Summary Plan Description

International Union of Operating Engineers
Local 825 Welfare Plan
Effective July 1, 2023

Operating Engineers Local 825 Welfare Fund

Summary Plan Description

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INTRODUCTION

General Information

This book, called the "Summary Plan Description" ("SPD"), describes the current health and welfare benefits available to you and your eligible dependents as of July 1, 2023 under the Operating Engineers Local 825 Welfare Fund (the "Fund" or "Plan"). We urge you to read this book carefully and share it with your family members.

This SPD provides a summary of your health and welfare benefits. Additional details about your benefits are also contained in the other official Plan Documents, which legally govern the operation of the Plan. If there is ever a conflict between the information in this SPD and the applicable insurance policies or other official Plan Documents, the terms of the insurance policies or other official Plan Documents, whichever is applicable, shall control in all cases.

Additionally, please note that the Trustees reserve the right, within their sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of this Plan (including without limitation any benefits to retirees, related Plan Documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized agent(s) of the Trustees.

The Operating Engineers Local 825 Welfare Fund is the result of collective bargaining agreements between the International Union of Operating Engineers Local 825 (the "Union") and certain employers and employer associations.

A plan of benefits (the "Plan") is administered by a board of trustees (the "Trustees") comprised of persons appointed by the Union and certain employer associations. This booklet called a Summary Plan Description ("SPD") sets out the benefits under the Plan. The Plan's purpose is to provide benefits which help you pay certain costs of health care incurred by you and your eligible dependents, including costs for medical, surgical, hospital, prescription drugs, dental and vision care. The Plan also provides certain life insurance benefits and disability benefits for you. Your eligibility under the Plan is based upon fringe benefit contributions paid by your employers that are parties to collective bargaining agreements with the Union and self-payments as outlined in the SPD.

The Plan is a self-funded welfare plan, within the meaning of section 3(1) of the Employee Retirement Income Security Act (ERISA). As such, the Plan is governed by the rules set forth in ERISA and by the regulations issued thereunder by the U.S. Department of Labor. Please note the Plan is exempt from complying with state laws governing health insurance, including laws mandating coverage for specific health insurance benefits and laws granting individuals the right to appeal final decisions to reduce or deny treatment for a covered health care service to an independent entity.

This SPD sets forth the benefits available under the Plan. While these benefits are quite broad, there are limitations and exclusions in coverage, such as where workers' compensation or automobile insurance is available. In addition, the Plan coordinates its benefits with coverage provided by other insurance, such as where Medicare or a spouse's group plan is available. As a result, you should take time to read this SPD carefully.

Claim Information

Shortly after you are enrolled in the Welfare Plan, you will receive several identification cards containing important information about your coverage under the Plan such as where to submit claims for reimbursement and telephone numbers for assistance. When visiting a healthcare provider (physician, hospital, dentist, optometrist, pharmacy), you must present the proper identification card. If you use a network provider, the provider is responsible for filing claims on your behalf. Any copayments are typically due at the time services are received. If you use an out-of-network provider, you may have to pay the provider's charge at the time services are received and then file a claim for reimbursement.

Whether a claim is filed on your behalf or by you, only clean claims will be processed for payment. A clean claim is a claim that includes complete and accurate information to allow for processing in accordance with the Plan including, but not limited to, itemized charges with CPT codes (uniform identification codes for reporting medical procedures and services), diagnoses codes, and insured's identification number. Submission of receipts, cancelled checks, and/or bills indicating balance forward is not acceptable. A single claim cannot include services for more than one individual. All claims must be submitted within 12 months after the date services are rendered to be considered for payment.

The Fund may require you or your dependent to furnish any information or proof reasonably required to determine entitlement to benefits under the Plan. The Fund shall have the right to recover any benefit payments improperly or mistakenly made in reliance on any incorrect, false or fraudulent statement, information or proof submitted by a claimant. The Fund may recover the amounts of such improper or mistaken benefit payments by any legal available means, including withholding all or some portion of any other benefits claimed by you or your dependent until the Fund is fully reimbursed. Alternatively, the Fund shall have the right to seek repayment directly from you and may protect its rights and recover such improper or mistaken benefit payments through court action.

In order to avoid delay in the payment of a benefit, you must make sure that information on your status is kept up to date in the Fund Office. Any change in marital status, dependents, name or address must be reported promptly. Your life insurance benefit is payable to your last named beneficiary.

In the case of a claim involving urgent care, as defined below, you or your representative may submit a request for an expedited determination. Such request may be made orally or in writing. In such a case, all information, including the Fund's benefit determination, may be transmitted between the Fund and you or your representative by telephone, facsimile, or other similarly expeditious method. A claim involving "urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could jeopardize your life or your ability to regain maximum function, or, (b) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.

In the event that you or your representative makes a benefit request in connection with a preservice claim that fails to comply with the requirements of the Fund's procedures for making a claim, the Plan Administrator shall notify you or your representative of such failure and of the Fund's procedures for filing a claim. The Plan Administrator shall provide this notification within a reasonable period of time appropriate to the circumstances, taking into account any pertinent medical exigencies, not to exceed 5 calendar days (24 hours in the case of a benefit request involving urgent care, i.e., treatment in process,) following receipt of the benefit request by the Fund.

As used herein, a preservice claim is a claim which involves a request for approval of a benefit for which receipt of such benefit, in whole or in part, is dependent upon approval of the Plan in advance of obtaining medical care; and a post-service claim is a claim which involves a request for reimbursement of costs for medical care that has already been provided.

The Plan's internal claims and appeals procedures are designed to provide you with full, fair, and fast claim review, as well as to ensure that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative, bypassing the need for completion of the Plan's written authorized representative form.

As part of the internal appeals process, the Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with a denied claim. Such evidence 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) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the 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) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process has been exhausted. You will be provided with written notice of an appeal determination which will include an explanation of the external review process, along with any time limits and information about how to initiate a request for an external review.

All notices relating to external review sent will contain a notice about the availability of Spanish, Chinese, Tagalog, Korean, Portuguese, Gujarati, Polish, Italian, Arabic, French Creole, Hindi Vietnamese, French, Urdu, Yiddish, Bengali, Greek and Albanian language services. Assistance with filing a claim for external review in any of the above languages is available by calling (973) 671-6800. Notices relating to external review will be provided in the above languages upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al (973) 671-6800 .

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (973) 671-6800.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (973) 671-6800

KOREAN (한국어): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (973) 671-6800번으로 전화해 주십시오.

PORTUGESE (Português): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (973) 671-6800.

GUJARATI (ગુજરાતી): **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** (973) 671-6800.

POLISH (Polski): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (973) 671-6800.

ITALIAN (Italiano): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (973) 671-6800.

ARABIC (العربية): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- (973) 671-6800.

FRENCH CREOLE (Kreyòl Ayisyen): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (973) 671-6800.

HINDI (हिंदी): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (973) 671-6800 पर कॉल करें।

VIETNAMESE (Tiếng Việt): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (973) 671-6800.

FRENCH (Français): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (973) 671-6800.

URDU (اُردُو): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں (973) 671-6800.

YIDDISH (אידיש): אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (973) 671-6800.

BENGALI (বাংলা): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-(973) 671-6800

GREEK (λληνικά): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (973) 671-6800.

ALBANIAN (Shqip): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (973) 671-6800.

Claim Determination

In the case of a claim involving urgent care, the Plan Administrator shall notify you or your representative of the Fund's benefit determination as soon as possible, taking into account the medical exigencies of the case, after receipt of the claim by the Fund, but not later than 72 hours after receipt of the claim by the Fund, unless you or your representative fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Fund. In the case of such a failure, the Plan Administrator shall notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Fund, of the specific information necessary to complete the claim. You shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator shall notify you of the Fund's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: the Fund's receipt of the specified information, or the end of the period afforded to you to provide the specified additional information.

In the case of a claim that does not involve urgent care, the Plan Administrator shall notify you of the Fund's benefit determination within a reasonable period of time appropriate to the circumstances, taking into account any pertinent medical circumstances, but not later than 15 calendar days after receipt of a preservice claim or 30 calendar days after receipt of a post-service claim by the Fund, unless the Plan Administrator determines that an extension of the period for the Fund's benefit determination is necessary for reasons beyond the control of the Plan, or if you or your representative fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Fund, in which case the period for notifying you of the Fund's benefit determination may be extended for a period not to exceed 15 days after expiration of the relevant period applicable to the Fund's initial benefit determination (15 calendar days for preservice claims or 30 calendar days for post-service claims). You shall receive written notice of any extension indicating the circumstances requiring an extension and the date by which a decision is expected to be rendered or specific information necessary to complete your claim prior to expiration of the relevant period applicable to the Fund's initial benefit determination (15 calendar days for preservice claims or 30 calendar days for post-service claims). For incomplete claims, you shall be afforded not less than 45 days after receipt of notice to furnish the specified information to the Fund. You shall be notified of the Fund's benefit determination within a reasonable period of time, but in no event later than 15 days after the Fund's receipt of the specified additional information.

For ongoing treatment covering a period of time or a number of treatments, notice of a reduction or termination (other than by Plan amendment or termination) of previously approved benefits shall be provided you or your representative sufficiently in advance of such reduction or termination to allow you or your representative to appeal and obtain a determination on review before such reduction or termination takes effect.

If you or your representative make a request to extend a course of treatment beyond an initially prescribed period of time or number of treatments for a claim involving urgent care, the Plan Administrator shall notify you of the Fund's benefit determination as soon as possible, taking into account the medical exigencies of the case, after receipt of the claim by the Fund, but not later than 24 hours after receipt of the claim by the Fund, provided that such claim is made to the Fund at least 24 hours prior to the expiration of the initially prescribed period of time or number of treatments.

Review of Adverse Benefit Determination

In the event an adverse benefit determination is made with respect to your claim, written notice regarding such determination shall set forth specific reason(s) for the denial, specific provisions of the Plan on which the determination is based, a description of any additional material or information needed to perfect the claim and an explanation of why such material or information is necessary, and a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following an adverse benefit determination on review. This notice shall also include any internal rule, guideline, protocol, or other similar criterion or, in the case of an adverse benefit determination based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon in making the determination, or a statement that such a rule, guideline, protocol, or other similar criterion or explanation of scientific or clinical judgment will be provided free of charge to you upon request.

The Fund has established a procedure to provide you with a reasonable opportunity to appeal a denied claim. Within 180 calendar days after you receive notice of denial, you must make a written request to the Plan Administrator to have the Board of Trustees review your claim. Upon request and free of charge, you will be provided reasonable access to, and copies of, documents and other information relevant to your claim and be apprised of the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether such documents and other information or advice were relied upon in making the determination. You may also submit any additional written comments, documents and other information for the Board of Trustees to consider. The Board of Trustees or a Review Committee comprised of members of the Board will look at the claim as if it is being originally submitted, and will not simply defer or ratify the initial denial of your claim. All comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination, will be taken into account. The object of the review procedure is to provide a fair and complete review of all information concerning the claim.

In deciding appeals of any denial of a claim involving a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be independent of any health care professional who participated in the initial denial of the claim.

In the case of a denied claim involving urgent care you may request an expedited appeal of the denial of your claim, and such request may be submitted orally or in writing. In such a case, all necessary information including the Fund's benefit determination on review may be transmitted between you and the Fund by telephone, facsimile or other available similarly expeditious method.

The Trustees shall make a benefit determination on review within a reasonable period of time appropriate to the circumstances, taking into account any pertinent medical circumstances, but not later than 30 calendar days after receipt by the Fund of your request for review of the initial denial of a preservice claim or the date of the meeting of the Board of Trustees that immediately follows receipt of your request for review of the initial denial of a post-service claim, unless your request is filed within 30 calendar days preceding the date of such meeting. In such case, the Trustees' benefit determination shall be made no later than the date of the second meeting following receipt of your request for review. The Plan Administrator shall notify you of the Trustees' benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

If your claim involves urgent care, the Trustees shall make a benefit determination on review as soon as possible, taking into account the medical exigencies of the case, after receipt by the Fund of the request for review, but not later than 72 hours after receipt of your request for review of the initial denial of your claim.

Notice of an adverse benefit determination on review shall set forth specific reason(s) for the denial, specific provisions of the Plan on which the determination is based, any internal rule, guideline, protocol, or other similar criterion or, in the case of an adverse benefit determination based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon in making the determination, or a statement that such a rule, guideline, protocol or other similar criterion or explanation of scientific or clinical judgment will be provided free of charge to you upon request, and your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents and other information relevant to your claim, regardless of whether such documents or other information were relied upon in making the determination. This notice will also contain a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Following the exhaustion of your right to the review of a denial of your claim, you have the right to initiate a civil action under section 502(a) of ERISA.

ELIGIBILITY

Introduction

In order to become eligible for benefits under the Plan, you must work for an employer required to make contributions to the Fund on your behalf pursuant to a collective bargaining agreement or participation agreement.

Whether employed under an outside construction contract or a shop contract, there are four levels of benefit coverage for which a participant can become eligible. These levels provide the benefits shown in the chart below.

LEVEL OF BENEFIT PROGRAM

Level 1	Life insurance benefits, survivor benefits, accidental death and dismemberment, inpatient hospital, outpatient pre-admission testing, outpatient emergency room, in-network outpatient surgicenter, convalescent care, ambulance, home health care, hospice care, surgical, anesthesia, doctor visits, X-ray and laboratory, maternity, EAP, mental health, substance abuse, cancer medications, diabetic supplies, chiropractor, podiatrist, Medicare
Level 2	Includes all benefits in Level 1 plus vision and accident and sickness
Level 3	Includes all benefits in Levels 1 & 2 plus Dental
Level 4	Includes all benefits in Levels 1, 2, & 3 plus Prescription Drugs

Eligibility and Termination

Your initial and continued eligibility for benefits as well as your eligibility termination are determined by the collective bargaining agreement or participation agreement under which you are employed.

Basic Eligibility

Employees Working Under Construction Contracts and Shop Contracts (Quarterly Eligibility)

Your eligibility is determined by the amount of fringe benefit contributions paid by your employer(s) on your behalf. However, you do not become eligible upon the initial date of your employment. There is a three-month lag between the date contributions are earned and the date you become eligible for benefits.

Eligibility for the current year:	Is based upon contributions for periods worked in:
January, February, and March	July, August and September of the previous year
April, May and June	October, November and December of the previous year
July, August and September	January, February and March of the current year
October, November and December	April, May and June of the current year

Though a three-month lag applies to your eligibility based upon contributions from an employer, you may voluntarily purchase coverage starting at the beginning of the second month following the date on which employer contributions initially are received on your behalf. This allows you to participate in the Plan shortly after you begin working for a contributing employer.

If employer contributions made on your behalf are insufficient for any one of the four levels of benefit coverage, you may purchase coverage, thereby making you and your dependents eligible for a particular level. On a quarterly basis, you will receive a statement indicating the level of benefit coverage, if any, for which you are eligible. If employer contributions are insufficient for one or more levels of benefit coverage, your statement will indicate amounts necessary for coverage under these levels. Should you elect not to upgrade your level of benefit coverage, any contributions in excess of the cost of the current level of benefit coverage at which you remain will be carried forward to the next calendar quarter's benefit.

If contributions received on your behalf in a calendar quarter exceed the amount required for Level 4 coverage, this excess will be carried forward for the next calendar quarter's benefit to a maximum of four quarters. Note, however, that you will not be able to use any carried forward contributions if you leave the industry.

Employees Working Under Shop Contracts (Monthly Eligibility with Coverage Commencing First of the Month Following Contribution Receipt)

Your eligibility is determined based upon contributions received on your behalf from employers with contracts requiring contributions to be made on a monthly basis. Eligibility will commence on the first of the month following the initial month employer contributions are received on your behalf. On a monthly basis, you will receive a statement indicating the level of benefit coverage, if any, for which you are eligible. If employer contributions are insufficient for one or more levels of benefit coverage, your statement will include amounts necessary for coverage under these levels. Your self-payment must be received by the Fund Office by the fifth (5th) day of the current eligibility month. Should you elect not to upgrade your level of benefit coverage, any contributions in excess of the cost of the current level of benefit coverage at which you remain will be carried forward to the next month's benefit.

If contributions received on your behalf in a month exceed the amount required for Level 4 coverage, this excess will be carried forward for the next month's benefit to a maximum of 12

months. Note, however, that you will not be able to use any carried forward contributions if you leave the industry.

Employees Working Under Shop Contracts (Monthly Eligibility with Coverage Commencing First of the Third Month Following Contribution Receipt)

Your eligibility is determined based upon contributions received on your behalf from employers with contracts requiring contributions to be made on a monthly basis. Eligibility will commence on the first of the third month following the initial month employer contributions are received on your behalf. On a monthly basis, you will receive a statement indicating the level of benefit coverage, if any, for which you are eligible. If employer contributions are insufficient for one or more levels of benefit coverage, your statement will include amounts necessary for coverage under these levels. Your self-payment must be received by the Fund Office by the fifth (5th) day of the current eligibility month. Should you elect not to upgrade your level of benefit coverage, any contributions in excess of the cost of the current level of benefit coverage at which you remain will be carried forward to the next month's benefit.

If contributions received on your behalf in a month exceed the amount required for Level 4 coverage, this excess will be carried forward for the next month's benefit to a maximum of 12 months. Note, however, that you will not be able to use any carried forward contributions if you leave the industry.

