



LOCAL 139

OPERATING ENGINEERS HEALTH BENEFIT FUND

SUMMARY PLAN DESCRIPTION

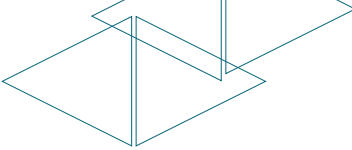
2026 Edition





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External Review of Protected Services inserts in the front pocket of this SPD.

See the **Summary of Benefits and Contact Information** inserts in the front pocket of this SPD for additional information about your benefits.

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.

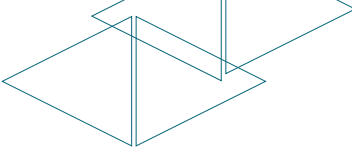
The Fund also provides benefits to you and/or your beneficiaries in the event of your:

- 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), to change, add, or delete benefits, self-payment contribution rates, eligibility rules, or any other provisions relating to the operation of the Fund. This SPD is the Plan Document for purposes of ERISA. The Trustees also reserve the right to amend, modify, or terminate the Plan at any time and retain the exclusive right to interpret coverage and benefit provisions of the Fund.



About This SPD

We are pleased to provide you with this new SPD which outlines the benefits provided on behalf of you and your eligible Dependents under the Plan. This SPD is intended to give you an understanding of the benefits provided by the Fund, effective as of January 1, 2025, 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 SPD contains several sections including:

- An **eligibility** section that tells you how you become a Participant 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 that shows 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 SPD.
- A **front pocket** that houses a *Summary of Benefits* insert, which gives you a brief overview of all of the benefits available to you through the Fund and provides contact information so you'll know who to call when you have questions.

Glossary

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

This SPD replaces and supersedes all prior SPDs and announcements provided before January 1, 2025. We recommend that you keep this SPD 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 front 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 certain 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.

No Employer, Union, or any representative of any Employer or Union, in such capacity, is authorized to interpret the Plan nor can any such person act as agent of the Trustees. The Trustees reserve the right to amend, modify, or discontinue any or all parts of the Plan whenever, in their judgement, conditions so warrant.

Questions regarding which protections apply and which 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 (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 SPD thoroughly and, if you are married, share it with your spouse.

Sincerely,

Board of Trustees

Active Eligibility And Coverage

Becoming Eligible

This section describes the eligibility rules for Active Participants and their eligible Dependents. For eligibility information for Retired and Disabled Participants, and surviving Dependents, see page 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. See the section on *“The Quarters System”* (page 6) for more information about these eligibility requirements.

When you first become eligible for benefits, you will receive three separate Identification (ID) cards; (1) medical and vision, (2) dental, and (3) Prescription drug. Keep one of each card and, if you are married, give the other copy of each ID card to your spouse. The ID cards will only have your name on them. Your Dependent(s), if any, will not be listed on the ID cards. If you need extra ID cards for eligible Dependents, contact the Fund Office.

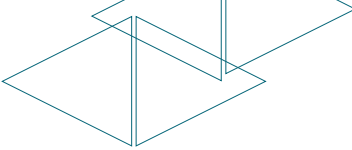
Your Dependents

If you elect coverage for yourself, you are also eligible to enroll your Dependents for coverage. In general, your Dependents are your legal spouse and your children.

Your Dependents become eligible on the later of the day you become eligible for your own medical coverage or the day you acquire a Dependent either by marriage, birth, adoption, or placement for adoption, but only if:

- You have completed a written Enrollment Form that may be obtained from the Fund Office; and
- You provide the Plan’s required proof of Dependent status.

To obtain coverage for a Dependent, you must complete an Enrollment Form for yourself and/or any of your Dependent(s) within 30 days after the date you and/or they first become eligible for enrollment. Your Enrollment Form will not be considered complete until you have submitted proof of Dependent status.



Specific documentation proving Dependent status will be required by the Plan, and may include a birth certificate, marriage certificate, proof of the Dependent's age, the Dependent's social security number, proof of initial and ongoing Disability, legal guardianship/custody/conservatorship order signed by a judge, a valid medical child support order document signed by a judge or a National Medical Support Notice, and other documents deemed necessary by the Plan.

Your Dependent child is covered up to the last day of the month in which he or she reaches age 26.

Coverage for a Dependent for whom you are the legal guardian/custodian/ward will end on the earlier of:

- The date indicated in the legal guardianship/custody/conservatorship order signed by a judge; or
- The last day of the month following termination allowed by federal law.

Special rules for coverage of a newborn: Your newborn Dependent child(ren) **will be covered from the** date of birth but only if you follow the enrollment procedure of this Plan:

- Within 60 days of the child's birth you notify the Fund Office of the birth via letter, call, or email; and
- Within six months of the child's birth you submit a completed Enrollment Form and proof of Dependent status to the Fund Office.

Remember that you may not enroll a newborn Dependent child for coverage unless you, the Participant, are also enrolled for coverage.

Start of coverage following late enrollment: If you fail to submit a completed Enrollment Form and documentation proving Dependent status in the required timeframes, enrollment of your Dependent will be late. **No claims incurred prior to late enrollment will be paid.** Coverage based on late enrollment begins on the first day of the Eligibility Quarter (see page 6) when the Enrollment Form and documentation proving Dependent status are received by the Fund Office.

When Your Spouse Is Eligible For Other Coverage

If your spouse is employed and eligible for "Minimum Essential" 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 also 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.

The IRS does not allow you or your spouse to have a high deductible health plan and a health savings account (HSA) with our type of Plan. Your spouse will still be required to take his or her Employer's medical and Prescription drug coverage and will not be covered by this Plan for medical benefits. However, your spouse will be eligible for this Plan's dental and vision coverage. Your spouse should check with their Employer to ask if they are allowed to waive the HSA. If allowed, benefits for your spouse can then be coordinated with this Plan for secondary coverage.

When you are first eligible for coverage and wish to cover your Dependent(s), you must:

- Complete an Enrollment Form, which provides information about your Dependent(s). You must also provide birth certificates and/or marriage certificates for your eligible Dependent(s) and indicate on the Enrollment Form whether your spouse (if applicable) is employed and has health coverage available through his or her Employer. The Enrollment Form and any supporting documents must be submitted to the Fund Office within 30 days to the Plan. Otherwise, the request for enrollment is considered late.
- 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 medical and Prescription drug coverage but has refused it, your spouse's coverage under this Plan will be terminated immediately. Written notice will be sent to you if and when coverage under this Plan ends. The Fund reserves the right to recoup from you and/or your spouse all claims paid during the period of time when your spouse was eligible for other coverage.

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 75).

What Is Minimum Essential Coverage?

"Minimum Essential Coverage" is health insurance that meets the requirements of the Affordable Care Act (ACA). Primarily, it refers to comprehensive coverage. Therefore, an individual who has limited benefits (for example, coverage for only preventive care) does not have Minimum Essential Coverage.

Special Enrollment Rights

Federal law requires you also be eligible to enroll if:

- You and/or your Dependent(s) decline coverage under this Plan because you have other health coverage and then you and/or your Dependents later lose the other health coverage;
- You and/or your Dependent(s) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you and/or your Dependent(s) lose eligibility for that coverage or become eligible for premium assistance through Medicaid or CHIP; and
- You acquire a Dependent through marriage, birth, legal guardianship/custody/conservatorship, 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 Plan or other health insurance when coverage under this Plan was declined, and enrollment must have been declined due to such other coverage.

You may not avail yourself of this opportunity for Special Enrollment for yourself or any Dependent(s) unless, when coverage under this Plan was previously offered, you indicated that the reason you, your spouse and/or your Dependent child(ren) declined coverage was because you or they had coverage under another health insurance policy or plan.

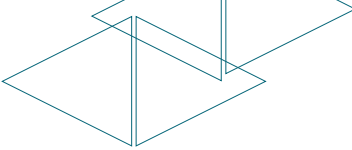
If the other health coverage is COBRA Continuation Coverage, a special enrollment opportunity is only available after the COBRA Continuation Coverage has been exhausted. COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than due to either the failure of the individual to pay the applicable COBRA Continuation Coverage premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage).

For a loss of coverage, coverage will become effective on the date you and/or your Dependent(s) lose the other health coverage **but only if** you or your Dependent(s) submit a completed Enrollment Form and documentation proving Dependent status within 30 days of loss of the other coverage. If you fail to submit a completed Enrollment Form and documentation proving Dependent status within 30 days of loss of coverage, enrollment will be late. Coverage based on late enrollment is the first day of the Eligibility Quarter when the Enrollment Form and any documentation proving Dependent status are received by the Fund Office. **No claims incurred prior to late enrollment will be paid.**

If you or your Dependent become eligible for premium assistance through Medicaid, coverage will become effective on the date you and/or your Dependent(s) become eligible for premium assistance, **but only if** you [or your Dependent(s)] submit a completed Enrollment Form and documentation proving Dependent status within 60 days of when you and/or your Dependent(s) become eligible for premium assistance. If you fail to submit a completed Enrollment Form, proof of eligibility for premium assistance and documentation proving Dependent status within 60 days, enrollment will be late. Coverage based on late enrollment is the first day of the Eligibility Quarter when the Enrollment Form, proof of eligibility for premium assistance and any documentation proving Dependent status are received by the Fund Office. **No claims incurred prior to late enrollment will be paid.**

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

Special enrollment is not available if you lose coverage as the result of the failure to pay premiums, fraud or misrepresentation.



The Quarters System

The 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:

- Work Quarters; and
- Eligibility Quarters.

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. 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. An Eligibility Quarter is the period of time you are eligible for benefits. It is important for you to understand the difference between these two types of quarters and how they relate to each other.

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:

- 330 or more hours in the current Work Quarter; or
- 1,320 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 27.5 hours of contributions each week, not to exceed 110 hours per month, for up to a maximum of:

- 24 months, if you are receiving Workers’ Compensation benefits;
- 26 weeks, if you are receiving loss of time Benefits; or
- 8 weeks, if you are receiving loss of time benefits due to intensive outpatient treatment or a partial Hospitalization program.

Initial Eligibility

If You Are A Bargaining Unit Participant 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 330 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 Participant, 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 Participant 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 27.5 hours per week, up to 110 hours per month, for up to eight Work Quarters, to help maintain your eligibility for benefits.

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 2,640 hours.

If You Are A Bargaining Unit Participant Employed By A Public Employer

If you are a Bargaining Unit Participant who is employed by a public Employer that entered into a collective bargaining agreement with the Union on or after November 1, 2016, and if your public Employer elects to have you covered by the Plan, you become eligible to receive benefits under the Plan on the first day of the month after the Fund receives 173.33 hours of contributions from your Employer. Note that your public Employer will be required to pay 173.33 hours of Employer contributions to the Fund per month on your behalf

If you are a Non-Bargaining Unit Employee or a Bargaining Unit Employee who is employed by a public Employer that entered into a collective bargaining agreement with the Union on or after November 1, 2016, you are not eligible for the Fund's "bank of hours" provision.

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 a Participant in the Union, the Employer 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 Participant 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;
- Complies with the non-discrimination rules of the Agreement; and
- The bargaining unit contributions that are due to the Fund are current.

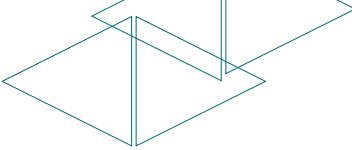
As a regular Non-Bargaining Unit Participant, you are not eligible to make self-payment contributions for coverage, and you can only make COBRA Continuation Coverage payments if your employment terminates.

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. 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 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 330 hours per Work Quarter and the Fund receives Employer contributions for those hours. If you do not work at least 330 hours in a Work Quarter, you can still be eligible if at least 1,320 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 example in the following "Bank of Hours" section).



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 330 hours in a Work Quarter, you will keep your eligibility as long as you have at least 1,320 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 330 hours for the next two Work Quarters, so his eligibility continued. In his fourth Work Quarter, Mike worked only 280 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 1,350 hours in his bank at the end of the Work Quarter that he worked only 280 hours. This is more than the minimum of 1,320—so his eligibility continues.

Work Performed During This Work Quarter:	Reported 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 September	350+350=700	December, January, February
October, November, December	370	Prior January – Current December	370+700=1,070	March, April, May
January, February, March	280	Prior April – Current March	280+1,070=1,350	June, July, August

However, in the next Work Quarter (April, May, June), Mike works only 290 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 1,290 (290 + 350 + 370 +280), which is less than the 1,320 minimum.

You are not eligible for a bank of hours if you are a Non-Bargaining Unit Participant or a bargaining unit Participant employed by a public Employer that has entered into a collective bargaining agreement with the Union on or after November 1, 2016.

Quarterly Status Report

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;
 - The total number of hours you had reported on your behalf for the current and three prior Work Quarters; and
 - 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 28 for information regarding your HRA.
- If you do not agree with the hours reported on your Quarterly Status Report, return the report to the Fund Office, along with copies of any payroll check stubs or other supporting documentation.
- When you first become eligible for benefits, you will receive three separate Identification (ID) cards; (1) medical and vision, (2) dental, and (3) Prescription drug. Keep one of each card and, if you are married, give the other copy of each ID card to your spouse. The ID cards will only have your name on them. Your Dependent(s), if any, will not be listed on the ID cards. If you need extra ID cards for eligible Dependents, contact the Fund Office.

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:
 - » 330 hours of Employer contributions received on your behalf in a Work Quarter; or
 - » 1,320 hours of Employer contributions 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 23);
- You are a bargaining unit Participant 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 30); or
- There is a written amendment to this SPD that affects eligibility.

