then the rules of that plan determine the order of payment; or
- If none of the above applies, the plan covering the individual the longest is primary.

» If the Dependent child does not have coverage through the above rules, then the Dependent child is covered through the Dependent child's parents and if the parents are divorced or separated:

- If there is a court decree that establishes financial responsibility for health care expenses, the plan covering the Dependent child of the parent who has financial responsibility is primary; or
- If there is no court decree or if there is decree that does not establish financial responsibility for health care expense, the plan of the:
  - Custodial parent pays first; then
  - Spouse of the parent with custody (if applicable) pays next; then
  - Parent without custody pays next; then
  - Spouse of the parent without custody pays last, if applicable.
- If there is no court decree, or if there is a decree that does not establish financial responsibility for health care expenses, and the dependent child lives independently from the dependent child's parents, the plan of the:
  - Most recent custodial parent pays first; then
  - Spouse of the parent with most recent custody (if applicable) pays next; then
  - Parent without recent custody pays next; then
  - Spouse of the parent without recent custody pays last, if applicable.

If the above rules do not determine the order of benefits, then the plan that has covered the individual for the longest period is primary, except when:

- One plan covers a claimant as a laid-off or a retired employee (or a Dependent of such an employee), in which case the plan that covers the claimant as an active employee or Dependent of an active employee will pay its benefits before the plan that covers the claimant as a laid-off or retired employee or the Dependent of such an employee; or
- If the other plan includes the above rule for laid-off or retired employees (or is issued in a state that requires this rule by law); then the plan that covers the claimant as other than a laid-off or retired employee (or a Dependent of such an employee) will pay first.

Medicaid: If you or your Dependent is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

Coordination Of Benefits With Medicare

Medicare consists of four parts:

- The first part is officially called Hospital Insurance Benefits for the Aged and Disabled, and is commonly referred to as Part A of Medicare. Part A of Medicare primarily covers Hospital benefits, although it also provides other benefits.
- The second part is officially called Supplementary Medical Insurance Benefits for the Aged and Disabled, and is commonly referred to as Part B of Medicare. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services.
- The third part is Medicare Advantage, and is commonly referred to as Part C. Part C is the managed care program under Medicare. If you are Eligible for Medicare, the Plan's payment is based on both Medicare Part A and Part B benefits.
- The fourth part is Prescription drug coverage that is commonly referred to as Medicare Part D. If you enroll in Medicare Part D, you will not be eligible for Prescription drug coverage under this Plan.

The Fund only coordinates coverage with Medicare Parts A, B and C.

Typically, you become Eligible for Medicare upon reaching age 65. Under certain circumstances, you may become Eligible for Medicare before age 65 if you are a Disabled worker, Dependent widow, or have chronic End-Stage Renal Disease (ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Part B of Medicare.

If you or one of your Dependents are entitled to Medicare due to age, Disability, or End Stage Renal Disease (ESRD), you should enroll in Medicare Part A and Part B. The Fund will not pay benefits that exceed the amounts specified in the ***Summary of Benefits*** insert (in the back pocket of this booklet). In addition, the combined amounts paid by Medicare and the Fund will not exceed the eligible expenses incurred as the result of any one Injury or Illness. Benefits paid by Medicare include those that would have been paid if the Eligible Person had properly enrolled when eligible to do so.

> To facilitate Plan payments in the absence of Medicare payments, it may be necessary for the Trustees to estimate Medicare payments.

If you are Eligible for Medicare due to:

- Age or Disability (other than ESRD) and you are covered as:
  - » A retiree, Disabled Participant, or surviving spouse or Dependent of such Participant, Medicare will be your primary plan and Plan benefit payments will be reduced by the amount of benefits paid (or payable) under Medicare (see ***How The Plan Coordinates Benefits With Medicare*** on this page). If you subsequently become entitled to Medicare due to ESRD, Medicare will continue to be your primary plan; or
  - » An active Participant or Dependent of an active Participant, this Plan will be your primary plan and Plan benefit payments will not be reduced. However, if you become entitled to Medicare due to age, you may elect to make Medicare your primary source of coverage. In this instance, the Fund is legally prohibited from supplementing Medicare coverage. If you subsequently become entitled to Medicare due to ESRD, this Plan will continue to be the primary plan for the first 30 months (refer to the following item for more information).

> You, and the Plan, are not responsible for paying any charges that exceed legal limits set by the Medicare Physician Payment Reform Act, which limits the amount that Physicians can bill Medicare patients for a particular procedure or service, unless services are privately contracted by you.

- If you are entitled to Medicare because you have ESRD, the Plan will be the primary source of coverage for up to the first 30 consecutive months. Beginning in the 31st month, Medicare will become the primary plan and benefit payments under this Plan will be reduced by the amount of benefits paid (or payable) under Medicare (see ***How The Plan Coordinates Benefits With Medicare*** on this page).

If you are eligible for retiree coverage and Medicare is your primary plan, the benefits paid (or payable) under this Plan for services:

- Incurred at a Veterans Administration (VA) facility for non-service connected Disability will be reduced by the amount that would have been paid by Medicare had the services been rendered by a Medicare approved facility.

> Your claims and your spouse's claims (if he or she also is Eligible for Medicare) should be submitted to Medicare **first**.

- Otherwise covered by Medicare, but that are privately contracted with a provider, will be limited to the amount that would have been paid by the Fund had the services been paid by Medicare.

If Medicare is your primary plan, your claims or your spouse's claims (if he or she is Eligible for Medicare) should be submitted to Medicare first. After Medicare pays the claim, submit an itemized statement along with the Medicare Explanation of Benefits to the Fund Office.