Reduction, Delay or Loss of Benefits

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in the previous sections, but your benefits will also be affected if:

- You or your beneficiary do not file a claim for benefits properly or on time.
- You or your beneficiary do not furnish the information required to complete or verify a claim.
- You or your beneficiary do not have your current address on file with the Fund Office.

You should also be aware that Fund benefits are not payable for enrolled dependents who become ineligible due to age or divorce (unless they elect and pay for COBRA benefits as described in the *Continuation of Coverage* section of this SPD).

If the Welfare Fund mistakenly pays a larger benefit that you are not eligible for or pays benefits that were not authorized by the Plan, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error.

Information You or Your Dependents Must Furnish to the Plan

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan.

Failure to give this Plan a timely notice (as noted above) may cause your spouse and/or dependent child(ren) to lose their right to obtain COBRA continuation coverage, or may cause the coverage of a dependent child to end when it otherwise might continue because of a disability, or may cause claims to not be considered for payment until eligibility issues have been resolved, or may result in

a Participant's liability to the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the Participant's future medical, dental and vision benefits.

Continuation of Coverage

Certain events may cause you and/or your dependents to lose coverage. Depending upon the nature of the event, you may be entitled to purchase continued coverage from the Fund in accordance with the Level of Benefit Buy-In Provision, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

The circumstances under which you may purchase continued coverage and your rights and obligations in connection with such purchase are described in this section.

Level of Benefit Buy-In Provision

If your employment is terminated for reasons other than your decision to leave the industry, or if employer contributions made on your behalf are insufficient to purchase even Level 1 benefits under the Plan, any excess contributions received on your behalf will be exhausted as described above. If you have no carry forward contributions, or upon exhaustion of such carry forward contributions, you have the option of purchasing any of the levels of benefit coverage described above on a quarterly basis for a maximum of four calendar quarters (Quarterly Eligibility) or on a monthly basis for a maximum of 12 months (Monthly Eligibility).

As is mentioned above, if you leave the industry, you will not be able to use any of your excess contributions carried forward. You will not be entitled to continued coverage under this Buy-In Provision. However, you may be entitled to continued coverage through COBRA.

When your employment is terminated other than for your gross misconduct, or when you experience a reduction of hours which results in employer contributions insufficient to purchase any benefits under the Plan, at the time of such termination or reduction in hours you will have the option to purchase continuation coverage in accordance with COBRA, as described below.

COBRA Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The law provides that the Plan can charge up to 102 percent of the Plan's cost for individual or family coverage.

If you are a participant in the Plan by virtue of your employment, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of work in covered employment for which contributions are paid on your behalf are reduced to a level where you are no longer eligible for benefits or you are eligible for a reduced level of benefits; or

2. Your covered employment ends for any reason other than your gross misconduct.

If you are the spouse of a participant, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's hours of work in covered employment for which contributions are paid on his or her behalf are reduced to a level where he or she is no longer eligible for benefits or is eligible for a reduced level of benefits;

3. Your spouse's covered employment ends for any reason other than his or her gross misconduct; or

4. You become divorced from your spouse.

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

1. The parent-participant dies;

2. The parent-participant's hours of work in covered employment for which contributions are paid on his or her behalf are reduced to a level where he or she is no longer eligible for benefits or is eligible for a reduced level of benefits;

3. The parent-participant's employment ends for any reason other than his or her gross misconduct;

4. The parents become divorced; or

5. The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of covered employment or a reduction of hours in covered employment or the death of the participant, the participant's employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events. In order to facilitate COBRA administration and to avoid delay or oversight, the Plan requests that you or your family also notify the Plan Administrator promptly and in writing of the occurrence of any of these events.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Operating Engineers Local 825 Fund Service Facilities, Attention: COBRA Continuation Coverage, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event. The COBRA continuation coverage period will run from that date even if coverage under the Plan continues immediately after the qualifying event due to operation of other terms of the Plan (i.e., the run-out of your eligibility based upon employer contributions made to the Welfare Fund, the exhaustion of any carried forward excess contributions in accordance with the Plan, your self-purchase of coverage under the Plan's Level of Benefit Buy-In Provision, and your continuation of coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act). COBRA extends health benefits only and does not extend life insurance, accidental death and dismemberment, survivor, and supplemental accident and sickness benefits.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the participant, divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of covered employment or reduction of the participant's hours of employment, and the participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement. For example, if a participant becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of covered employment or reduction of the participant's hours of employment, COBRA continuation coverage lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. If the disability determination is made prior to the occurrence of a qualifying event, you must make sure that the Plan Administrator is notified within 60 days after the later of the date on which the qualifying event occurs or the date on which the qualified beneficiary would lose coverage under the Plan as a result of the qualifying event. Notice should be sent to: Operating Engineers Local 825 Fund Service Facilities, Attention: COBRA Continuation Coverage, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081.

The Fund may require you to pay a higher cost, up to 150 percent of the Fund's cost, for COBRA continuation coverage during the additional 11 months of a disability extension of coverage. You must notify the Plan Administrator within 30 calendar days if you are no longer disabled.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can obtain up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension is available to the spouse and dependent children receiving continuation coverage if the former participant dies or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child**. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.** This notice must be sent to: Operating Engineers Local 825 Fund Service Facilities, Attention: COBRA Continuation Coverage, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081.

COBRA Continuation Coverage Not Extended Due to Other Continuation of Coverage

Despite the occurrence of a qualifying event, you and/or your eligible dependents may have other rights to continued coverage under the terms of the Plan or by operation of law. Specifically, your coverage under the Plan may be continued until the run-out of your eligibility based upon employer contributions made to the Welfare Fund, the exhaustion of any carried forward excess contributions in accordance with the Plan, and your self-purchase of coverage under the Plan's Level of Benefit Buy-In Provision. Additionally, you may be entitled to continuation of coverage under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Please note that your entitlement to continued coverage under such Plan provisions and under USERRA runs concurrent with your entitlement to COBRA coverage, meaning that such other continuation of your coverage will not extend your entitlement to COBRA continuation coverage beyond the maximum periods of COBRA coverage described above.

Termination of COBRA Coverage

The law provides that COBRA coverage, if elected, will terminate for any of the following reasons:

1. The Plan ceases to provide group health coverage to any participants.

2. The premium for COBRA continuation coverage is not received by the Fund Office on a timely basis.

3. After the qualified beneficiary has elected to continue coverage, he or she initially becomes covered under any other group health plan.

4. After the qualified beneficiary has elected to continue coverage, he or she initially becomes entitled to Medicare benefits. Entitlement to Medicare benefits occurs upon the earlier of the effective date of enrollment in Part A or Part B.

5. COBRA coverage has been extended to 29 months due to a disability of you or a family member and you or your family member is deemed no longer disabled. Coverage will end the month that begins 30 calendar days after the date of the final determination that you are no longer disabled.

6. Upon the expiration of the maximum coverage period, as set forth above.

COBRA continuation coverage may be retroactively terminated for cause (i.e., fraudulent activity) on the same basis that the Plan terminates coverage of a similarly situated active participant for cause.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records, of any notices you send the Plan Administrator.

Health Insurance Marketplace

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage, including coverage through Medicaid or the Health Insurance Marketplace. To sign up for Marketplace coverage, visit www.HealthCare.gov or call 800-318-2596 (TTY: 855-889-4325). People in most states use www.HealthCare.gov to apply for and enroll in health coverage; if your state has its own Marketplace platform, you can find contact information here: www.HealthCare.gov/marketplace-in-your-state/. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period/. Note, you may apply for and, if eligible, enroll in Medicaid coverage at any time.

USERRA Coverage

If you are absent from work in covered employment by reason of your service in the Uniformed Services, you shall be entitled to elect continuation of coverage for yourself and your covered dependents in accordance with USERRA. The maximum period of continued coverage for you and your dependents under such an election shall be the lesser of (a) the 24-month period beginning on the date on which your absence from covered employment begins; or (b) the day after the date on which you are required under USERRA to apply for return to a position or employment and fail to do so. To avail yourself of USERRA continuation coverage, you must notify the Fund Office that you are leaving covered employment for military service. USERRA coverage provides the same health benefits available to a covered participant under the Plan.

If you elect to continue coverage under the Plan in accordance with USERRA, you will be required to pay up to 102 percent of the full premium under the Plan, except if you are on active duty for 30 days or less.

Your entitlement to USERRA continuation coverage is concurrent with your entitlement to COBRA continuation coverage, meaning that if you elect USERRA continuation coverage, at the expiration of your coverage under USERRA you will have no entitlement to continued coverage under COBRA (similarly, if you elect COBRA continuation coverage instead of USERRA continuation coverage, you will not be entitled to elect USERRA continuation coverage upon the expiration of your COBRA coverage). However, if your spouse or dependent children might lose USERRA continuation coverage as the result of a qualifying event such as your death, your divorce, or a cessation of

dependent status, your spouse and/or dependent children must be given an opportunity to elect COBRA continuation coverage, with a maximum coverage period of 36 months measured from the date of such qualifying event.

USERRA also provides that upon your return from military service, you may be entitled to immediate reinstatement of your benefits under the Plan (your eligibility bank earned prior to the date you entered military service) as if no military absence occurred. In order for you to avail yourself of your right to immediate reinstatement of benefits, the following requirements must be satisfied:

- Your military service must have been in the Uniformed Services, as defined herein;
- You have provided the Fund Office with advance notice that you will experience an absence from covered employment due to service in the Uniformed Services, unless circumstances make such advance notice impossible or unreasonable;
- You notify the Fund Office of your return from military service;
- You were not separated from a Uniformed Service with a dishonorable or bad conduct discharge, or under other than honorable conditions; and
- You are available for work, meaning you have placed your name on the hiring hall list maintained by the Union, within a specified time frame after completion of active duty as outlined below:

Length of Military Service	Availability Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

With certain narrow exceptions, a participant's reemployment rights cover up to five years in total leave for active service. If a participant is hospitalized or otherwise incapacitated by a service-related illness or injury, reemployment periods may be extended up to two years.

For purposes of this section, "Uniformed Services" means performance of duty on a voluntary or involuntary basis in the Army, the Navy, and Air Force, the Marine Corps or the Coast Guard, including their Reserve components, when the service member is engaged in active duty, active duty for special work, active duty for training, initial active duty for training, inactive duty training, annual training or full-time National Guard duty, and examination to determine the fitness of the person to perform any such duty.

Termination Benefits

If you are no longer eligible for coverage based upon employer contributions, including any excess contributions carried forward, and you fail to exercise your buy-in rights or COBRA rights, your benefits will terminate immediately, **INCLUDING YOUR LIFE INSURANCE BENEFIT.**

If you leave the industry, your benefits will terminate at the end of the current calendar quarter (Quarterly Eligibility) or at the end of your last eligibility month (Monthly Eligibility). You will not be able to use any excess contributions carried forward, nor will you be entitled to the buy-in provision. However, COBRA coverage may be available for purchase.

Eligibility of Dependents of Active Employees

The Plan provides certain benefits for your eligible dependents. Dependents do not receive life insurance benefits, accidental death or dismemberment benefits, or supplemental accident and sickness benefits.

The Plan covers a spouse to whom a participant is married as a dependent. Married means a legal relationship between two individuals of any gender who are lawfully married pursuant to an official marriage license or similar document issued by any state (meaning any domestic or foreign jurisdiction having the legal authority to sanction marriages) without regard to the law of the state in which the individuals are currently domiciled, but the terms do not include civil unions, domestic partnerships or any other status unless such status is fully equivalent to marriage under the law of the issuing state. Once a divorce occurs, your ex-spouse is no longer eligible for coverage under the Plan as of the first of the month following the month in which a divorce is granted, except that continued coverage can be purchased by or for your ex-spouse for 36 months under COBRA. Upon the expiration of COBRA coverage, all benefits cease. Divorce shall include the status of “divorce absolute”, “divorce from bed and board”, “legal separation”, “judgments of nullity” and “dissolution of a civil union”.

If you have any obligation under a divorce decree to provide health insurance coverage, you must secure individual coverage for your ex-spouse through other sources upon the expiration of COBRA coverage.

The Plan covers your natural children, adopted children, children placed for adoption for whom you have assumed a legal obligation in anticipation of adoption, and stepchildren until the end of the month in which the child attains age 26. Coverage is provided regardless of whether the child is married or unmarried, a student, employed or financially dependent on you. The only eligibility requirement is the child’s relationship to you.

You must provide proof of the relationship as follows:

- For all children, a copy of the child’s birth certificate.
- For adopted children or those placed for adoption with you, a copy of the adoption certificate as well as the child’s birth certificate.
- For a stepchild, you must provide a copy of your and your spouse’s (the child’s natural parent) marriage certificate, as well as the child’s birth certificate.

An unmarried grandchild under age 19 (or age 24 if a full-time student in an institution of higher education or other institution offering a degree or certificate upon program completion) will be eligible for coverage as a dependent provided you have the primary responsibility for his/her support and maintenance, and the child can be claimed on your tax return as a dependent for each year for which coverage is offered. You will be required to provide a birth certificate for the child and supply proof you have primary responsibility for the child through a court order, judgment or decree, or adoption certificate. The child must reside at the same principal residence in which you

reside for more than one-half of the year, and must receive over one-half of his/her support from you for the calendar year.

IF A CHILD BECOMES ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME, MEDICAID AND/OR MEDICARE BENEFITS, IT IS MANDATORY THAT YOU AVAIL YOURSELF OF THESE BENEFITS.

Children born during your marriage may remain eligible for coverage following your divorce if you have the primary responsibility or obligation to maintain health coverage in accordance with a court order, judgment or decree.

Procedures for Qualified Medical Child Support Order (QMCSO)

ERISA requires that the Fund honor court orders or administrative court directives which provide medical coverage or other benefits under the Plan to eligible children ("alternate recipients") provided such orders or directives constitute a Qualified Medical Child Support Order ("QMCSO"). Coverage under the Plan will be provided only if an order has been determined to be a QMCSO.

In accordance with ERISA, the Plan has established the following procedures for determining if a medical child support order (MCSO) meets the requirements of a QMCSO.

Upon receipt of a MCSO, as defined in ERISA Section 609(a), the Fund Office will:

- Promptly notify you as well as any alternate recipient of receipt of the MCSO. This notice will include a copy of these procedures. An alternate recipient may designate a representative to receive copies of all notices to be sent to the alternate recipient. Notice shall be sent to the addresses set forth in the MCSO.

- Determine within a reasonable period of time after receipt of the MCSO whether it qualifies as a QMCSO and notify you and the alternate recipient (or his/her designated representative) of its determination.

To qualify as a QMCSO, an MCSO must:

- Be made pursuant to a state's or administrative court's directive to provide medical coverage.

- Recognize the existence of an alternate recipient's right to medical coverage under the Plan.

- Specify the name and last known mailing address of yourself and each alternate recipient (or his/her designated representative).

- Specify the type and period of medical coverage. (An alternate recipient's eligibility for coverage is based upon your eligibility. An alternate recipient will be considered eligible for medical benefit coverage only during periods you are eligible. If employer contributions are insufficient to provide you with a level of coverage specified in an order, you are responsible for making the necessary self-payment required by the Plan.)

- Specify the Operating Engineers Local 825 Welfare Plan as the plan to which the order applies.

- Must not require the Plan to provide any type or form of benefit or option not otherwise provided under this Plan.

Eligibility of Retired Members

Retiree coverage is not vested and may be changed at any time.

Members who retire under the IUOE Local 825 Pension Plan (the "Pension Plan"):

- with at least 10.00 years of Credited Service, and
- an average of at least Level 1 coverage under the Fund's plan of benefits for active employees ("Active Plan") during the last three years of employment immediately preceding their retirement date, or
- at least one hour of service in covered employment during each of the three years immediately preceding their retirement date

are eligible to purchase continued health coverage as a retiree for a period of time based upon years of Credited Service at retirement as outlined below. If coverage under the Level of Benefit Program is extended as described later in this section, then the length of time the retiree is eligible to purchase continued health coverage as a retiree will be reduced by the period of time his/her coverage under the Active Plan is extended on and after the member's retirement effective date.

Years of Credited Service	Maximum Years of Welfare Coverage For Each Year of Credited Service
Less than 10 years	No Coverage
10 years up to 20	½ Year Welfare Coverage
20 years and over	Lifetime*

**As described herein, the Trustees have sole and exclusive discretion to amend or terminate coverage under this Plan at any time for any reason.*

The costs for continued health coverage as a retiree are established by the Board of Trustees. In order to be eligible for the life insurance benefit and accidental death and dismemberment benefit, you must purchase continued health coverage as a retiree. If you choose to purchase continued health coverage as a retiree and thereafter cancel your coverage, you will not have the opportunity to reinstate it at a later date.

If a retiree expires prior to exhausting his or her maximum years of welfare coverage, his or her surviving spouse will be eligible to purchase coverage, excluding benefits applicable for members only, until the later of: (1) the balance of the unused portion of the retiree's welfare coverage period up to a maximum of 36 months or (2) the surviving spouse's Medicare entitlement. A surviving spouse who is employed where there is other group coverage of a non-contributory nature will only be considered for secondary coverage under the Plan. If a surviving spouse remarries, all welfare benefits terminate under the Plan.

A retiree who expires while eligible for benefits will have life insurance coverage, the amount of which is determined based upon the retiree's pension effective date. Members who retired or retire on or after September 1, 1988, will have life insurance coverage in the amount of $1,000 per year of Credited Service up to a maximum of $25,000.