If you work for a non-participating Employer in the construction industry, you must notify the Fund Office. 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 25.

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 25).

In addition, your eligible Dependent child loses eligibility on the last day of the month in which he or she turns age 26, unless your child is mentally or physically handicapped (see the definition of "Dependent" on page 88).

Reinstating Eligibility

If you lose your eligibility for coverage, you can become eligible for coverage again if you have 330 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 6, 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 330 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 330 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.

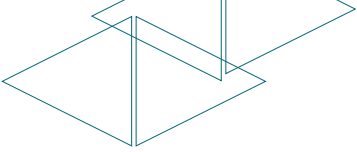
If you lose eligibility because you enter the Armed Forces, the Initial Eligibility and/or Reinstating Eligibility rules may be waived. See page 30 for more information regarding coverage when you enter the Armed Forces.

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. 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 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.
- The Plan retroactively terminates your spouse's coverage if your spouse is employed and does not take the coverage offered by his or her Employer.

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.

Cooperation With The Fund

The Fund requires that you and your Dependents cooperate with the Fund and provide all documents and records that the Fund reasonably requires. The Fund may also reasonably require you to take certain actions. For example, the Fund may request that you provide documentation of your Dependents' eligibility for coverage. This includes, but is not limited to, proof of marriage, proof of divorce, birth certificates, or other documentation. You and your Dependents must provide all such requested information or take action to obtain those documents. Failure to provide the requested information could result in loss of some or all benefits under the Fund, as determined by the Trustees. It could result in a loss of future eligibility for you or your Dependents. It may also be evidence that your benefits can be rescinded on a retroactive basis, as described previously.

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 Pre-Medicare Coverage

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.

Coverage Under this Plan as a Retiree Prior to Age 65: When you are no longer Actively employed due to retirement or Disability and you are eligible for Retiree coverage, and you are under age 65, you must enroll for Retiree coverage under this Plan. In addition, in the event of your death, your surviving spouse may enroll for Retiree coverage.

Medicare Retirees: Effective January 1, 2024, all Medicare-eligible Retirees and their Medicare eligible spouses were automatically enrolled in the Medicare Advantage Preferred (PPO) with Senior RX Plus Plan (Medicare Advantage). The Medicare Advantage Plan is specifically designed for Retirees and their spouses who are enrolled in Medicare Part A and Part B. You should refer to the separate Summary Plan Description and Evidence of Coverage for additional information regarding Medicare eligible Retiree Plan benefits.

Retiree Plan 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 12).

You are eligible for Retiree coverage if you are Retired, which for Plan purposes 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; or
- **Disabled Retired:** You have provided proof of a Social Security Disability award, at any age, with 10 or more service credits.

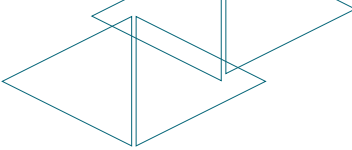
If you retired without 10 or more service credits, but otherwise meet the eligibility requirements for Retiree coverage, you will be required to pay the full cost of Retiree coverage.

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);

Service Credits

You are awarded service credits based on your Employer contribution hours each Calendar Year. See page 12 for more information.



- 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 on or after June 6, 2011: If the above hours requirement is not met, you can still be eligible for Retiree benefits 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 Workers' Compensation credits, are not included toward meeting the hours requirement, detailed above.

If you are a Non-Bargaining Unit or Alumni Participant, 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.

Effective May 31, 2025, if you are/were an owner of an Employer and have Retiree coverage following Active coverage under a Non-Bargaining Unit or Alumni Agreement, your Retiree coverage will terminate the first day of the month after the Employer ceases to be bound by a collective bargaining agreement with the Union.

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, including hours worked under a reciprocal agreement, 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, if you have medical coverage available through another Group Plan, such as one offered through your spouse's Employer, 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.

If you have medical coverage through an Affordable Care Act (ACA) marketplace plan, the category of the coverage must be at the Silver level or higher.

During the period in which you opt out of coverage, the Plan will freeze your HRA balance. When you opt back into Retiree coverage, your HRA balance will be restored for use by you and your Dependents. Refer to page 28 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. Request a Retiree In-and-Out Program Participation Form from the Fund Office.

You may also opt-out of the Fund's Retiree coverage one time and enroll in an individual or a different group Medicare Advantage Plan (Part C and Part D) or a Medicare Supplement Plan (medical and Prescription drug) not sponsored by the Fund. Note that once you and your spouse reach age 65, you may only enroll in the Medicare Advantage Plan coverage. Under the terms of the Medicare Advantage Plan, your opportunity to enroll is limited to specific times of year or Special Enrollment Opportunities. Therefore, as you approach age 65, if you have opted out of coverage, and intend to opt-in, you must carefully plan for enrollment and you must also follow the terms under the Medicare Advantage Plan.

If you choose to opt out of the Retiree Plan, the Fund will provide you and your eligible Dependents the ability to pay a premium to continue coverage for Optional Ancillary Benefits, as defined on page 92. There is a premium for the Optional Ancillary Benefits. You may elect to take and pay the premium for all of the Optional Ancillary Benefits, or you may elect to take and pay a premium for only the death and dismemberment benefits. ***You are not required to take these Optional Ancillary Benefits. If you choose to pay the required premium to maintain these Optional Ancillary Benefits, you and your eligible Dependents will no longer have access to your HRA balance and no HRA amounts will remain available to your spouse or Dependents upon your death.***

You will remain entitled to these Optional Ancillary Benefits as long as:

- The Fund continues to offer these benefits;
- You remain continuously enrolled in another Group Plan or Medicare Supplemental or Advantage Plan; and
- You timely pay the required monthly premium.

You must self-pay the monthly premium amount for all Optional Ancillary Benefits. The premium will be set

annually by the Trustees. You cannot use any service credits to either pay for or offset the costs of these Optional Ancillary Benefits.

Dental and vision benefits remain subject to the same terms and conditions, as outlined in the sections beginning on pages 56 and 59, respectively.

You may opt back into the Plan one time. Unless you qualify for Special Enrollment Rights as explained on page 5, coverage begins January 1. If you had ACA marketplace coverage, coverage begins the January 1st following at least 12 months after you opted out. To opt back into the Plan, you will need to:

- File a written application with the Fund Office:
 - » No later than 30 days prior to January 1; or
 - » If you qualify for Special Enrollment Rights, no later than 30 days following the date your other coverage ends; and
- 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 3.

If you have opted out of the Plan and you are approaching age 65, you must follow the enrollment rules under the Medicare Advantage Plan.

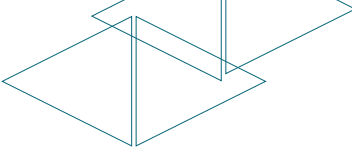
Retiree Coverage

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 were not married at the time you retired, you are not allowed to add a spouse at a later date. 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.

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.

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.

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.



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 are 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 15.

Note: Regardless of your retirement date or your Employer's participation in the pre-funded program, you may not use any service credits described in this SPD to pay for or offset the costs of the Optional Ancillary Benefits that are available to you under the Retiree In-and-Out Program. You must pay the required monthly premium for these Optional Ancillary Benefits on a self-pay basis.

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.

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.

At the time of your retirement, Disability, or death, the service credits you have earned will be applied to a service credit rate

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 12).

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.

(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 or older than age 65. 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 you must enroll in Medicare Parts A and B in order to enroll in the Medicare Advantage Plan.

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 service credit rates are:

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.

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 the age when you subsequently retire. You may only have your service credit rate adjusted once.

Service Credits For Married Participants

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

The total career hours of both Participants 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 spouse will continue to be entitled to use combined service credits for the self-payment.

If these Participant 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

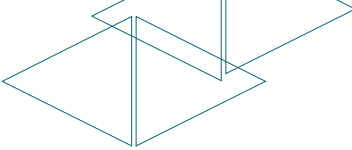
Pat retired at age 55 on June 1, 2024. Since Pat was younger than age 65, the monthly cost of his Retiree coverage is \$1,553 and his service credit rate is \$21.30. In the event of Pat's death before age 65, his surviving spouse's self-payment contribution will continue at the pre-age 65 rates until 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. The Fund will look at the Retiree's age 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.



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.

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.

To assist you in making your self-payment contributions in a timely and consistent manner, the Fund requires 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 opted to enroll in a separate individual or group Medicare Advantage Plan (Parts C and D) not sponsored by the Plan or a Medicare Supplement Plan (medical and Prescription drug) and elect to pay the premium for the Optional Ancillary Benefits, you must self-pay your entire monthly premium amount for these benefits, and you will no longer have access to your HRA balance.

Life Events

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:

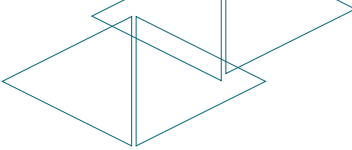
- Marital status (if you marry, separate, or divorce);
- Spouse's employment and/or access to other health insurance coverage (including Medicare eligibility);
- Dependents (provide the name, Social Security number, and birth date of your newborn or adopted child, a child placed with you for adoption,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

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

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.



Getting Married

If you get married, your spouse is automatically eligible for coverage effective as of the date of your marriage, **but only if** you submit a completed Enrollment Form and provide a marriage certificate to the Fund Office within 30 days of the date of your marriage. If you fail to submit a completed Enrollment Form and provide a marriage certificate within 30 days of the date of your marriage, the request for enrollment is considered late. Coverage based on late enrollment is the first day of the Eligibility Quarter when the Enrollment Form and any supporting documentation are received by the Fund Office. **No claims incurred prior to late enrollment will be paid.**

In addition, if your spouse is eligible for other medical and/ or Prescription drug coverage from his or her Employer and does not enroll for that coverage, he or she will not be covered under this Plan. To be covered by this Plan, your spouse must follow the *“When Your Spouse Is Eligible For Other Coverage”* provisions (see page 4).

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. **Once you are divorced, stepchildren from your former marriage are no longer eligible to be covered under the Plan, as of the date of divorce, but may be eligible for COBRA Continuation Coverage.** See page 25.

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 your former spouse is designated as your beneficiary, the beneficiary designation is null and void, as set forth on page 64.

If your spouse and/ or Dependent(s) are covered under another Group Plan (medical or dental), 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.

Adding A Child

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.

To add a Dependent child other than a newborn, you must complete an Enrollment Form and provide documentation proving Dependent status within 30 days after the child becomes your legal responsibility. 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;
- You submit a completed Enrollment Form and provide documentation proving Dependent status within 30 days; and
- The child meets the Plan’s definition of a Dependent child.

Stepchildren are eligible for coverage on the date of your marriage **but only if** you submit a completed Enrollment Form and provide documentation proving Dependent status within 30 days of the date of marriage.

In order for the Fund Office to determine a Dependent’s eligibility, you must provide legal documentation of Dependent status, such as a birth certificate, adoption papers, the legal guardianship/ custody/conservatorship order signed by a judge, marriage certificate, guardianship documents, divorce decree, or paternity order, as well as other coverage information from Parents within 30 days. Receipt of a valid QMCSO by the Fund Office will automatically result in the enrollment of that person.

If you fail to submit a completed Enrollment Form and documentation proving Dependent status within 30 days after the child becomes your legal responsibility, eligibility is late. Coverage based on late enrollment is the first day of the Eligibility Quarter when the Enrollment Form and any supporting documentation are received by the Fund Office. **No claims incurred prior to late enrollment will be paid.**

Covered Dependents **do not** include your grandchildren unless the Participant is the legal guardian/conservator/custodian or has legally adopted them.

Special rules for coverage of a newborn: Your newborn Dependent child(ren) will be covered from the date of birth, but only if you:

- Notify the Fund Office of the birth via letter, call or email within 60 days of the child’s birth; and
- Submit to the Fund Office a completed Enrollment Form and documentation proving Dependent status within six months of the child’s birth.

If you fail to notify the Fund Office of the child’s birth within 60 days or fail to submit a completed Enrollment Form and documentation proving Dependent status within six months of your child’s birth, eligibility is late. Coverage based on late enrollment is the first day of the Eligibility Quarter when the

Enrollment Form and any supporting documentation are received by the Fund Office. **No claims incurred prior to late enrollment will be paid.**

Child Losing Eligibility

Your child is no longer eligible for coverage on the last day of the month in which he or she reaches age 26.

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 on page 88.

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 become eligible again under the Plan by meeting the Plan's Initial Eligibility (see page 6) or reinstatement requirements (see page 9).

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, request a reciprocity authorization form from the Union or Fund Office 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 330 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, 2024, the Fund's contribution rate was \$10.91 per hour for Active Participants. Jake worked 330 hours in a state where the rate was \$11.25. He received eligibility credit for 340.28 hours under the Fund, even though he only worked 330 hours, because the rate was higher in the other state. If the other state had a \$6.75 per hour contribution rate, Jake would have only received credit for 204.17 hours under this Fund.

You should contact the Union or the Fund Office immediately if you accept work as an Operating Engineer outside of the state of Wisconsin to request a reciprocity authorization form.

Taking A Leave Of Absence

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

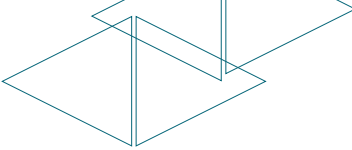
FMLA Provisions

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:

- The birth, adoption, or placement with you for adoption of a child;
- To care for a seriously ill spouse, Parent, or child;
- You are unable to work because of a serious illness; or
- 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 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 Continuation Coverage

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, as long as your Employer remits the required contributions.

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 Continuation Coverage, which requires a self-payment.

