Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue
Springfield, New Jersey 07081
(973) 921-1661

Pre-Cert and PPO
(800) 677-3237

December 9, 2005

Dear Member:

The Trustees of the Operating Engineers Local 825 Welfare Fund have recently approved the following changes to the Welfare Plan.

Motorcycles – Coverage is expanded to include injuries sustained by an operator of a motorcycle under the Plan's non-renewable lifetime aggregate maximum of $50,000 for all injuries sustained in connection with a motorized recreational vehicle accident. This benefit is effective for initial claims incurred on and after July 1, 2004.

Physician Assistant – Coverage is expanded to include physician assistant services rendered during a surgical procedure. Benefit is limited to 50 percent of the amount payable under the Plan for services rendered by an assistant surgeon. This benefit is effective for services rendered on and after July 1, 2005.

Pain Management – The $600 per visit limitation for professional and facility charges is increased to $2,000. This benefit continues to remain subject to a $6,000 calendar year maximum. This change is effective for services rendered on and after January 1, 2006.

Speech Therapy – A $15 copayment per session for the first 24 sessions and a $25 copayment per session for sessions in excess of 24 apply to covered services. Services which are generally available through the school system are not covered. This change is effective for services rendered on and after January 1, 2006.

Should you have any questions regarding the above, please do not hesitate to call the Fund Office.

Sincerely,

Christine Medich

Christine Medich
Administrator

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue
Springfield, New Jersey 07081
(973) 921-1661

Pre-Cert and PPO
(800) 677-3237

December 15, 2006

Dear Participant:

Enclosed are the Welfare Fund's 2006 Annual Notification under the Women's Health and Cancer Rights Act of 1998 and notice of Express Scripts' 2007 formulary.

During this past year the Board of Trustees approved several improvements to the Welfare Plan, including an increase in the weekly supplemental accident and sickness benefit from $180.00 to $350.00 per week for periods of disability commencing on and after January 1, 2006, increases in the amounts reimbursed under the dental schedule for a number of dental procedures, and expanding coverage for mental health treatment rendered outside of the Plan's network to include the same providers approved for coverage in network.

At this time I would like to remind you that coverage provided under the Welfare Plan for hospital and surgicenter facility charges is administered by Horizon Blue Cross Blue Shield of New Jersey. Whenever you visit a **hospital or surgicenter**, provide your **Horizon** identification card. **For all other services**, provide your **Operating Engineers Local 825 Fund Service Facilities** identification card. If you are receiving Medicare benefits, provide your Medicare card in addition to either your Horizon or Operating Engineers card.

Following the above procedure will help avoid delays resulting from incorrect claim filing by your healthcare providers on your behalf as well as problems resulting from miscommunication of benefit information during precertification. **For all services requiring precertification, call the Welfare Fund office at 1-800-677-3237.**

Best wishes for the holiday season and the coming year.

Sincerely,

Christine Medich
Administrator

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue
Springfield, New Jersey 07081
(973) 921-1661

Pre-Cert and PPO
(800) 677-3237

December 21, 2007

Dear Participant:

Enclosed is the Welfare Fund's 2007 Annual Notification under the Women's Health and Cancer Rights Act of 1998.

During the past year the Board of Trustees approved the following changes to the Welfare Plan:

- The exclusion of coverage for treatment relating to self-inflicted injuries has been removed for dates of service on and after 4/01/07.

- The benefit for hearing aids has been increased from $800 per aid to $1,500 per aid and the frequency of benefit eligibility has been changed from once every 24 months to once every 36 months effective for hearing aids dispensed on and after 4/01/07.

- The coverage period for surviving spouses who are currently receiving coverage as of 4/01/07 or who become eligible for coverage on and after 4/01/07 has been changed as follows:

  Surviving spouses of participants who expire pre-retirement and eligible for welfare benefits and who have accumulated at least 10.00 years of credited service under the Pension Plan may purchase continued coverage under the Welfare Plan following exhaustion of 60 months of free coverage (at member's benefit level at time of death) until the earlier of: (1) surviving spouse's Medicare entitlement or (2) remarriage.

Surviving spouses of participants who expire post-retirement and eligible for continued welfare benefits may purchase continued coverage under the Welfare Plan until the later of: (1) balance of unused portion of retiree's welfare coverage period up to a maximum of 36 months or (2) surviving spouse's Medicare entitlement. If a surviving spouse remarries, welfare benefits terminate.

- The ambulance benefit has been increased from a maximum of $500 per trip to a maximum of $1,500 per calendar year for all trips to a maximum of $1,000 per trip to a maximum of $3,000 per calendar year for all trips (advanced life support) and to a maximum of $700 per trip to a maximum of $2,100 per calendar year for all trips (basic life support). The maximum for all trips (advanced and basic life support combined) is $3,000 per calendar year. This increase applies to services rendered on and after 10/01/07.

- The $3,000 maximum lifetime benefit for BRCA1 and BRCA2 gene analysis and counseling has been increased to $5,000 for services rendered on and after 1/01/08.

Best wishes for good health throughout the coming year.

Sincerely,

Christine Medich

Christine Medich
Administrator

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue
Springfield, New Jersey 07081
(973) 921-1661

Pre-Cert and PPO
(800) 677-3237

January 5, 2009

Summary of Material Modifications
Operating Engineers Local 825 Welfare Plan

Dear Participant:

The following changes were made to the Operating Engineers Local 825 Welfare Plan during the calendar year 2008:

1. Adoption of a National Health & Welfare Reciprocity Agreement for International Union of Operating Engineers national and local health and welfare funds. For signatory funds, this agreement provides for the transfer of welfare contributions received on a travelling member's behalf to his or her home local.

2. A retiree who engages in employment will have his or her welfare benefits (including the death benefit) suspended, regardless of whether such employment is considered "disqualifying employment" under the Pension Plan. A retiree will be permitted to self-purchase welfare coverage under the Welfare Plan's Level of Benefit Program until eligibility for welfare coverage has been established based upon employer contributions. If a retiree returns to work but does not become eligible, either due to insufficient employer contributions or a failure to self-purchase coverage, no death benefit is payable.