How The Plan Coordinates Benefits With Medicare

The Plan's benefit payment coordinates with Medicare's payment for services covered under Medicare Parts A and B only. For inpatient Hospital claims, the Fund pays a percentage of Medicare's inpatient deductibles and copayments (the coinsurance percentage is listed on the ***Summary of Benefits*** insert (in the back pocket of this booklet). For other Covered Expenses, you pay a percentage (as listed on the ***Summary of Benefits*** insert in the back pocket of this booklet) of the total Medicare-approved amount. Medicare and the Fund then share the remaining percentage amount. Medicare pays a certain percentage, and then the Fund pays the difference. For these expenses, the Fund "carves out" Medicare's payment, as follows:

- Covered charges under this Plan are determined; then
- The amount Medicare pays for these same changes is subtracted from the above; then
- The balance, if any, is the amount used in computing the benefit under this Plan.

EXAMPLE: MEDICARE COORDINATION OF BENEFITS

Jeff's mother's birthday is March 3rd and his father's birthday is August 20th. His mother's plan is primary because her birthday is earlier than his father's. This is called the "birthday rule."

Chris is hospitalized for an Illness. His Hospital and Physician charges are both covered under Medicare and the Plan. Here's how benefits would be coordinated.

Chris' Hospital Covered Charges:	$10,000.00
Medicare Pays:	-$9,188.00
Medicare Part A Deductible Chris Is Responsible For Paying:	$812.00
Fund Pays (95%):	-$771.40
Chris Pays:	**$40.60**
Chris' Physician Medicare Approved Covered Charges:	$4,000.00
Medicare Pays 80%:	-$3,200.00
Chris Pays 10% of Medicare Allowed Charges:	**-$400.00**
Fund Pays Balance (not to exceed 90%):	$400.00

* This example assumes that this is an assigned claim, which means the provider accepts Medicare.

INFORMATION GATHERING

To implement the Coordination of Benefit provisions, the Trustees may release or obtain any information necessary, in compliance with any applicable legislation. Anyone claiming benefits under this Plan must provide any information necessary to implement the Coordination of Benefits provisions or to determine their applicability.

IN CASE OF INCOMPETENCE

If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that individual, the Trustees may, at their discretion, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual. If the individual should die before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator or personal representative of his or her estate or to his surviving spouse, parent, child or children, or to any other person or persons who are entitled to such payment, in the Trustees' opinion. Any payments made by the Trustees in accordance with these provisions will fully discharge the liability of the Trustees to the extent of such payment.

PRIVACY POLICY

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan.

The Fund is required to protect the confidentiality of your private health information (PHI). The Fund's privacy rules, adopted April 14, 2003, are still in effect.

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

Your rights under HIPAA include the right to:

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

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Fund Office.

Use And Disclosure Of Protected Health Information

The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

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

- Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;

- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review, and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement. The following PHI may be disclosed for payment purposes:
  - » Name and address;
  - » Date of birth;
  - » Social Security Number;
  - » Payment history;
  - » Account number; and
  - » Name and address of the provider and/or health Plan; and
- Reimbursement to the Plan.

Health Care Operations

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

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives, and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- Business management and general administrative activities of the entity, including, but not limited to:
  - » Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
  - » Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
  - » Resolution of internal grievances; and
  - » Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and
- Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs, and other documents.

Additional Privacy Information

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

For purposes of this section, the Board of Trustees of the Operating Engineers Local 139 Health Benefit Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor of the following provisions.

- With respect to PHI, the Plan Sponsor agrees:
  - » Not to use or further disclose the information other than as permitted or required by this Summary Plan Description or as required by law;
  - » To ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
  - » Not to use or disclose the information for employment-related actions and decisions unless authorized by the individual;
  - » Not to use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual;
  - » To report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
  - » To make PHI available to the individual in accordance with the access requirements of HIPAA;
  - » To make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

- » To make available the information required to provide an accounting of disclosures;
- » To make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA; and
- » If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Plan will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

- Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
  - » The Plan Administrator; and
  - » Staff designated by the Plan Administrator.

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

  If the persons described above do not comply with this Summary Plan Description, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, the Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and no other Plan functions or benefits.

In compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;
- Ensure that the adequate separation specific to electronic PHI is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Breach Notification Rights for Unsecured Protected Health Information under HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund to provide notification to the media.

If your unsecured PHI is breached, the Fund will notify you without unreasonable delay and in no case no later than 60 calendar days after discovery of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Fund up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund has improperly followed the breach notification process.

SUBROGATION

BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE

Whenever the Fund provides benefits for an Illness, Injury, or death for which a third party may be liable, the Fund may make a claim or take legal action against the third party. The Fund has the right to recover all of the benefits it has paid to you or to those who provided your medical treatment from another payment source or from you if you have received the payment directly. The Fund also has the right to recover those payments, whether or not you have been fully paid for your treatment or other expenses from the same Illness or 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 in the Accident. If the Fund paid for your expenses that the automobile insurance company is responsible for, the Fund has the right to recover those expenses from the automobile insurance company or from you if they were paid to you.

If you were injured out of or in the course of any occupation or employment, the Plan generally excludes any claims that arose out of that Injury. (See *General Plan Exclusions and Limitations* on page 63.) The Fund may agree to pay any such claims, if you complete a Reimbursement Agreement.

Definitions

Throughout this section, the term "you" refers to you or an eligible covered Dependent. The following definitions apply to the terms used in this section:

- **Another Person** or **Entity** means any individual, corporation, municipality, or other governmental entity, partnership, association, trust, or any other organization, no matter how the person or entity has been identified.
- **An Other 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 for any Accident coverage, No-Fault Motor Vehicle Plan coverage, uninsured or underinsured motorist coverage, personal Injury protection, homeowners insurance, or school or athletic insurance; or
  - » Another Person or Entity (such as a company, organization, or corporation) that is responsible for the acts of the person that caused your expenses, such as a homeowner or other property owner.

  An Other 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 Coordination of Benefits provisions of this Plan.

- **Compensable Injury** means any Injury for which you or your Dependent may recover from an Other Source or have already been paid by an Other Source before this Plan provides coverage for the same claim.
- **Injury** means either an Illness or an Injury, if caused by the actions of Another Person. 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 an Other Source as a result of 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. are all defined as recoveries.