Taking A Military Leave

The Fund provides coverage to Participants returning from active service when coverage through the military (TRICARE 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

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 Continuation Coverage, except that only you (the Participant) have the right to elect USERRA coverage for yourself and your Dependents.

Your coverage under USERRA will continue until the earlier of:

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

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

- Your coverage would otherwise end as described directly above;
- You lose your rights under USERRA (for instance, for a dishonorable discharge);
- Your self-payment contribution is due and unpaid; or
- 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 either (1) return to work for a contributing Employer or (2) be registered and available for full-time work in the "out-of-work book" with Local 139 within 90 days after discharge and have not refused to accept, or rejected, a work referral from Local 139.

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.

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).

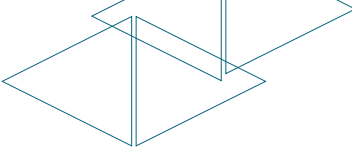
Loss of Time benefits are not available to salaried Alumni or Non-Bargaining Unit Participants.

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 27.5 hours of contributions each week, not to exceed 110 hours per month, to a maximum of:

- 26 weeks, if you are receiving Loss of Time benefits;
- 24 months, if you are receiving Workers' Compensation benefits; or
- 8 weeks, if you are receiving Loss of Time benefits due to intensive outpatient treatment or partial Hospitalization program.

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.

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



Permanent Disability

If you are permanently Disabled, you may be eligible for Retiree coverage under the Plan. See page 11. 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;
 - » 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.

In addition, if you are a Non-Bargaining Unit Participant, 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. Benefits will be in accordance with the terms of the Medicare Advantage Plan of benefits.

If you become Disabled, you may be eligible for an AD&D benefit. Refer to page 63 for information regarding the Plan's AD&D benefit.

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 63 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 15).

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 11) and Medicare Advantage Plan.

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

Your Dependent children will also continue to be eligible for medical benefits until the end of the month in which they reach age 26, as long as your surviving spouse is eligible to and 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 23).

When You Retire

When you retire, you may be eligible to continue Retiree coverage under the Plan. See page 11 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 for Medicare Part A and B must be enrolled in 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 11); 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 14.

Self-Payment Contributions For Active Coverage

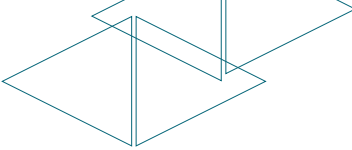
If you are a bargaining unit Participant or Fund-related Operating Engineer who is available for full-time employment within the jurisdiction of the Fund, it is possible that there will be Work Quarters in which you have less than 330 hours and where you have less than 1,320 hours in the last four Work Quarters. If this happens, **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 Continuation Coverage.*** See page 25 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 you were short of the minimum required hours and on the self-payment contribution rate. This rate is set periodically by the Trustees.

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.



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 25.

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 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 shows 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. You can use your Health Reimbursement Account (HRA) balance as one of the allowed payment methods. You can also complete the Self-Payment process by using the Health Fund’s website.

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

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

The Self-Payment 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.

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.

- 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 25.
- 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 25, you have 60 days to elect to continue your coverage through COBRA Continuation Coverage.
- 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.

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 and submit the paid receipt to the Fund Office for processing. The Fund will not reimburse you (make benefit payment) until the self-payment amount that is due has been received.

COBRA Continuation Coverage

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

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 Continuation Coverage notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. You may elect COBRA Continuation Coverage on behalf of yourself and your family members or they can each elect their own coverage. Parents may elect COBRA Continuation 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:

- If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents.
- 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.
- 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.
- 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 Continuation Coverage, 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 Continuation Coverage qualifying event; with the exception that you are **not** eligible to continue coverage for Loss of Time, Death, Pre-Funding, and AD&D benefits (or dental and vision benefits if you elect medical benefits only). Both COBRA elections will include your continued enrollment in the HRA and access to the existing HRA balance. However, no new contributions may be made to the HRA.

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.

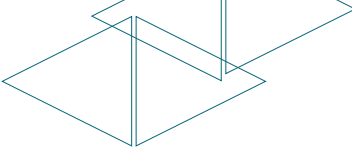
Children born, adopted, or placed for adoption as described above, have the same COBRA Continuation Coverage rights as a Dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, such child's continued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

Qualifying Events

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; and
- Your child losing Dependent status under the Plan.

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



Notifying The Fund Office

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.

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 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; 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 Continuation Coverage 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.

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

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

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 Continuation 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, 2025	August 31, 2025
Payment Privileges Continue Until	February 28, 2027	February 28, 2027
Coverages	Medical, dental, vision, death, and loss of time benefits	Medical, dental, and vision benefits or Medical only
Cost	Current self-pay 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 the date on the 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 Continuation Coverage 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 you 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.
- 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 to qualify for this benefit. In addition, you must complete 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 32). 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-payment, Retiree coverage Self-payment contributions (excluding reimbursement for Medicare Part B premium), and post-tax premiums your spouse pays for other group coverage.
- Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance.
- Health care expenses not covered, 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 SPD/Plan Document. 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 continues to be 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.

However, if you opt-out of Retiree coverage and enroll in an individual or Other Group Medicare Advantage Plan (Part C and Part D) not sponsored by the Plan or a Medicare Supplement Plan (medical and Prescription drug) and elect to pay the premium for the Optional Ancillary Benefits, you and your Dependents will no longer have access to your HRA balance. In addition, no HRA amounts will remain available to your spouse or Dependents upon your death.

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 if 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, 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. Additionally, the HRA may not be used to pay for Medicare Part A or B coverage.

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

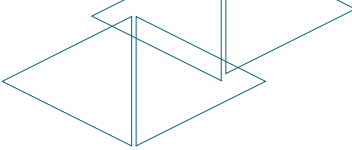
You may freeze your HRA balance if you opt out of the Plan's coverage because you have coverage available through another Group Plan, such as through your spouse's Employer. To be eligible to freeze your HRA balance during the time you have opted out of coverage, you must follow the Plan's formal process to opt out of coverage (see the *"Retiree In-and-Out Program"* on page 13). 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.

In addition, if you opt-out of Retiree coverage and enroll in an individual or Other Group Medicare Advantage Plan (Part C and Part D) not sponsored by the Plan or a Medicare Supplement Plan (medical and Prescription drug) and elect to pay the premium for the Optional Ancillary Benefits, you and your Dependents will no longer have access to your HRA balance. In addition, no HRA amounts will remain available to your spouse or Dependents upon your death.

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.

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

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

If eligibility ends because of a COBRA Continuation Coverage 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 Continuation Coverage (subject to all conditions and limitations of COBRA Continuation Coverage). This also applies to your HRA.

If you are a public Participant 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 and within 24 months of the date of service or expense is incurred.

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 a claim for reimbursement of eligible expenses that were 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 USERRA. If your military service lasts 31 days or longer, you have two options:
 - » Continue your coverage by making self-payments or electing COBRA Continuation Coverage, at which time your HRA balance will be available for use; or
 - » Notify the Fund Office of your entry into the military, in writing; 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 9.
- **When You Retire. No new contributions will be credited to your HRA.** 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 32 for more information). The HRA may not be used to pay for Medicare Part A or B coverage.

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; 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. 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.

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.

However, if you opt-out of Retiree coverage and enroll in an individual or Other Group Medicare Advantage Plan (Part C and Part D) not sponsored by the Plan or a Medicare Supplement Plan (medical and Prescription drug) and elect to pay the premium for the Optional Ancillary Benefits, you and your Dependents will no longer have access to your HRA balance. In addition, no HRA amounts will remain available to your spouse or Dependents upon your death.

Contributions

On June 1, 2024, the hourly contribution rate was \$10.91 per hour, including pre-funding. For each hour of contributions made on your behalf (on and after June 1, 2024), \$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 \$3,818.50 ($\10.91×350 hours) of contributions made on his behalf, \$350.00 ($\1.00×350 hours) will be credited to his HRA.

When looking at hours of contributions made on your behalf, the Fund includes reciprocal hours of contributions. 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 stated purposes.

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 rolls over into the next year, allowing you to save for future eligible expenses.

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.

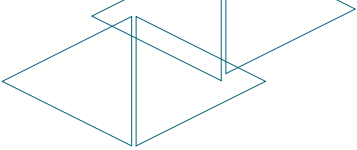
Any unused amount in your account at the end of a Calendar Year carries forward, even into retirement. After termination of eligibility, your HRA may be carried forward up to 36 consecutive months (12 calendar quarters) without forfeiture. After retirement, your HRA balance will be carried forward until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

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.



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 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.

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

HRA 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, excluding Medicare Parts A and B coverage;
 - » That you and/or your spouse pay for Other Group Plan coverage, such as Employer insurance or group policy insurance; 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. 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. Note: You are not able to use the funds in your HRA to cover the expenses of individuals who are not covered under the Fund's medical benefits. This applies to individuals who are not eligible to enroll in our Plan because they are enrolled in a Health Savings Account (HSA) through their Employer's health plan.

HRA Eligible Expenses Not Otherwise Covered by the Fund

Expenses must qualify as medical care under Internal Revenue Code Section 213(d) to be eligible for reimbursement from your HRA. All expenses must be properly substantiated. The reimbursement of any ineligible expense will not qualify for an exclusion from your gross income under Code Section 105(b). There is a list of ineligible expenses in "Expenses Not Eligible for Reimbursement" on page 33. You may also see IRS Publication 502 for further details.

Expenses eligible for reimbursement from your HRA—as long as they are not reimbursed or reimbursable from another source—include, but are not limited to the following:

- Acupuncture (excluding remedies and treatment prescribed by an acupuncturist)
- After-tax premiums your spouse pays for other coverage
- Alcoholism and chemical dependency treatment
- Ambulance
- Artificial limbs/teeth
- Breast pumps
- Chiropractic treatment

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

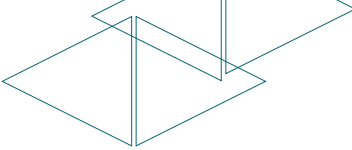
If you have any questions as to whether an expense is eligible for reimbursement, contact the Fund Office.

- Contact lenses and solution
- Copayments
- Crutches
- Custom orthopedic devices
- Deductibles
- Dental fees
- Diagnostic fees
- Expenses applied to the out-of-pocket maximum
- Eye examination fees
- Eye surgery, including laser eye surgery (e.g., cataracts, LASIK, radial keratotomy)
- 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
- Massage therapy provided by a state licensed massage therapist
- Medications and medical supplies (e.g., syringes, needles, etc.)
- Obstetrical expenses
- Oral Surgery
- Orthodontic fees
- Over-the-counter medications obtained with a Prescription from your Physician
- Oxygen
- 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, excluding Medicare Parts A and B coverage.
- Physician fees
- Premiums paid for group health, or long-term care insurance, unless the premium is paid or could have been paid pre-tax from another source
- Prescription eyeglasses
- Prescription medications from the United States
- Prescription smoking-cessation programs
- 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 or FDA approved medication 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, vitamins, or supplements
- 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.

Expenses Not Eligible For HRA Reimbursement

Expenses that are not eligible for reimbursement from the HRA include items that do not constitute "medical care," as defined in Internal Revenue Code § 213(d). 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 improve 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
- Expenses submitted for someone who is not enrolled in the Plan, including a Dependent who, as a result of enrollment in an HSA, is not eligible for enrollment 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
- Premiums for disability coverage, individual market coverage, insurance plans purchased from a state or federal marketplace, or Medicare Part B
- Prescription medications received from outside the United States (such as from Canada or Mexico)
- Social activities (such as dance lessons)
- Uniforms or special clothing (such as maternity clothing)
- Weight loss programs or FDA-approved medications for general health or appearance

Note: 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 "Claims Information" on page 68.

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:

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.

- Make sure your claim totals at least \$250 if requesting payment by check instead of an electronic payment.
- Check and make sure that the item or service is an eligible expense.
- If you are submitting a large number of claims, separate the claims and provide a separate total 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.iuoe139healthfund.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.

Certain claims are eligible for HRA reimbursement via the Fund's website. Contact the Fund Office for details.

Comprehensive Medical Benefits

In general, the Fund does not cover charges from out-of-network providers.

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. The Fund has contracted with a Preferred Provider Organization (PPO).

You **must** get your medical care from providers who participate in the PPO network (described on page 37) in order for your care to be covered by the Plan. Only a few exceptions apply, as explained on page 37. **All Active and Retired Participants who have satisfied the eligibility requirements of the Fund, and their covered Dependents, are eligible for medical benefits Under the Plan's Comprehensive Medical Benefits program.** However, there are some limitations on coverage. Refer to "*General Plan Exclusions and Limitations*" (starting on page 65).

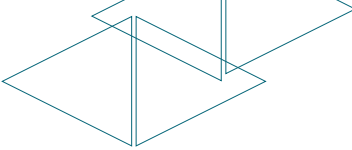
Comprehensive Medical Benefits are designed to provide coverage only for care that is Medically Necessary in the treatment of an Illness or Injury. Therefore, medical treatment for elective Cosmetic Surgery or similar non-Medically Necessary treatment is not covered. If you have any questions, please 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 47.

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. Here's how the Plan covers medical benefits:

- You are responsible for meeting your annual deductible(s) between June 1 and May 31 each year.
- 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. Refer to the *Summary of Benefits* insert (in the front pocket of this SPD) for details.



- 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: Some benefits and expenses may be covered differently or be subject to benefit maximums. Refer to the **Summary of Benefits** insert (in the front pocket of this SPD) 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 front pocket of this SPD).