If you have any questions or concerns regarding these changes, please call or write the Funds Office.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

February 1, 2010

Summary of Material Modifications
Operating Engineers Local 825 Welfare Plan

The following changes to the Operating Engineers Local 825 Welfare Plan were adopted during calendar year 2009.

Michelle's Law

Recent federal legislation known as Michelle's Law provides that group health plans continue health coverage for a dependent college student who takes a leave of absence from school or changes to part-time status due to a medically necessary leave of absence for a period of one year after the first day of a medically necessary leave of absence or, if earlier, until the date on which health coverage would otherwise terminate under the terms of the Plan (e.g., child attains age 25).

Effective January 1, 2010, the Welfare Plan has been amended to extend health coverage under Michelle's law. To be eligible for this extension, a child must be an eligible dependent under the Plan on the basis of being a full-time student at a post-secondary educational institution on or after January 1, 2010 and immediately before the first day of the medical leave. Written certification from a child's treating physician verifying that a child's illness or injury is serious enough to require a medical leave of absence or change in enrollment must be received by the Welfare Plan.

Children's Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, special enrollment rules became effective under the Welfare Plan to provide that you and/or your dependents may enroll in the Welfare Plan 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. 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 by the Fund Office.

Should you have any questions or concerns regarding these changes, please call or write the Funds Office.

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(800) 677-3237

February 1, 2010

Dear Participant:

For the past fiscal year ended June 30, 2009, the Welfare Fund paid out a little over $75,000,000 in health benefits for both active and retired participants.

The continuing rise in health care costs coupled with a downturn in the economy and employment have resulted in a significant negative impact on Fund. The Trustees are reviewing options to manage increasing costs while maintaining a satisfactory benefit package. Several important changes are outlined in this letter.

Out-of-Network Ambulatory Surgery Centers

The cost of providing benefits for the fiscal year just ended included about $2,600,000 in charges for services provided at out-of-network ambulatory surgery centers. When services are rendered at these out-of-network facilities, the Fund does not benefit from any negotiated discount available through its contract with Horizon Blue Cross Blue Shield of New Jersey. Compared to in-network ambulatory surgery centers, where the Fund paid roughly 28 percent of charges, the Fund paid roughly 78 percent of charges for out-of-network ambulatory surgery center services. Recent charges received by the Fund for services rendered at out-of-network ambulatory surgery centers range from $25,000 to $44,700 -- which does not include an overnight stay -- Effective for services rendered on and after April 1, 2010, the Fund will no longer cover claims from out-of-network ambulatory surgery centers, unless Medicare is your primary insurer. To view the list of participating in-network ambulatory surgery centers and in-network hospitals, go to www.horizonblue.com (see enclosed directions) or call 1-800-810-BLUE (2583). Also, please check with your provider/facility to verify the most current information on network participation status.

Change in the Dollar Amount Required for Coverage for Active Participants Under the Level of Benefit Program

The cost to provide Level 4 coverage per active participant (including family members) rose to $10,900 for the fiscal year ended 6/30/09 from $9,700 the previous fiscal year. Effective for eligibility beginning July 1, 2010, the costs of coverage for active participants under the Welfare Plan's Level of Benefit Program will adjust from current levels to the following:

	Yearly	Quarterly	Monthly
Level 1	$ 8,800	$2,200	$734
Level 2	$ 9,000	$2,250	$750
Level 3	$ 9,800	$2,450	$817
Level 4	$11,400	$2,850	$950

Change in Cost to Continue Coverage Under the Welfare Plan as a Retiree

The cost of providing benefits to pre-Medicare retirees continues to escalate at a significant rate. Effective for retirement dates on and after July 1, 2010, the monthly costs for coverage under the Welfare Plan's Level of Benefit Program for **pre-Medicare** retirees eligible to purchase continued health coverage will increase from their current levels to the costs listed below.

Level 1	Level 2	Level 3	Level 4
$885	$1,085	$1,140	$1,310

As in the past, the above increases do not apply to members who retire with a total disability (as evidenced by the granting of a Social Security Disability Award). The costs of coverage for these members will continue to be the same as the costs for post-Medicare retirees.

If you have any questions regarding this letter, please contact the Fund Office.

Sincerely,

Christine Medich

Christine Medich
Administrator

INSTRUCTIONS FOR ACCESSING AMBULATORY SURGERY CENTERS THROUGH HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY ONLINE SERVICES

To register online:

Go to www.HorizonBlue.com. Select "Not Registered?" under Member Sign On and follow the instructions. You will be asked to provide the ID Number from your Horizon Blue Cross Blue Shield of New Jersey identification card. Record and file your User ID and Password in a safe place where it can be accessed when you visit Horizon Blue Cross Blue Shield of New Jersey's Online Services. Follow the directions below.

If you are already registered with Member Online Services, you do not need to re-register. After entering your User ID and Password, follow the directions below.

To find ambulatory surgery centers:

- Click on Provider Directory located in the top blue line
- Click on Hospital/Ancillary
- Click on Ancillary Providers
- Select Ambulatory Surgery Centers from the drop down box
- Click on Search Ancillary

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
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Important Information Regarding Your Health Fund Benefits

This notice contains important information concerning the benefits provided by the Operating Engineers Local 825 Welfare Fund. Please attach this letter to your Summary Plan Description (SPD). It should be read and retained with your SPD for future reference.

Date: January 2012

To: All Participants in the Operating Engineers Local 825 Welfare Fund and Their Covered Dependents
All Retirees in the Operating Engineers Local 825 Welfare Fund and Their Covered Dependents
All COBRA Participants

From: The Board of Trustees

We are providing you and your family with this Welfare Fund announcement letter to provide you with notices required under the Patient Protection and Affordable Care Act and to inform you of benefit changes effective July 1, 2011.

Notice of Grandfathered Plan

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (973) 671-6800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Plan Changes Effective July 1, 2011

Please remember to keep this information with your Summary Plan Description (SPD). You may want to mark your SPD on the pages where this letter has modified it. The page references below refer to the SPD.

A. Definition of Dependents

Sub-section C. Eligibility of Dependents of Active Employees on page 15 of the SPD is revised to read as follows:

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

The Plan covers a legal spouse as a dependent. Once a divorce occurs, your ex-spouse is no longer eligible for coverage under the Plan, 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.