Agreement To Reimburse Fund For Other Payments

Whenever you or your Dependent have an Injury that may be paid for by Another Person or Entity, you (and your Dependent if your Dependent is Injured) must complete a Reimbursement Agreement to receive benefits from 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 Reimbursement Agreement. You and your Dependent must also comply with the following terms:

- You must agree to repay the Fund out of any Recovery or any benefits the Fund has paid because of your Illness or Injury. This provision applies even if the Recovery does not fully pay you for the expenses.
- You will only be required to hold any recovery in constructive trust for the Fund and to repay the Fund the amount of the benefits the Fund paid on the claim, or the amount you have recovered, whichever is less, without regard to attorney's fees and expenses you paid to obtain the Recovery.
- The Reimbursement Agreement gives the Fund a lien – or claim – on the money you recover from an Other Source, both to the full extent of the Plan's Subrogation rights and to the full extent of its right to repayment under the Reimbursement Agreement. The lien is valid whether or not the Reimbursement 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. You must assist and cooperate with representatives of the Fund and sign all documents required by the Fund to recover benefits paid by the Plan.
- If you receive a judgment or settlement, you must repay the Fund the lesser of the full amount of benefits paid by the Plan, or the amount of the Recovery. This applies, whether or not the source of the Recovery was legally responsible for paying those expenses. If you do not repay the Plan, the Fund may reduce future benefits for your claims until the Fund has recovered the benefits it paid. The Fund's right to reduce future benefits is in addition to any other legal rights the Fund has to recover benefits.
- You, your Dependent, or your Dependent's representative:
  - » Must not assign to Another Person or Entity your right to recover benefits from an Other Source;
  - » Must obtain the Plan's consent before releasing Another Person or Entity from liability for any Injury; and
  - » Must not interfere with the Plan's claim and lien.

  If you attempt to assign your right to Recovery of benefits, the Fund may take you to court, along with Another 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 an Other Source.
- The Fund is not responsible for legal fees and expenses you pay to obtain a Recovery from an Other Source, unless the Fund has agreed to that in writing.
- The Fund may require your attorney(s) to sign an agreement that they will honor and enforce the terms of the Reimbursement Agreement before the Fund disburses any money received as a Recovery from a Compensable Injury.

Fund's Right Of Subrogation

This Fund will be reimbursed for all benefit payments made as the result of Injuries or Illnesses that are caused by the actions of a third party and that give rise to a court ordered financial award or out-of-court settlement to a covered individual from a third party person, party, or tort-feasor. This Fund will provide benefits, otherwise payable under this Plan, to or on behalf of the covered individual only on the following terms and conditions:

- The Fund's right of recovery will be a prior lien against any proceeds recovered by the covered individual, which right will not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No covered individual will incur any expenses on behalf of the Fund in pursuit of the Fund's rights; specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right will not be defeated by any so called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- Your agreement to repay in the Reimbursement Agreement and the Fund's right of Subrogation are separate and distinct rights and obligations. If either the Agreement or the right of Subrogation fails or is invalid in some way, it will not affect the validity of the other.

- The provisions in the previous section, ***Agreement To Reimburse Fund For Other Payments,*** also apply to the Fund's right of Subrogation. If you fail or refuse to sign a Reimbursement Agreement, it does not affect the Plan's Subrogation rights or the Fund's right to claim a lien against and collect benefits from any source of possible Recovery.
- The Fund has the right to intervene and participate in any legal action you bring against an Other Source.
- If you fail or refuse to take legal action against an Other Source within a reasonable time, the Fund may do so in your name to recover amounts due under the Fund's right of Subrogation. If the Fund takes the legal action, the Fund has the right to take its expenses, costs, and attorney's fees out of any Recovery or settlement. However, the Fund is not required by this provision to pursue your claim against Another Person.
- If you recover any amounts from an Other Source and do not repay the Fund, the Fund may sue you to recover the benefit the Fund paid to you. The Fund may also reduce any of your future benefits until the Fund is fully repaid, regardless of whether or not the future claim is related to the Compensable Injury.
- If you accept a settlement from an Other Source, receive an award from an Other Source, future medical expenses for any Injury or Illness caused by the third party are not eligible expenses under this Plan. The Trustees or their authorized representative have the sole discretion to interpret the Fund's Subrogation provisions and to settle any of the Plan's Subrogation claims and liens.
- The Trustees have the sole discretion to determine questions of whether any benefit payment is related to a Compensable Injury. If the Trustees or their representative reasonably request it, you must sign any and all necessary documents, releases, and waivers that relate to their determination.
- Keep in mind that this Plan is governed by federal law under the Employee Retirement Income Security Act (ERISA), and is generally not subject to any state law doctrines, which purport to limit the Fund's right to recover amounts paid to you.

Compensated Injuries

If an Other Source has already paid you for your Injury, the Fund will not begin paying benefits until the total expenses for your Injury exceed the total amount you have recovered from an Other Source.

- Any and all 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 Another 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 decrease the Fund's right to Subrogation for medical expenses that were incurred and paid before you recovered the expenses from your Injury.

RIGHT OF RECOVERY

If the Fund pays more benefits than it is liable to pay for, including, but not limited to, benefits paid in error, the Fund can recover such excess benefit payments from any person, organization, Physician, Hospital, or other health care provider that has received such excess benefit payments.

The Fund can also recover such excess benefit payments from any other insurance company, service plan, or benefit plan that has received such excess benefit payments.

> Please be aware that benefits paid by the Fund may be recovered from you, even if you did not receive such payment; for example, if payment was made to a provider or your Dependent.

If the Fund cannot recover such excess benefit payments from an Other Source, it can also recover such excess benefit payments from you, including any benefits that may have been paid to one of your Dependents or a provider.

When the Fund requests that you pay a portion of the excess benefit payments, you agree to pay such amount immediately upon notification. The Fund may, at its option, reduce any future benefit payments for which the Fund is liable under the policy on other claims by the amount of the excess benefit payment, in order to recover such payments. The Fund will reduce benefits otherwise payable for claims until the excess benefit payments are recovered by the Fund.