Note: Both an in-network and out-of-network deductible apply. However, the Plan offers limited coverage for care you receive out-of-network. Refer to “Out-of-Network” on page 37.

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

Covered Expenses, which are for Protected Services and/or Continuing Care Services, will apply to satisfy the annual deductible, as if such Services were furnished by an in-network provider as defined on pages 37.

Example: Annual Deductible Family Maximum

Dan, his wife Debbie, and their two daughters are covered under the Plan. In August 2024, Dan’s two daughters each incurred \$175 in medical Covered Expenses for in-network services. In May 2025, Dan and his wife each incurred \$200 in medical Covered Expenses for in-network services. 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 met his or her individual medical deductible, because the family paid \$750 in medical Covered Expenses (\$175 + \$175 + \$200 + \$200), Dan’s family met the family maximum and no further medical deductibles needed to be paid for the June 1, 2024 through May 31, 2025 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.

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 Participants 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 copayment amounts.

Coinsurance

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

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

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 front pocket of this SPD). Once you or one of your Dependents meet the per person annual out-of-pocket maximum, 100% of that individual's 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' Covered Expenses will be paid for the remainder of the Calendar Year.

Remember that if you use an out-of-network provider, where allowed, the amounts that exceed the Fund's Allowable Charge are not applied to the annual out-of-pocket maximum. In general, the Fund does not cover charges incurred at an out-of-network provider.

Covered Expenses, which are for Protected Services and/or Continuing Care Services, will apply to satisfy the annual deductible, as if such Services were furnished by an in-network provider as defined on pages 37.

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 front pocket of this SPD).

Allowable Charges

The Plan covers costs for services and supplies only to the extent that they are Allowable Charges. For PPO network providers (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 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 92.

Preferred Provider Organization (PPO) Network

Providers (Physicians, Hospitals, and other professional health care providers) participating in the PPO network have agreed to provide discounted fees for the care they provide. Since the billable charge is reduced, the Fund pays less and any cost-sharing amount you are required to pay is also less.

Preferred Or Network Provider

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

In addition, the PPO network providers cannot balance bill you for any difference (the remaining balance) between their billed charges and the Fund's Allowable Charge, which is the negotiated fee/rate PPO network providers have agreed to charge for supplies and services rendered.

Note: The Fund primarily does not cover the costs of services you receive from providers who do not participate in the PPO network. There are only a few services that you can receive from out-of-network providers that are covered by the Plan (see below) such as certain Protected Services (for example, certain Emergency Services).

If a service is covered, it's important for you to understand that out-of-network providers (where allowed) may not be obligated to discount their fees. This means you and the Fund pay more when you use their services, and they may be able to balance bill you. Your deductible, coinsurance, and out-of-pocket maximums may also be higher when you use out-of-network providers.

Federal law, the No Surprises Act, may protect you from some balance billing by out-of-network providers.

The Preferred/Non-Preferred Provider Feature

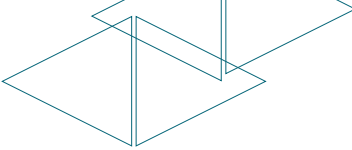
To take advantage of the savings the PPO provides, always check to see if your provider is in the network (providers participating in the network change periodically). You must show your Health Fund ID card at the time that you receive service. If you do not notify your provider of your network coverage 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 **Summary of Benefits** insert (in the front pocket of this SPD) or the information provided on your ID card.

Out-of-Network

The Plan maintains a broad network of providers who are part of the PPO network. **Out-of-network benefits are not covered under the Plan, subject to the following exceptions:**

- In the event of an emergency, out-of-network treatment and services are covered; this also applies to emergency ambulance services. Protected Services will be covered by the Plan
- Medically Necessary radiologist, pathologist, anesthesiologist, emergency room Physician, and laboratory technicians are Covered Expenses when performed at a network facility or doctor's office, regardless of whether or not the provider is a Preferred Provider, on the terms set forth in the previous section
- Chiropractic therapy



- Acupuncture
- Hearing aids
- Prescription drugs
- Continuing Care Services
- Cologuard test kits.

Although the above listed services may be covered on an out-of-network basis, they are still subject to all other Plan limits and exclusions, including but not limited to deductibles, out-of-pocket maximums, Usual, Customary, and Reasonable limitations, and Medical Necessity, to the extent allowed by applicable law.

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 on the **Summary of Benefits** insert in the front pocket of this SPD) 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.

This provision (and all Plan provisions) shall be interpreted to apply consistently with the No Surprises Act, including its limitations on amounts, which a Covered Person can be required to pay.

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.

Preauthorization Requirement

In order for you to receive Plan coverage for certain services and/or supplies, you or your provider must contact the Fund Office and have the service and/or supply preauthorized including but not limited to:

- Inpatient Hospitalizations, including inpatient treatment of mental health and substance disorders, and excluding routine deliveries and Cesarean sections
- Outpatient surgeries
- Discograms
- Durable Medical Equipment for a rental that exceeds three months or at a cost that exceeds \$500, including Continuous Passive Motion (CPM) devices
- Ear/nose/throat surgeries
- Genetic testing
- Hand/wrist surgery
- Home Health Care
- Hysterectomies
- Injections for migraine headaches
- Joint and spine injections and surgeries (such as back, hip, and knee)
- Neuropsychological testing
- Radiofrequency ablation
- Specialty (high dollar) drugs
- Speech therapy
- Spinal surgery
- 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
- Varicose vein procedures.

If you do not call to preauthorize care for the listed services and/or supplies, and if it is determined that the procedure/service is not Medically Necessary, it will not be covered under the Plan.

This is just a **sample** list of services that require preauthorization. All services are subject to Medical Necessity review. The preauthorization process is in place to help you identify whether a particular service or supply is covered by the Plan, thereby allowing you to avoid unnecessary expenses.

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 front pocket of this SPD) for the percent payable under the Plan and any specific Plan maximums. The following information describes the specific coverage provided.

If you or your eligible Dependent are Eligible for Medicare, you **must** enroll for both Medicare Parts A and B. When you retire, you will have the option to enroll in the Medicare Advantage Plan.

If you retroactively retire, and if you or your eligible Dependent(s) were Eligible for Medicare, any claims processed after the retirement date may be reprocessed and denied. Medicare coverage under the Fund is only available by timely enrollment in the Medicare Advantage Plan. If you had not enrolled in Medicare Part A and Part B when eligible, you may be personally responsible for claims as of the retroactive retirement date.

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. Note: 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 preauthorization is 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
- 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. See the definition on page 87. The Plan will also cover Protected Services if required under the No Surprises Act.

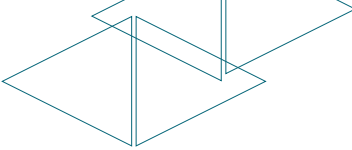
The Plan is grandfathered for purposes of federal law. The Plan does not cover Dependent pregnancy.

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 within the scope of a licensed Registered Nurse (RN) other than assisting at surgery, Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP), 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) and replacements of artificial breast(s) following mastectomy
- 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
- 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)

The Plan covers immunizations for both children and adults at 100%, no deductible. You can log on to the CDC website at www.cdc.gov/vaccines/schedules to see the list of covered 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.

- 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 front pocket of this SPD)
- 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 front pocket of this SPD). 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 when there is a medical condition for treatment of flat feet; subluxation of the foot; cutting or removal of corns and calluses; and nail trimming, cutting and debridement (not covered for routine diagnoses or care)
- CPAP/BiPAP supplies (when preauthorized as required) as provided on the **Summary of Benefits** insert (in the front pocket of this SPD)
- 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**
- Weight loss programs, if supervised by a Physician.

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 Health 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 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. Refer to the **Summary of Benefits** insert (in the front pocket of this SPD) for the percent paid by the Plan for these benefits.

Annual Physical HRA Bonus

In order to promote wellness and early detection, the Fund will credit eligible, Actively working Participants' HRA account if you receive an annual physical exam. If you are married, then both you and your spouse must receive annual physicals to qualify for this benefit. You must complete an **HRA Bonus Request Form**, available from the Fund Office or the Fund's website, to obtain this benefit.

If you and/or your spouse choose to have your routine physical exam performed by your personal Physician, the physical must consist of the following components in order to qualify:

- 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 50
- A pap smear for females over age 21 (at least once every three years)
- A mammogram for females over age 40.

Due to varying guidelines, you are not required to have the PSA, pap, or mammogram if your personal Physician recommends against it. However, you must submit a written statement from your Physician stating that the test is not required for you or your spouse.

This benefit will generally be processed within 30 days. A letter will be returned to you indicating the date that the bonus was credited to your HRA account or the reason the claim was denied.

"Annual" means once per Calendar Year.

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 front pocket of this SPD).

Note: 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

When you obtain a pap smear and/or mammogram, the Plan covers its coinsurance listed on the **Summary of Benefits** insert (in the front pocket of this SPD) 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 have already obtained the pap smear and mammogram.

Colorectal Cancer Screening Benefits

When you go 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 front pocket of this SPD). 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 under the routine physical exam benefit.

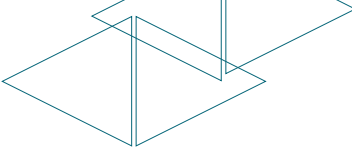
Once you meet your annual deductible, the Plan covers a percentage of covered colorectal cancer screening procedures.

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;
- 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 45
- 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



- Colorectal cancer screening with the Cologuard test kit beginning at age 45, as frequently as every three years, for individuals at average risk for colon cancer
- 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); and/or
 - » 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); and/or
 - » 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. Care provided in connection with a medical emergency at an Independent Freestanding Emergency Department that provides Emergency Services and is geographically distinct and licensed separately from a Hospital will be covered as if the emergency department is a Hospital, as required by law.

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—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; and
- 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.

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

While diet and increased physical activity to lose weight are recommended, this method alone is not always effective. 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, surgery, and combinations of these techniques.

Surgical weight loss alternatives, such as gastric bypass surgery, have always been an option under the Plan; however, surgery must be Medically Necessary. Surgical methods can be very costly; without specific restrictions or guidelines, they are not as effective as they could be, and could be potentially dangerous for the individual. To ensure you get the most out of your Plan benefits, certain requirements and limits apply to 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.

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.

Nutritional Counseling

The Plan will cover nutritional counseling if Medically Necessary and related to a medical procedure, such as gastric bypass surgery, or a chronic medical condition, such as diabetes, obesity, an eating disorder, or cancer. Nutritional counseling will not be covered for medical conditions such as asthma, autism, attention deficit hyperactivity disorder, or chronic fatigue syndrome. Nutritional counseling must be prescribed by a Physician and furnished by a licensed nutritionist, registered dietician or other qualified licensed health care professional, such as a nurse who is trained in nutrition.

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 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 front pocket of this SPD). This maximum applies regardless of whether the treatment is rendered by an in-network Physician or in-network Dentist. Benefits for treatment of TMJ are only covered under Comprehensive Medical Benefits. There is no maximum amount payable on surgical treatment of TMJ; such care is covered under Surgical Benefits (see previous section). There is no coverage for out-of-network providers.

Certain Oral Care

Medically Necessary oral/dental treatment is 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. In addition, the Plan will cover a palatal obturator device that is required as a result of sinus cancer; such coverage will be subject to the deductible and coinsurance for medical benefits as specified on the **Summary of Benefits** insert (in the front pocket of this SPD).

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 only for rehabilitative speech therapy (i.e., habilitative speech therapy is not covered) provided the treatment is:

- Medically Necessary;
- Ordered by a Physician;
- Provided by a certified therapist; and
- Is not due to a developmental delay (i.e., habilitative speech therapy).

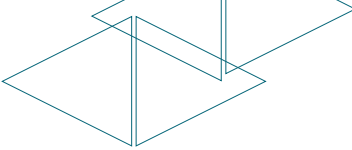
The certified therapist must be someone other than a spouse, child, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, or a person ordinarily living in your home.

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

Physical Therapy / Occupational Therapy

The Plan covers Physical Therapy and Occupational 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. Coverage is not provided for habilitative therapy, such as when associated to a developmental delay.

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



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

Kidney And Cornea Transplants

Comprehensive Medical Benefits cover organ transplants for Medically Necessary services, including:

- 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 front pocket of this SPD)
- Diagnostic x-ray and laboratory, 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 (EAP) (see page 49). There is no requirement to first use the EAP prior to receiving other mental health or substance use disorder treatment.

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. You must use a provider that participates in the PPO network. Out-of-network providers are not covered, except in the event of an emergency. Treatment for mental health and substance abuse disorders is subject to the maximums and limitations listed on the *Summary of Benefits* insert (in the front pocket of this SPD).

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 as noted on the back of your ID card. 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 but is later determined to be Medically Necessary, there will be no penalty, 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 front pocket of this SPD).

Diabetic Self-Management Education Benefits

The Plan provides coverage for diabetic self-management education programs, provided the program is Medically Necessary and prescribed by a Physician. Covered Expenses include services such as nutritional 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 front pocket of this SPD). 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 front pocket of this SPD).

Hearing Care Benefits

The Plan covers hearing aids and hearing aid repair up to the maximums listed on the *Summary of Benefits* insert (in the front pocket of this SPD) except that the Plan covers hearing aids up to the dollar maximum listed on the *Summary of Benefits* whenever Medically Necessary due to complications with skin cancer. 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 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.

Telehealth Services

The Plan covers telehealth services for Medically Necessary treatment from Preferred Providers at the same benefit level as in-person treatments, subject to all other Plan terms and requirements, including deductibles and coinsurance. The Plan does not cover telehealth services from out-of-network providers.