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 step children 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 the child's birth certificate.*

Unmarried grandchildren 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 dependents provided you have the primary responsibility for their 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 in the same principal residence in which you reside for more than ½ of the year, and must receive over ½ of his/her support from you for the calendar year.

Please note: An adult child who is eligible for any employment-based health benefits other than those provided by this Plan or the plan of another parent or stepparent, will not be eligible for coverage with this Plan, regardless of whether the other coverage is declined or is not as extensive as the coverage provided by this Plan.

B. Removal of Lifetime Limits

Any individual whose coverage or benefits ended prior to July 1, 2011 due to reaching the lifetime limit will be able to have coverage restored as of that date with an unlimited lifetime maximum for dates of service on and after July 1, 2011.

C. Other Plan Changes

Section X. EXCLUSIONS AND LIMITATIONS is amended as follows:

1. Exclusion number 16 (page 30) is revised to read as follows:
   Cosmetic surgery which does not directly result from an accident.

2. Exclusion number 44 (page 31) is revised to read as follows:
   Expenses incurred by a child on and after the first of the month after the child turns age 26.

3. The $50,000 lifetime limit on AIDS/HIV (page 32) is eliminated. These benefits will be payable according to the Plan.

4. The text describing GENETIC TESTING (page 32) is deleted and replaced by the following text:
   Coverage for genetic testing is limited to amniocentesis testing and up to three counseling sessions during pregnancy and, when preauthorized by the Fund, BRCA1 and BRCA2 gene analysis and counseling.

5. The $2,500 lifetime limit on JAW JOINT DISORDERS (page 32) is eliminated. These benefits will be payable according to the Plan.

6. The $50,000 lifetime limit on WEIGHT CONTROL TREATMENT FOR MORBID OBESITY AND CO-MORBIDITIES ASSOCIATED WITH MORBID OBESITY (page 32) is eliminated. These benefits will be payable according to the Plan.

7. The $50,000 lifetime limit on NEONATAL services (page 33) is eliminated. These benefits will be payable according to the Plan.

Section XIII. HEALTH CARE BENEFITS is amended as follows:

1. The following text is deleted from the last paragraph on page 37:
   Also, excluding accident and sickness, survivor, death, vision and dental benefits, all benefits payable under the Plan are subject to a lifetime maximum of $1,000,000 per person. However, $1,000 of benefits will be reinstated at the beginning of each calendar year.

2. Item No. 4 (page 38): The text *", provided such services are rendered within 12 months of the date of accident"* are deleted. Item No. 4 should read as follows:
   4. Dental services required as a result of accidental bodily injury.

3. The limitation on hearing aids of *"once every two years."* (Item 5, page 38) is eliminated. These benefits will be payable according to the Plan.

Section XIV. LEVEL I BENEFITS OF HEALTH CARE is amended as follows:

Subsection A. Inpatient Hospital Coverage

The $50,000 lifetime limit on NEONATAL services (page 39) is eliminated. These benefits will be payable according to the Plan.

Subsection F. Ambulance (page 40) is revised to read as follows:

The Plan will pay 100% of charges up to a maximum of $700 per trip Basic Life Support (BLS) and $1,000 per trip Advanced Life Support (ALS) for emergency ambulance service.

Subsection N. Diabetic Supplies (page 43) is amended to remove the following limitation on glucometers: *"one during any 36 consecutive months."* The last sentence of the description of the benefit is revised to read as follows:

Reimbursement for glucometers is limited to a maximum of $100 per unit.

Section XV. LEVEL 2 BENEFITS OF HEALTH CARE is amended as follows:

The paragraph immediately below the table listing Vision Care Services and Benefit Amounts (page 44) is deleted and replaced by the following text:

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

Examinations are limited to one per calendar year, lenses are limited to two per person during any 12 consecutive months and frames are limited to one set per person during any 24 consecutive months. The Plan does not cover the replacement of lenses or frames originally furnished under the Plan and thereafter lost, stolen or broken.

These limitations do not apply to dependents below age 19.

Section XVI. LEVEL 3 BENEFITS OF HEALTH CARE (DENTAL COVERAGE)

1. The last sentence of the second paragraph on page 46 is deleted and replaced by the following text:

   The maximum amount payable in any calendar year for all courses of dental treatment for participants and dependents who are age 19 and older is $1,200 per covered person. This maximum does not apply to dependents below age 19.

2. The first sentence of the first paragraph on page 48 is revised to read as follows:

   Coverage for the removal of bony impacted teeth and coverage for treatment of jaw joint disorders is provided under the medical portion of the Plan.

Section XVII. LEVEL 4 BENEFITS OF HEALTH CARE (PRESCRIPTION DRUG COVERAGE)

The annual limitation on medications for pain management is eliminated and medications for weight loss are not subject to an overall maximum payment for weight control treatment for morbid obesity and co-morbidities associated with morbid obesity. The last sentence of the third paragraph below the table listing prescription drug copayments (page 52) is revised to read as follows:

Also, medications prescribed for infertility, smoking cessation, and migraine headaches are covered with limitations.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

January 2012

Notice of Plan Merger

Effective August 1, 2011, the Local 825 Vacation Savings Fund (the "Savings Fund") was merged into the Local 825 Welfare Fund (the "Welfare Fund"). The merger was done to ease the costs of administration including government filings (e.g., going forward only one (1) annual report must be filed with the government). Savings benefit balances in accounts, which were maintained in the Savings Fund, have been transferred to the Welfare Fund with payment of those accounts made at such time as payment would have been made from the Savings Fund. This seamless transition does not affect a participant's right or entitlement to payments of amounts that had been contributed on the participant's behalf to the Savings Fund. Going forward from August 1, 2011 on, employers are required to make contributions to the Welfare Fund that were required to be made to the Savings Fund, which will be separately accounted for and distributed to participants entitled to savings benefits (generally in December of each year) in accordance with the rules that were in place with respect to the Savings Fund. A Summary of Material Modification containing the rules and regulations applicable to the vacation savings benefit follows this notice.