ADMINISTRATIVE INFORMATION

INFORMATION ABOUT THE PLAN

Plan Name

The Operating Engineers Local 139 Health Benefit Fund.

Plan Numbers

The Internal Revenue Service assigns an Employer Identification Number (EIN) to organizations sponsoring benefit plans. The EIN number assigned to the Board of Trustees, the sponsor of our Plan, is 23-7166771.

The Trustees assign a Plan Number for use in reporting and disclosure filings required under the Employee Retirement Income Security Act of 1974 (ERISA). The Plan Number assigned is 599.

Taken together, the Plan's name, number, and the Trustee's EIN identify our Plan with government agencies.

Plan Year

All records for the Fund are kept on a Plan Year basis. The Plan Year starts on June 1 and ends on May 31.

Plan Sponsor And Plan Administrator

The Plan is sponsored and administered by the Trustees. The Board is made up of Employee Trustees (appointed by the Union) and Employer Trustees (appointed by the Employer Associations). The duties, responsibilities, and authority of the Trustees are explained clearly in the Trust Agreement establishing and governing the administration of the Fund. A copy of the Trust Agreement may be obtained by writing to the Fund Office. The Plan Administrator has full discretionary authority to interpret the Plan and to determine eligibility for participation and entitlement to benefits and its decisions will be final and binding.

If you wish to contact the Board or an individual Trustee, you may use the address, phone numbers, or Internet address below:

Operating Engineers Local 139 Health Benefit Fund
N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160
(262) 549-9190
(800) 242-7018
www.iuoe139.org

Board Of Trustees

The current Trustees are:

Union Trustees	Employer Trustees
Steven Buffalo	David Bohl
Mary Jane DeBattista	Tim Peterson
Terrance E. McGowan	John Topp
Len Shelton	Richard W. Wanta
Daniel Sperberg	Thomas P. Wolf

The Trustees meet periodically to discuss the operation of the Fund. The Trustees make all major decisions regarding benefits, setting of investment policy, and establishing guidelines for administering the Fund. The decisions are made with the interests of Fund Participants in mind and in a manner that does not discriminate in favor of or against any Participant or group. Any action by the Board of Trustees must be voted on and supported by a majority of the Board.

The Trustees have delegated some administrative responsibilities to other individuals or organizations. See the ***Important Contact Information*** insert (in the back pocket of this booklet) for a listing of those organizations and their responsibilities.

Each year the Fund's finances are audited by the Fund Auditor. A summary of their report is published annually and distributed to all Fund Participants.

Administrative Manager

Certain record keeping and claims processing duties are performed by the Administrative Manager, at the request of the Trustees. The Administrative Manager is Carday Associates, Inc., a nationally known administration firm.

Administration is handled from the Fund Office at:

Operating Engineers Local 139 Health Benefit Fund
N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160

The office telephone number is (262) 549-9190 or toll-free at (800) 242-7018. You are invited to visit this office Monday through Friday from 8:00 a.m. to 4:30 p.m. or feel free to visit the website at **www.iuoe139.org** at any time.

Parties To The Collective Bargaining Agreement

The Fund is the result of collective bargaining agreements between Local 139 of the International Union of Operating Engineers and principally the following Employer Associations:

- Wisconsin Transportation Employers Council;
- Associated General Contractors Association, Inc.;
- Wisconsin Underground Contractors Association, Inc.;
- Allied Construction Employers Association, Inc.;
- Associated Earth Movers, Inc.; and
- Other Employers.

Upon written request to the Fund Office, you or your beneficiaries may receive information on whether or not a particular employer is authorized to contribute to the Fund. In addition, a complete list of all contributing employers is available for review at the Fund Office. You may also obtain a copy of the collective bargaining agreements by writing to the Fund Office.

Plan Funding

The Health Benefit Fund has been created to provide health care coverage to Eligible Persons. A portion of the negotiated wage package determined by collective bargaining between Local 139 and your employer has been designated for the Fund to provide this coverage.

This is the primary source of income to the Fund—income generated from hours worked by active employees. Several collective bargaining agreements establish the amount that employers must contribute for every hour worked by an active Participant. As a Participant, you are not required to make contributions to the Fund unless you lose your eligibility. Then, if permitted, you may make self-payment contributions to keep benefits in force.

In addition to employer contributions, monthly self-payment contributions for retiree coverage are deposited in the Trust Fund.

Investments

The money in the Fund is invested by the Trustees. Earnings from investments are an additional source of income to the Fund for benefits. It is the Trustees' responsibility to invest the money in a way that keeps a reasonable balance between investment safety and investment return, while providing enough cash to pay day-to-day claims. The money in the Fund is invested and paid out for the exclusive benefit of Fund Participants and their beneficiaries.

Self-Funded Benefits

Most of the benefits provided through the Fund are self-funded (refer to the ***Important Contact Information*** insert in the back pocket of this booklet for information regarding the vendors that contract with the Fund). This means your employer's contributions and any self-payment contributions are made directly to the Fund, and benefit payments to you or your beneficiaries are made directly from the Fund. There is no insurance company in between to collect premiums and pay benefits.

This procedure helps keep costs down and enables the Fund to provide more money for benefits. In addition, it means that all of us are part of a self-sufficient group. This places responsibility upon all of us, both Trustees and Participants, to spend the Fund's money for benefits with the same care and cost consciousness we would use in spending our own money.

Insured Benefits

Because certain benefits typically require catastrophic coverage, it is more economical for the Fund to offer these benefits through an insurance policy. Insurers collect premiums from the Fund and pay benefits.

Death, Accidental Death and Dismemberment benefits are insured through Metropolitan Life Insurance Company, 200 Park Avenue, New York, New York, 10166. The policy number is 121172-1-G.

All other benefits are self-funded from accumulated assets and are provided directly from the Fund.

Type Of Plan

The Health Benefit Fund is classified with the U.S. Department of Labor as a welfare benefit plan providing medical, prescription drug, dental, vision, disability, and death benefits.