Prescription Drug Benefits

Prescription drug benefits are offered through a Pharmacy Benefit Manager (also commonly referred to as a PBM), 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.

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.

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:

- The Plan's pharmacy network has thousands of locations nationwide, including most major chain stores.
- When you are eligible for Plan coverage, you receive two ID cards that contain the information the pharmacist will need to process your Prescriptions.
- You can go to any retail pharmacy in the Pharmacy Benefit Manager's network to have your Prescription(s) filled (up to a 90-day supply at one time). When you use a Preferred Provider Pharmacy, you receive your Prescription at preferred prices.
- Show your ID card when you have your Prescription filled. Only the Participant's name will be listed on the ID card, Eligible family member names are not listed on the ID cards.
- Pay the coinsurance amount listed on the **Summary of Benefits** insert (in the front pocket of this SPD).
- If your spouse has other primary insurance, he/she will not be eligible to use the drug card. Prescriptions for your spouse should be submitted to his/her insurance company first. Detailed receipts can be submitted to the Health Fund to coordinate benefits for secondary coverage, if eligible.

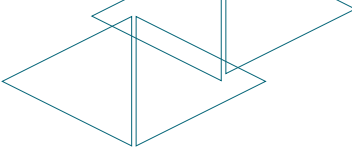
Although your ID card lists only the name of the Participant, the names and information for eligible family members are in the Pharmacy Benefit Manager's computer system. If you need additional cards, contact the Fund Office.

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 (Home Delivery) Program

You should use the mail order program when you need to have Prescriptions filled for maintenance medications—Prescription drugs that are used on an ongoing basis 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 some Prescriptions at one time.



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 Pharmacy Benefit Manager (refer to the **Summary of Benefits** insert in the front pocket of this SPD).
- 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.

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 Pharmacy Benefit Manager for the exact amount of the coinsurance due from you.

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 **Summary of Benefits** insert (in the front pocket of this SPD).

Specialty Medication Program

The Plan covers specialty medications when filled through the Pharmacy Benefit Manager's specialty pharmacy mail order program.

You will be required to pay the amount listed on the **Summary of Benefits** insert (in the front pocket of this SPD). 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 on the **Summary of Benefits** insert.

To receive Plan coverage for specialty medications, you must contact the Pharmacy Benefit Manager to have your medication preauthorized. 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 back of your Prescription Drug ID card or the number shown on the **Summary of Benefits** insert (in the front pocket of this SPD) 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 a 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. You must either try the other recommended medications or have your doctor submit a Prior Authorization request to the Pharmacy Benefit Manager stating the medical reasons why you cannot try the other medications recommended by the Pharmacy Benefit Manager.

You must contact the Pharmacy Benefit Manager's specialty pharmacy and have the medication preauthorized. If it is determined that the medication is **not** Medically Necessary, it will **not** be covered under the Plan.

Covered Prescription Drug Expenses

The Pharmacy Benefit Manager has a formulary exclusion list, which identifies the medications that are not covered by the Plan, recommended alternative medications, and daily dosage and coverage limits. The formulary exclusion list is subject to change and is usually updated in July and January. Contact the Pharmacy Benefit Manager or the Fund Office for more details.

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; limit of one fill for 25 days)
- 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) (see the **Summary of Benefits** insert for Lifetime benefit maximums)
- Prenatal vitamins
- Immunosuppressant (anti-rejection) drugs
- AIDS-related drugs
- 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)

- Nicotine addiction medications
- Weight loss medications are not covered, regardless of FDA approval status. For example, diabetes drugs in the GLP-1 agonist class may be covered for the treatment of type 2 diabetes (subject to Step Therapy or other applicable plan requirement). They are not covered for weight loss treatment. Some examples are, dulaglutide (Trulicity), semaglutide (Ozempic and Wegovy), liraglutide (Victoza and Saxenda), and tirzepatide (Mounjaro).

The Plan does cover medications related to the treatment of attention deficit and attention deficit hyperactivity disorders. However, as with all benefits, the medication must be Medically Necessary.

You may see or have seen advertisements on television and in the newspapers about Prescription drugs being available from pharmacies outside of the United States at a cost that is much lower than that of United States pharmacies. It is not legal for the Fund to participate in a program that directly imports Prescription drugs from a foreign country. The Health Fund will not reimburse you for Prescriptions that you purchase from pharmacies outside of the United States.

If You Are Eligible For Medicare

Active Participants And Their Dependents

At age 65, you generally become Eligible for Medicare benefits. If 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 they are also Eligible for Medicare). Medicare benefits will be secondary, if you are enrolled for coverage.

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.

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.

All Other Participants

If you or your eligible Dependent are Retired, Disabled, or a surviving spouse and become Eligible for Medicare, you must enroll for both Medicare Parts A and B. When you retire, you will have the option to enroll in the Medicare Advantage Plan. If you are Retired and your spouse becomes Eligible for Medicare, even if you are not yet eligible, then your spouse must enroll.

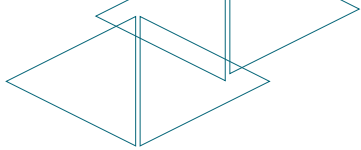
If you retroactively retire, and if you or your eligible Dependent(s) were Eligible for Medicare, any claims processed after the retirement date may be reprocessed and denied. Medicare

coverage under the Fund is only available by timely enrollment in the Medicare Advantage Plan. If you had not enrolled in Medicare Part A and Part B when eligible, you may be personally responsible for claims as of the retroactive retirement date.

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 65), Comprehensive Medical Benefits are not paid for the following expenses:

1. Out-of-network claims, except as provided in "Out-of-Network" (see page 37)
2. Abortion procedures, except complications of abortion
3. Autism treatment (treatment is an eligible expense under the HRA)
4. Blood donor services
5. Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning
6. Consultation services related to medical or surgical services when rendered by the same Physician during the same Hospital admission, except at the sole discretion of the Plan
7. Convenience items provided while you are an inpatient
8. Dental implants (these may be covered under the Plan's dental benefits)
9. Dental treatment, except as specifically described elsewhere in this SPD
10. Durable Medical Equipment supplies and repairs, except that repairs to wheelchairs and prosthetics are covered
11. 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
12. Eye exams or glasses, except as specifically described elsewhere in this SPD
13. Gene therapy (medical and/or Prescription drug), which typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered Experimental or Investigative. Some examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma



14. Maternity services for Dependent children, except an Emergency Service required by the federal law known as the No Surprises Act.
15. Motor vehicles, lifts for wheelchairs, stair lifts, hot tubs, and filtration systems
16. 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
17. Nursing home care
18. Prescription Drug benefit exclusions:
 - a. Administration or injection of any drug (this may be covered under the Plan's medical benefits)
 - b. Medications:
 - i. 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
 - ii. Individually packaged medications purchased through or billed by a nursing home or similar facility
 - iii. Non-legend (over-the-counter) drugs other than insulin
 - iv. Topical Minoxidil (Rogaine)
 - v. Weight loss medications are not covered, regardless of FDA approval status. For example, diabetes drugs in the GLP-1 agonist class may be covered for the treatment of type 2 diabetes (subject to Step Therapy or other applicable plan requirements). They are not covered for weight loss treatment. Some examples are, dulaglutide (Trulicity), semaglutide (Ozempic and Wegovy), liraglutide (Victoza and Saxenda), and tirzepatide (Mounjaro)
 - 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
 - e. Prescription medications received from outside of the United States (such as those from Canada or Mexico)
19. Preventive control programs, such as dietary instruction or educational training, except for diabetic self-management education as described on page 44
20. Private Hospital room and/or private duty nursing, unless determined to be Medically Necessary and preauthorized
21. Reconstructive or Cosmetic Surgery, except for Medically Necessary surgery or as specifically listed as covered elsewhere in this SPD
22. 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
23. Speech Therapy, unless it is rehabilitative in nature, such as for certain stroke, head Injury or situational mutism conditions.
24. Sterilization reversal procedures, if the Fund paid benefits for the sterilization
25. 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)
26. Surrogate maternity services
27. Therapy services, such as recreational, educational, water, horse, music or art therapies, or physical fitness or exercise programs
28. Topical application form of Minoxidil, Rogaine or their medical equivalent
29. Transplants, except as specifically listed as covered elsewhere in this SPD
30. Transportation or travel to or from medical treatment, except as specifically described elsewhere in this SPD
31. Treatment of organic brain diseases, such as dementia and Alzheimer's.
32. Upgraded lenses after cataract surgery that are available to correct refraction (the Plan covers only the standard lenses)
33. Vision therapy and training.
34. Speech generating devices, including but not limited to, augmentative and alternative communication devices with digitized or synthesized speech output. This exclusion does not apply to a voice prosthesis following a medically necessary laryngectomy.

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 four 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 **Summary of Benefits** insert (in the front pocket of this SPD). 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 four visits, mental health and substance abuse treatments will continue to be covered as explained on page 44.

For answers to your questions about the EAP, call the EAP or visit the website. Contact information is provided at the end of the **Summary of Benefits** insert (in the front pocket of this SPD). For answers to your questions about your mental health and substance abuse benefits, contact the Fund Office.

Transplant Benefits

Except Kidney And Cornea

Coverage for kidney only and cornea transplants are provided under the Plan's Comprehensive Medical Benefits, not the Transplant Benefits.

The Plan provides coverage for the following transplant surgeries:

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

Transplants are very expensive medical procedures. The Fund provides benefits to help you receive the care you need and help manage your costs. **Note:** Kidney-only transplants and cornea transplants are covered under Comprehensive Medical Benefits (see page 35).

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 Center for Transplants facility.

The Plan's Transplant Benefits include:

- **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.
- **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.** 370 continuous days; begins five days before the covered organ transplant procedure
- **Bone marrow transplant benefit period.** 395 continuous days; begins 30 days before a covered bone marrow transplant infusion
- **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.** 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.

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. 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.

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

- » 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

- » 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

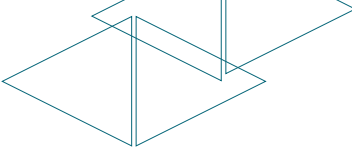
- » Occupational Therapy

- » Speech therapy

- » 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



- » 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; 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
 - » 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," below).

Certain limitations may apply to the above Covered Expenses. Prescription drugs are covered under the Plan's Prescription drug benefits. Contact the Fund Office for more 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 front pocket of this SPD).

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 front pocket of this SPD) 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, 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 65), Transplant Benefits are not paid for the following expenses:

- **Care, services, or supplies:**
 - » Not prescribed by or performed by or upon the direction of a Physician or professional/facility Provider
 - » Rendered by a provider that is a member of the Participants' immediate family
 - » Rendered by Hospitals, Physicians, or other providers that do not meet the Plan's definitions of such providers
 - **Charges:**
 - » A Participant would not legally have to pay if there were no insurance.
 - » For personal hygiene and convenience items such as, air conditioners, humidifiers, or physical fitness equipment
 - » For telephone consultations, failure to keep a scheduled visit, or for completion of a Claim Form
 - » **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.
 - **Custodial.** Custodial or long-term Care, domiciliary care, or rest cures.
 - **Experimental or Investigative,** except for Medically Necessary drug therapy following organ transplant for treatment of antibody mediated rejection where two or more other therapies have failed.
 - **Medical Necessity.** Services or supplies that are not Medically Necessary.
 - **Other Coverage:**
 - » Provided, or that would be provided, by any governmental unit, such as Medicare
 - » 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
- » 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
 - » 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)
- **Rehabilitation:**
 - » the Plan will not cover rehabilitation if not Medically Necessary in relation to the transplant
 - **Second Transplant:**
 - » A second transplant of the same organ is not covered where failure of the first transplant is caused, in whole or in part, by your failure to adhere to transplant protocol, including, but not limited to, failure to take medications.
 - **Transplant:**
 - » For a transplant procedure performed after the date coverage ends, including a transplant performed with a benefit period beginning after coverage ends but during a continuous Hospital stay that began before coverage ended.
 - » For a transplant procedure performed prior to becoming eligible or for an inpatient admission that began and ended before being covered.
 - » 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.
 - » For any non-human organ transplant.
 - » For donor expenses other than those specifically listed as covered.
 - » For non-transplant related costs.
 - » For recurrence of the disease for which the transplant was performed.

Recovery Incentive

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, up to a maximum of \$1,000 per occurrence.

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 recovery 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 you a check for 10% of the actual amount paid 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.
- 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:
 - » 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

Optional Ancillary Benefits for dental include Preventive Care and Restorative Procedures only.

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 elected to opt-out of Retiree coverage and elect to pay the premium for the Optional Ancillary Benefits, as provided under the Retiree In-and-Out Program.

The Fund has entered into a contract with a dental network provider that allows you and your eligible Dependents access to their dental PPO network and discounted dental services. To find out if a Dentist participates in the dental network, refer to the *Summary of Benefits* insert in the front pocket of this book.

You can continue to use your current Dentist, even if he or she does not participate in the dental network. If your Dentist is not contracted with the dental network consider switching to an in-network Dentist.

General Dentists, specialty Dentists, and orthodontists who participate in-network have agreed to charge discounted rates for dental care they provide, which means you and the Fund will save money when you use a network Dentist. In addition, in-network Dentists will not balance bill you for charges in excess of the discounted amount, you will not need a referral to see a specialty Dentist, and in-network Dentists file claims for you.

Covered Expenses

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

- Preventive;
- Restorative; 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 front pocket of this SPD). This Calendar Year maximum does not apply to Diagnostic and Preventive Services, Dental Oral Surgery, or Orthodontic services. However, the Plan has a separate Lifetime maximum for Orthodontic services (refer to the *Summary of Benefits*) that does not apply to Dependent children under age 19.