Rules and Regulations for the Vacation Savings Benefit Provided By 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 August 1, 2011 and thereafter as part of the Welfare Fund.

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
John F. Daly	Gregory Lalevee
Richard Forman	John P. Lynch
Jack Kocsis, Jr.	Robert Occhiuzzi
Ross Pepe	Matty White

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.

Table of Contents

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 October 31 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.

The Operating Engineers Local 825, the Operating Engineers Local 825 Apprenticeship Training and Retraining Fund and the Operating Engineers Local 825 Benefit Funds have entered into ***participation agreements*** with the Trustees under which contributions are made for eligible employees of Local 825 or any of the Local 825 Funds.

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 November 1 and October 31. The Plan Administrator allocates these contributions to an ***account*** in your name within the Fund. In addition, the Plan Administrator adjusts your ***account*** on October 31 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 November 1 to October 31;
- The Plan Administrator deducts your pro rata share of reasonable and necessary administrative expenses during the period of October 1 to September 30 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 October 31.

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.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

January 2, 2013

Summary of Material Modification to the

Operating Engineers Local 825 Welfare Plan

This Summary of Material Modification ("SMM") provides you with notice of changes to the Summary Plan Description for the Welfare Plan effective July 1, 2011 to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and implementing regulations. Please keep this SMM with your copy of the Plan's Summary Plan Description (SPD).

Section XIV. Level 1 Benefits of Health Care, Sub-section L. Mental Health/Substance Abuse Treatment on pages 41 and 42 of the SPD is deleted and replaced to now read as follows:

Mental Health/Substance Abuse Treatment

Mental health and substance abuse benefits provided under the Plan are managed through Magellan Behavioral Health. A table of mental health and substance abuse benefits for in-network and out-of-network services follows. Only active members and retirees who are not Medicare eligible are eligible to utilize the services of in-network providers.

In addition to mental health and substance abuse benefits, an Employee Assistance Program (EAP) is available for all active members through Magellan Behavioral Health. This service is available 24 hours per day at no cost by telephoning 1-800-346-5486. 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	Plan's reasonable fee, not to exceed actual charges, minus $15 copayment per partial hospitalization treatment plan and 20% coinsurance
Intensive Outpatient (IOP)	100% minus $15 copayment per intensive outpatient treatment plan	Plan's reasonable fee, not to exceed actual charges, minus $15 copayment per intensive outpatient treatment plan 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	Plan's reasonable fee, not to exceed actual charges, minus $15 copayment per partial hospitalization treatment plan and 20% coinsurance
Intensive Outpatient (IOP)	100% minus $15 copayment per intensive outpatient treatment plan	Plan's reasonable fee, not to exceed actual charges, minus $15 copayment per intensive outpatient treatment plan 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).

Section X. Exclusions and Limitations, the following numbered exclusion and limitation on page 29 of the SPD is deleted and replaced to now read as follows:

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

Section XVII. Level 4 Benefits of Health Care (Prescription Drug Coverage), the last sentence of the third paragraph below the table listing prescription drug copayments on page 52 is revised to now read as follows:

Also, medications prescribed for infertility and migraine headaches are covered with limitations.

Operating Engineers Local 825 Welfare Plan

Notice of Grandfathered Plans

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (973) 671-6800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

Important Information Regarding Your Health Fund Benefits

Date: October 2013

To: All Participants in the Operating Engineers Local 825 Welfare Fund and Their Covered Dependents
All Retirees and Their Covered Dependents
All COBRA Participants

From: The Board of Trustees

This document is a Summary of Material Modifications ("SMM") intended to notify you about important information concerning the benefits provided by the International Union of Operating Engineers Local 825 Welfare Fund ("Fund" or "Plan"). Please attach this letter to your Summary Plan Description ("SPD"). You should take the time to read this SMM carefully and keep it with your SPD for future reference. If you need another copy of the SPD or if you have any questions regarding this change to the Plan, please contact the Plan Administrator during normal business hours at 973-671-6800.

Effective June 23, 2013, the Plan is amended to increase the scope of coverage as follows. The Plan will cover claims for benefits by you and/or your dependents if the claim involves self-inflicted injuries occurring as the result of a medical condition or injuries in general arising from an act of domestic violence. Except as modified, such claims remain subject to the terms of the SPD and its applicable limits and restrictions.

Specifically, "Section X - EXCLUSIONS AND LIMITATIONS" beginning on page 29 of the SPD is amended as follows:

1. **Exclusion number 10 is revised to read as follows:** Intentionally self-inflicted injuries except where such injuries are the result of a medical condition.

2. **Exclusion number 11 is revised to read as follows:** 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.

ERISA Information

Plan Sponsor: Board of Trustees of the International Union of Operating Engineers Local 825 Welfare Fund
Sponsor's EIN #: 22-6033381
Plan Number: 501
Plan Year: July 1 – June 30

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

IMPORTANT GOVERNMENT NOTICE REGARDING THE PLAN'S GRANDFATHERED PLAN STATUS

The Board of Trustees believes that the Plan is a "grandfathered plan" as such term is defined under the Patient Protection and Affordable Care Act of 2010 (more commonly known as "Health Care Reform" or the "Affordable Care Act"). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when Health Care Reform was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the plan may not include certain consumer protections of Health Care Reform that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator during normal business hours at 973-671-6800. You may also contact the Department of Labor at (866) 444–3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

Operating Engineers Local 825 Fund Service Facilities

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June 1, 2014

Dear Participant:

Effective July 1, 2014 the Operating Engineers Local 825 Welfare Fund has elected a new behavioral health partnership with Horizon Behavioral Health administered by ValueOptions to manage EAP and mental health and substance abuse benefits under the Welfare Plan. ValueOptions is the largest independent behavioral health company in the United States and specializes in the management of all behavioral health issues, recovery, employee assistance and wellness. ValueOptions is focused on making sure a person receives the right care when needed.

About this transition

This change will not affect Mental Health/Substance Abuse Treatment/Employee Assistance Program benefits under the Welfare Plan – your copayments and coinsurance will remain the same. Additionally, the provider network will remain the same. To find a behavioral health provider, visit **HorizonBlue.com** and select *Provider Search* or call 1-800-626-2212.