Legal Process

Service of legal process may be delivered to one of the Trustees individually or to:

Board of Trustees
Operating Engineers Local 139 Health Benefit Fund
Office of the Administrative Manager
N27 W23233 Roundy Drive
Pewaukee, Wisconsin 53072-0160

Plan Amendment and Termination

The Board of Trustees expects that the Fund will be permanent. However, the Trustees have the right to change, modify, or terminate all or any part of the Plan at any time, in accordance with the Trust Agreement and the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Trustees will notify you in writing if the Plan is amended or terminated. If all or a part of the Plan is terminated, the Trustees will provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plan, and distribute the balance of the assets in a manner consistent with the purpose of the Fund.

Board of Trustees' Discretion and Authority

The Trustees or, where Trustee responsibility has been delegated to others, the other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan. Decisions of the Trustees or their delegates are final and binding. The Trustees or their delegates have broad discretion to determine eligibility for benefits and to interpret Plan language and their decisions will be accorded judicial deference in any subsequent action at a court or administrative proceeding.

Benefits under this Plan will be paid only when the Trustees decide, or persons delegated by the Trustees decide, in their discretion, that you or a beneficiary is entitled to benefits in accordance with the terms of the Plan. Your coverage by this Plan does not constitute a guarantee of employment and you are not vested in the benefits described in this booklet.

In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that the decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over the matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. You may, at your own expense, have legal representation at any stage of the review process.

If a provision of the Trust Agreement or the Plan, or any amendment made to the Trust Agreement or the Plan, is determined or judged unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

YOUR ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information About Your Plan And Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and 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 Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to furnish to each Participant.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, your spouse, or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse, or your Dependents may have to pay for such coverage. Review this SPD and any 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 the 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 Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or at:

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

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by:

- Calling (866) 444-3272;
- Sending electronic inquires to **www.askebsa.dol.gov**; or
- Visiting the website of the EBSA at **www.dol.gov/ebsa**.

GLOSSARY

Terms defined in this glossary are capitalized throughout this booklet.

Accident is an immediate unforeseen event caused by external trauma to the body.

Acute Rehabilitation Facility is a facility that provides, for compensation, rehabilitation care services on an inpatient basis for acute care, which is care of a short duration for Illnesses or Injuries that are rapid and abbreviated in onset. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients Disabled by disease or Injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Allowable Charge means, with respect to a network provider, the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility or organization and the Plan.

Ambulatory Care Center or **Ambulatory Surgical Center** is a lawfully operated clinic that maintains and operates facilities similar to a Hospital emergency room. In addition, an Ambulatory Surgical Center is a facility equipped to perform surgeries on a same-day basis and that:

- Is established, equipped, and operated in accordance with the laws of the jurisdiction in which it is located, primarily for the purpose of performing surgical procedures;
- Is operated under the supervision of a licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO), who is devoted full time to such supervision, and permits surgical procedures to be performed only by a legally qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital (as defined) in the area;
- Requires that, in all cases other than those requiring local infiltration anesthetics, a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;
- Provides at least two operating rooms and at least one post-anesthesia recovery room and:
  - » Is equipped to perform diagnostic x-ray and laboratory examinations; and
  - » Has available to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, a defibrillator, a tracheotomy set, a blood bank, or blood supply;

- Provides full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- Maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative Confinement.

Brain Damage means permanent and irreversible physical damage to the brain causing complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the Accidental Injury, require a hospitalization of at least five days, and persist for 12 consecutive months after the date of the Accidental Injury.

Calendar Year is January 1 through December 31.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the Accidental Injury and continue for seven consecutive days.

Complications of Pregnancy occur before the pregnancy ends and include:

- Acute nephritis;
- Nephrosis;
- Cardiac decomposition;
- Missed abortion;
- Hyperemesis gravidarum;
- Eclampsia of pregnancy; and
- Other pregnancy-related conditions that are as medically severe as the above.

The following conditions are defined as Complications of Pregnancy at termination:

- Ectopic pregnancy; and
- Miscarriage or spontaneous abortion where a live birth is not possible.

Confined or **Confinement** is the period starting with a Participant's admission on an inpatient basis to a Hospital or other facility for treatment of an Illness or Injury. Confinement ends with the Participant's discharge from the same Hospital or other facility. If the Participant is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it is still considered one Confinement.

Cosmetic or **Reconstructive Surgery** is any surgical procedure performed primarily to:

- Improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- Prevent a mental or nervous disorder through a change in bodily form.

Cosmetic or Reconstructive Surgery does not include surgery following a mastectomy, see page 39.

Covered Expense includes expenses covered under the Plan for treatment, care, services, or supplies, but only to the extent that:

- They are Medically Necessary;
- Charges are Allowable Charges;
- Coverage is not excluded under the Plan; and
- No Plan maximums for those expenses have been reached.

Custodial Care is 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.

Deductible Period is June 1 through May 31.

Dental Hygienist is any person who currently is licensed (if licensing is required in the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene, and who works under the supervision of a Dentist.

Dental Procedures:

- **Diagnostics** are procedures used by a Dentist to assist and evaluate an oral examination, including full-mouth or panoramic x-rays and bitewing x-rays (cavity detection).
- **Endodontics** is treatment of the inner, living portion of the tooth, including root canal therapy and treatment of pulp diseases.
- **Orthodontics** is a procedure to straighten teeth or correct malocclusion (incorrect bite), including diagnosis and treatment.
- **Periodontics** is treatment for disease of teeth-supporting tissues, including treatment of gum diseases.
- **Preventive Services** are routine examinations and cleaning procedures to prevent the occurrence of dental abnormalities and oral disease.
- **Prosthodontics** is procedures associated with the construction, insertion, and repair of dentures and bridges, including initial insertion of fixed bridges, or partial or full dentures.
- **Restorative Procedures** are services to restore diseased or damaged teeth, including:
  - » Direct (regular) fillings such as amalgam, silicate, acrylic synthetic porcelain, and composite fillings;

» Indirect filling such as precious metal cast restorations; and

» Inlays, onlays, and crowns when Medically Necessary.