Members who retired from September 1, 1973 to September 1, 1988, will have life insurance coverage in the amount of $12,000. Members who retired prior to September 1, 1973, will have life insurance coverage in the amount of $3,000.

If at your time of retirement you have remaining eligibility under the Level of Benefit Program based upon your employment as an active member, your coverage under the Level of Benefit Program will be extended for a period of time based upon your eligibility bank. If applicable, you will be provided with a notice outlining this coverage. If you are eligible to purchase continued health coverage as a retiree, then when extended coverage under the Level of Benefit Program is exhausted, you will then be eligible to commence purchasing continued health coverage as a retiree. You may also be eligible for COBRA continuation coverage. The length of time COBRA coverage is available will be reduced by the length of time coverage is extended under the Level of Benefit Program. If you are eligible for COBRA continuation coverage and you elect to purchase continued health coverage as a retiree, you will not have any further continuation coverage rights under COBRA. If you are not eligible to purchase continued health coverage as a retiree, then when extended coverage under the Level of Benefit Program is exhausted, you may be eligible for COBRA continuation coverage. Again, the length of time COBRA coverage is available will be reduced by the length of time coverage is extended under the Level of Benefit Program.

This Plan provides comprehensive benefits for retirees and their dependents who are not yet Medicare eligible ("Pre-Medicare retirees and dependents"), which include the following benefits:

Life insurance (not available for dependents), accidental death and dismemberment (not available for dependents), inpatient hospital, outpatient pre-admission testing, outpatient emergency room, in-network outpatient surgicenter, convalescent care, ambulance, home health care, hospice care, surgical, anesthesia, doctor visits, X-ray and laboratory, maternity, mental health, substance abuse, cancer medications, diabetic supplies, chiropractor, podiatrist, vision, dental, and prescription drugs.

The Trustees offer a Medicare Advantage Plan for Medicare retirees and Medicare dependents of retirees through Aetna. This Medicare Advantage Plan includes hospital, medical, routine vision and prescription drug coverage. For information regarding the Medicare Advantage Plan, including but not limited to covered services, exclusions, claims and appeals procedures, and cost-sharing, etc., please see the separate Evidence of Coverage booklet you will receive from Aetna. Life insurance, accidental death and dismemberment and dental coverage for Medicare retirees and dental coverage for Medicare dependents of retirees are as outlined in this booklet.

Eligibility Upon a Return To Covered Employment

A retiree who returns to covered employment and is eligible to continue receiving pension benefit payments under the terms of the IUOE 825 Pension Plan will continue to receive retiree welfare benefits earned as of his or her original retirement date. The retiree will not accumulate any additional years of welfare coverage as a result of re-employment, and the amount of life insurance coverage will not increase.

A retiree who returns to covered employment and whose pension benefit payments have been suspended under the terms of the IUOE 825 Pension Plan will have his or her welfare benefits

(including the life insurance benefits) suspended. Such retiree will be permitted to self-purchase coverage on a monthly basis under the Level of Benefit Program for active participants until eligibility for coverage is established through employer contributions. Should a retiree not establish eligibility for welfare coverage either because of insufficient employer contributions or because of a retiree's failure to self-purchase coverage on a monthly basis, no life insurance and accidental death and dismemberment benefits are payable.

The life insurance benefit amount upon a retiree's return to covered employment as well as re-retirement will be calculated based upon both pre-retirement and post-retirement years of Plan participation, to a maximum of $25,000.

Regardless of whether a retiree's pension benefits have been suspended, a retiree who returns to covered employment will not be entitled to receive survivor benefits and supplemental accident and sickness benefits.

Eligibility Upon Re-Retirement

Where applicable, in determining the length of time a member is entitled to purchase continued health coverage as a retiree upon re-retirement, years of Credited Service earned as a result of reemployment will be combined with Credited Service at the time of original retirement. The period of welfare coverage already exhausted by a member during his or her original retirement period will be subtracted from the combined years of coverage at re-retirement.

Special Enrollment Rights

If you or your dependents are eligible for benefits under this Plan, you and/or they may decline enrollment for such benefits for any reason, such as if you and/or they are covered under another health plan.

If you and/or your eligible dependents have declined enrollment in this Plan, you and/or they will be permitted to enroll for benefits under this Plan at any time so long as you and/or they meet the Plan's eligibility requirements. For instance, if you have declined enrollment in this Plan due to coverage under another plan and your coverage under such other plan is terminated for any reason, you may then enroll for benefits under this Plan so long as you are eligible to be a participant in the Plan.

Such enrollment shall be effective not later than the first day of the first calendar month following the date the written request for enrollment is received by the Fund Office.

If you are eligible to be a participant under the Plan (even if you have declined coverage as described above), a person who becomes your eligible dependent through marriage, birth, or adoption or placement for adoption may be enrolled for benefits coverage under the Plan at any time after such person becomes your eligible dependent.

If you seek to enroll your newly acquired eligible dependent within 30 days after the date of the marriage, birth, adoption or placement for adoption, the coverage for such eligible dependent shall become effective:

- in the case of marriage, not later than the first day of the first month beginning after the date the written request for enrollment is received;

- in the case of a dependent's birth, as of the date of such birth; or

- in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

If you and/or your dependents were previously covered through Medicaid or a State Children's Health Insurance Program (CHIP) but subsequently lost eligibility for that coverage, you and/or your dependents may enroll in this Plan. In addition, you and/or your dependents may enroll in this Plan if you and/or your dependents become eligible for premium assistance through Medicaid or CHIP. You and/or your dependents must request enrollment within 60 days after the Medicaid or CHIP coverage ends or within 60 days after you and/or your dependents are determined to be eligible for such assistance. Coverage for you and/or your dependents will be effective not later than the first day of the month after the date a written request for enrollment is received.

On or before the time you are offered the opportunity to enroll under the Plan, the Plan shall provide you with a description of the Plan's special enrollment rules.

COORDINATION OF BENEFITS

Introduction

The purpose of all group health benefits is to help people pay their actual expenses. Some individuals are covered by more than one group plan. This is especially true when both spouses are employed, each covered under separate group plans which provide health care benefits. If each plan paid its full benefit, total benefits paid on one claim could exceed actual expenses, which could create undesirable inflationary pressure on the cost of health services. In order to guard against health care overpayments and to provide a fair and orderly method for paying claims where more than one group plan is involved, the Plan contains what is known as a "coordination of benefits" provision. This means that if you or one of your family members is covered under another group plan, the Plan will share benefit payments with the other group plan so that you will receive no more than 100 percent of allowable incurred charges. **Allowable incurred charges include any necessary, reasonable *medical* expenses.**

It is the intent of the Plan to coordinate benefits with all other group plans. You must make full disclosure of all benefits that you are entitled to receive from another plan or source in your application for benefits under the Plan. In the event that you fail to disclose any other source or plan for payment, your claim shall be considered to be fraudulent; and you will be subject to penalties, including disqualification from receiving any benefits under the Plan.

In coordinating benefits, only reasonable fees will be considered. Also, the yearly deductible and any applicable copayments still apply. When the Plan is secondarily liable, it will provide a reduced benefit which, when added to the benefits under other group plans, will equal 100 percent of reasonable expenses. In no event will the Plan's liability as a secondary carrier exceed its liability as a primary carrier.

All claims must be submitted within three (3) months of receipt of payment from the primary carrier or fifteen (15) months from date of service.

Exceptions

1. If the other group plan claims to provide excess coverage only, the Plan will only consider 20% of reasonable fees as primary carrier. Following payment under the Plan, the remaining balance should be submitted to the other plan for payment.

2. Where other coverage is provided by any program sponsored or arranged through a school, a league association or victims of violent crimes, the Plan will only consider up to 50% of reasonable charges as the primary carrier.

3. Where another group plan is primary, the Plan will not pay for charges denied by the primary plan because of a failure to follow the primary plan's prerequisites for coverage, including, but not limited to, failure to obtain prior authorization or failure to participate in clinical pathways or wellness programs.

Order of Benefit Payment Determination

When coverage exists under more than one group health plan, the following rules determine which plan pays first:

- The Plan covering an individual as an employee pays first and the plan covering the same person as a dependent pays second.

- For a child covered as a dependent under the plans of both parents not divorced, the plan of the parent whose birth date (month and day only) occurs earlier in the calendar year pays first. If both parents have the same birthday, the plan that has covered the child longest pays first. If one of the two plans has not adopted the birthday rule, the rules of the plan without the birthday rule will determine the order of benefit payment.

- When a child is covered under the plans of parents who are divorced, the plan of the parent whom a court has required to provide health coverage for the child pays first. If a court order states both parents are responsible for the child's healthcare expenses, the birthday rule will determine the order of benefit payment. If no court order exists or is silent as to which parent is financially responsible for the child's healthcare expenses, the plan of the parent who has legal custody of the child pays first.

- The Plan covering an individual as an active employee pays first and the plan covering the same person as a retiree pays second.

When none of the above rules determine the order of benefit payment, the plan that has covered the individual for a longer period of time is primary.

Coordination with Medicare if you have End-Stage Renal Disease (ESRD)

If you have permanent kidney failure that requires dialysis or a kidney transplant and have enough work history to qualify for Medicare for individuals with End-Stage Renal Disease (ESRD Medicare), the Plan requires that you avail yourself of this coverage.

The Plan will coordinate benefit payments when eligibility for ESRD begins and for so long as an individual retains Medicare eligibility for ESRD.

SUBROGATION AND REIMBURSEMENT

Where a third party is liable for expenses incurred by you or a dependent for an illness or injury for which benefits may be payable under the Plan, the Fund shall have reimbursement and assignment/subrogation rights.

By acceptance of benefits from the Fund, where a third party is liable, you or your dependent, under this provision of the Plan have agreed to assign to the Plan the right to proceed against the third party for recovery of medical expenses paid by the Plan. Further, the Fund retains a right of subrogation. This right of subrogation allows the Fund to obtain reimbursement of claims paid by the Fund by pursuing the rights of a member or dependent who has a legal claim for repayment from another party.

If a member or dependent suffers injuries or sickness from an accident, he or she shall assign to the Fund any claim against any third party to the extent that the Fund has paid claims arising from the accident. The Fund will require the member or dependent to sign a subrogation and lien acknowledgement form, prior to the payment of any benefits, and to reveal the identity of any person or entity against which he or she has a claim.

In accordance with the Fund's right of reimbursement, in the event you or your dependent recover any monies from a third party who is responsible for your illness or injury, you or your dependent agree that such money, to the extent of the medical expenses advanced by the Fund, shall belong to the Fund. It is agreed that you will pay to the Fund from such monies any benefits paid as a result of such illness or injury. In the event you or your dependent fail to pursue claims against the third party, the Fund's assignment/subrogation rights allow the Fund to seek recovery directly against the third party for benefits the Fund has paid as a result of the illness or injury.

As a condition of the payment of benefits, the Fund will require you or your dependent to fully complete and sign a form acknowledging the Fund's reimbursement and assignment/subrogation rights.

If the member or dependent neglects, or refuses to notify the Fund of the existence of a legal claim against another party, the member or dependent, as the case may be, shall be deemed to have consented to such assignment by the receipt of benefits under this Plan. Acceptance of any benefits under this Plan shall be recognized as consent to these provisions of subrogation, assignment and reimbursement. If a member or dependent collects any funds from any third party, he or she is obligated to recognize that such receipt is made on behalf of the Fund, and thus, to pay these funds to the Fund up to the amount of claims paid by the Fund. It is understood as a condition of receiving benefits under the Plan, that the Fund shall have a lien on the monies received from the third party, the extent of the lien being established by the amount of claims paid by the Fund.

You and your dependents are obligated to cooperate with the Fund in its efforts to enforce its reimbursement and/or assignment/subrogation rights and should refrain from any actions which interfere with those efforts. To the extent of any benefits paid, it shall be your duty to furnish the Fund with all pertinent information for the purpose of complying with this provision.

This provision shall apply to recoveries of current, as well as future, expenses estimated to be incurred. If a settlement has been reached which includes payment for future medical expenses,

any later arising claims relating to the injury or illness which were part of the settlement will not be considered for payment under the Plan.

In the event you or your dependents fail or refuse to comply with this provision, the Fund, in addition to any other rights it may have, shall have the right to withhold any and all current and future benefits due or which become due to you or your dependent until the Fund is fully reimbursed.

LIFE INSURANCE BENEFITS

A life insurance benefit is provided under a Group Policy issued by Amalgamated Life Insurance Company.

This benefit is payable in the event of your death only and goes into effect when you become eligible for benefits. It remains in effect only as long as you remain eligible for benefits under the Plan. If a retiree returns to covered employment but does not become eligible, either because of insufficient employer contributions received on the retiree's behalf or because of the retiree's failure to purchase benefits on a monthly basis, no life insurance benefit will be payable.

Provided you die while eligible for benefits, a life insurance benefit will be paid to the beneficiary you have named. You may name anyone as your beneficiary and you may change a designation from time to time; however, the benefit will be paid to your last named beneficiary. Upon your initial enrollment, you will be provided an enrollment form, which includes an area for you to designate a beneficiary for your life insurance. If at any time thereafter you wish to change your beneficiary designation, it will be necessary for you to complete a Notice of Change in Dependent Status and/or Change of Beneficiary Form (Section 2 of form). The designations you make on a Notice of Change in Dependent Status and/or Change of Beneficiary Form replace prior designations. **For a beneficiary designation to be effective, it must be signed and dated by you (a change in beneficiary designation also requires signature and date of a witness other than your beneficiary) and received by the Fund Office.**

If you name more than one beneficiary, all beneficiaries who survive you will share equally in the life insurance benefit unless you specify otherwise. If any one beneficiary does not survive you, the remaining surviving beneficiaries will share equally in the life insurance benefit. It is important that you make any changes immediately so that your current wishes are properly reflected. If at the time of your death you have not designated a beneficiary, or if designated, your beneficiary is not living, the life insurance benefit will be paid to your estate. If no beneficiary survives you and there is no estate, benefits will be paid to your survivors in the following order:

- Your surviving spouse
- Your children equally
- Your parents equally
- Your siblings equally

The amount of your life insurance benefit coverage will be determined by multiplying your years of Plan participation by $1,000, to a maximum of $25,000. Years of Plan participation will be based upon years of Credited Service as determined under the Pension Plan. For those active members who are not participants in the Pension Plan, years of Plan participation will be based upon years of eligibility for coverage under the Welfare Plan. For example, if you have participated in the Plan for 10 consecutive years, your life insurance benefit will be $10,000. If your Plan participation is not continuous, then upon your return as a Plan participant, your years of Plan participation prior to your break in participation will not be counted towards your years of Plan participation unless your return as a Plan participant occurs within three (3) years from the last time you were an active participant (in which case, your years of Plan participation prior to your break will be combined with your years of Plan participation after your return as a Plan participant).

Should your eligibility for benefits under the Welfare Plan terminate, you may be eligible to convert the life insurance benefit under the Group Policy to an individual policy for which you will pay your own premiums without having to provide evidence of good health. You have **45** days from the date your eligibility terminates to submit an application to Amalgamated Life for individual coverage. Call the Fund Office at 973-671-6800 for a Request for Conversion Application.

Should you become totally disabled before reaching age 60, a waiver of premium provision may continue your life insurance benefit in force without any further premium payments from the Fund or you after nine continuous months of total disability. Call the Fund Office at 973-671-6800 for forms to apply for this protection. You must provide Amalgamated with required forms and proof of claim no later than 12 months after you cease work due to total disability.

Waiver of premium protection ends 31 days after you: (a) cease to be totally disabled; or (b) reach the earlier of age 65 or the age at which you complete five (5) years of being totally disabled or the age at which your normal retirement begins; or (c) fail to provide required proof of continued disability; or (d) fail to submit to a health examination.

Members who retire under the Union's Pension Plan who are eligible to purchase coverage less than lifetime will have the option of extending their life insurance benefit coverage for a longer period of time by accepting a reduced amount of coverage. The amount of coverage is based on the member's age at retirement. For more information, contact the Fund Office.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Accidental death and dismemberment benefits are provided under Amalgamated Life Insurance Company. If you expire or suffer a covered loss as a result of an accident occurring (on or off the job) while eligible for benefits, the Plan will pay a benefit as indicated below. The accidental death and dismemberment benefit is payable to the same beneficiary you designate for your life insurance benefit. Dismemberment benefits are paid to you.

Loss of:	Benefit
Life	Full amount equal to life insurance benefit (paid to your beneficiary in addition to your regular life insurance benefit)
Both hands Both feet Sight of both eyes	Full amount equal to life insurance benefit (paid to you)
One hand and one foot One hand and sight of one eye One foot and sight of one eye	Full amount equal to life insurance benefit (paid to you)
One hand One foot Sight of one eye	One-half the amount of life insurance benefit (paid to you)

The loss must take place within 90 days after the accident and must be a direct result of the accident and may not be caused directly or indirectly by:

- Sickness, disease or bodily infirmity. (This does not include bacterial infection which results from an accidental cut or wound or accidental ingestion of a poisonous food substance.);
- Intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a physician;
- Intentionally self-inflicted injury, while sane or insane;
- Suicide or attempted suicide, while sane or insane;

- Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in any aircraft then licensed to carry passengers;

- Commission of or participation in a felony.

Written notice of claim must be provided to the Fund Office no later than 30 days after the loss for which a claim is made. Upon receipt of a notice of claim, forms will be furnished for filing a proof of claim. Proof of claim forms must be received by Amalgamated within 90 days after the date of loss for which a claim is made.