Members and dependents admitted to inpatient or residential levels of care before July 1 will transition to ValueOptions on July 1. ValueOptions will have a list of patients to ensure coordination of care from Magellan to ValueOptions.

Members and dependents in active treatment at the partial hospital or intensive outpatient levels of care will transition to ValueOptions on July 1. ValueOptions expects to receive information on these patients the last two weeks of June and will work with providers who are rendering services to ensure it understands the care plan and is in a position to support patients/providers in the transition of management from Magellan to ValueOptions.

Dedicated support 24/7

ValueOptions is committed to providing needed support 24 hours a day, 7 days a week, 365 days a year.

To access behavioral health or substance abuse benefits, call **1-800-626-2212.** To access EAP benefits, call **1-800-346-5486.**

BOARD OF TRUSTEES
OPERATING ENGINEERS LOCAL 825 WELFARE FUND

Enclosure

VALUEOPTIONS®
Innovative Solutions. Better Health.

YOUR EAP AND MHSA PROGRAM

Life is busy. When you need more resources to manage it all, our employee assistance program (EAP) professionals can help.

The EAP provides information, guidance and support to help you and your family reach your personal and professional goals, manage daily stresses and develop fulfilling relationships.

THE EAP CAN HELP

You don't have to handle your concerns on your own. It's OK to ask for help. In fact, seeking help early enables you to take immediate control of your situation and can prevent small issues from turning into big problems. EAP counselors are available 24 hours a day, 7 days a week.

Benefits of the EAP include:

COUNSELING SERVICES

Talk one-on-one with an experienced, licensed counselor for support with stress management, strengthening relationships, work/life balance, feelings of grief and loss, and more. You can access a counselor face-to-face, online or by phone.

LEGAL SERVICES

Legal support for:

- divorce
- landlord and tenant issues
- real estate transactions
- wills and power of attorney
- civil lawsuits and contracts
- identity theft recovery

FINANCIAL SERVICES

Talk to a financial coach for guidance on:

- saving for college
- debt consolidation
- mortgage issues
- estate planning
- general tax questions
- retirement planning
- family budgeting

ONLINE RESOURCES

Visit the Achieve Solutions® website to access articles and tools to help you improve your health and manage life events. You can also search for service providers in your area. Topics include:

- depression
- strengthening marriage and relationships
- stress management
- anxiety
- conflict management
- weight management
- debt management
- communication

MHSA PROGRAM

In addition to EAP services, you and your immediate family members are eligible for mental health and substance abuse (MHSA) benefits. As with physical health issues, there are things a person can do to make life better and manage the symptoms of a mental health condition.

Benefits of the MHSA program include counseling and referral services and online access to resources.

WHAT IS COVERED?

The MHSA benefit program covers mental health and substance abuse services that are deemed clinically appropriate and medically necessary. Services must be preauthorized to avoid out-of-pocket expenses. Covered services include:

- inpatient admission
- partial hospitalization programs
- outpatient visits
- psychological testing

HOW THE PROGRAMS WORK

- **Access is easy.** Whether the issue is large or small, simply go online or call the toll-free phone number any time day or night.
- **Staffed by professionals.** EAP and MHSA professionals are highly trained and qualified.
- **Your call is private.** Your personal information is kept confidential in accordance with federal and state laws.

EAP 800-346-5486 | MHSA 800-626-2212

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

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IMPORTANT NOTICE TO PARTICIPANTS OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 825 WELFARE PLAN

Please keep this letter with your Summary Plan Description

Notice of Grandfathered Health Plan

The International Union of Operating Engineers Local 825 Welfare Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund administrator at 973-671-6800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

June 1, 2014

Dear Local 825 Welfare Plan Participant and Covered Dependents:

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes and clarifications made to the International Union of Operating Engineers Local 825 Welfare Plan (the "Plan"). You should take the time to read this SMM carefully and keep it with the copy of the summary plan description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office during normal business hours at 973-671-6800. All changes are effective as of July 1, 2014.

Elimination of Annual Dollar Maximum Limits on Essential Health Benefits

Effective for plan years beginning on or after January 1, 2014, the Patient Protection and Affordable Care Act ("ACA") prohibits group health plans (like the Plan) from maintaining annual or lifetime dollar maximum limits on essential health benefits. Consistent with this requirement under the ACA, the lifetime and annual dollar maximum limits set forth in the SPD will not apply to "essential health benefits" as such term is defined

under the ACA. The determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan Administrator of the guidance available as of the date on which the determination is made. Essential health benefits will be paid at reasonable rates as determined by the Plan's claims administrators as of the date on which the determination is made and in accordance with the terms set forth in the SPD. Set forth below are various changes made to the relevant lifetime and annual dollar maximums under the Plan that will be effective as of July 1, 2014.

Orthodontic Services

The current $2,500 lifetime dollar limit on orthodontic services will be eliminated. Coverage for orthodontic services will remain limited to the necessary treatment of injury or disease.

Infertility

Currently there is a $2,000 dollar limit per 12-month period for all infertility procedures and medications. The $2,000 dollar limit will be removed for the following infertility treatments:

- artificial insemination
- standard dosages, lengths of treatment and cycles of therapy of prescription drugs

The $2,000 dollar limit per 12-month period will remain for all other infertility treatments.

Pain Management (Other Than Prescription Drugs)

The $6,000 annual dollar limit will be removed for pain management services other than prescription drugs. The current $2,000 per visit limit will remain. By way of background, the annual dollar limit on prescription drugs and medications for pain management was previously eliminated effective July 1, 2011.

Acupuncture

The Plan currently covers acupuncture only when administered for the management of pain. When acupuncture is necessary as a substitute for anesthesia, the current $6,000 annual dollar limit will not apply to such services. The $6,000 annual dollar limit will remain for all other uses of acupuncture.

Chiropractor

The current $1,000 annual dollar limit will be eliminated. Chiropractic visits will be limited to 52 visits per calendar year.

Routine Podiatry

The $750 annual dollar limit for routine podiatry will remain. However, this limit will not apply to:

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

Home Health Care for Terminally Ill

The current $200 per day dollar limit will remain and the 365 maximum day limit per illness (day limit applies to hospital and home health care combined) will be eliminated.