Dentist is any person who currently is licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry, and who is acting within the usual scope of such license.

Dependent is an individual, as defined below, who is eligible for certain benefits from the Fund. In general, covered Dependents include your:

- Legal spouse in accordance with federal law;
- Child under age 26 who is your natural-born child, adopted child, child placed with you for adoption, or stepchild;
- Unmarried child for whom you have been appointed legal guardian, provided the child: (i) maintains a principal place of residence in your home and is a member of your household for the entire Calendar Year, (ii) is dependent on you for more than one-half of his or her support, (iii) is one for whom you have received a court decree or order of legal guardianship, and (iv) is not claimed as any other person's Dependent child during the Calendar Year;
- Unmarried child age 26 or older, who is: (i) dependent on you for more than one-half of his or her support for the Calendar Year, (ii) resides with you for more than one-half of the Calendar Year, and (iii) is permanently and totally Disabled according to the terms of Internal Revenue Code section 22(e)(3), and (iv) the permanent and total Disability existed prior to the date the child attained age 26. Proof of total and permanent Disability must be submitted to the Trustees within 31 days of the date the child's coverage would otherwise end or within 31 days after he or she initially becomes eligible for benefits from the Fund; and
- Your Dependent child who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Board of Trustees.

> To be totally and permanently Disabled for this purpose means a child is unable to engage in any substantial gainful activity due to any medically determinable physical and/or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months.

If your unmarried child for whom you have been appointed legal guardian or your unmarried disabled child age 26 or older does not live with you, he or she will be considered an eligible Dependent child, provided that:

- The child's parents: (i) are divorced or legally separated under a decree of divorce or separate maintenance; (ii) are separated under a written separation agreement; or (iii) live apart at all times during the last six months of the Calendar Year;
- The child's parents provide over one-half of the child's support; and
- The child is in the custody of one or both of his or her parents for more than one-half of the Calendar Year; and
- The child is not the qualifying child or qualifying relative of any other person.

To determine an individual's eligibility as a Dependent, you will be asked to provide legal documentation, such as a birth certificate, adoption papers, marriage certificate, guardianship documents, divorce decree, or paternity order, as well as other coverage information from natural parents.

Disabled or **Disability** means you or your Dependent is prevented from performing the major duties of your occupation solely because of a non-occupational Illness or Injury. Injuries on the job are not covered.

Durable Medical Equipment is equipment that:

- Is primarily and customarily used to serve a medical purpose;
- Can withstand repeated use;
- Generally is not useful to a person in the absence of an Illness or Injury; and
- Is appropriate for use in the home.

Equipment presumed to be medical includes such items as Hospital beds, wheelchairs, hemodialysis equipment, intermittent positive pressure breathing machines, walkers, and traction equipment.

Equipment presumed to be non-medical includes such items as air conditioners, humidifiers, dehumidifiers, and electric air cleaners. In addition, medical equipment does not include non-medical equipment:

- That basically serves comfort or convenience functions;
- That is primarily for the convenience of a person caring for the patient, such as stairway elevators, posture chairs, and cushion lift chairs; and
- For physical fitness, such as exercycle, precautionary-type equipment, preset portable oxygen units, training equipment, and speech teaching machines.

You are responsible for expenses associated with the maintenance or repair of Durable Medical Equipment.

Durable Medical Equipment may, at the Fund's discretion, be replaced if the:

- Equipment is no longer useful and has exceeded its reasonable lifetime under normal use; or
- Patient's condition has significantly changed so as to make the original equipment inappropriate in the judgment of the Physician.

Durable Medical Equipment is not replaced as a result of loss due to Accident, theft, or abuse.

Eligible for Medicare means you are age 65 or older or are Disabled and have been receiving Social Security benefits for 24 months or you meet the requirements relative to End-Stage Renal Disease.

Eligible Person is either the eligible employee or the eligible Dependent.

Enrollment Form information is needed by the Fund Office to provide benefits to you. Your Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an eligible Dependent. However, if you do not notify the Fund Office within 30 days of when your new Dependent becomes eligible, your Dependent's coverage will not begin until the first day of the month after you complete and return the Enrollment Form to the Fund Office adding the Dependent. No benefits will be processed by the Fund Office without this information. This form also includes your beneficiary designation for the Death Benefit provided by the Fund. It is your responsibility to notify the Fund Office of any changes.

This form is used to report spousal employment and the availability of medical coverage as a result of employment. The Fund requires annual certification if a spouse is not employed or if coverage is not offered through employment.

Experimental or **Investigational** is the use of any treatment, service or supply for a Participant's Illness or Injury that, at the time it is used:

- Requires approval by the appropriate federal or other government agency that has not been granted, such as, but not limited to, the Food and Drug Administration (FDA);
- Is not yet recognized as acceptable medical practice throughout the United States to treat that Illness or Injury;
- Is the subject of either:
  - » A written Investigational or research protocol;
  - » A written informed consent of protocol used by the treating facility in which reference is made to it being Experimental, Investigative, educational, for a research study, posing an uncertain outcome, or having an unusual risk;
  - » An ongoing phase I, II or III clinical trial; or
  - » An ongoing review by an Institutional Review Board (IRB); or
- Does not have either:
  - » The positive endorsement of national medical bodies or panels, such as the American Cancer Society; or
  - » Multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment, service, or supply, and reflecting its recognition and reproducibility by non-affiliated sources determined to be authoritative by the Fund.

Extended Care Facility is an institution that is primarily engaged in providing skilled nursing, rehabilitative, and related services to inpatients. Such care must be provided under the supervision of professional medical personnel who are duly licensed and who practice according to general medical ethical standards. Further, such institution must also be licensed or approved by the state or locality in which it operates, according to the licensing requirements of that area.

Freestanding Surgical Center is a center that:

- Has an operating room, recovery room, and all required equipment for use before, during, and after surgery;
- Is supervised by an organized medical staff;
- Has a contract with a nearby Hospital for acceptance of patients who require Hospital care after surgery; and
- Is not a private office or clinic of one or more Physicians.