The amount of this benefit is determined by the life insurance benefit amount to which you are entitled. The maximum benefit payment for any one accident may not exceed the amount of your life insurance benefit. You must submit medical records/documentation from your physician substantiating the loss.

SURVIVOR BENEFITS

This benefit is only available to your spouse or dependent children in the event you die in active employment and are eligible for benefits under the Plan at the time of death. Moreover, the survivor benefit is not available in connection with the death of a dependent.

The Plan will make payments of $15 per month for each year of Plan participation, as defined above, up to a maximum of $300 per month.

This benefit is payable to your surviving spouse or to your eligible dependent children for a period not exceeding 60 months after your death or until your surviving spouse remarries, whichever occurs first. Payment for the balance of 60 months will continue to be paid after remarriage as long as there is an eligible dependent child to maintain.

As an additional survivor benefit, your surviving spouse and your dependent children at the time of your death (as long as they remain eligible) will receive at no charge health benefits at the level of benefit coverage you are eligible for at time of death, excluding benefits applicable for members only, for a period up to 60 months after your death or until your surviving spouse remarries. Health benefits for the balance of 60 months will continue after remarriage as long as there is an eligible dependent child to maintain. If your level of benefit coverage at death is less than Level 4, your survivors have the option to self-purchase a higher level of benefit coverage at a cost equal to the difference in cost for coverage provided at no charge and the cost of coverage at the level of benefit coverage desired. Once a level of benefit coverage is chosen, it cannot be changed at a later date.

Upon expiration of the 60 months of coverage indicated above, an unmarried surviving spouse of a participant who has accumulated at least 10.00 years of Credited Service under the Union's Pension Plan is eligible to purchase coverage up to the level of benefit coverage in effect immediately prior to exhaustion of coverage until the earlier of: (1) the surviving spouse's Medicare entitlement or (2) remarriage.

SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFIT

Supplemental accident and sickness benefits are only available to active, eligible members. There is no supplemental accident and sickness benefit for a dependent. To be eligible for supplemental accident and sickness benefits, you must be eligible for at least Level 2 coverage at the time your accident or sickness commences.

The Plan provides accident (including on-the-job injuries) and sickness benefits to supplement statutory short-term disability benefits. You must qualify for disability benefits with the State or your employer's private disability or compensation plan before becoming eligible for supplemental benefits under the Plan. You must submit a completed Accident and Sickness claim form as well as proof of payment from a primary source.

If you are unable to work because of an accident, you will receive a weekly payment of $350 starting with the first day of disability. Payment will continue for as long as you are disabled up to a maximum of 26 weeks.

If you are unable to work because of an illness, you will receive a weekly payment of $350 starting with the eighth day of disability. In the event that your illness continues through the twenty-second day of disability, you may then apply for benefit payment for the first seven days of your disability. Payment will continue for as long as you are disabled up to a maximum of 26 weeks.

Successive disabilities separated by less than two weeks of full-time work will be considered one continuous disability unless the second disability is due to a different cause and does not begin before you return to full-time work.

OVERVIEW OF HEALTH COVERAGE

As outlined in this SPD, there are four levels of benefit coverage, each of which provides for specific benefits. You must be eligible for a particular level in order for the Plan to consider a claim for benefits for you or your dependents. Once it has been determined that you are eligible for benefits, the Plan will pay benefits for covered expenses. Covered expenses are reasonable charges for medically necessary treatment meant to improve a condition. When more than one treatment option is available, and one option is no more effective than another, a covered expense is the least costly option that is no less effective than any other option. Certain expenses are excluded from coverage under the Plan. These exclusions are set forth below. In addition to these exclusions, dollar or frequency limitations apply to some benefits. Wherever the term treatment is referred to in this booklet, it shall mean medical care, services or supplies, including, but not limited to, advice, consultation, the prescribing of drugs or medicines or surgery. Medically necessary includes treatment which (1) is ordered by a physician and rendered by a provider licensed or certified to provide the treatment under the laws of the state where the provider practices, (2) is consistent with the diagnosis and treatment of a patient's condition, (3) is generally recognized by the medical community as safe and effective or appropriate for a patient's condition, (4) is approved by the Food and Drug Administration for the particular use for which coverage is sought, (5) is approved for reimbursement by Medicare and Medicaid Services for the particular use for which coverage is sought, (6) is not experimental or provided in connection with medical or other research or lacking credible evidence to support positive short- or long-term outcomes, (7) is not primarily for the convenience of a patient or his or her family or the treatment provider, and (8) does not exceed frequency or duration deemed appropriate by accepted medical practice. If a particular treatment is not outlined in this booklet, call the Fund Office.

In addition to illness or injury, the Plan provides benefits for preventive care. Some services, which are covered as a preventive benefit, include routine examinations, routine laboratory screenings, routine mammograms, sensory screenings, and immunizations.

The Trustees have reserved for themselves full discretion for interpretation of the Plan and all determinations that need to be made in the administration of the Plan. All determinations of eligibility for benefits and benefit coverage made by the Trustees or their designee shall be final and binding upon any individual claiming benefits under the Plan and shall be given full force and applicability in all courts of law and not be overturned or set aside by any court of law unless found to be arbitrary and capricious or made in actual bad faith.

Prohibition Against Assignments

You are expressly prohibited from assigning the benefits to which you are entitled under this Plan. Therefore, you may not assign your benefits to any provider and the Plan will not honor any assignment you make to a provider, for any reason. However, the Plan may choose, in its sole and exclusive discretion, to pay a provider from whom you obtain services directly. Without waiver of the above, the Plan retains discretion to negotiate with an out-of-network provider to reduce billed charges on your behalf. However, if payment is made directly to you as opposed to the provider, it will be your responsibility to pay the provider.

In accordance with the Plan's claims and appeals procedures, the Plan will allow a personal representative authorized by a participant or beneficiary to act on the participant's or beneficiary's behalf for claims and appeals purposes only. The Plan's recognition of a personal representative for this purpose shall not be construed as a waiver of the Plan's prohibition against assignments described herein.

All mandatory remedies under the Plan must be exhausted before a participant can bring a civil action. Thus, you may not start a lawsuit to obtain benefits until after you have timely requested a review and a final decision has been reached on review, or until the appropriate time frame has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. After you have filed an appeal and received a written decision from the Board of Trustees, you have 180 days to begin any further legal action, after which no legal action may be commenced against the Fund and/or the Board of Trustees. Additionally, if no appeal is filed within the time prescribed, any and all legal action will be waived and forfeited.

EXCLUSIONS AND LIMITATIONS

The Plan does not cover and will not pay benefits under any circumstances, regardless of your level of coverage, for the following:

1. Treatment provided by any federal, state or local government.

2. Treatment for injuries resulting from a motor vehicle accident. “Motor Vehicles” include automobiles, trucks, and vans**. IF YOU RESIDE IN A STATE WHERE YOU ARE GIVEN THE OPTION OF ELECTING A PIP DEDUCTIBLE, REMEMBER THAT THE PLAN WILL NOT PAY FOR ANY TREATMENT, INCLUDING TREATMENT NOT PAID BY YOUR INSURANCE CARRIER. THEREFORE, THE DEDUCTIBLE UNDER YOUR PIP IS EXCLUDED FROM COVERAGE.** For motorcycles, this exclusion applies to injuries sustained by other than a motorcycle operator.

3. Treatment for any sickness, disease or injury arising out of or in the course of employment, whether or not there is Workers’ Compensation available.

4. Treatment not ordered by a physician (the term “physician” solely refers to a duly licensed Doctor of Medicine (M.D.), Osteopath (D.O.), Podiatrist, Chiropractor, Dentist, and Optometrist) and treatment not rendered by a provider licensed or certified to provide treatment under the laws of the state where the provider practices.

5. Treatment which is not approved by the Food and Drug Administration or approved for reimbursement by Medicare and Medicaid for the particular use for which coverage is sought.

6. Treatment which is not considered medically necessary as defined in this Plan.

7. Medical expenses you are not legally required to pay.

8. Any charges in excess of reasonable fees as defined in this Plan.

9. Sickness, disease or injury resulting from war or an act of war or incurred during military service.

10. Intentionally self-inflicted injuries, except where such injuries are the result of a medical condition.

11. Injuries incurred while committing an act which constitutes a crime, whether or not the injury is caused by an unintentional event, except where such injuries are the result of a medical condition or domestic violence.

12. Private nursing care, whether in a hospital or at home.

13. Care or treatment rendered in a rest facility, a nursing home or a facility for the aged.

14. Care or treatment in other than an accredited facility.

15. Out-of-network ambulatory surgery center facility charges.

16. Custodial care or treatment, even if rendered in an accredited facility. Custodial care includes, but is not limited to, assistance in daily living activities, such as walking, bathing, feeding; preparation of special diets; and supervision of medication which is usually self-administered.

17. Treatment rendered by a provider who is an immediate family member (spouse, parent, child, stepchild, sibling, in-law).

18. Maintenance treatment which is not reasonably expected to result in additional functional improvement.

19. Surgical procedures for cosmetic purposes and considered reconstructive in nature performed to improve appearance and from which no improvement in physiologic function can be expected, except where surgery directly results from an accident.

20. Any treatment for weight control, except treatment for morbid obesity and co-morbid conditions associated with morbid obesity, which treatment has been preauthorized by the Fund, and treatment covered under Preventive Benefits.

21. Non-emergency ground ambulance service and all air transport service.

22. Standby surgeon.

23. Reduction mammoplasty, with the exception of post-mastectomy patients. For other than post-mastectomy patients, the Fund must approve medical necessity.

24. Removal of breast implants, except post-mastectomy.

25. Treatment for erectile dysfunction, including penile implants or any medication or devices.

26. Intersex surgery and any related charges, unless medically necessary to treat a diagnosed condition of gender dysphoria or a similar accepted and diagnosed physical or psychological condition.

27. In vitro fertilization.

28. Blepharoplasty performed on lower eyelid.

29. Drugs available without a prescription, even if a prescription has been issued by a doctor, or drugs dispensed by anyone other than a licensed pharmacist (except for medications covered under Preventive Benefits).

30. Food substitutes, supplements and infant formulas, whether or not prescribed by a physician.

31. Special foods prescribed as part of a weight control program.

32. Nutritional counseling, except for diabetes or morbid obesity diagnoses, and counseling covered under Preventive Benefits.

33. Any donor expenses associated with a body organ transplant.

34. Services to a child-dependent related to childbirth, miscarriage, abortion or infertility.

35. Personal expenses incurred during a hospital confinement, such as guest meals, television rental and phone charges.

36. Specially molded shoes.

37. Visual therapy.

38. Radial keratotomy or any other surgical procedure to correct vision.

39. Medical treatment of eye disease or injury rendered by an optometrist who does not hold a therapeutic license to treat ocular diseases.

40. Sterilization reversal.

41. Bras, except two/year post-mastectomy patients; cranial prosthesis; and specialty clothing.

42. Marriage counseling.

43. Lamaze classes.

44. Comfort and convenience items including, but not limited to: specialty beds (including waterbeds), chairs, air conditioners, humidifiers, dehumidifiers, whirlpool baths, heating pads, and exercise equipment.

45. Spa or health club memberships.

46. Aquatic therapy that is not rendered by a physical therapist or other recognized licensed provider on a direct, one-on-one, patient contact. Charges for aquatic exercise programs or separate charges for use of a pool are not covered.

47. CPM (Continuous Passive Motion Machine).

48. Supportive care.

49. Expenses incurred by a child on and after the first of the month after a child turns age 26.

50. If you elect not to take part 'B' Medicare and Medicare is your primary carrier, any charges that would be covered under part B are not eligible.

51. Blood pressure monitoring machines.

52. Biofeedback.

53. Treatment for complications relating to an excludable treatment under the Plan.

54. Acupuncture treatment rendered for other than pain management.

55. Charges for missed appointments, interest on late payments, and collections.

56. Non-emergency treatment outside of the United States.

In addition to the exclusions outlined above, there are limits to which the Plan will provide benefits as outlined below:

AMBULANCE	$700/TRIP BASIC LIFE SUPPORT $1,000/TRIP ADVANCED LIFE SUPPORT
GENETIC TESTING	Coverage for and charges related to genetic testing is limited to only amniocentesis testing and up to three counseling sessions during pregnancy, cystic fibrosis carrier screening during first pregnancy of expectant mother, BRCA1 and BRCA2 gene analysis and counseling, and Oncotype DX breast cancer assay. Genetic tests not specifically listed above are NOT covered by the Plan under any circumstances. This includes, but is not limited to, genetic tests intended to determine whether particular genetic mutations are present and/or whether particular drug therapies might work for a particular patient including genetic testing performed before gene therapy is initiated.
GENE THERAPY	Gene Therapy – the Plan does not cover any charges related to gene therapies that have received approval from the U.S. Food and Drug Administration (FDA) after March 23, 2010, and are deemed medically necessary, or that are considered experimental or investigational. Illustrative examples of gene therapies include, without limitation, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as Luxturna and Zolgensma. This list is not exhaustive, and new applications for gene therapies are submitted to the FDA every year.
HEARING AIDS	$1,500 PER AID
INFERTILITY	Except for artificial insemination and standard dosages, lengths of treatment and cycles of therapy of prescription drugs, benefits for infertility treatment are limited to $2,000 per 12-month period, including all expenses related to surgical procedures, drugs, and expenses associated with a spouse's participation.

MAGNETIC RESONANCE IMAGING (Except for brain, brain stem and cervical spinal cord, which are covered in accordance with the Plan's reasonable fee)	$500 PER SITE
ORGAN TRANSPLANTS	Benefits provided for recipient expenses to a maximum of $100,000 per procedure for kidney, liver, heart, lung and bone marrow transplant surgeries and to a maximum of $40,000 per procedure for corneal transplant surgery. Donor expenses are not covered. Charges for immunosuppressant medications following surgeries are covered under Level 4 in accordance with the Plan's prescription drug program in addition to transplant procedure maximums.
PAIN MANAGEMENT	Acupuncture treatment for management of pain must be rendered by a medical doctor (M.D. or D.O.) certified to perform acupuncture or by non-medical practitioner holding license to practice acupuncture in the state where services are rendered. Except when necessary as a substitute for anesthesia, acupuncture benefit payments are limited to $6,000 per calendar year. In addition to satisfying the medical necessity requirements in this Plan, in order to be eligible for a permanent spinal cord stimulator, the following conditions must be met: • Your physician must provide a written confirmation that all other available treatment methods have failed, are contraindicated, or are not likely to be successful in otherwise managing your pain; and • Your physician must provide a written confirmation that a trial spinal cord stimulator was successful in managing your pain for a sustained measurable period.

PRECERTIFICATION

The Plan has a precertification program to confirm prior to treatment being provided whether the treatment is a covered benefit and to assist you in obtaining the maximum, cost effective benefits available under the Plan. Please note: the decision to proceed with a particular treatment ultimately lies with a patient and his or her physician. ***Precertification does not guarantee eligibility or payment.***

Requests for precertification for treatment to be provided in a hospital (inpatient or outpatient) or surgical center should be directed to the Welfare Fund by calling 800-677-3237; and requests for precertification for treatment to be provided in other than a hospital or surgical center, such as a physician office or at home, as well as all radiology requests, regardless of place of service, should be directed to Horizon Blue Cross Blue Shield at the numbers listed on the back of your Horizon Blue Cross Blue Shield ID card.

Precertification calls should be made as early as possible prior to scheduled treatment. For emergency treatment, precertification requests should be received within two (2) working days following such treatment. At the time a precertification call is received, basic information regarding the scheduled treatment will be requested. If necessary, additional information will be obtained from the service provider. You will receive written notice of a precertification determination. If precertification is denied, this notice will include reason for denial and information about how to appeal the determination.

Following is a list of services which require precertification (or prior authorization).

1. All hospital activity: inpatient admissions, same-day surgeries, outpatient diagnostic and non-diagnostic procedures.

2. All surgical procedures, regardless of place of surgery.

3. Skilled nursing facility.

4. Infertility treatment.

5. Home health care.

6. Home I.V. therapy.

7. Diagnostic tests: myelogram, MRI, CAT scan, RAST testing, PET scan, sleep apnea studies, amniocentesis, or any other procedure where fee exceeds $600.

8. Long-term treatment plans: rehabilitation, speech therapy, physical therapy, occupational therapy and radiation therapy.

9. Durable medical equipment.

10. Drug therapy: chemotherapy, injectables (except insulin and immunization).

11. Lyme disease treatment.

12. BRCA1 and BRCA2 gene analysis and Oncotype DX breast cancer assay.

COPAYMENTS

A copayment is the amount you or your family member is responsible for and which should be paid to a service provider at the time services are rendered. In processing claims for benefits, any applicable copayment will be deducted from the total amount allowed under the Plan before calculating payment.