Motorized Recreational Vehicles

The current $50,000 non-renewable lifetime dollar limit for treatment of injuries in connection with a motorized recreational vehicle accident will be eliminated.

Waiting Periods in Excess of 90 Days

Currently, the Plan imposes a three-to-six month or six-to-nine month lag associated with a participant's eligibility for coverage based on employer contributions. However, participants working under an outside construction or quarterly shop contract may self-purchase coverage commencing on the first day of the calendar quarter following the date on which the Plan first receives employer contributions on behalf of a participant.

Generally speaking, ACA prohibits waiting periods for health coverage that exceed 90 days from the date on which a participant first satisfies the plan's eligibility conditions. To comply with ACA, the following changes will be effective as of July 1, 2014, and will have the effect of reducing the Plan's waiting periods thereby making coverage available to you more quickly than before.

Eligibility Waiting Period for Self Pay Coverage

Effective July 1, 2014, participants working under an outside construction or quarterly shop contract may self-purchase coverage commencing on the first day the second month following the date on which the Plan first receives employer contributions on behalf of a participant (i.e., if the Plan first receives contributions on behalf of a participant on for the payroll period beginning July 7, the participant will be eligible to self-purchase coverage as of September 1).

Eligibility Waiting Period for Coverage Based Upon Employer Contributions for Participants Working Under Construction Contracts

Effective July 1, 2014, the six-to-nine month lag associated with a participant's eligibility based on employer contributions is reduced to a three-to-six month lag (i.e., contributions for periods worked July, August and September of 2014 will be applied towards eligibility January, February and March of 2015).

Adult Dependent Children Up to Age 26

The Plan currently excludes adult dependent children who have access to employment-based coverage from the adult child's employer or spouse's employer. ACA, however, requires that dependent coverage be extended to adult children to age 26 regardless of the availability of other coverage from other sources. To comply with ACA, effective July 1, 2014, this exclusion of coverage for adult dependent children up to age 26 due to the availability of coverage under another health plan is eliminated. Contact the Fund Office for information if you have a dependent child who was previously excluded from coverage who you wish to cover. The following order of benefits determination will apply to Coordination of Benefits.

Adult Children up to Age 26 Coordination of Benefits				
Patient	**Status**	**Primary Plan**	**Secondary Plan**	**Tertiary Plan**
Dependent	Child and/or Child's spouse is employed with benefits	Child's Plan	Child's spouse's plan	Plan of parent whose birthday occurs earlier in the year, regardless of which parent is older (birthday rule)

Pre-existing Condition Exclusions

The Plan does not impose any preexisting condition exclusion or limitation for coverage purposes, regardless of a participant's or a dependent's age.

Important Notice Regarding Termination of Healthcare Coverage for Cause, Including Fraud or Intentional Misrepresentation

As always, the Plan reserves the right to terminate coverage for you and /or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to ACA, coverage will not be rescinded (within the meaning of ACA) retroactively (as opposed to prospectively) except in the circumstances permitted by law, such as the failure to pay premiums or the commission of fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Plan administrator or its delegates) by you, your covered dependent(s), or someone seeking coverage on your behalf. In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30-days' notice. Failure to inform the Fund Office that you or your dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation.

Sincerely,

Board of Trustees
International Operating Engineers Local 825 Welfare Plan

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan documents are at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

ERISA Information

Plan Sponsor: Board of Trustees of the International Operating Engineers Local 825 Welfare Fund

Sponsor's EIN Number: 22-6033381

Plan Number: 501

Plan Year: July 1 through June 30

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

June 23, 2015

SUMMARY OF MATERIAL MODIFICATIONS TO THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 825 WELFARE PLAN

To: **All Covered Participants and Beneficiaries**

From: **The Board of Trustees of the International Union of Operating Engineers Local 825 Welfare Plan**

Re: **Plan Changes Resulting from the Repeal of DOMA**

Notice of Grandfathered Health Plan

The International Union of Operating Engineers Local 825 Welfare Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund administrator at 973-671-6800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes to the International Union of Operating Engineers Local 825 Welfare Plan (the "Plan") in order to address changes to the federal law's treatment of same-sex marriages stemming from the U.S. Supreme Court's decision in United States v. Windsor. This summary is intended to satisfy the requirements for issuance of a SMM under the Employee Retirement Income Security Act of 1974, as amended. You should take the time to read this SMM carefully and keep it with the Summary Plan Description ("SPD") that was previously provided to you. If you need another copy of the SPD, or if you have any questions

regarding this change to the Plan, please contact the Plan Administrator during normal business hours at:65 Springfield Avenue, Second Floor, Springfield, NJ 07081; telephone number: (973) 671-6800.

On June 26, 2013 the U.S. Supreme Court held that a portion of the federal Defense of Marriage Act (DOMA) is unconstitutional. The part of DOMA that was found to be unconstitutional limited "marriage", for all federal law purposes, to a legal union between one man and one woman and limited "spouse" to a person of the opposite sex who is a husband or wife. The Court generally concluded that states have the right to determine issues relating to family matters, including the definition of marriage, and that the federal law should look to those state determinations.

Since the Supreme Court's decision, federal regulators have ruled that all same-sex couples legally married in jurisdictions that recognize same-sex marriages will be treated as married for federal tax purposes, regardless of whether the couple lives in a state or other jurisdiction that recognizes same-sex marriage. This means that, effective as of June 26, 2013, if you are legally married in a state or other jurisdiction that permits same-sex marriage, your same-sex spouse will be considered your spouse for all purposes under the Plan regardless of the marriage laws of the state or other jurisdiction in which you currently live. As a result:

- Your same-sex spouse will be considered a spouse for purposes of dependent eligibility, COBRA eligibility and HIPAA special enrollment rights.
- Your same-sex spouse's children will be recognized by the Plan as Step-Children and they are eligible to be added to the Plan as your covered dependents.
- The value of your same-sex spouse's coverage under the Plan is no longer taxable income to you for federal tax purposes.

However, you should note that similar rights are not available to same-sex domestic partners who are not "spouses" under state law. So, for instance, couples in domestic partnerships, civil unions or other relationships that are not considered "marriages" under state law also are not considered to be married (or each other's spouse) for benefit purposes under the Plan.