Home Health Care Agency is a public or private organization that is primarily engaged in providing skilled nursing and therapeutic services on an at-home basis. A Home Health Care Agency must be supervised by professional medical personnel and be licensed or approved by the state or locality in which it operates.

Hospice is an agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, and social care for terminally Ill persons assessed to have a life expectancy of six months or less. The agency or organization must:

- Be certified by Medicare; or
- Be licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, the agency or organization must:
  - » Provide 24 hour-a-day, 7 day-a-week service;
  - » Be under the direct supervision of a duly qualified Physician;
  - » Have a full-time administrator;
  - » Have a nurse coordinator who is a registered nurse, with experience involving care for Terminally Ill patients;
  - » Have a main purpose of providing Hospice services;
  - » Maintain written records of services provided to the patient; and
  - » Maintain malpractice insurance coverage.

A Hospice that is part of a Hospital will be considered a Hospice for the purposes of this Plan.

Hospice Program is a program that:

- Has received a certificate of need from the state or locality in which it operates to provide Hospice care in a given area;

- Is eligible to satisfy accreditation requirements as developed by Medicare and/or the Joint Commission
- Meets the following criteria:
  - » The patient and family are seen as a unit of care;
  - » An integrated, centralized administrative structure ensures continuity of care for home care and inpatient care;
  - » There is direct provision of care by a team consisting of Physicians, nurses, social workers, chaplains, and volunteers;
  - » Volunteers are used to assist paid staff members; and
  - » 24-hour-a-day, 7-day-per-week service is available.

Hospital is an establishment that:

- Holds a license as a Hospital (if licensing is required in the state);
- Operates primarily for the reception, care, and treatment of Sick or Injured persons as inpatients;
- Provides 24-hour-a-day nursing service by registered graduate nurses;
- Has a staff of one or more licensed Physicians available at all times; and
- Provides organized facilities for diagnostic and major surgical facilities.

In no event does the term Hospital mean an institution or that part of an institution that principally is used as a:

- Clinic;
- Convalescent home;
- Rest home;
- Nursing home; or
- Home for the aged or drug addicts.

Hospital also means an approved public or private treatment facility licensed by the state of Wisconsin for the treatment of alcoholism.

For the purpose of mental or nervous disorders, Hospital means a place, other than a convalescent, nursing, or rest home, that:

- Has accommodations for resident bed patients;
- Has facilities for the treatment of mental or nervous disorders;
- Has a resident psychiatrist on duty at all times; and
- Charges the patient for the expense of Confinement as a regular practice.

Illness or **Sickness** is a disease, disorder, or condition (including pregnancy, childbirth, and any related conditions) that requires treatment by a Physician. Expenses related to tubal ligations and vasectomies are covered as an Illness or Sickness.

Initial Eligibility means you become eligible to receive benefits on the first of the month after a Work Quarter in which the Fund received at least 300 hours of employer contributions made on your behalf. The initial period of eligibility is five months.

Injury is physical damage caused to a person's body that is independent of an Illness and requires treatment by a Physician.

Intensive Care Unit is a special area of a Hospital, exclusively reserved for critically Ill patients requiring constant observation, which in its normal course of operation provides:

- Personal care by specialized registered professional nurses and other nursing care on a 24-hour-a-day basis;
- Special equipment and supplies that are immediately available on a standby basis; and
- Care required but not rendered in the general surgical or medical nursing units of the Hospital.

The term Intensive Care Unit also means an area of the Hospital designated and operated exclusively as a coronary care unit or cardiac care unit.

Lifetime means, when in reference to benefit maximums and limitations, while covered under the Operating Engineers Local 139 Health Benefit Fund. Under no circumstances does Lifetime mean "during the Lifetime of the covered Participant."

Loss of hearing means the entire and irrecoverable Loss of hearing in both ears that continues for six consecutive months following the Accidental Injury.

Loss of sight means permanent and uncorrectable Loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of speech means the entire and irrecoverable Loss of speech that continues for six consecutive months following the Accidental Injury.

Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Medically Necessary or **Medical Necessity** means that a specific service or supply is required to treat your condition. Medically Necessary expenses include expenses that:

- Are appropriate and consistent with a medical diagnosis provided by a legally qualified Physician or surgeon operating within the scope of his or her license;
- Are in accordance with the acceptable standards of community practice; and
- Could not have been omitted without adversely affecting either you or your eligible Dependent's condition or quality of medical care.

Inpatient care in a Hospital is Medically Necessary only if treatment for the Illness or Injury cannot be provided safely on an outpatient basis.

A service or supply **is not** automatically considered Medically Necessary just because it is prescribed by a Physician or other medical provider.

Medicare is a health care program for the aged and Disabled, established by Title XVIII of the Social Security Act of 1965, as amended.

No Fault Motor Vehicle Plan is a motor vehicle plan that is required by law and provides payments for medical expenses (including transplants), in whole or in part, without regard to fault. Anyone subject to this kind of law who does not comply will be deemed to have received the benefits required by the law.

Occupational Therapy or **Physical Therapy** is therapy provided by a registered physical therapist or registered or state-licensed occupational therapist for short-term, non-maintenance therapy rendered for the purpose of physical restoration of a physical Disability for which there is a reasonable expectation of significant improvement as determined by the Plan. Services must be ordered by a Physician under an individual treatment plan that is designed to improve the patient's condition through short-term care.

Optician, Optometrist, or **Ophthalmologist** is any person who is qualified and currently licensed (if licensing is required in the state) to practice each such profession by the appropriate governmental authority having jurisdiction over the licensure and practice of such profession, and who is acting within the usual scope of such practice.

Oral Surgery includes surgical removal of teeth or multiple extractions requiring Hospital Confinement, removal of impacted teeth, soft tissue, alveolectomy, gingivectomy, apicoectomy, torus palatines, torus mandibulous, frenectomy, excision of cysts, osteoplasty, and stomatoplasty.