SERVICE	COPAYMENT
Emergency Room	$25.00 per incident
Surgery	$25.00 per procedure where surgical fee is greater than $100.00 $10.00 per procedure where surgical fee is $100.00 or less
Hospital	$25.00 per confinement (in network) $500.00 per confinement (out of network) $25.00 outpatient surgery/per incident (in and out of network)
In-Network Ambulatory Surgery Center	$25.00 per incident
Doctor Visits (in hospital and office)	$15.00 per visit
Preventative Services	No copayment (payable 100% when received from an In-Network Provider)
Second Opinion	$15.00 per visit
Chiropractor Visit	$15.00 per visit
Podiatry Visit	$15.00 per visit
Laboratory Services (excluding venipuncture) rendered in outpatient department of hospital, a freestanding facility or physician office	$10.00; if multiple laboratory services are rendered on any one day, maximum daily copayment is $10.00
Diagnostic Testing (radiology, EKGs, echoes, etc.) rendered in outpatient department of hospital, a freestanding facility or physician office	$25.00; if multiple diagnostic tests are rendered on any one day, maximum daily copayment is $25.00

Short-Term Therapies (occupational, physical, cardiac, rehabilitation, respiratory or cognitive)	$15.00 initial evaluation and re-evaluation
Speech Therapy	$15.00/visit for visits 1-24; $25.00/visit thereafter

Prescription Drug		
Medication Type	**Network Pharmacy**	**Mail Pharmacy Service**
Generic Medications	$7	$14
Preferred Brand (Formulary)	20% coinsurance $75 maximum	20% coinsurance $150 maximum
Non-Preferred Brand (Non-formulary)	35% coinsurance $75 maximum	35% coinsurance $150 maximum
Non-Preferred (Non-formulary)	50% coinsurance $30 minimum	50% coinsurance $60 minimum
Specialty-generic and preferred brand	Not covered	$50 for a 30-day prescription through Optum Specialty Pharmacy

HEALTH CARE BENEFITS IN NETWORK/OUT OF NETWORK

Under the Plan, you have the freedom to choose your health care providers. No referrals are required, although precertification requirements under the Plan may apply. You and the Fund will benefit most when you use participating facilities and medical, behavioral health, or vision service and supplier providers participating in the Horizon Blue Cross Blue Shield networks. Telephone numbers and a website address are on your Horizon ID card. Remember, providers may shift into and out of the participating provider networks. Therefore, it is strongly suggested that you confirm a provider's network status before scheduling services.

Your share of costs is lowest when care is received from an in-network provider. For treatment rendered by an in-network provider, the Plan will pay benefits based upon pre-negotiated discount rates. The only out-of-pocket expense you will incur is any applicable copayment.

The out-of-pocket limit for In-Network PPO medical benefits is $5,100 per individual and $10,200 per family. Once any covered individual of your family meets the individual limit, the Fund will pay 100% of covered Medical expenses from an In-Network provider for that person for the remainder of the calendar year. Once two individuals of your family meet their individual limits, or your family as a whole reaches the $10,200 limit, the Plan will pay 100% for the entire family for the balance of the year. Expenses for services the Plan does not cover, balance billing, penalties for failure to obtain precertification and expenses for Out-of-Network providers (except for "eligible" emergency room expenses) will not count toward the out-of-pocket limit.

The Plan also maintains a separate out-of-pocket limit of $4,000 per individual and $8,000 for families for prescription drugs. Please see the *Prescription Drug Coverage* section for important information about the applicability of this limit for prescription drugs.

For treatment rendered by an out-of-network medical or behavioral health service or supplier provider, you are generally responsible for 20 percent coinsurance, any applicable copayment, and any charges in excess of reasonable fees (or allowances), after satisfaction of the annual calendar year deductible. The deductible is $200 per family member of eligible expenses to a maximum of $600 per family. No more than $200 will be applied towards the family deductible for expenses incurred by any one family member. In determining benefits payable for services rendered by a non-participating medical or behavioral health service or supplier provider, reasonable fees are based upon the lesser of (1) 150% of Medicare's Fee Schedule or (2) actual billed charges. As noted above, the amount by which the Plan's reasonable fee is exceeded by a provider's charge is your responsibility. This amount may be significant. If possible, you should discuss billing procedures prior to receiving treatment from a non-participating provider.

Whether services are rendered by an in-network or out-of-network provider, the Plan will not consider payment for any charges which exceed specific maximum benefit limitations.

In addition to the benefits described in greater detail in the sections which follow for specific services, below is a list of other services and supplies covered under the Plan. For any services and supplies not addressed in the Plan, please contact the Fund Office.

1. The services of a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.), except one who is a member of your family or who ordinarily lives in your home, provided that such services are deemed necessary by an attending physician.

2. Rental or purchase of durable medical equipment such as oxygen equipment, a wheelchair and hospital-type bed prescribed by a physician and which is for a therapeutic purpose consistent with an illness or injury. You must submit a written request from the prescribing physician for this equipment. Preauthorization is required in advance of rental or purchase. Items used for comfort and convenience and not primarily medical in nature (whether prescribed by a physician or not) are not covered.

3. Purchase of braces, artificial limbs, prostheses and medical supplies. You must submit a written request from a prescribing physician for this equipment. Preauthorization is required in advance of purchase.

4. Dental services required as a result of accidental bodily injury.

5. Hearing aids prescribed by a medical doctor. An otologist is not a doctor. The Fund will pay up to $1,500 per aid for purchase and up to $150 per aid for repair, not to exceed actual charge. Whether dispensed or repaired by an in-network or out-of-network provider, the Plan's payments are not subject to a deductible, copayment or coinsurance.

6. For diabetic patients, up to two nutritional counseling sessions provided by a certified diabetic educator or a registered dietitian. For individuals who have received preauthorization from the Fund for bariatric surgery, mandatory preoperative nutritional counseling provided by a registered dietitian. Preauthorization is required in advance of postoperative nutritional counseling.

7. For post-mastectomy patients, reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prosthesis and physical complications of all states of a mastectomy, including lymphedemas.

Important Information

Designation of Primary Care Provider

Under the Plan, there is no requirement to designate a primary care provider. However, should you wish to choose a primary care provider, you have the right to designate any primary care provider who participates in the Plan's Network and who is available to accept you or your family members. This includes the right to designate a participating pediatrician as your child's primary care provider. For information on how to select a primary care provider, and for a list of participating primary care providers, contact Horizon Blue Cross Blue Shield.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however,

may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Horizon Blue Cross Blue Shield.

Provider Non-Discrimination

In accordance with Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan or issuer. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Routine Patient Costs in Connection with Approved Clinical Trials

If you are eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition, the Plan will:

- Not deny you participation in the trial;
- Not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items, services or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial; and
- Will not discriminate against you because of your participation in the trial.

The Plan will deem you eligible to participate in the trial if:

- Your health care provider is a participating provider in this Plan and that provider has concluded that your participation in the trial would be medically appropriate; or
- You provide medical and scientific information establishing that your participation would be medically appropriate.

Routine patient costs do not include the following:

- The investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more of the Plan's participating providers is participating in a clinical trial, the Plan may require that you participate in the trial through such participating provider if the provider will accept you as a participant in the trial.

An Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is funded or approved by the federal government, conducted under an investigational new drug application reviewed by the federal Food and Drug Administration, or a drug trial exempt from having such an investigational new drug application. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LEVEL 1 BENEFITS OF HEALTH CARE

Inpatient Hospital Coverage

If an injury or illness makes hospitalization for you or your eligible dependents medically necessary, semi-private room and board, including special diets and general nursing care, are covered in full for up to 365 days per injury or illness. Essential services when charged for by a hospital are also covered, if they are consistent with the diagnosis and treatment of the illness or injury. At the time of confinement in a hospital, present your hospital identification card to the admitting officer. The Fund will pay the full amount of eligible charges minus a $25 copayment if a confinement occurs in a BlueCard PPO hospital. If a confinement occurs in an out-of-network hospital, the Fund will pay 70 percent of eligible charges minus a $500 copayment, unless a confinement occurs as a result of an emergency or a patient's primary coverage is Medicare, in which case benefits will be paid as if the confinement occurred in a participating hospital.

Outpatient Preadmission Testing

The Plan will provide coverage for preadmission testing performed at a hospital or another facility used by the hospital for preadmission services.

Outpatient Emergency Room Care

The Plan covers expenses for outpatient services for hospital emergency room (ER) facility. Benefits are only payable for Emergency Services provided in Hospital emergency rooms when the patient is suffering from an Emergency Condition as defined below. Coverage only includes those Emergency Services and supplies that are Medically Necessary and performed to treat or stabilize the patient's Emergency Condition in a Hospital emergency room. There is no requirement to pre-certify (prior authorize) the use of a hospital-based emergency room visit.

The $25 copayment applies to both in-network and out-of-network emergency rooms. The Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Affordable Care Act (ACA) and No Surprises Act regulations.

No Surprises Act Coverage

Emergency Care/Services in an Emergency Room

Emergency Care/Services to treat an Emergency Medical Condition is covered in the hospital emergency room. To be covered as Emergency Care, the medical condition, including mental health condition or substance use disorder, must be manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average

knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- placing the health of an individual or an unborn child in serious jeopardy.

Emergency services are covered:

- without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;
- without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services;
- without imposing any administrative requirement or limitation on out-of-network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities;
- without imposing cost-sharing requirements on out-of-network emergency services that are greater than the requirements that would apply if the services were provided by an in-network provider or an in-network emergency facility; and
- by counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as if such cost-sharing payments were made with respect to items and services received from an in-network provider.

Non-Emergency Services by Non-Participating Providers

Certain Non-Emergency services by non-participating providers at participating facilities may be covered based on In-Network cost-sharing. With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a nonparticipating provider at a participating facility, the items or services are covered by the Plan:

- with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider;
- by calculating the cost-sharing requirements as if the total amount charged for the items and services was equal to the recognized amount for the items and services; and
- by counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the Plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a participating provider.

Please note, if a non-participating provider satisfies the notice and consent criteria, the non-Emergency services performed by the non-participating providers at the participating facilities do not have to be covered based on in-network cost-sharing.

Non-Emergency items or services performed by a non-participating provider at a participating facility will be covered based upon your out-of-network coverage if:

- at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a non-participating provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any participating providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and

- the participant or beneficiary gives informed consent to continued treatment by the non-participating provider, acknowledging that the participant or beneficiary understands that continued treatment by the non-participating provider may result in greater cost to the participant or beneficiary.

The notice and consent exception does not apply to Ancillary services and items, or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-participating provider satisfied the notice and consent criteria and therefore these services will be covered:

- with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider;

- with cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the recognized amount for the items and services; and

- with cost-sharing counted toward any in-network deductible and in-network out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

To implement the protections of the No Surprises Act, the Fund is adopting the following new/revised definitions of terms in the SPD as follows:

Ancillary Services means, with respect to a participating health care facility, the following:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

2. Items and services provided by assistant surgeons, hospitalists, and intensivists;

3. Diagnostic services, including radiology and laboratory services; and

4. Items and services provided by a non-participating provider if there is no participating provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a "Serious and Complex Condition", (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) undergoing a course of institutional or inpatient care from the Provider or facility.

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- placing the health of an individual or an unborn child in serious jeopardy.

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department (some urgent care facilities, but not all, qualify), as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and

2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

3. Emergency Services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

    a) The Provider or facility determines that you are able to travel using nonmedical transportation or non-emergency medical transportation; and

    b) You are supplied with a written notice, as required by federal law, that the Provider is an Out-of-Network Provider with respect to the Welfare Fund, of the estimated charges for your treatment and any advance limitations that the Welfare Fund may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

    c) You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

Health Care Facility (for Non-Emergency Services) means each of following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);

2. A hospital outpatient department;

3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

No Surprises Services means the following, to the extent covered under the Welfare Fund:

1. Out-of-Network Emergency Services;

2. Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network Provider at an In-Network facility; and

3. Other Out-of-Network Non-Emergency Services performed by an Out-of-Network Provider at an In-Network health care facility with respect to which the provider does not comply with federal notice and consent requirements.

Recognized Amount means one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or

3. If there is no applicable All-Payer Model Agreement or state law, the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount ("QPA").

Qualifying Payment Amount or QPA means generally the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR 716-6(c).

Serious and Complex Condition means one of the following:

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 injury; or

2. In the case of a chronic illness or condition, a condition that is the following:

    a) Life-threatening, degenerative, potentially disabling, or congenital; and

    b) Requires specialized medical care over a prolonged period of time.

Ambulatory Surgery Center Coverage

Services provided by a licensed freestanding surgical center will be covered for ambulatory same-day surgery. Eligible services are the same as inpatient hospital, except for room and board. **There is no coverage for out-of-network ambulatory surgery centers, unless Medicare is your primary coverage. If you decide to receive treatment at an out-of-network ambulatory surgery center, you will be financially liable for the facility fee.**

Convalescent Care (Subacute) Following a Hospital Stay

This benefit will help pay for a convalescence at a licensed intermediate care facility after a hospital stay of at least five consecutive days. The confinement must start within seven days after release from a hospital and must be required by your doctor for the condition causing the hospitalization. Up to 100 days per condition will be covered for expenses at a convalescent care facility. Any extension beyond 100 days is subject to approval by the Fund. The Plan places a 365-day limit on the payment for hospitalization and convalescent benefits combined for any one condition. **Medicare patients must be admitted to a Medicare certified facility for benefits to be paid.** For non-Medicare patients, payment is limited to 50 percent of the standard daily semi-private room rate charge for room and board for the hospital from which the patient was transferred.

Ambulance

The Plan will pay 100 percent of charges up to a maximum of $700 per trip for basic life support services and up to $1,000 per trip for advanced life support services for emergency *ground ambulance* transportation.

Home Health Care

Benefits are provided for the provision of medical care in the home to treat an illness or injury. This care may include intravenous therapy, skilled nursing care, and rehabilitation services. Care must be prescribed by a physician, be medically necessary, and involve a medical skill. Only home health care delivered by a licensed health care professional through an accredited home health care agency will be considered for coverage. Examples of a licensed home health care professional include a registered nurse, licensed practical nurse, or physical therapist. No coverage is provided for custodial or non-medical care. Care provided by a family member is not covered.

Hospice Care

This benefit is provided to a terminally ill patient with a medical diagnosis of an “end-stage disease” and a life expectancy of less than six months. The patient’s physician must certify the need for hospice care, medical diagnosis and life expectancy.

Hospice care is usually provided in the home, although you may also receive care in a facility certified to provide hospice care. Hospice care does not include treatment to cure your terminal illness. Covered services include room and board in a facility certified to provide hospice care, services of hospice team professionals and volunteers, and medical equipment and supplies for comfort and pain control. Care provided by a relative is not covered.

Surgical

The Plan provides benefits for surgical charges of a physician to diagnose and treat an illness or injury. Benefits are payable whether surgery is performed in the hospital on an inpatient or outpatient basis or in a physician’s office.

Benefits will be provided for charges by an assistant surgeon where a surgical procedure requires the services of an assistant surgeon. The assistant surgeon must be a medical doctor and charges must be billed separate from the primary surgeon. Reasonable fee for an assistant surgeon is based on the reasonable fee for the primary surgeon. For medically necessary assistant in surgery services provided by non-physician practitioners such as a physician assistant (PA) and a registered nurse first assistant (RNFA), reasonable fee is based on the reasonable fee for an assistant surgeon.

When more than one operation is performed in the same operative field or through one incision, the maximum benefit will be the amount payable for the primary procedure. If the operations are in different fields and require separate incisions, the maximum benefit will be 100 percent of the amount payable for the primary surgical procedure plus 50 percent of the amount payable for the second and subsequent procedures, except where the third and subsequent procedures do not add any significant time or complexity to the patient's care, in which case the amount payable for the third and subsequent procedures will be 25 percent of the amount payable for such procedures.

Various services associated with a surgical procedure that are considered integral parts of the procedure and included in the surgical fee are ineligible for separate reimbursement. Examples include but are not limited to incidental procedures, component procedures, and post-operative visits within a surgical global period.

General Anesthesia

When general anesthesia is administered by an anesthesiologist (MD or DO) in conjunction with a covered surgical procedure, the Plan pays 100% of a reimbursement amount calculated by multiplying the sum of (1) anesthesia base units (2) time units and (3) modifying units (if any) by the Plan's fixed conversion factor for anesthesia reimbursement adjusted by the Plan from time to time. The number of base units is assigned based on the surgical procedure performed, and the number of time units is based on the amount of time a provider renders anesthesia services in increments of 15-minute units or fraction thereof. Modifying units account for special conditions affecting anesthesia such as a patient's health at time of surgery.

When services are administered by a certified registered nurse anesthetist (CRNA), the Plan's reimbursement amount is reduced to reflect services of a non-medical provider by using a lower fixed conversion factor than when calculating anesthesiologist reimbursement.

Only one general anesthesia charge per procedure will be considered for payment. When general anesthesia services are rendered by both an anesthesiologist and CRNA, reimbursement for both providers will not exceed the amount which would have been paid had services been furnished by an anesthesiologist alone.

General anesthesia administered for pain management procedures is not covered.

Maternity Care

Maternity benefits are provided for a female member and the legal spouse of a male member provided delivery occurs while you are eligible to participate in the Plan. There is no coverage for a dependent child.

The Plan will consider up to 50 percent of the reasonable fee for services of an obstetrician for maternity care (antepartum, delivery and postpartum) rendered by a certified nurse-midwife.

Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. Plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

Doctor Visits

The Plan will consider charges for in-hospital and out-of-hospital doctor visits up to reasonable fees. If a surgical operation is performed, the Plan will pay for your doctor visits up to the day the operation is performed. No additional payment will be made for post-operative care provided during a global surgery period applicable to a particular procedure.

X-ray and Laboratory Care

For X-ray and laboratory services ordered by a physician to diagnose an illness or injury, charges up to reasonable fees will be considered.

Mental Health/Substance Abuse Treatment

Mental health and substance abuse benefits provided under the Plan are managed through Horizon Behavioral Health. A table summarizing mental health and substance abuse benefits for in-network and out-of-network services follows.