As a result of the foregoing change, effective as of June 26, 2013, the SPD is modified to redefine the following terms wherever they may appear therein:

Marital/Married/Marriage: "Marital", "Married", and "Marriage" refer to 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 (without regard to the law of the state in which the individuals live), but not including civil unions, domestic partnerships, or any other status unless such status is fully equivalent to marriage under the laws of the issuing state.

Spousal/Spouse: A person's spouse is the individual to whom the person is married, as defined herein.

Adding a Same-Sex Spouse

Some participants may not have added their same-sex spouses as a dependent on the Plan's coverage because of the federal tax impact of doing so. As a result of the new tax treatment of these benefits, you can add your same-sex spouse to the Plan. Simply complete the Plan's form to enroll a dependent and attach a copy of your "certified" marriage certificate. Your spouse will be added effective for coverage as of the first day of the month following the Plan's receipt of this information.

What if I have been paying additional taxes for my same-sex spouse but am legally married?
If you have been paying such tax but have been legally married, the relevant tax payments should be refunded to you for the applicable period upon proof of your marriage certificate, and you should no longer be charged such tax on a going forward basis. You should contact your tax advisor regarding whether you are entitled to a refund from the government for past overpaid income tax.

What if I plan to be married?
If you are planning to be married, your same-sex spouse can be added as of date of marriage, pursuant to the same rules that apply to opposite-sex spouses.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

March 1, 2018

Dear Member:

The Board of Trustees of the IUOE Local 825 Welfare Fund remains dedicated to providing you and your family with a comprehensive health plan. To this end, the Trustees are pleased to announce that effective April 1, 2018, the Fund will be moving from MagnaCare to Horizon Blue Cross Blue Shield of New Jersey for access to their medical health care provider network as well as claims administration services.

For dates of service on and after April 1, 2018:

- The MagnaCare and Local 825 participating medical provider networks will no longer be available. However, you will have a broad choice of qualified physicians and other health care providers to meet your various health care needs through Horizon's extensive PPO network. To check if a provider is in the Horizon network, visit HorizonBlue.com/doctorfinder.
- The medical network and medical claims administration will be provided by Horizon Blue Cross Blue Shield of New Jersey.
- General vision benefits will be with Horizon Blue Cross Blue Shield of New Jersey, administered through Davis Vision.
- The hospital network and hospital claims administration will continue to be provided by Horizon Blue Cross Blue Shield of New Jersey.
- Mental health, substance abuse, and EAP networks and claims administration will continue to be provided by Horizon Blue Cross Blue Shield of New Jersey.
- Dental benefits will continue to be provided by Fidelio Dental Insurance.
- Prescription drug benefits will continue to be provided by Caremark.

The Trustees hope you will be happy with this change. In the coming weeks currently eligible members will receive three new identification cards – two from Horizon Blue Cross Blue Shield of New Jersey, one to be used for hospital services, physician services, and lab and diagnostic services as well as behavioral health services (mental, substance abuse, EAP) and one to be used when receiving routine vision services (eye examination and materials). These cards will be mailed to you separately. An identification card will also be issued by Caremark which is to be presented to your pharmacist when filling a prescription. **Please begin using these new ID cards when receiving services on and after April 1, 2018**. Continue to use your

Fidelio Dental Insurance identification card when receiving dental treatment. If you are not currently eligible for benefits, you will receive new identification cards shortly after you reestablish eligibility.

There will be no change to the medical benefits currently provided – copayments are the same. If you utilize an in-network provider, you will only be responsible for any applicable copayment. If you utilize the services of an out-of-network provider, the Plan's approved amount will be 150% of Medicare's fee schedule. You will be responsible for the deductible, coinsurance, any copayments and any balance billed by a provider. Benefits for general vision services (including routine eye examinations, lenses and frames) will be provided in accordance with Horizon Vision Vista II plan benefits. Along with a Horizon Vision Vista II plan benefit card mailed to your home you will receive a Welcome Package that explains your vision benefit and offers simple instructions on how to take full advantage of all the general vision services available to you.

As of April 1, your current MagnaCare ID card will no longer be valid. However, claims for physician services and supplies received on or before March 31, 2018 should continue to be submitted to MagnaCare for processing in accordance with the current Plan for in- and out-of-network providers.

Should you have any questions regarding implementation of this change, please call the Fund Office at 973-671-6800.

Sincerely,

BOARD OF TRUSTEES
IUOE Local 825 Welfare Fund

Notice of Grandfathered Plan

Operating Engineers Local 825 Welfare Plan

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (973) 671-6800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

July 2018

Important Annual Reminders

Annual Notice of Women's Health and Cancer Rights Act (WHCRA)

Your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, call the Fund Office at (973) 671-6800.

This coverage is subject to any plan copayments, annual deductibles, and coinsurance that may be applicable, consistent with those established for other benefits under the plan. These provisions are described in the Plan's Summary Plan Description (SPD).

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact the Fund Office at (973) 671-6800.

Availability of a HIPAA Privacy Notice for Your Group Health Plan

If you would like to see (or obtain a copy of) the plan's HIPAA Notice of Privacy Practices, please contact the Privacy Officer at the Fund Office located at 65 Springfield Avenue, Springfield, NJ 07081, telephone (973) 671-6800. The Notice describes how the plan uses and discloses protected health information for the following self-funded benefits: Hospital, Medical, Dental, Prescription Drug, Mental Health and Substance Abuse. It also discusses important federal rights that you have with respect to your protected health information.

ERISA Information

Plan Sponsor: Board of Trustees of the Operating Engineers Local 825 Welfare Fund
Sponsor's EIN#: 22-6033381
Plan Numbers: 501 and 502
Plan Year: July 1 – June 30

OPTUMRx®

15218003500

15218003500

Dear .