For Dentists that are not in the dental network, when the charge is higher than the Allowable Charge, you will be informed through an Explanation of Benefits (EOB). You are responsible for paying the difference between the Plan's benefit and the amount charged. To protect yourself against excessive dental expenses, request that your Dentist submit a Pretreatment Estimate to the Fund Office.

Preventive Care

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 (may be done by a Dental Hygienist)
- One full mouth xray every two Calendar Years
- Sealants twice per Calendar Year
- Two topical fluoride treatments per Calendar Year.

Restorative Procedures

Covered dental services and procedures are subject to the Calendar Year maximum and include:

- Palliative exams that are related to treatment
- 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
- Periodontal cleanings
- Periodontic services, including procedures for treating gums and the supporting structures of the teeth.
- 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 five year period
- 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.

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. Benefits for Prosthodontics are covered as set forth in the **Summary of Benefits**. Palatal obturator devices that are required as a result of sinus cancer will be covered as medical benefits, subject to the medical deductible and coinsurance, as provided in "**Certain Oral Care**" on page 43.

Dental Oral Surgery

Medically necessary Dental Oral Surgery (as defined on page 92). Certain dental care may be covered under the medical benefits, such as services related to the treatment of oral cancer.

Orthodontic Services (Braces)

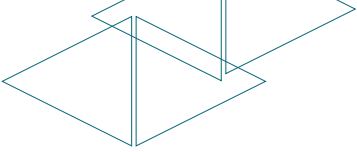
Your eligible Dependent children are covered if they need Orthodontic care. Benefits are paid as specified on the **Summary of Benefits** insert (in the front pocket of this SPD) based on the Allowable Charges incurred during an entire period of Orthodontic treatment, provided your Dependent is eligible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

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.

Dependent children under age 19 have no Orthodontic benefit maximum. Dependent children who are age 19 or older are subject to the Lifetime Maximum for Orthodontics listed in the **Summary of Benefits**.

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. If the Orthodontic appliance used by the orthodontist is Invisalign or a similar type of appliance with a series of clear removable orthodontic trays that are designed to straighten teeth gradually, only one course of treatment will be covered per lifetime. Failure to adhere to treatment protocol, such as wearing the trays the required length of time per day, may result in the denial of coverage for the remainder of the treatment.

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

Some dental expenses are not covered by the Plan. For example, you may opt out of the dental coverage. In that situation, your dental expenses would not be covered. In addition to any ***“General Plan Exclusions and Limitations”*** (see page 65), dental benefits are not paid for:

- Prosthetic replacement more than once in a five-year period, unless Medically Necessary
- Replacement of a lost or stolen appliance or of duplicate appliances
- Equipment sterilization
- Temporomandibular Joint Disorder treatment, which is covered under comprehensive medical benefits
- Preventive control programs, including oral hygiene instruction, plaque control, hydrotherapy, or dietary planning
- Rebase or relines of dentures within six months of initial placement
- Temporary procedures
- Orthodontic treatment for you or your spouse
- 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)
- Bleaching or whitening procedures or supplies.

Vision Benefits

Eye care is an important part of overall health. Vision benefits are available for Active Participants and their eligible Dependents, and eligible Retired Participants and their Dependents who have enrolled and make self-payment contributions for this coverage. Vision coverage is also available to Retirees and their Dependents who elected to opt-out of Retiree coverage and elect to pay the premium for the Optional Ancillary Benefits, as provided under the Retiree In-and-Out Program.

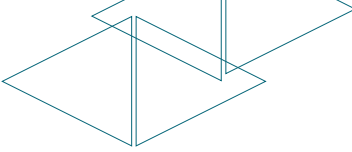
The Plan covers 100% of one vision exam, one refraction, and one contact lenses fitting) per person each Calendar Year. In addition, the Plan covers 100% of expenses for eligible materials—lenses, frames, and contacts—up to the per person maximum listed on the *Summary of Benefits* insert (in the front pocket of this SPD). All charges are subject to Usual, Customary, and Reasonable amounts. 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 or seasonal sales.

Covered Expenses

Covered vision benefits, up to the per person maximum listed on the *Summary of Benefits*, are as follows

- A complete eye examination
- Eyeglass lenses and frames, including single vision, bifocal, trifocal, and lenticular lenses
- Contact lenses
- Prescription sunglasses
- Prescription safety glasses.

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. For example, you may opt out of the vision coverage. In that situation, your vision expenses would not be covered. In addition to any ***“General Plan Exclusions and Limitations”*** (see page 65), vision benefits are not paid for the following expenses.

- Services, including:
 - » Eye exams required by an Employer
 - » Eye exercises, including remedial reading exercises
 - » Orthoptics or visual training
 - » Services performed or supplies furnished by a provider other than an Optician, Optometrist, or Ophthalmologist
 - » Supplemental services not covered in basic care
- Supplies, including:
 - » Aniseikonic lenses (for binocular vision)
 - » Non-Prescription lenses
 - » Non-Prescription sunglasses
 - » Subnormal vision aids
- 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
- Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except as specifically noted elsewhere in this SPD, 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)

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 and unable to work because of a non-job-related Illness or 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 off-the-job Accident; or
- Eighth day you are off work due to a non-job-related Illness.

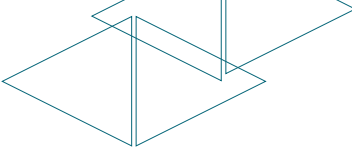
Loss of Time Benefits are paid weekly, at the rate listed on the **Summary of Benefits** insert (in the front pocket of this SPD). Benefits may run for a maximum of 26 weeks for any one Period of Disability, except that the maximum is eight (8) weeks for any one Period of Disability due to intensive outpatient treatment or a partial Hospitalization program.

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 27.5 hours of contributions each week, not to exceed 110 hours



per month, to a maximum of:

- 24 months if you are receiving Workers' Compensation benefits;
- 26 weeks if you are receiving Loss of Time Benefits; or
- 8 weeks, if you are receiving Loss of Time Benefits due to intensive outpatient treatment or a partial Hospitalization program.

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 65), loss of time benefits are not paid for any period of time for which you are:

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

Loss of Time Benefits due to intensive outpatient treatment or a partial Hospitalization program are limited to a maximum of eight (8) weeks. Medical Necessity requirements for intensive outpatient treatment or a partial Hospitalization program must also be met to receive Loss of Time Benefits.

Death And Dismemberment Benefits

Death and AD&D benefits are for Active and Retired Participants only; Dependents and surviving spouses are not covered.

Note: The higher death benefit amount available to Active Participants is available for Participants who retire due to a Disability and die before reaching age 55.

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 Voya (ReliaStar Life Insurance Company (ReliaStar Life)). If you have opted out of medical coverage under the Retiree In and Out Program (refer to section beginning on page 13), you must have elected to maintain coverage for Optional Ancillary Benefits and paid the applicable premium to be covered by the Death Benefit and Accidental Death and Dismemberment Benefit. Dependents and surviving spouses are not eligible for coverage.

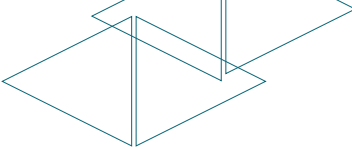
Death Benefit

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 ReliaStar Life. 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 front pocket of this SPD).

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 front pocket of this SPD). 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; 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

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

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 AD&D 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.

Exclusions And Limitations

In addition to any "General Plan Exclusions and Limitations" that apply (see page 65), AD&D benefits are not paid for any loss caused or contributed to by:

- Physical or mental Illness or infirmity, or the diagnosis or treatment of such Illness or infirmity
- Infection, other than infection occurring in an external Accidental wound
- Suicide or attempted suicide
- Intentionally self-inflicted Injury
- Service in the armed forces of any country or international authority, except the United States National Guard
- Any incident related to:
 - » Travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger
 - » Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight
 - » Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation

- » Travel in an aircraft or device used:
 - For testing or Experimental purposes
 - By or for any military authority
 - For travel or designed for travel beyond the earth's atmosphere
- Committing or attempting to commit a felony
- The voluntary intake or use by any means of:
 - » Any drug, medication or sedative, unless it is:
 - Taken or used as prescribed by a Physician
 - An over the counter drug, medication, or sedative taken as directed
 - » Alcohol in combination with any drug, medication, or sedative
 - » Poison, gas, or fumes
- War, whether declared or undeclared, or act of war, insurrection, rebellion, or riot
- 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 for the required form. You may also name more than one beneficiary.

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.

If your marital status or the number of your Dependents changes, you may want to review your beneficiary designation. It is your responsibility to keep your beneficiary designation current.

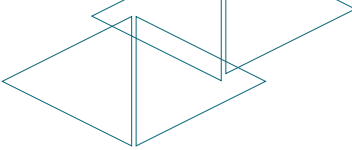
In the event a married Employee designates his or her spouse as beneficiary and that marriage is legally terminated by divorce, then any prior beneficiary designation naming the former spouse as beneficiary shall be null and void. If the Employee desires to again designate the former spouse as beneficiary, the Employee must complete and submit a new beneficiary designation form after the marriage is terminated, listing such former spouse as beneficiary.

General Plan Exclusions And Limitations

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 SPD, Plan benefits are **not** paid for the following:

- Charges:
 - » For completion of Claim Forms or failure to keep any appointment
 - » Above the Allowable Charges of the Plan
 - » Related to interest on expenses or sales tax
- 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:
 - » Cosmetic reconstruction of the nose
 - » Electrolysis
 - » Keloids
 - » Removal of wrinkles or excess skin
 - » Revision of previous elective procedures
 - » Treatment of male pattern baldness
 - » Wigs
- Custodial Care, residential care, nursing home care, domiciliary care, long-term care or rest cures. This limitation still applies if a Participant is receiving maintenance care that cannot reasonably be expected to substantially improve a medical condition
- Dependent child pregnancy, except an Emergency Service required by the federal law known as the No Surprises Act
- Durable Medical Equipment and Medical supplies used only for a Participant's comfort, personal hygiene, or convenience, including: 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
- Experimental or 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

Custodial Care, residential care, nursing home care, domiciliary care, long-term care or rest cures, which are not covered under the Plan, include expenses incurred for accommodations (including room and board and other institutional services) and nursing services, due to age or a mental or physical condition.



- **Governmental.** Any treatment, care, service, or supply furnished by or payable under any plan or law through any municipal, state, or federal government or any political subdivision (whether or not the Eligible Person claims the benefits or compensation, or recovers losses from a third party), except for:
 - » The Veterans Administration, when services are provided to a veteran for a Disability that is not service connected
 - » A military Hospital or facility, when services are provided to a Retiree (or Dependent of a Retiree) from the armed services
 - » A group health plan established by a government for its own civilian employees and their Dependents
- **Other coverage.** Any treatment, care, service, or supply for which you or your eligible Dependents have received or are entitled to receive benefits under 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, or 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

- **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:
 - » 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)
 - » 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
- **Post-Eligibility.** Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except as specifically noted elsewhere in this SPD, 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

- » 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

Treatment, care, services, or supplies:

- » 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 required by applicable federal law)
 - » 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
 - » Other than those specifically listed as Covered Expenses
 - » 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
 - » Rendered by a person who ordinarily resides in your home or who is a member of the Eligible Person's immediate family
 - » Required while incarcerated in a federal, state, or local penal institution, or required while in custody of federal, state, or local law enforcement authorities
 - » 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)
 - » 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
- 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
 - Treatment for developmental disorders and delays, including autism, other than initial diagnosis
 - 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. Weight loss medications are not covered regardless of FDA approval status. For example, diabetes drugs in the GLP-1 agonist class may be covered for the treatment of type 2 diabetes (subject to Step Therapy or other applicable plan requirements). They are not covered for weight loss treatment. Some examples are, dulaglutide (Trulicity), semaglutide (Ozempic and Wegovy), liraglutide (Victoza and Saxenda), and tirzepatide (Mounjaro)
 - Court-ordered testing and treatment, if not Medically Necessary

- Ancillary services such as vocational rehabilitation, behavior training, sleep therapy, and employment counseling, training, or educational therapy for learning Disabilities or other educational services
- 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
- Inpatient services, treatment, or supplies rendered without preauthorization, except in the event of an emergency
- Non-emergency care when traveling outside the United States
- Room and board except when Medically Necessary as part of a covered in-patient stay.

Claims Information

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.

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 75).

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, you must use in-network providers in most circumstances. Always check to see if your provider is in the network (providers participating in the network change periodically). You must show your ID cards 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.

When you use a medical Preferred Provider or if you use the Fund ID cards to obtain Prescriptions, 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, as shown on your ID card;
- The patient's name and date of birth;
- The Physician's name, address, phone number, and professional degree or license;

- The Physician's tax identification number (TIN);
- The dates of treatment or purchase;
- The type of services, treatment, or product for which payment is requested (Physician's office visit, Hospital, lab tests, etc.);
- The charge made for each service, treatment, or product;
- 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.

Generally, you must include all of the information listed above in the section addressing itemized bills. Failure to supply complete information requires the Fund Office to send a request for additional information. This causes delays in processing your benefits. When another plan is primary payer, the Fund Office may also require a copy of the other plan's explanation of benefits (EOB) statement along with the submitted claim.

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

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

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.

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

Information most often omitted by Physicians in completing Claim Forms includes:

- Diagnosis of the condition for which the patient received treatment;
- The Physician's TIN; or
- Correct itemization for charges.

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

Filing Specific Benefit Claims

Health Care Claims

Many 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 your responsibility to do so.