In addition to mental health and substance abuse benefits, an Employee Assistance Program (EAP) is available for all active members through Carelon Life Solutions. This service is available 24 hours per day at no cost by telephoning 866-843-0980. Use of the program is on a **voluntary** basis.

EAP counselors will assist you and your family members in dealing with a variety of problems, such as stress, depression, work and family life conflicts, financial difficulties, and substance abuse. All calls to the EAP are held in complete confidence; under no circumstances will any information about you be shared with your employer, the Union or the Fund without your written consent.

Mental Health	In-Network	Out-of-Network
Inpatient Facility	100% minus $25 per admission copayment	70% of eligible charges minus $500 per admission copayment
Inpatient Physician Visits	100%	Plan's reasonable fee, not to exceed actual charges, minus 20% coinsurance
Partial Hospitalization (PHP)	100% minus $15 copayment per partial hospitalization treatment plan	Facility: 100% minus $15 copayment Physician visits: Plan's reasonable fee, not to exceed actual charges, minus $15 copayment and 20% coinsurance
Intensive Outpatient (IOP)	100% minus $15 copayment per intensive outpatient treatment plan	Facility: 100% minus $15 copayment Physician visits: Plan's reasonable fee, not to exceed actual charges, minus $15 copayment and 20% coinsurance
Outpatient (office visits)	100% minus $15 per visit copayment	Plan's reasonable fee, not to exceed actual charges, minus $15 per visit copayment and 20% coinsurance
Substance Abuse	**In-Network**	**Out-of-Network**
Inpatient Facility	100% minus $25 per admission copayment	70% of eligible charges minus $500 per admission copayment
Inpatient Physician Visits	100%	Plan's reasonable fee, not to exceed actual charges, minus 20% coinsurance
Partial Hospitalization (PHP)	100% minus $15 copayment per partial hospitalization treatment plan	Facility: 100% minus $15 copayment Physician visits: Plan's reasonable fee, not to exceed actual charges, minus $15 copayment and 20% coinsurance
Intensive Outpatient (IOP)	100% minus $15 copayment per intensive outpatient treatment plan	Facility: 100% minus $15 copayment Physician visits: Plan's

Mental Health	In-Network	Out-of-Network
		reasonable fee, not to exceed actual charges, minus $15 copayment and 20% coinsurance
Outpatient (office visits)	100% minus $15 per visit copayment	Plan's reasonable fee, not to exceed actual charges, minus $15 per visit copayment and 20% coinsurance.

Inpatient, partial hospitalization and intensive outpatient treatment in network and out of network must be preauthorized for medical necessity. If treatment is not preauthorized and it is determined to be not medically necessary, there is no benefit.

A $15 copayment applies to office visits and a $25 copayment applies to diagnostic services (i.e. neuropsychological testing).

Cancer Medications

The Plan will consider up to reasonable fees for chemotherapy medications supplied by a physician's office administering chemotherapy treatment. Chemotherapy medications purchased at a retail or mail order pharmacy are eligible under Level 1 benefit coverage, with coverage determined in accordance with the Plan's prescription drug program. For adjunct therapy medications, i.e., anti-nausea medications, purchased at a retail or mail order pharmacy, you must be eligible for Level 4 benefit coverage. Coverage for adjunct therapy medications purchased at a retail or mail order pharmacy will be determined in accordance with the Plan's prescription drug program.

Diabetic Supplies

Charges for glucometers, test strips, syringes/needles and lancets and insulin pumps supplied through a durable medical equipment provider will be considered up to reasonable fees. For diabetic supplies purchased at a retail or mail order pharmacy, you must be eligible for Level 4 benefit coverage. Coverage for diabetic supplies purchased at a retail or mail order pharmacy will be considered in accordance with the Plan's prescription drug program.

Chiropractor Care

Reasonable fees for chiropractic treatment will be considered and paid up to a maximum of 52 visits per calendar year for all services rendered by a licensed chiropractor (including any X-rays).

Covered chiropractic treatment is limited to manipulation for the correction of a vertebra subluxation only indicated by the following diagnoses:

- Incomplete dislocation of vertebrae

- Off-centering of vertebrae
- Misalignment of vertebrae
- Fixation of vertebrae
- Abnormal spacing of vertebrae

Podiatry Care

Reasonable fees for routine podiatry care will be considered and paid up to a maximum of $750 per calendar year. Evaluation and management of conditions which fall within the scope of practice of a podiatrist, including examination of the patient, evaluation for any required orthotics, trimming or removal of nail or nail bed, and other minor office procedures, are considered routine podiatry care.

Routine podiatry care does not include the following services:

- open cutting procedures to treat weak, strained, unstable or unbalanced feet, or bunions;
- removal of nail roots;
- treatment of corns, calluses or toenails in conjunction with treatment of metabolic or peripheral vascular disease; and
- orthotics obtained from a licensed orthotist or certified pedorthist.

These services are not subject to a maximum of $750 per calendar year.

No coverage is provided for specially molded shoes.

Preventive Services Benefit

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010. Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit unless there is no provider in the Plan's network who can provide the particular service. In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Preventive Services Benefit Overview

Only benefits that are considered "preventive benefits" as descripted in this section are available with no cost-sharing. In certain circumstances, as determined by Horizon Blue Cross Blue Shield, the preventive benefit is only payable with an appropriate diagnosis. Non-preventive Services are not covered without cost-sharing. The Plan will impose cost-sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Except as noted below (relating to children through age 21 and well woman visits), annual routine physical examinations are subject to the Plan's normal cost-sharing amounts (e.g., copayments for in- and out-of-network providers and subject to deductible and coinsurance for out-of-network providers). All covered participants and dependents are eligible to obtain, without cost-sharing, all required in-network preventive services applicable to them (e.g., for their age group). This includes ACA-required pregnancy-related preventive services and well woman visits, which must be provided to dependent children (up to age 26) where an attending provider determines that the services are age and developmentally appropriate.

Covered Preventive Services for Adults

a. Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.

b. Unhealthy alcohol use screening and counseling: screening and behavioral counseling interventions to reduce unhealthy alcohol use by adults ages 18 and older, including pregnant women, in primary care settings.

c. Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.

d. Cholesterol screening (Lipid Disorders Screening) for adults aged 40-75 years.

e. Colorectal Cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The Plan will not impose cost-sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.

f. Depression screening for adults.

g. Type 2 Diabetes screening in adults aged 40 to 70 who are overweight or obese, as part of cardiovascular risk assessment, with intensive behavioral counseling for those with abnormal blood glucose to promote a healthful diet and physical activity.

h. Diet counseling for adults at higher risk for chronic disease.

i. HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.

j. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.

k. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.

l. Tobacco Use screening for all adults and cessation interventions for tobacco users.

m. Syphilis screening for all adults at increased risk of infection.

n. Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

o. Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.

p. Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.

q. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.

r. Screening for hepatitis B virus infection in adults at high risk for infection.

s. Screening for latent tuberculosis infection in populations at increased risk.

Covered Preventive Services for Women, Including Pregnant Women

a. Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.

b. Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

c. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.

d. BRCA counseling about genetic testing for women at higher risk. Women whose personal or family history is associated with – who have an ancestry associated with – an increased risk for deleterious mutations in BRCA1 or BRCA2 genes will receive referral for counseling. The Plan will cover BRCA1 or 2 genetic tests without cost-sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.

e. Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.

f. Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifene, raloxifene or aromatase inhibitors) for women at increased risk for breast cancer and at low risk for adverse medication effects.

g. Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the plan administrator.

h. Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.

i. Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.

j. FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, including barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. See the Prescription Drug section for details. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost-sharing.

k. Gonorrhea screening for sexually active women age 24 and younger and in older women who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.

l. Counseling for sexually transmitted infections, once per year as part of a well woman visit.

m. Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.

n. Hepatitis B screening for pregnant women at their first prenatal visit.

o. Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool will be eligible for screening. The Plan will pay for the most cost-effective test methodology only.

p. Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.

q. Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.

r. Screening for diabetes after pregnancy in women with history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.

s. Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.

t. Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.

u. Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

v. Depression screening for pregnant and postpartum women.

w. Counseling interventions for pregnant and postpartum women at increased risk of perinatal depression.

x. Screening for urinary incontinence annually.

y. Screening for anxiety.

Covered Preventive Services for Children

a. Developmental screening for children under age 3, and surveillance throughout childhood

b. Behavioral assessments for children of all ages

c. Medical history

d. Anxiety screen for adolescent women

e. Blood pressure screening

f. Depression screening for adolescents ages 12 and older

g. Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors

h. Hearing screening

i. Height, Weight and Body Mass Index measurements for children

j. Autism screening for children at 18 and 24 months

k. Alcohol and Drug Use assessments for adolescents

l. Critical congenital heart defect screening in newborns

m. Hematocrit or Hemoglobin screening for children

n. Lead screening for children at risk of exposure

o. Tuberculin testing for children at higher risk of tuberculosis

p. Dyslipidemia screening for children at higher risk of lipid disorders

q. Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents

r. Cervical Dysplasia screening at age 21

s. Oral Health risk assessment

t. Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).

u. Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.

v. Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.

w. Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.

x. HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.

y. Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

z. Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

aa. Screening for hepatitis B virus infection in adolescents at high risk for infection.

bb. Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.

cc. Syphilis screening for adolescents who are at increased risk for infection.

dd. For adolescents, screening and counseling for interpersonal and domestic violence.

ee. Well-baby and well-child visits

Immunizations

Routine adult immunizations are covered for participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

a. Immunization vaccines for adults--doses, recommended ages, and recommended populations must be satisfied:

    i. Diphtheria/tetanus/pertussis

ii. Measles/mumps/rubella (MMR)

iii. Influenza

iv. Human papillomavirus (HPV)

v. Pneumococcal (polysaccharide)

vi. Zoster

vii. Hepatitis A

viii. Hepatitis B

ix. Meningococcal

x. Varicella

xi. COVID-19

b. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations must be satisfied:

- Hepatitis B

- Rotavirus

- Diphtheria, Tetanus, Pertussis

- Haemophilus influenzae type b

- Pneumococcal

- Inactivated Poliovirus

- Influenza

- Measles, Mumps, Rubella

- Varicella

- Hepatitis A

- Meningococcal

- Human papillomavirus (HPV)

- COVID-19

Office Visit Coverage

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the

Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit.

- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.

- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost-sharing with respect to the office visit.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100%. Well woman visits are also treated as Preventive Services and paid at 100%.

Preventive Services Coverage Limitations and Exclusions

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the participant or dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

2. Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.

3. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.

5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

- When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

- When related to judicial or administrative proceedings;

- When related to medical research or trials; or

- When required to maintain employment or a license of any kind.

7. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

8. Services related to a man's reproductive capacity, such as vasectomies and condoms.

Medicare Eligible Retiree Coverage

You and your eligible dependents become eligible for Medicare upon turning age 65, after receiving Social Security disability benefits for 24 months or when suffering from end-stage renal disease (kidney failure).

Coverage for Medicare eligible retirees and Medicare eligible dependents of retirees is provided under a group Medicare Advantage plan through a contract between the Welfare Fund and Aetna Life Insurance Company (the “Aetna Plan”). The Aetna Plan includes medical, hospital, routine vision and prescription drug coverage. The Welfare Fund will automatically enroll you and your dependents in the Aetna Plan upon each attaining Medicare eligibility.

Shortly after your enrollment in the Aetna Plan, you will receive an Evidence of Coverage booklet, which explains in detail covered services and exclusions and procedures governing how this plan provides coverage. It is important for you to familiarize yourself with the Aetna Plan rules and coverage and services available as a member of the Aetna Plan. You will also receive a plan membership card which must be used whenever you receive services covered under the Aetna Plan. Do not use your red, white and blue Medicare card because you may have to pay the full cost of services yourself. Keep your red, white and blue Medicare card in a safe place should you need it at a later date.

You must have both Medicare Part A (hospital coverage) and Medicare Part B (medical coverage) to be eligible for enrollment in the Aetna Plan. Whether you are receiving continued health coverage as a retiree based on exhaustion of your eligibility bank as an active member or self-payment of a premium, if you do not obtain Medicare coverage for yourself or your eligible dependents when Medicare eligible, claims will not be considered for coverage under the Welfare Plan.

Roughly three months before turning age 65, Medicare should be contacted about enrolling for Medicare coverage. While Part A is usually premium free, there is a premium for Part B. A copy of your red, white and blue Medicare card should be mailed in to the Fund Office/Attention: Pension Department. If your spouse is covered under a group health plan based on his or her current employment, your spouse can delay signing up for Medicare until his or her employment ends. It is important that you familiarize yourself with Medicare’s enrollment rules and, in particular, its criteria for determining a person’s “current employment” status. If you or your spouse enroll late, the start of Medicare coverage and coverage under this Plan as well as the Medicare premiums may be adversely impacted.

Coverage for life insurance, accidental death and dismemberment, and dental benefits for Medicare eligible retirees and Medicare eligible dependents of retirees is provided as outlined in those sections of this SPD.

LEVEL 2 BENEFITS OF HEALTH CARE (VISION COVERAGE)

If you are eligible to receive Level 2 benefits, in addition to the benefits included in Level 1, you will also receive vision coverage and accident and sickness benefits.

Benefits

The Plan provides coverage for general vision services, including regular eye examinations and eyewear, with Horizon Blue Cross Blue Shield of New Jersey, administered through Davis Vision.

In-network plan benefits include:

- Eye Examinations – covered in full minus a $10.00 copayment
- Lenses – covered in full minus a $25.00 copayment
- Frames – covered in full from Davis Vision collection
- Contact Lenses – in lieu of eyeglasses, up to a $100.00 allowance toward contact lenses

For a complete listing of Plan benefits, log on to the Davis Vision member site at davisvision.com.

You will receive the greatest benefit value by using an in-network vision provider. If you go out of network you must pay the provider at time of service and submit a claim to Davis Vision for reimbursement.

Reimbursement will be made up to the following amounts:

Eye examination	$40
Single vision lenses	$40
Bifocal lenses	$60
Trifocal lenses	$80
Lenticular lenses	$100
Frames	$50

A Direct Reimbursement Claim Form to request reimbursement for services received from out-of-network providers and directions for submitting this form are available on the Davis Vision member site.

The following limitations apply to vision coverage for participants and dependents age 19 and over:

- Examinations are limited to one per person during any calendar year
- Lenses are limited to two per person during any calendar year
- Frames are limited to one set per person every other calendar year
- No coverage is provided for the replacement of lost, stolen or broken eyewear

These limitations do not apply to dependents below age 19.

Coverage for medical treatment of eye disease or injury is covered under the medical portion of the Plan as medically necessary.

Exclusions

No coverage is provided for vision therapy.

LEVEL 3 BENEFITS OF HEALTH CARE (DENTAL COVERAGE)

If you are eligible to receive Level 3 benefits, in addition to the benefits included in Levels 1 and 2, you will also receive dental benefits.

Benefits

The Fund has contracted with Fidelio Insurance Company to underwrite, administer and pay dental benefits for the Welfare Plan's dental benefit program. When you become eligible for benefits under the Welfare Plan, you will receive a Fidelio Insurance Company identification card.

You may visit any dentist you choose. Your share of costs for covered benefits, if any, will depend on whether you visit a dentist who participates in the Fidelio dental provider network and has contractually agreed to:

1. No-Copay: accept Fidelio's payment as payment in full with no patient cost for most covered dental benefits.

2. Copay: accept Fidelio's reduced fee reimbursement schedule and patient is responsible for a fixed co-payment amount which is no more than the difference between Fidelio's payment and amounts specified under the reduced fee reimbursement schedule.

3. Co-Insurance: accept Fidelio's reduced fee reimbursement schedule and patient is responsible for a coinsurance. Fidelio's reduced fee reimbursement schedule and patient coinsurance amount will vary with different dentists.

4. Flagship: accept Fidelio's reduced fee reimbursement schedule as payment in full with no patient cost for most covered dental benefits. Using a Fidelio flagship dentist will increase your annual maximum benefit from $1,200 per covered person per year to $1,500 per covered person per year. The maximum amount payable in any calendar year for all courses of dental treatment (in network and out of network combined) for participants and dependents age 19 and over is $1,200 per covered person. If services are provided at a Fidelio "Flagship Office", the $1,200 calendar year maximum is increased to $1,500 per covered person per year. Orthodontic benefit payments are not applied towards the calendar year maximum. Yearly maximums do not apply to dependents below age 19.

To locate a participating dentist or to determine if your current dentist is in the Fidelio network, visit www.fideliodental.com or call a Fidelio customer service representative at 215-885-2443 or 800-262-4949 during normal business hours.

When you have chosen a dentist and call the office to schedule an appointment, identify yourself as a patient with Fidelio Insurance Company coverage and *reconfirm the dentist currently participates with Fidelio.* Present your identification card at the time of your visit to ensure that you receive the full benefits available to you.

If you choose to visit a dentist who does not participate in the network, identify yourself as a patient with Fidelio Insurance Company coverage and present your identification card at the time of your visit and ask your dentist to submit completed claims to:

Fidelio Insurance Company
2826 Mt. Carmel Avenue
Glenside, PA 19038

Claims for dental benefits must include member's name and Social Security number, patient's name, procedure codes, treatment description(s), date(s) of service and charge for each treatment procedure. Reimbursement for treatment will be made up to Fidelio's reduced fee reimbursement schedule. If your dentist's charges exceed amounts under this schedule, you will be responsible for the difference.