Other Group Plan is any plan, policy, contract, or other arrangement for benefits or services that provides benefits or services for, or by reason of, medical, dental, vision, or hearing care, treatment or healing under:

- Benefit programs provided by an employer;
- Group insurance;
- Group practice, Blue Cross/Blue Shield, individual practice, or other prepayment coverage;
- Health Maintenance Organizations;
- Labor management trusteed, union welfare, employer organization, or employee benefit organization plans; or
- Government programs or coverage required or provided by any statute.

Outpatient Psychiatric Facility is a Hospital or a community mental health center, a day care center, or a night care center associated with a Hospital and licensed as required by applicable law. These facilities do not include institutions or facilities primarily engaged in providing services that are custodial, recreational, social, or educational in nature. An approved Outpatient Psychiatric Facility will be recognized only if there is a psychiatric Physician present in the facility on a regularly scheduled basis who assumes the overall responsibility for coordinating the care of all patients. Services must be available through the professional staff of the facility, as needed, from a psychiatric Physician, clinical psychologist, registered nurse, and psychiatric social worker. Emergency medical care must be accessible through formal agreement with the Hospital.

Paralysis means loss of use of a limb, without severance. A Physician must determine the Paralysis to be permanent, complete and irreversible.

Participant, as used in most contracts and by this Plan, is any person who qualifies for coverage by virtue of employment (including retired employees) and/or union membership (as opposed to a Dependent, who qualifies for coverage by virtue of his or her relationship to a Participant).

Participant Classes are defined under this Plan as:

- Actives—eligible active employees;
- Non-Bargaining Unit Employees and Alumni—eligible employees who are not performing work under a collective bargaining agreement, but whose employer is signatory to either a Non-Bargaining Unit Agreement or an Alumni agreement with the Trustees of the Fund that allows for their participation;
- Retired—early retirees (under age 65), regular retirees (age 65 or older), surviving spouses, and totally and permanently Disabled Participants; and
- COBRA—any Participant or Dependent who has had a "qualifying event," as described in the Consolidated Omnibus Budget Reconciliation Act, who has elected such coverage, and is making the required premium payment for such coverage.

Period of Disability is the continuous period during which you are Disabled. See page 18 for more information.

Physician is a person who is licensed by the governmental authority having jurisdiction over such licensure to practice medicine and who is acting within the scope of such license. This definition includes chiropractors, osteopaths, chiropodists, podiatrists, Optometrists, licensed clinical psychologists, psychiatrists, Dentists, dental surgeons, and approved Christian Science practitioners.

Plan Year or **Fiscal Year** is June 1 through May 31.

Preferred Provider is any of the following who alone, or as part of a group enter into a contract with the Trustees and agree to be compensated for services and supplies as covered under this Plan according to the terms of the contract while such contract is in effect:

- Physician, Dentist, registered nurse, physical therapist, or other licensed health care provider;
- Hospital;
- Alcohol and controlled substance abuse treatment facility;
- Hospice;
- Laboratory;
- Outpatient surgical facility;
- Pharmacy;
- Business establishment selling or renting Durable Medical Equipment; or
- Any other source for services or supplies covered under this Plan.

Current types of Preferred Providers include the following:

- Preferred Provider Hospital or Contract Hospital is any of the Hospitals that contract with the Trustees directly or through their agents from time to time and that are named in this SPD/Plan Document; and
- Preferred Provider Pharmacy is any of the pharmacies that are party to a contract with the Trustees.

Prescription is a written order issued by a legally qualified Physician or surgeon to a legally qualified and duly licensed pharmacist for any drug or medicine that has been approved for general use by the FDA and that is given by such Physician or surgeon for the Eligible Person.

This does not include drugs or other forms of medication that may be legally obtained without a Prescription, even though such drugs or medications may be prescribed.

Prescription will also include the following diabetic supplies provided on the written order of a legally qualified Physician or surgeon:

- Insulin;
- Insulin syringe;
- Needles;
- Sugar test tablets;
- Sugar test tape;
- Acetone test tablets;
- Benedict's solution or equivalent; and
- Swabs and alcohol wipes.

Pretreatment Estimate is a predetermination of the benefits payable by the Plan. Predetermination of benefits helps you avoid surprises by letting you and your provider know in advance what services are covered and what payment will be made.

Qualified Medical Child Support Order (QMCSO) means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law, which has the force and effect of law under applicable state law, that:

Provides for child support payments related to health benefits with respect to a child of a Participant or requires health benefit coverage for such child by the Plan, and is ordered under state domestic relations law; or

Enforces a state law relating to medical child support payments with respect to the Plan; and

Creates or recognizes the right of a child as an alternate recipient who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to an eligible employee who is a Participant in the Plan; and

Includes the name and last known mailing address (if any) of the Participant from whom such child's status as an alternate recipient under the Plan is derived and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of state or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient, a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient or the manner in which the type of coverage is determined, and the period for which coverage must be provided;

Does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; and

Has been determined by the Plan Administrator to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Fund Office upon request at no charge.

Skilled Nursing Facility is a facility that is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring 24-hour-a-day skilled nursing services but not requiring Confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Minimal care, Custodial Care, ambulatory care, or part-time care services; or
- Care or treatment of mental Illness, substance (alcohol or drug) abuse, or pulmonary tuberculosis.

Terminally Ill or Terminal Illness means that due to Injury or Sickness you are expected to die within six months.

Trustees are the Trustees of the Operating Engineers Local 139 Health Benefit Fund.

Trust Fund or **Fund** is the entire trust estate of the Operating Engineers Local 139 Health Benefit Fund as it may, from time to time, be constituted, including policies of insurance, investments and the income from investments, employers' contributions, self-payment contributions, and other assets, property or money received by or held by the Trustees for the uses and purposes of this Fund.

Usual, **Customary and Reasonable** means, with respect to an out-of-network provider, the amount as determined by the Trustees for a particular service or supply. Under no circumstances shall the Plan pay more than the Usual, Customary and Reasonable amount for out-of-network services or supplies that is determined by any provider, facility, or other person or organization other than the Trustees.

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