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

Types Of Health Care Claims

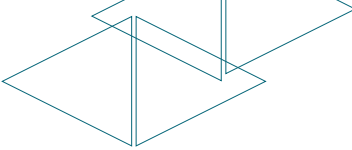
There are four basic types of health care claims:

- **Urgent care.** A type of pre-service 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.

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. However, the Plan will not deny benefits for urgent care services if it is not possible to obtain a pre-approval and the urgent care services are determined to be Medically Necessary.

- **Pre-service.** A claim for treatment where the Plan requires that you obtain preauthorization for all inpatient and certain outpatient treatments. The Plan will not deny Medically Necessary 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 claim for Plan benefits that is not a pre-service claim (i.e., you have already received the services in your claim).
- **Concurrent care.** 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.



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.

In certain circumstances, 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. 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 79).

When you or a Dependent are covered under Medicare, with Medicare as the primary payor, such as disability due to ESRD or ALS, you must submit a copy of Medicare's EOB with your claim.

Please do not send the Fund the itemized statement until you have the Medicare EOB to provide, as well. If you do, the Fund Office will deny your claim requesting the Medicare EOB.

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. 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 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, 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 unless the claim is subject to the No Surprises Act and you are protected from balance billing.

Prescription Drug Claims

If you need to file a claim for Prescription drug benefits that you purchased without using your Prescription Drug ID card at a 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; however, to reduce administrative expenses when receiving payment by check, 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. The minimum does not apply when receiving electronic payment. In addition, the amount reimbursed for any eligible expense will not exceed your HRA balance at the time reimbursement is requested. In the event your Plan coverage ends, you may submit eligible expenses totaling less than \$250 to close out your Account.

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. Claim Forms can be obtained from the Fund

Office or downloaded from the Fund's website. You must sign your Claim Form to verify 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 Claim 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); and/or
- 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 the address shown on your ID card.

Loss Of Time Claims

If you are Disabled and unable to work, be sure your 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" or "unknown" is too vague. The Fund needs this information to know when your Disability began and when it is expected to end.

Request a Claim Form from the Fund Office and 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 respond to any question

If you need a Claim Form, please contact the Fund 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.

regarding your Disability or complete another Loss of Time Benefits form if you are unable to return to work after the initial estimated return date that your Physician indicated.

Death And Dismemberment Claims

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

For assistance, call or write the Fund Office and explain the type of claim you are filing. The Fund Office can send you the proper Claim Form.

Claim Decisions And Payment Of Claims

When you submit a claim for benefits, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. After complete claim information is received, claims are processed promptly by the Fund Office. If recurrent payments are required, benefit amounts are paid as they accrue, but not less often than monthly.

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.

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.

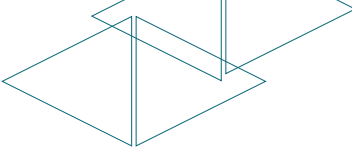
Health Care Claims

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 Fund may attempt to communicate electronically in addition to writing.

The deadlines differ for the different types of claims:

- **Urgent care claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within



three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. 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 due to matters beyond the control of the Plan, you will be informed of an extension of up to 15 additional calendar days 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. 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 a maximum of 60 additional days. 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, 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 Voya/ReliaStar Life 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;
- Notify you of its denial of your claim within the timeframes previously described, and
- State that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

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.

In addition, for a Loss of Time Benefit claim, the notice of the initial denial will:

- Explain the basis for the Fund disagreeing with or not following:
 - » The views presented by you to the Fund of health care professionals treating you and vocational professionals who evaluated you;
 - » The views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and/or
 - » A Disability determination regarding you, presented by you to the Fund, and made by the Social Security Administration.

Denial Information

When the Fund Office notifies you of its 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;
- A copy of the Plan's review procedures and time periods to appeal your claim; and
- 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, for a loss of time benefit, if no such rule, guideline, protocol, standard, or similar criteria exists, a statement that none exists); 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 decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

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 by you or obtained by the Fund.

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:

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

- **Health care or loss of time benefit claims.** 180 days from the date of a decision
- **Life insurance claims.** 60 days from the date proof is filed
- **AD&D claims.** Three years after the date proof is required.

When appealing a claim, you may authorize an attorney 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).

Records and documents you submit on appeal will be considered without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, if your claim is for health care or loss of time benefits and is denied based on:

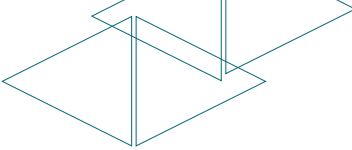
- **An internal rule, guideline, protocol, or other similar criteria.** You have the right to request a free copy of such information.
- **A Medical Necessity, Experimental treatment or similar exclusion or limit.** You have the right to request a free copy of an explanation of the scientific or clinical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

If the Trustees consider any new or additional evidence in the appeal, the Fund shall provide you, free of charge, with the new evidence that was considered, relied upon, or generated by the Fund. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination is required to be provided to you (as set forth in the "*Appeal Decisions*" section that follows), in order to give you a reasonable opportunity to respond prior to that date. In addition, before the Fund issues an adverse benefit determination based on a new or additional rationale, the Fund will provide you, free of charge, with that rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided in order to give you a reasonable opportunity to respond prior to that date.

If the Fund has a contractual limitation on when you must bring a lawsuit relating to a denied *Loss of Time Benefit* claim, and the time limitation could be impacted by the time required for the this internal appeal process, the Fund will provide notice to you stating the calendar date on which the contractual limitations period expires for your claim.

You may request an opportunity to appear before the Trustees (or an authorized committee of the Board) in person or by representative, at which time you may present additional written materials/evidence or testimony. 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 to appeal before the Board of Trustees, you will be notified in writing of the date, time, and location. 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 to appear and do not appear (without requesting an extension), the Trustees will proceed to consider your appeal based on the written information submitted.



Send your written request for a claim appeal and 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

Appeal Decisions

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.

Any lawsuit that challenges the Fund’s decision on a claim, which is filed under ERISA, the federal law governing employee benefits, must be filed no later than one year (12 months) from the date of the Fund’s written decision.

Jurisdiction and venue of any lawsuit filed against the Fund or its Trustees will be the United States District Court for the Eastern District of Wisconsin.

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 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.

Notice Of Decision

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. Any interpretation, determination, or other action of the Trustees shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion.

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 have, at your own expense, 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.

External Review

External review is available only for Protected Services under the No Surprises Act. See the **External Review for Protected Services** (in the front pocket of this SPD)

Coordination Of Benefits

Your and your Dependents' benefits are coordinated with Other Group Plans or prepaid group health care plans, but only to the extent coordination is permissible under federal law, including Treasury or IRS regulations.

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.

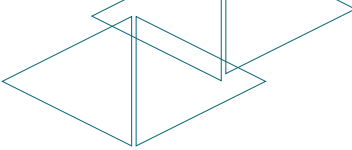
The Fund pays regular benefits when this Plan is the primary plan. When this Plan is the secondary plan, benefits the Fund pays will be no more than the total percentage of costs that the Fund would have paid had this Plan been the primary plan. Remember that the Fund will not pay an amount that is greater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

Non-Dependent Of Dependent

The plan that covers the Eligible Person other than as a Dependent, for example as an employee, member, subscriber, policyholder, or Retiree, is the primary plan and the plan that covers the person as a Dependent is the secondary plan.

Dependent Child Covered Under More Than One Plan

- (a) Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:
 - » For a Dependent child whose Parents are married or are living together, whether or not they have ever been married:
 - The plan of the Parent whose birthday falls earlier in the Calendar Year is the primary plan; or
 - If both Parents have the same birthday, the plan that has covered the Parent longest is the primary plan.
- (b) For a Dependent child whose Parents are divorced or separated or are not living together, whether or not they have ever been married:
 - » If a court decree states that one of the Parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that Parent has actual knowledge of those terms, that plan is primary. If the Parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that Parent's spouse does, that Parent's spouse's plan is the primary plan (i.e., the step-Parent's plan). This item will not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
 - » If a court decree states that both Parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions set forth in paragraph (a) shall determine the order of benefits;
 - » If a court decree states that the Parents have joint custody without specifying that one Parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions in paragraph (a) above shall determine the order of benefits; or
 - » If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
 - The plan covering the Custodial Parent;
 - The plan covering the Custodial Parent's spouse;
 - The plan covering the Non-Custodial Parent; and then
 - The plan covering the Non-Custodial Parent's spouse.
 - » The order of benefits determined by court decree in paragraphs (a) and (b) shall will apply even after the Dependent child reaches the age of eighteen or the court decree expires.
- (c) For a Dependent child covered under more than one plan of individuals who are not the Parents of the child, the order of benefits shall be determined, as applicable, under paragraph (a) or (b) as if those individuals were the Parents of the child.
- (d) For a Dependent child who has coverage under either or both Parents' plans and also has his or her own coverage as a Dependent under a spouse's plan:



The rule in “Longer or Shorter Length of Coverage” below applies.

- » In the event the Dependent child’s coverage under the spouse’s plan began on the same date as the Dependent child’s coverage under either or both Parents’ plans, the order of benefits shall be determined by applying the rule in paragraph (a) to the Dependent child’s Parent(s) and the Dependent’s spouse.

Active Employee Or Retired Or Laid-Off Employee

- (a) The plan that covers an Eligible Person as an Active employee that is, an employee who is neither laid off nor Retired or as a Dependent of an Active employee is the primary plan. The plan covering that same Eligible Person as a Retired or laid-off employee or as a Dependent of a Retired or laid-off employee is the secondary plan.
- (b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the prior rule in “Non-Dependent of Dependent” can determine the order of benefits.

COBRA Or State Continuation Coverage

- (a) If a Eligible Person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the Eligible Person as an 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 plan covering that same Eligible Person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
- (b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the rule in “Non-Dependent of Dependent” can determine the order of benefits.

Longer Or Shorter Length Of Coverage

- (a) If the preceding rules do not determine the order of benefits, the plan that covered the Eligible Person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
- (b) To determine the length of time an Eligible Person has been covered under a plan, two successive plans shall be treated as one if the Eligible Person was eligible under the second plan within 24 hours after coverage under the first plan ended.
- (c) The start of a new plan does not include:
 - » A change in the amount or scope of a plan’s benefits;
 - » A change in the entity that pays, provides or administers the plan’s benefits; or

- » A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

- (d) The Eligible Person’s length of time covered under a plan is measured from the Eligible Person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the Eligible Person first became a member of the group shall be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

No Other Rule Applies

If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

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:

- **Part A:** Primarily covers Hospital and facility benefits, although it also provides other benefits.
- **Part B:** Primarily covers Physician’s services and outpatient care, although it covers a number of other items and services.
- **Part C:** Private health insurance company policies that provide coverage similar to Medicare Parts A and B.
- **Part D: Prescription drug coverage.** 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 and B.

Typically, you become Eligible for Medicare upon reaching age 65. If you are Retired, you will be enrolled in the Medicare Advantage Plan. Even if you do not choose to retire and do not begin receiving Social Security 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.

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).

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

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

amounts specified on the **Summary of Benefits** insert (in the front pocket of this SPD). 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.

- **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” below). However, when this Plan is secondary to Medicare as a result of Active coverage (not Retiree coverage), Plan benefits will not exceed the total percentage of costs that the Fund would have paid had this Plan been the primary plan. In any event, the Fund will not pay an amount that is greater than, when added to other amounts paid or payable, the actual expenses incurred.

How The Plan Coordinates Benefits With Medicare

In limited situations such as ESRD, 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 front pocket of this SPD). For other Covered Expenses, you pay a percentage (as listed on the **Summary of Benefits** insert) of the total Medicare-approved amount. Medicare pays a certain percentage, and then the Fund pays a portion of 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 charges 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

Chris is Hospitalized for ESRD and Medicare is primary. His Hospital and Physician charges are both covered under Medicare and the Plan. Here’s how benefits would be coordinated.

Chris’s Hospital Covered Expenses:	\$10,000.00
Medicare pays:	- \$8,324.00
Medicare Part A Deductible Chris is responsible for paying:	\$1,676.00
Fund pays (95%):	- \$1,592.20
Chris pays:	\$83.80
Chris’s Physician Medicare-approved Covered Expenses:	\$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.

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 65). The Fund may agree to make advance payment for any such claims, but only 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:** 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:** 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 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 reasonable attorney's fees and expenses you paid to obtain the Recovery.
- The Reimbursement Agreement gives the Fund a lien—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, provide requested documentation, 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, including but not limited to, liability for future medical or loss of time claims;
 - » Must obtain the Plan's consent before entering into a compromise, limited compromise, or settlement agreement that in any way relates to the Plan's claim and lien, this includes any agreement that purports to hold you harmless for the Fund's lien; and
 - » Must not interfere with the Plan's claim and lien.

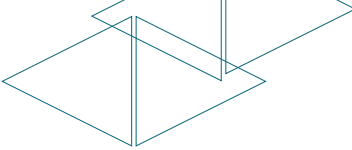
If you attempt to assign your right to Recovery of benefits, the Fund may take you to court, along with Another Person or Entity to which you assigned your rights, to cancel your assignment and recover the benefits paid by the Plan.

- 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, administrative or arbitration, 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 and all 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 Reimbursement 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 "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, but not the obligation, to intervene and participate in any legal action you bring against an Other Source. Even if the Fund does not participate in a legal action brought by you against an Other Source, the Fund's right of Recovery, claim, lien, and constructive trust will be unaffected.
- 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 fail or refuse to take legal action against an Other Source within a reasonable time, the Fund may reduce 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 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, or fail or refuse to take legal action against 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, 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 for 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;
 - » The allocation of damages in any award, judgment, or settlement; 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.