Pretreatment Estimates

Whenever the cost of treatment is expected to exceed $300.00, ask your dentist to submit a request for predetermination of covered benefits to Fidelio. Fidelio will review the proposed treatment and notify the dentist and patient if the treatment is covered and the dollar amount of benefits payable, provided you are eligible for benefits at the time treatment is actually rendered. Fidelio will also notify a patient of his/her out-of-pocket cost for treatment. To facilitate either a predetermination or the review of completed services, Fidelio requires that all pertinent documentation be provided by the treating dentist, including where applicable, appropriate X-rays, charting of periodontal pocket depths, and a treatment narrative.

Orthodontic Treatment

Orthodontic benefits are provided for dependent children under the age of 19 years to treat injury or disease (treatment must commence during the time an eligible dependent is under the age of 18 years). Benefits for orthodontic treatment are paid in equal installments depending on the length of treatment (typically, a 24-month treatment plan is paid in four installments with the initial payment made at banding). Subsequent installments are made approximately 8 months apart with final payment at de-banding. You must remain eligible for dental benefits for installments to be paid. Invisalign type of treatment is not a covered benefit.

Impacted Wisdom Teeth, etc.

Coverage for the removal of soft tissue and bony impacted teeth, residual roots and coverage for treatment of jaw joint disorders is provided under the medical portion of the Plan for in- and out-of-network providers. Pre-determinations and claims should be sent to Fidelio. The Explanation of Benefits ("EOB") with or without a check will be issued by the Fund.

Coverage Exclusions

Plan payments will not be made for the following:

- Experimental procedures.

- Appliances, restorations, and procedures to alter vertical dimension, including, but not limited to, occlusal guards and periodontal splinting.

- Space maintainers for dependent children age 10 or over.

- Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance.

- Restorations that are not of any dental health benefit, but cosmetic in nature (e.g., bleaching, veneers, Invisalign, etc.).

- Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including the use of fixed bridgework, where a removable partial denture would restore the arch. Payment of the applicable percentage of the Plan allowance for the alternate service will be made towards such treatment, and the balance of the cost remains the responsibility of the patient.

- Expenses incurred for a temporary denture.

- Expenses incurred for the replacement of a denture, crown, or bridge for which benefits were previously paid, if such replacement occurs within five years from the date the expense was originally benefited.

- General anesthesia, except for the following reasons:

    - Removal of one or more impacted teeth.

    - Removal of four or more erupted teeth.

    - Treatment of a physically or mentally impaired person.

    - Treatment of a person who has a medical problem, when a medical physician requests in writing that the treating dentist administer general anesthesia. This request must accompany the dental claim form.

- Duplicate charges.

- Services incurred prior to the effective date of coverage.

- Services incurred after cancellation of coverage, except for work which was initiated prior to cancellation by: (1) an impression taken for dentures or bridges or other appliances or modifications of an appliance, (2) a tooth was prepared for a crown or restoration, or (3) a pulp chamber was opened for a root canal therapy.

- More than two oral examinations per calendar year.

- Services incurred in excess of the calendar year maximum.

- Services or supplies that are not necessary according to accepted standards of dental practice or are incomplete.

- Orthodontic services which did not commence during the time an eligible dependent is under the age of 18, or which are provided after the loss of eligibility.

- Sealants on teeth other than the first and second permanent unrestored molars, or applications applied more frequently than every thirty-six months or a service provided outside of ages five through under age fourteen.

- Services such as trauma, bony impaction removal, or jaw joint treatment for which coverage is provided under the medical portion of the Plan.

- Any combination of more than four prophylaxes or periodontal maintenance appointments per calendar year.

- More than one full mouth X-ray series or Panorex in any period of thirty-six consecutive months.

- More than one bitewing X-ray series per calendar year.

- Adjustments or repairs to dentures performed within six months of the installation of the denture.

- Services or supplies in connection with periodontal splinting.

- Services related to Implants (Implant Body, Abutment, and Implant Crown). Alternate benefit of a regular crown (ADA #2750) is allowed for an Implant Crown.

- Expenses incurred for the replacement of a missing or stolen appliance or for an existing denture, which is or can be made satisfactory.

- Training in plaque control or oral hygiene, or for dietary instructions.

- Completion of reporting forms.

- Charges made by the attending dentist for the patient's failure to appear as scheduled for an appointment.

- Charges for services and supplies which are not necessary for treatment of the injury or disease, or are not recommended and approved by the American Dental Association (ADA), or charges which are not reasonable.

- Scaling and root planing which is not followed, where indicated, by definitive pocket elimination procedures. In the absence of continuing periodontal therapy, scaling and root planing will be considered a prophylaxis and subject to the limitations of that procedure. Scaling is limited to 1 time per 12-month period per quadrant and with a limit of 2 quadrants per visit.

LEVEL 4 BENEFITS OF HEALTH CARE (PRESCRIPTION DRUG COVERAGE)

If you are eligible to receive Level 4 benefits, in addition to the benefits included in Levels 1, 2 and 3, you will also receive prescription drug benefits.

The Fund has contracted with OptumRx to administer prescription drug benefits.

You may purchase your prescription from:

- An OptumRx network retail pharmacy
- A retail pharmacy outside the OptumRx network
- OptumRx Home Delivery

OptumRx Network Pharmacy

When you fill a prescription at an OptumRx network retail pharmacy, present your OptumRx identification card, which includes information required by a pharmacy to submit your claim for prescription drug benefits to OptumRx. Up to a 30-day supply of a covered medication is covered, less the applicable copayment. To locate an OptumRx network retail pharmacy in your area, log in to optumrx.com or call OptumRx at 855-295-9140.

Out-of-Network Pharmacy

When you fill a prescription at an out-of-network retail pharmacy, you must pay the full cost of the prescription up-front. Up to a 30-day supply of a covered medication is covered. Ask the pharmacist for a receipt and obtain an OptumRx Prescription Reimbursement Request Form from OptumRx or the Fund Office. Complete the form, attach your receipt and mail to OptumRx at the address on the claim form. OptumRx will reimburse you the cost of your prescription up to their negotiated amount, less the applicable copayment.

OptumRx Home Delivery

Medication home delivery is available for medications you take on a regular or long-term basis (also called maintenance medications). When you enroll in OptumRx home delivery you can receive up to a 90-day supply of a covered medication at one time right to your mailbox, with payment of the applicable copayment.

To start home delivery, log in to optumrx.com or call OptumRx at 855-295-9140. Please have the following information ready: physician's contact information, medication name and strength and payment information.

CVS90 Saver Program

The OptumRx CVS90 Saver program offers you the convenience of ordering a 90-day supply of a maintenance medication at a CVS pharmacy retail location at home delivery pricing. Bring your prescription for a 90-day supply to a CVS retail pharmacy or call the pharmacy for assistance.

Copayments

Copayments are determined by the type of medication purchased and place of purchase.

Medication Type	Network Pharmacy 30-day supply	Home Delivery 90-day supply
Generic Medication	$7	$14
Preferred Brand (Formulary)	20% coinsurance $75 maximum	20% coinsurance $150 maximum
Non-Preferred Brand (Non-formulary)	35% coinsurance $75 maximum	35% coinsurance $150 maximum
Non-Preferred (Non-formulary)	50% coinsurance $30 minimum	50% coinsurance $60 minimum
Specialty – generic and preferred brand	Not Covered	$50 Optum Specialty per 30-day fill

Listings of the most commonly prescribed medications which fall under the above medication categories can be obtained by visiting optumrx.com or calling the Fund Office.

When visiting your physician, ask him or her to consider prescribing a generic or preferred brand name medication or writing a prescription which allows for a generic substitution. When you present a prescription for a brand name medication at the pharmacy or at OptumRx Home Delivery, your order will be filled with a generic equivalent if one is available. Regardless of whether or not your physician's written prescription is restrictive, your order will never be filled with a lower-cost therapeutically-equivalent preferred brand name medication unless your physician's consent is obtained.

Out-of-Pocket Maximum

The Plan will pay 100% of covered participating provider expenses if you or your family reaches the applicable calendar year prescription drug out-of-pocket maximum of $4,000 per individual and $8,000 for families. Once any covered individual of your family meets the individual limit, the Fund will pay 100% of covered prescription drug expenses incurred at a participating pharmacy for that person for the remainder of the calendar year. Once two individuals of your family meet their individual limit, or the family as a whole meets the $8,000 limit, the Plan will pay 100% for the entire family for the balance of the calendar year.

Expenses for services the Plan does not cover, balance billing, penalties for failure to follow the Plan's medical management requirements, and expenses for drugs purchased at non-participating pharmacies will not count toward the maximum.

Excluded Medications

Some medications are not covered by the Welfare Plan's prescription drug program without prior approval for medical necessity from OptumRx. **This approval is only made in limited circumstances.** Without prior approval, you will pay 100 percent of the medication price.

For a list of excluded medications, including covered medication options, visit optumrx.com or call the Fund Office. Should your physician prescribe an excluded medication, ask him or her to consider changing your prescription to a generic or brand formulary option. If your physician believes there is a clinical reason why one of the generic or brand formulary options is not suitable for you, your physician should call OptumRx at 855-295-9140 to request prior authorization for your use of the prescribed excluded medication. Prior approvals will be reviewed and either approved or denied by OptumRx. You will receive written notification of the approval or denial and information on appealing denials to the Welfare Fund.

In addition to specific excluded medications, except for items covered under Preventive Benefits, no coverage is provided for over-the-counter items, such as cold remedies and wound dressings which, even though prescribed by a physician, can be legally purchased without a prescription, as well as medications prescribed to treat impotency and vitamins, minerals and herbs.

Preventive Benefits

Certain preventive prescriptions (as listed below), including contraceptive methods are covered by the Plan at no cost. Most preventive prescriptions will be covered under the Prescription Drug Plan but a few may be covered under the Medical Plan. For a preventive prescription to be covered, it must be prescribed by a doctor and meet the criteria set out by OptumRx. If a covered item or drug is available over-the-counter and is covered under this provision, you must present a prescription at the time of purchase in order for it to be covered under the Plan. To find out if a particular preventive service will be paid at 100% when provided by a participating in-network provider, contact OptumRx by calling the number on your ID card.

The Plan may cover a generic drug without cost-sharing and charge cost-sharing for an equivalent non-preferred or non-formulary drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate (or where a generic is not yet available), as determined by the individual's health care provider.

- **Aspirin** to prevent cardiovascular disease when prescribed by a health care provider.

- **Low-dose aspirin** after 12 weeks of gestation for women who are at high risk for preeclampsia.

- **Oral Fluoride** supplements at currently recommended doses (based on local water supplies) to preschool children age 6 months through age 16 whose primary water source is deficient in fluoride.

- **Folic Acid** (over the counter/generic only) supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid.

- **FDA-approved contraceptive methods for women**, including contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. Where the FDA has approved one or more therapeutic and pharmaceutical equivalent versions of a contraceptive drug, device, or product, please note only the generic version (or if there is no generic, only one version of the drug in the Plan's formulary) of the therapeutic and equivalent version of a contraceptive drug, device or product will be paid without cost-sharing. You may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by your attending health care provider.

- **FDA-approved tobacco cessation medications** (including both prescription and over-the-counter medications and including cessation treatment for e-cigarettes use) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization including generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system), brand Nicotrol NS (nasal spray), brand Chantix and generic Zyban. Single source brands are only covered until generics become available. Over-the-counter medications are covered only with a prescription.

- **Bowel Preps** in connection with a screening colonoscopy.

- **Risk-reducing medications (such as tamoxifen, raloxifene or aromatase inhibitors)** for women at increased risk for breast cancer and at a low risk for adverse medication effects.

- **Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors** (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.

- **Pre-exposure Prophylaxis ("PrEP")** for the prevention of HIV infection. Single source brands are only covered until generics become available.

- **Routine adult immunizations and immunization vaccines for children from birth to age 18**, including administration of such immunizations, are covered for participants and

dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

- Breast **cancer preventive medications** for women who have a higher chance for breast cancer but have not had breast cancer. These preventive medications are available for free. To qualify, you must:
    - Be age 35 or older
    - Be at increased chance for the first occurrence of breast cancer - after risk assessment and counseling
    - Obtain copay waiver

  Your doctor must submit a Healthcare Reform Copay Waiver Request Form to request $0 cost share for primary prevention, if you meet the coverage criteria. If you qualify, you can receive these drugs for free for up to 5 years, minus any time you have been taking them for prevention. If you do not qualify to get these medications for free, the Plan covers these medications with normal cost sharing for the treatment of breast cancer, to prevent breast cancer recurrence and for other indications.

  The prescription medications include:

    - anastrozole
    - exemestane
    - raloxifene
    - tamoxifen

Optum Specialty Pharmacy

Optum Specialty Pharmacy provides specialty medications and clinical support for complex conditions including, but not limited to, cancer, rheumatoid arthritis, multiple sclerosis and cystic fibrosis. For more information about the Optum Specialty Pharmacy and/or filling your first specialty medication, visit specialty.optumrx.com or call 855-427-4682.

For a specialty medication to be covered, it must (1) be approved for coverage under the Welfare Plan's prescription drug program by OptumRx and (2) be filled through Optum Specialty Pharmacy. Optum Specialty Pharmacy provides personalized pharmacy care management services from a team of clinical experts specially trained in your health condition.

Optum Specialty Pharmacy offers the option of having your specialty medication delivered to your home, doctor's office or a location of your choice, or picked up at a local pharmacy.

AMENDMENT AND TERMINATION

The Trustees have the sole and exclusive discretion and authority to increase, decrease, change or terminate benefits, eligibility rules or other provisions of the Plan at any time as they deem necessary for efficient administration of the Fund. These changes must be consistent with the provisions of the Trust Agreement.

The Trustees intend to continue the Plan indefinitely; however, the Trustees reserve the right to amend or terminate this Plan by a majority vote of the Trustees present at a duly constituted Board of Trustees meeting with a quorum present. Benefits may be adjusted upward or downward in the future reflecting the claims experience of the Plan and changing levels of available income. If the Plan is terminated, monies in the Fund will be paid in accordance with the Trust Agreement and applicable law. The termination of this Plan shall not result in any reversion of Fund assets to any contributing employer.

ERISA RIGHTS

As a participant in the Operating Engineers Local 825 Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, including union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive this material 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 Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may

file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the 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 the:

National Office:
Division of Technical Assistance and Inquiries Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
(866) 444-3272

For more information about your rights and responsibilities under ERISA, call (866) 444-3272 or visit www.dol.gov/ebsa.

CONFIDENTIALITY OF PERSONAL INFORMATION

Confidentiality of Your Health Care Information

HIPAA: Use and Disclosure of Protected Health Information

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that self-funded group health plans like the Local 825 group health plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- PHI does not include health information contained in employment records held by a contributing employer who participates in this Fund in its role as an employer, including but not limited to health information on Weekly Loss of Time (Short Term Disability) benefits, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), state Paid leave, and death benefits.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the Fund Office and on the website. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan and the Plan Sponsor will not use or further disclose information that is protected by HIPAA (Protected Health Information or PHI) except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. The Plan's Use and Disclosure of PHI: The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

    1. **Treatment** is the provision, coordination, or management of healthcare and related services. It also includes but is not limited to consultations and referrals between one or

more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

2. **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

    a. Determination of eligibility, coverage, cost-sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

    b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

    c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

3. **Health Care Operations** includes, but is not limited to:

    a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities.

    b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions.

    c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

    d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.

    e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

    f. Compliance with and preparation of documents required by ERISA, including Form 5500, Summary Annual Reports and other documents.

B. When an Authorization Form is Needed: Generally, the Plan will require that you sign a valid authorization form (available from the Fund Office or an Applicable Claims Administrator) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a

government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI. In addition, the Plan needs an Authorization Form in order to speak with a spouse or adult dependent. Please make sure to revoke the form should you change your mind or get divorced.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. not use or disclose the information for employment-related actions and decisions;

4. not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. make PHI available to the individual in accordance with the access requirements of HIPAA;

7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. make available the information required to provide an accounting of PHI disclosures;

9. make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;

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

11. notify you if a breach of your unsecured protected health information (PHI) occurs.

D. In order to ensure that adequate separation between the Plan and the Board of Trustees is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Fund Administrator.

2. Staff designated by the Fund Administrator including Welfare Fund staff as delineated in the Plan's Privacy Policies and Procedures.

3. Business Associates under contract to the Plan including but not limited to the PPO/medical claims administrator, preferred provider organization network, utilization management company, Behavioral Health Program, outpatient and prescription drug program.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer.

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Fund Office or applicable Claims Administrator.

F. Effective April 21, 2005, in compliance with HIPAA Security regulations, the Plan Sponsor:

1. has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;

2. ensures that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. ensures that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

4. will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. Hybrid Entity: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical, prescription drug benefits, dental, vision, and COBRA administration.

ADMINISTRATIVE INFORMATION

Type of Plan

This Fund is a self-funded welfare fund providing a plan of benefits that includes hospital, surgical, convalescent care, ambulance, home health care, maternity, medical, anesthesia, PPO, mental health, substance abuse, life insurance, survivor, accidental death and dismemberment, vision, chiropractor, podiatrist, accident and sickness, dental, prescription drugs and other related benefits, depending upon the benefit coverage level for which the participant or beneficiary is eligible.

Plan Name	**Plan Number**	**Employer Identification Number:**	**Plan Year**
Operating Engineers Local 825 Welfare Fund	501	22-6033381	July 1 to June 30
Plan Administrator			
Ms. Christine Medich Operating Engineers Local 825 Fund Service Facilities 65 Springfield Avenue SECOND FLOOR Springfield, NJ 07081 973-671-6800			
Agent for Service of Legal Process:			
Susanin, Widman & Brennan, PC 1001 Old Cassatt Road, Suite 306 Berwyn, PA 19312 -OR- DeCotiis, Fitzpatrick, Cole & Giblin, LLP 61 South Paramus Road, Suite 250 Paramus, NJ 07652			

Service of Legal Process may also be made upon a Plan Trustee or upon the Plan Administrator.

Contributing Employers

The Plan is established and maintained by the Union and several contractor associations and other contributing employers. A list of all members of the associations and all other contributing employers may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available at the Fund Office for review by participants and beneficiaries.

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employer organization is a sponsor of the Plan, and if the employer is a Plan sponsor, then such Plan sponsor's address.

Plan Administration

The Plan is administered and maintained by a joint board of trustees, four of whom are appointed by the Union and four of whom are appointed by sponsoring employers.

The assets of the Plan are held in a trust fund under the trust agreement. The board of trustees may, in its discretion, delegate management of certain Plan assets to an investment manager.

The Plan is maintained and contribution amounts are determined according to the provisions of collective bargaining agreements between the Union and the contractor associations and/or employers. Copies of such collective bargaining agreements may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and such collective bargaining agreements are available at the Fund Office for review by participants and beneficiaries.

The Plan is self-administered. The actual day-to-day administration of the Plan is carried out at the Fund Office, which was established for this purpose.

Source of Contributions and Funding Medium

Payments are made to the trust fund by individual contributing employers under the provisions of any applicable collective bargaining agreement, by some participants through self-payments, and from any income earned from investment of contributions. All monies are used exclusively for providing self-funded benefits to all eligible participants and beneficiaries, and for the payment of other expenses incurred with respect to operation of the Plan.

BOARD OF TRUSTEES	
Employer Trustees	**Union Trustees**
Ross Pepe, Co-Chairman	Gregory Lalevee, Co-Chairman
Arthur B. Corwin	Joseph A. Grace, Jr.
Jack Kocsis, Jr.	Alex Kolbasowski
David Murawski	John Wood

Address for all Trustees:
Operating Engineers Local 825 Fund Service Facilities 65 Springfield Avenue Second Floor Springfield, NJ 07081

EXTERNAL REVIEW OF CLAIMS

An “Urgent Care Claim” is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant’s attending health care provider with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant’s life or health. In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative, bypassing the need for completion of the Plan’s written authorized representative form.

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan’s internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization (“IRO”). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

All notices relating to external review sent will contain a notice about the availability of Spanish, Chinese, Tagalog, Korean, Portuguese, Gujarati, Polish, Italian, Arabic, French Creole, Hindi, Vietnamese, French, Urdu, Yiddish, Bengali, Greek and Albanian language services. Assistance with filing a claim for external review in any of the above languages is available by calling (973) 671-6800. Notices relating to external review will be provided in the above languages upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al (973) 671-6800.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (973) 671-6800.

CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (973) 671-6800.

KOREAN (한국어): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (973) 671-6800번으로 전화해 주십시오.

PORTUGESE (Português): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (973) 671-6800.

GUJARATI (ગુજરાતી): **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** (973) 671-6800.

POLISH (Polski): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (973) 671-6800.

ITALIAN (Italiano): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (973) 671-6800.

ARABIC (العربية): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- (973) 671-6800

FRENCH CREOLE (Kreyòl Ayisyen): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (973) 671-6800.

HINDI (हिंदी): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (973) 671-6800 पर कॉल करें।

VIETNAMESE (Tiếng Việt): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (973) 671-6800.

FRENCH (Français): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (973) 671-6800.

URDU (اُردُو): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں(973) 671-6800.

YIDDISH (אידיש): אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט(973) 671-6800.

BENGALI (বাংলা): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-(973) 671-6800.

GREEK (λληνικά): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (973) 671-6800.

ALBANIAN (Shqip): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (973) 671-6800.

Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.

- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.

- A determination that you or your dependent are not eligible for coverage under the terms of the Plan (except for a determination that involves a rescission of coverage as described above).

- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.

- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

- Claims that relate to benefits other than health care benefits.

- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.

- In an urgent care situation (see "Expedited External Review of an Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.

- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeals process is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, do the following: mail your request to: Operating Engineers Local 825 Fund Service Facilities, Attention: External Review, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081 (telephone 973-671-6800) or e-mail to: Info825@825funds.org.

The Fund has contracted with the following three external review providers which are authorized to review eligible adverse benefit claim determinations:

Name	Address
MES Solutions	100 Morse Street Norwood, MA 01801
Reliable RS	604 Banyan Trail P.O. Box 810789 Boca Raton, FL 33481
MLS	20750 Civic Center Drive Suite 600 Southfield, MI 48076

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.

- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.

- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.

- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.

- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.

- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If the Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeals decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

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

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

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

- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.

- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.

- A statement that judicial review may be available to you.

- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

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

- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, do the following: mail your request to: Operating Engineers Local 825 Fund Service Facilities, Attention: External Review, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081 (telephone 973-671-6800) or e-mail to: Info825@825funds.org.

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care". The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

VACATION SAVINGS BENEFIT

Rules and Regulations for the Vacation Savings Benefit Provided By

The International Union of Operating Engineers Local 825 Welfare Fund

Highlights and General Information

Effective Date

The International Union of Operating Engineers Local 825 Vacation Savings Benefit was provided by and funded by the Vacation Savings Fund from March 20, 1974 to July 31, 2011. On August 1, 2011, the Vacation Savings Fund merged into the Welfare Fund. This document describes the Vacation Savings Benefit in operation on June 24, 2013 and thereafter.

Administration

The Benefit is self-administered by the Board of Trustees of the International Union of Operating Engineers Local 825 Welfare Fund and/or their designee:

65 Springfield Avenue, Second Floor
Springfield, NJ 07081
Telephone: 973-671-6800

Employer Trustees	Union Trustees
Ross Pepe, Co-Chairman	Gregory Lalevee, Co-Chairman
Arthur B. Corwin	Joseph A. Grace, Jr.
Jack Kocsis, Jr.	Alex Kolbasowski
David Murawski	John Wood

Contributions

The Benefit is funded by employer contributions as specified in a collective bargaining agreement with the Union or a participation agreement with the Trustees. This money is held and invested by the Trustees pursuant to a trust agreement for the purpose of paying benefits specified in these Rules and Regulations. Upon written request to the Plan Administrator, you are entitled to receive information as to whether a particular employer is a contributing employer and, if so, the employer's address. Additionally, you are entitled to receive a copy of the collective bargaining agreement or participation agreement under which you are covered upon written request to the Plan Administrator and you are entitled to examine the agreement at the Plan Administrator's office.

How the Benefit Works

The Vacation Savings Benefit provides you with an annual savings or vacation savings payment. The money for this benefit comes from ***contributing employers*** who have agreed to make vacation savings contributions to the Welfare Fund on your behalf as specified in a ***collective bargaining agreement*** with the ***Union*** or in a ***participation agreement*** with the Trustees. Only employers who have signed a written agreement to contribute are required to remit contributions to the Fund on your behalf. If you are uncertain whether your employer has a current signed contract, you may request in writing from the Plan Administrator information as to whether a particular employer is a ***contributing employer*** and, if so, the employer's address. Once remitted to the Fund, your contributions are held in your ***account*** within the Fund***,*** subject to investment gain or loss and subject to reasonable and necessary administrative expenses. Your ***account*** is valued each year on September 30 and the contents of your ***account***, as determined after this valuation, are distributed each year during the first week of December.

Eligibility

You are eligible to participate in the Benefit if you perform at least 1 hour of work that is covered by a ***collective bargaining agreement*** between a ***contributing employer*** and the ***Union*** or covered by a ***participation agreement*** between a ***contributing employer*** and the Trustees of the Fund.

Owner-Operators who have signed a ***collective bargaining agreement*** and who are primarily engaged in performing bargaining unit work and who have employees covered by a ***collective bargaining agreement*** with Local 825 are also eligible to participate in the Benefit. If you are an Owner-Operator and you are interested in participating in the Benefit, please contact the Plan Administrator for more information.

Contributions

Your ***contributing employer*** will make vacation savings contributions to the Welfare Fund on your behalf as specified in its ***collective bargaining agreement*** or ***participation agreement.***

Your Annual Benefit Amount

Your annual benefit amount is based upon vacation savings contributions made to the Welfare Fund on your behalf between October 1 and September 30. The Plan Administrator allocates these contributions to an ***account*** in your name within the Fund. In addition, the Plan Administrator adjusts your ***account*** on September 30 of each year as follows:

- The Plan Administrator credits or deducts your pro rata share of overall investment return or loss during the period of October 1 to September 30;

- The Plan Administrator deducts your pro rata share of reasonable and necessary administrative expenses during the period of September 1 to August 31 or during such other period of 12 consecutive months as determined in the discretion of the Trustees.

You have no right, title, or interest in your ***account*** while it is held in the Fund. You have only the right to a distribution subject to the terms and conditions specified in these Rules and Regulations.

Your account is reduced to zero each time you receive a distribution of your account under these Rules and Regulations.

Once every 12 months, you may request in writing a report on the balance in your ***account*** from the Plan Administrator. The balance specified in any such report is subject to adjustment as described in this section.

Distributions

The Plan Administrator distributes your benefit amount each year during the first week of December. You do not need to apply. Your savings benefit check is sent to you automatically by the Plan Administrator. In addition, you may receive a supplemental distribution if, after the annual December distribution, the Fund receives vacation savings contributions for work you performed prior to September 30.

Death

If you die, your surviving spouse will receive the full value of your ***account*****,** if any**,** in a lump sum on the December distribution date next succeeding the date of your death.

If you are not married at the time of your death, the full value of your ***account*** is distributed to your estate on the December distribution date next succeeding the date of your death.

Incapacity

In the event it is determined that you are unable to care for your affairs because of mental or physical incapacity, any benefit due may be paid to the legal guardian, committee, or legal representative designated to handle your affairs. The same rule applies in the case of a surviving spouse who is entitled to payment of a deceased participant's ***account*** balance.

No Assignment of Benefit

You do not have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, or commute any property while it is held in your ***account.*** In addition, except as otherwise provided by law, property held in your ***account*** is not subject to any legal process, to levy, to execution upon, to attachment, to garnishment, to bankruptcy and insolvency proceedings, or to any action by any creditor for payment of any obligation or debt incurred by you.

Exclusive Benefit

No part of the assets of the Benefit shall be returned to any ***contributing employer*** or the ***Union*** under any circumstances.

Taxation

Your ***contributing employer*** must include vacation savings contributions to the Fund on your behalf in your gross income.

Your ERISA Rights

Participants in the Benefit have certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. ERISA states that, as a participant, you are entitled to:

- Examine, without charge, all governing documents at the Plan Administrator's office and other specified locations. These documents include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor;

- Obtain copies of all governing documents including insurance contracts, collective bargaining agreements, the latest annual report and updated Rules and Regulations upon a written request directed to the Plan Administrator. The Plan Administrator may charge a reasonable amount for the copies;

- Receive a summary of the Fund’s annual financial report. The Plan Administrator is legally required to give participants a copy of this summary annual report; and

- Obtain a statement, free of charge, telling you the amount of your account. This statement must be requested in writing and the Plan Administrator is not obligated to provide it more than once a year.

Further, you may not be fired or discriminated against in any way as a means of preventing you from obtaining your savings benefits or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Fund 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 documents and pay you up to $110 a day until you receive them – unless you did not receive the materials for reasons beyond the Plan Administrator's control. In addition to defining the rights of participants, ERISA imposes obligations on the people responsible for operating the Benefit. These persons are legally referred to as fiduciaries and must act prudently and in the sole interest of the participants and beneficiaries. If the fiduciaries misuse the Fund's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, however, or if the court finds your claim to be frivolous, the court may order you to pay these costs and fees.

If you have any questions about your Benefit, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claim and Appeal Procedure

ERISA regulations describe steps that must be taken in the cases when a claim for payment is denied, either in whole or in part. A claim might be denied if:

- The Plan Administrator does not believe that you are entitled to payment; or
- The Plan Administrator disagrees with the payment amount to which you believe you are entitled.

If your claim is denied, the ***Plan Administrator*** has to notify you in writing within 90 days after receiving your claim. The notice must contain the following information:

- The specific reason(s) your claim was denied.
- The provisions of these Rule and Regulations that support the denial.
- If your application was incomplete, the additional information needed to complete your claim request and an explanation of why it is needed.
- Information on what you need to do in order to have the claim denial reviewed.
- A statement of claimant's right to bring a civil action under section 502(a) of ERISA following an adverse determination on review.

If you do not receive notice on the status of your claim from the ***Plan Administrator*** within 90 days, or within 180 days if it is a special case (see **Time Extensions**), you can assume your claim has been denied and you may request a review of your denial.

Once the ***Plan Administrator*** has reviewed your claim and notified you in writing of the denial within the required 90-day period, you may contest the denial. You must submit a written request for a review of that denial within 60 days of the date of the ***Plan Administrator's*** written notification. In case the ***Plan Administrator*** does not notify you of the denial within the required 90-day period, your request for review should be submitted immediately after the 90-day period expires.

If you wish, you (or your representative) may review the appropriate governing documents and submit written information supporting your claim to the Board of Trustees.

The Board of Trustees will review your request at their next quarterly meeting immediately following receipt of your request (unless you submitted your request less than 30 days prior to the next quarterly meeting in which case your request will be heard at the following quarterly meeting) and you will receive written notification of a final decision within five (5) days after a meeting at which your request is heard unless the ***Trustees*** need additional time (see **Time Extensions**). This notification will:

- Be written in clear, easily understood language;
- Inform you of the decision, the reasons why that decision was made, and the specific provisions from these Rules and Regulations that support it;

- Inform you of your right to receive free of charge upon your request reasonable access to, and copies of, all documents and other information relevant to your claim; and

- State your right to bring an action under section 502(a) of ERISA.

If you disagree with the results of the review, you may file suit in federal or state court. If your suit is successful, the court may award you legal costs, including attorneys' fees.

Time Extensions

Under special circumstances, the 90-day initial period for notice of a decision regarding an initial claim for benefits may be extended. Similarly, the ***Trustees*** may delay ruling on your request for review until the quarterly meeting following the meeting that immediately followed receipt of your request. You will be informed in writing of any extensions before the end of these initial notification periods. The extension notice will state the special circumstances necessitating the delay and the revised date by which you may expect a decision.

Factual Findings and Rule Interpretations

With respect to any claim or appeal, the Trustees shall be the sole judges of the standard of proof required in any case and factual findings by the Trustees shall be final and binding on the claimant. In this regard, each participant and/or beneficiary making a claim or appeal under these Rules and Regulations shall furnish to the Trustees any information or proof determined by the Trustees or their agent to be reasonably necessary for the administration of the Benefit or for the determination of any matter before the Trustees or their agent. If a participant and/or beneficiary makes false statements or furnishes fraudulent information in connection with a claim, appeal, or other matter before the Trustees or their agent and such statements or information result in payment of benefits in violation of these Rules and Regulations, then the Trustees may deny, suspend, or discontinue such benefits and shall have the right to recover any benefit payments made in reliance on such false statements or fraudulent information.

The Trustees have the sole and exclusive discretion to construe and interpret these Rules and Regulations and such constructions and interpretations shall be final and binding on the claimant.

Amendment

The Trustees may amend or modify these Rules and Regulations at any time in accordance with the Trust Agreement.

Termination

In the event of termination of this Benefit by the Trustees pursuant to the ***trust agreement*** or by operation of law, the Trustees shall adjust all participant ***accounts*** on the day prior to the effective date of the termination. The ***accounts*** shall be adjusted as described in the “Your Annual Benefit Amount” section of these Rules. On the effective date of termination or shortly thereafter, the Plan Administrator shall distribute to you the assets then remaining in your ***account.*** In the event that a

participant cannot be located within 6 months of the effective date of termination, such a participant's ***account*** shall be forfeited and distributed on a pro rata basis to all participants to whom payments have or can be made.

Glossary

ACCOUNT	An individual ***account*** is maintained for you in the Fund. An ***account*** contains your share of the total vacation savings assets, including all vacation savings contributions made on your behalf, earnings or losses on those contributions, and charges for administrative expenses.
COLLECTIVE BARGAINING AGREEMENT	An agreement between the ***Union*** and a ***contributing employer*** which describes the terms and conditions of employment for individuals covered under the agreement, including participation in this Benefit. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries.
CONTRIBUTING EMPLOYER	Any company that employs persons covered under a ***collective bargaining agreement*** or ***participation agreement*** requiring vacation savings contributions to the Fund.
PARTICIPATION AGREEMENT	An agreement between a ***contributing employer*** and the Trustees requiring contributions for employees covered by the agreement. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries.
TRUST AGREEMENT	An agreement granting beneficial ownership of vacation savings assets to participants and beneficiaries of this Benefit pursuant to the terms and conditions set forth herein and legal ownership and administration responsibilities to the Board of Trustees. This Benefit is part of the International Union of Operating Engineers Local 825 Welfare Fund and, therefore, the Trust Agreement for that Fund applies to this Benefit.
UNION	The International Union of Operating Engineers Local 825 and its affiliates.

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