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.

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.

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

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 the 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

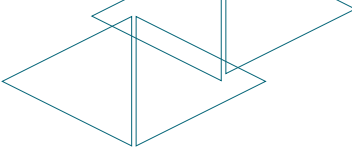
All records for the Fund are kept on a Plan Year basis. The Plan Year starts on June 1 and ends on May 31.

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 website below:

Operating Engineers Local 139 Health Benefit Fund
N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160
(262) 549-9190 or (800) 242-7018
www.iuoe139healthfund.org



Board Of Trustees

The current Trustees are:

Union Trustees	Employer Trustees
<p>Steven Buffalo Operating Engineers Local 139 Health Benefit Fund P.O. Box 160 Pewaukee, WI 53072-0160</p>	<p>Derek Allen AGC Of Wisconsin, Inc. 4814 E. Broadway Madison, WI 53716</p>
<p>Mary Jane DeBattista Operating Engineers Local 139 Health Benefit Fund P.O. Box 160 Pewaukee, WI 53072-0160</p>	<p>Jakob Anderson Super Excavators N59 W14601 Bobolink Avenue Menomonee Falls, WI 53051</p>
<p>Shane Griesbach Operating Engineers Local 139 Health Benefit Fund P.O. Box 160 Pewaukee, WI 53072-0160</p>	<p>Matt Marcellis Allied Construction Employers Association, Inc. 11001 W. Plank Court Wauwatosa, WI 53226</p>
<p>Terrance E. McGowan Operating Engineers Local 139 Health Benefit Fund P.O. Box 160 Pewaukee, WI 53072-0160</p>	<p>Tim Peterson James Peterson Sons, Inc. N2251 Gibson Drive Medford, WI 54451</p>
<p>Daniel Sperberg Operating Engineers Local 139 Health Benefit Fund P.O. Box 160 Pewaukee, WI 53072-0160</p>	<p>Phil Purpero C.W. Purpero, Inc. 7030 South 13th Street Oak Creek, WI 53154</p>

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 **Summary of Benefits** insert (in the front pocket of this SPD).

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

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
(262) 549-9190 or (800) 242-7018
www.iuoe139healthfund.org

The office is open Monday – Friday, 8:00 a.m. – 4:30 p.m.

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 Employer including addresses, is available for review at 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 *Summary of Benefits* insert in the front pocket of this SPD for contact 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

Death and Accidental Death and Dismemberment benefits are insured through Voya/ReliaStar Life,. The policy number is 73127-7. Voya Life Claims, PO Box 1548, Minneapolis, MN 55440.

All other benefits in this SPD 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 SPD.

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 have, at your own expense, 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.

ERISA Rights And Privacy Policy

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 concerning 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 the United States District Court for the Eastern District of Wisconsin. 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 the United States District Court for the Eastern District of Wisconsin. 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 the United States District Court for the Eastern District of Wisconsin. 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.

Privacy Policy

The Fund is required to protect the confidentiality of your private health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

You can find a complete description of your rights under HIPAA in the Plan's Privacy Notice. A copy of the Notice is available on the Fund's website: www.iuoe139healthfund.org.

Glossary

Terms defined in this glossary are capitalized throughout this SPD.

Accident or **Accidental Injury** is an immediate unforeseen event caused by external trauma to the body.

Acute Rehabilitation Facility is a facility that provides 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. For Protected Services, the Allowable Charge shall be the amount determined under the No Surprises Act, to the extent required by applicable law.

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.

Continuing Care Patient means an individual who, with respect to a provider or facility:

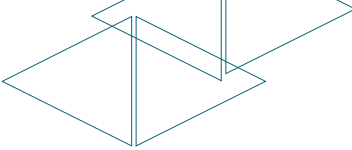
- Is undergoing a course of treatment for a serious and

complex condition from the provider or facility, with "serious and complex condition" meaning (1) in the case of an acute Illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic Illness or condition, a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time;

- Is undergoing a course of institutional or Inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be Terminally Ill and is receiving treatment for such Illness from such provider or facility.

Continuing Care Services means items and services provided in accordance with the following:

- In the case of an Eligible Person, and with respect to a provider or facility that has a contractual relationship with the Plan for furnishing items and services under the Plan (including a PPO provider or PPO facility), if, while such Eligible Person is a Continuing Care Patient with respect to such provider or facility: (1) such contractual relationship is terminated; (2) benefits provided under the Plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility; or (3) a contract between the Plan and a health insurance issuer offering health insurance coverage in connection with the Plan is terminated, resulting in a loss of benefits provided under the Plan with respect to such provider or facility; the Plan will meet the following requirements with respect to such Eligible Person:
 - » Notify each Eligible Person who is a Continuing Care Patient with respect to such a provider or facility of the termination and the individual's right to elect continued transitional care from such provider or facility;
 - » Provide the Eligible Person with an opportunity to notify the Plan of the Eligible Person's need for transitional care; and
 - » Permit the Eligible Person to elect to continue to have benefits provided under the Plan, under the same terms and conditions as would have applied, and with respect to such items and services as would have been covered under the Plan, had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a Continuing Care Patient during the period beginning on the date on which the Plan's notice of the termination is provided and ending on the earlier of the 90-day period, beginning on such date or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.



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.

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.

Custodial Parent means:

- The Parent awarded custody of a Dependent child by a court decree; or
- In the absence of a court decree, the Parent with whom the Dependent child resides more than one half of the Calendar Year without regard to any temporary visitation.

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** are 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, who is your natural-born child, adopted child, a child placed with you for adoption, or your stepchild, until the end of the month in which the child turns age 26;
- 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; 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.

If your unmarried child for whom you have been appointed legal guardian 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; and
- The guardianship or other court order is in effect.

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.

Generally, 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.

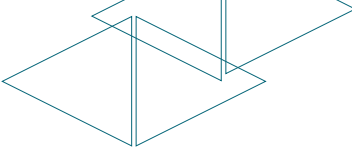
Eligible Person is either the eligible employee or the eligible Dependent.

Emergency Medical Condition means a condition, including a mental health condition, where a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the

individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs, or parts.

Emergency Service means, in general, certain medical services which are acutely needed to address severe pain or a life-threatening condition. Specifically, the term means, with respect to an Emergency Medical Condition:

- a. A medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital (as determined under the No Surprises Act) or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
 - b. Within the capabilities of the staff and facilities available at the Hospital (as determined under the No Surprises Act) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).
 - c. Subject to the exception described in subsection d. below, if an Eligible Person is furnished the services in subsections a. or b. Above with respect to an Emergency Medical Condition the term Emergency Services will also include items and services that the Plan would cover if furnished by an in-network provider, which are furnished by an out-of-network provider (regardless of the department of the Hospital (as determined under the No Surprises Act) in which such items and services are furnished) after the Eligible Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services described in subsections a. and b. above are furnished (for purposes of this definition, these items and services are "Post-Stabilization Services").
- Post-Stabilization Services will not be considered Emergency Services if all of the following conditions are met:
 - » The attending emergency Physician or treating provider determines the Eligible Person is able to travel using non-medical transportation or nonemergency medical transportation to an available PPO provider or PPO facility located within a reasonable travel distance, taking into account the individual's medical condition;
 - » The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of Public Health Service Act section 2799B-2(d) and its implementing regulations with respect to such items and services;
 - » The Eligible Person (or a person authorized by law to



provide consent on behalf of the Eligible Person) is in a condition to receive the information described in such notice and to provide informed consent; and

- » The provider satisfies any additional requirements or prohibitions imposed under state law.

Employer means: 1) Employer who is a member of, or is represented in collective bargaining by, an Employer Association and who is bound by a collective bargaining agreement (CBA) with the Union; 2) an Employer who is not represented by an Employer Association but who has entered into a CBA with the Union; 3) the Union; 4) the Fund or a peripheral fund; 5) the Fund Administrator; and/or 6) any Employer that has signed a participation agreement with the Fund.

Employer Association means: 1) Wisconsin Transportation Employers Council; 2) Associated General Contractors Association, Inc.; 3) Wisconsin Underground Contractors Association, Inc.; 4) Allied Construction Employers Association, Inc.; and/or 5) Associated Earth Movers, Inc.

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

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.

and submit a completed Enrollment Form and documentation proving Dependent status within 30 days (60 days for newborn children) of the date you acquire an eligible Dependent, your Dependent's coverage will not begin until the first day of the Eligibility Quarter when the Enrollment Form and any required documents are received by the Fund Office. No benefits will be processed or paid 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.

ERISA means the Employee Retirement Income Security Act of 1974

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)

- 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.
- For the purpose of mental health or substance abuse 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 for the Participant and their Spouse regardless of the existence of an underlying medical condition but are only covered for Dependent children when Medically Necessary to treat an underlying medical condition.

Independent Freestanding Emergency Department

means a health care facility that provides Emergency Services and is geographically separate and distinct from a Hospital, and separately licensed as such by a state, even if the facility is not licensed under the term "Independent Freestanding Emergency Department."

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 330 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.

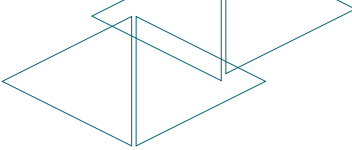
Lifetime is in reference to benefit maximums and limitations while covered under the Fund. Lifetime does **not** mean "during the Lifetime of the covered Participant."

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.

Non-Custodial Parent means:

- The Parent who was not awarded custody of a Dependent child by a court decree; or
- In the absence of a court decree, the Parent with whom the Dependent child does not reside more than one half of the Calendar Year without regard to any temporary visitation.

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.

Optional Ancillary Benefits means the dental (Preventive Care and Restorative Procedures only), vision, and death and dismemberment benefits described in pages 56-58, 59-60, and 63-64, respectively.

Oral Surgery includes surgical removal of teeth or multiple extractions, removal of impacted teeth, bone or soft tissue grafts, alveolectomy, gingivectomy, apicoectomy, torus palatines, torus mandibulosis, frenectomy, excision of cysts, osteoplasty, and stomatoplasty.

Other Group Plan is any plan, policy, contract, or other arrangement for benefits or services that provides Minimum

Essential Coverage (i.e., medical, dental, vision, or hearing benefits), treatment or healing under:

- Benefit programs provided by an Employer;
- Group insurance;
- Group practice, BlueCross/BlueShield, individual practice, or other prepayment coverage;
- Health Maintenance Organizations;
- Labor-management trustee, 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.

Parent means the biological or legally adopted Parent of a child.

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/Retirees** – early Retirees (under age 65), regular Retirees (age 65 or older), surviving spouses, and totally and permanently Disabled Participants
- **COBRA Continuation Coverage Participants** – 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 61 for more information.

Physical Therapy or **Occupational Therapy** is therapy provided by a registered Physical Therapist, Occupational Therapist, or registered or state-licensed Physical 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.

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, chiroprodists, podiatrists, Optometrists, licensed clinical psychologists, psychiatrists, Dentists, dental surgeons, and approved Christian Science practitioners.

Plan Administrator is the Board of Trustees who has been designated as the Plan Administrator by the Plan Sponsor and who has the responsibility for overall Plan Administration.

Plan Sponsor is the Board of Trustees of the Operating Engineers Local 139 Health and Welfare Fund.

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
- 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.** Any of the Hospitals contracted with the Trustees directly or through their agents from time to time and that are named in this SPD
- **Preferred Provider Pharmacy.** Any of the pharmacies contracted with the Trustees directly or through their agents from time to time and that are named in this SPD.

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. Note: 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.

Prescriptions also include the following diabetic supplies provided on the written order of a legally qualified Physician or surgeon:

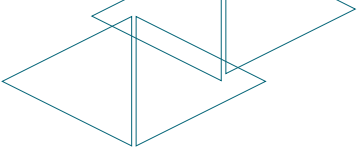
- Acetone test tablets
- Benedict's solution or equivalent
- Insulin
- Insulin syringe
- Needles
- Sugar test tablets
- Sugar test tape
- Swabs and alcohol wipes.

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.

Protected Services means each of the following:

- Emergency Services furnished by an out-of-network provider;
- Air ambulance services furnished by an out-of-network provider, if the Plan provides or covers any benefits for air ambulance services; or
- Items and services (other than Emergency Services) furnished by an out-of-network provider with respect to a visit at an in-network Hospital, Hospital outpatient department, critical access Hospital, or Ambulatory Surgical Center, if such items and services would be covered by the Plan if furnished by an in-network provider (an "NSA-Covered Facility Claim"). For the purposes of such an NSACovered Facility Claim, a "visit" includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the out-of-network provider furnishing such items or services is physically at the facility. However, the term "Protected Services" will not include these items and services if the out-of-network provider satisfies the notice and consent criteria of Public Health Service Act section 2799B-2(d) and its implementing regulations with respect to such items and services, and the Eligible Person consents to receive the items or services from the out-of-network provider.

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.

Union means the International Union of Operating Engineers, Local 139.

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 will 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. Out-of-network claims are not covered, subject to a few exceptions. Refer to the "Out-of-Network" section for details. For Protected Services furnished by an out-of-network provider, the Usual, Customary, and Reasonable amount is based on an amount required under the No Surprises Act (a federal law). Continuing Care Services are also paid at a similar level, as required by applicable law.

"Minimum Essential Coverage" is health insurance that meets the requirements of the Affordable Care Act (ACA). Primarily, it refers to comprehensive coverage. Therefore, an individual who has limited benefits (for example, coverage for only preventive care) does not have Minimum Essential Coverage.