Welcome to OptumRx®. We are pleased to be administering your prescription drug benefits under the IUOE Local 825 Welfare Plan, effective January 1, 2019. Our team of pharmacists, care managers and customer service advocates are working to make sure you get the medication you need, conveniently and cost-effectively. | *Bienvenido(a) a OptumRx. Tenemos el agrado de anunciarle que administraremos sus beneficios de medicamentos de venta con receta conforme al IUOE Local 825 Welfare Plan a partir del 1 de enero de 2019. Nuestro equipo de farmacéuticos, administradores de la atención y representantes de servicio al cliente están trabajando para garantizar que usted obtenga el medicamento que necesita, de forma conveniente y eficiente en costo.*

We invite you to read through the enclosed materials and the overview below for details about your new pharmacy care services. There is no change to the overall prescription program itself, including four tier benefit design and associated copayments. | *Lo(a) invitamos a leer bien los materiales adjuntos y el resumen siguiente para ver detalles sobre sus nuevos servicios de atención farmacéutica. No hay ningún cambio en el programa general de medicamentos de venta con receta, así como tampoco en el diseño de beneficios de cuatro niveles ni en los copagos asociados.*

Identification cards | *Tarjetas de identificación*
Once your plan is effective, show the enclosed pharmacy ID card when you pick up a prescription. The card will help you pay the lowest price for your medication, and it has contact information for questions about your pharmacy benefits. If you fill your prescriptions at a retail pharmacy, simply present your new member ID card at the pharmacy counter. | *Una vez que su plan entre en vigor, muestre la tarjeta de identificación farmacéutica adjunta cuando pase a buscar un medicamento de venta con receta. La tarjeta le ayudará a pagar el precio más bajo por su medicamento, y contiene información de contacto para hacer preguntas sobre sus beneficios farmacéuticos. Si surte sus recetas en una farmacia de venta al por menor, simplemente presente su nueva tarjeta de identificación de membresía en el mostrador de la farmacia.*

CVS90 Saver
Your plan includes a new maintenance medication program called CVS90 Saver. Once coverage begins, you have two grace fills before you need to take action. Then, you must get 90-day supplies through OptumRx home delivery or at a CVS® Pharmacy location to enjoy the savings of home delivery pricing. | *Su plan incluye un nuevo programa de medicamentos de mantenimiento llamado CVS90 Saver. Una vez que la cobertura comience, usted tiene dos surtidos de gracia antes de tener que hacer nada. Luego, deberá obtener suministros de 90 días a través del envío a domicilio de OptumRx o en una tienda de CVS Pharmacy para aprovechar los ahorros de los precios del pedido por correo: la elección es suya.*

Hassle-Free Fill℠
For even greater convenience, enroll your eligible home delivery medications in our Hassle-Free Fill℠ program. We'll automatically refill and send those medications when your supply runs low. | *Para mayor conveniencia todavía, inscriba sus medicamentos elegibles para el envío a domicilio en nuestro programa Hassle-Free Fill℠. Resurtiremos automáticamente esos medicamentos y se los enviaremos cuando le quede poco suministro.*

Medication home delivery | *Envío a domicilio de medicamentos*
You could save time and money by getting maintenance medications through the mail through OptumRx home delivery. Enroll in OptumRx home delivery to get up to a three-month supply of the medications you take regularly — often for less than what you'd pay at a retail pharmacy. Your medication will come right to your mailbox. To start home delivery, log in to **optumrx.com**, use the OptumRx App or call us at **1-855-295-9140**, TTY **711**. | *Podría ahorrar tiempo y dinero si pide sus medicamentos de mantenimiento a través del envío a domicilio por correo de OptumRx. Inscríbase en el envío a domicilio de OptumRx para obtener un suministro máximo de tres meses de los medicamentos que usted toma habitualmente; por lo general, por menos de lo que pagaría en una farmacia de venta al por menor. Recibirá sus medicamentos directamente en su buzón de correo. Para comenzar con el envío a domicilio, inicie sesión en* ***optumrx.com,*** *use la aplicación de OptumRx o llámenos al* ***1-855-295-9140****, TTY* ***711.***

Specialty pharmacy | *Farmacia especializada*
BriovaRx®, the OptumRx specialty pharmacy, is part of your benefit program. BriovaRx provides specialty medications and some clinical support for complex conditions, including cancer, arthritis and others. To learn more about BriovaRx, call **1-855-4Briova (1-855-427-4682)** or visit **BriovaRx.com.** | *BriovaRx®, la farmacia especializada de OptumRx, forma parte de su programa de beneficios. BriovaRx proporciona medicamentos especializados y apoyo clínico para condiciones complejas, como cáncer, artritis y otras. Para obtener más información sobre BriovaRx, llame al 1-855-4Briova (1-855-427-4682) o visite BriovaRx.com.*

Download the OptumRx App | *Descargue la Aplicación OptumRx*
Manage your home delivery prescriptions from your smartphone or tablet. The OptumRx App makes it easy to renew or refill your prescriptions and more—whenever you need to, day or night. Get the app by searching for OptumRx in the Apple® App Store® or Google Play℠. | *Administre sus recetas de envío a domicilio desde su teléfono inteligente o tableta. La aplicación hace que renovar o resurtir sus recetas sea más fácil, en cualquier momento en que lo necesite, de día o de noche. Para descargar la aplicación, busque OptumRx en la tienda Apple® App Store® o Google Play℠.*

Questions? | *¿Preguntas?*
After January 01, 2019, visit **optumrx.com** to get the latest details about your benefits, set up your online account and get familiar with all the other tools. Or call us at **1-855-295-9140**, TTY **711**, and we'll be happy to help. | *Después de 1 de enero de 2019, visite* ***optumrx.com*** *para conocer los últimos detalles sobre sus beneficios, configurar su cuenta en línea y familiarizarse con todas las demás herramientas. O bien, llámenos al* ***1-855-295-9140,*** *TTY* ***711,*** *y le ayudaremos con gusto.*

Next steps | *Próximos pasos*
Keep your identification card in a safe place until your OptumRx pharmacy benefit becomes effective. Then set up your online account or begin using the OptumRx App so you can manage your medication on the go. We look forward to serving you. | *Guarde su tarjeta de identificación en un lugar seguro hasta que entre en vigencia su beneficio farmacéutico de OptumRx. Luego configure su cuenta en línea o comience a usar la aplicación de OptumRx para poder administrar sus medicamentos desde cualquier lugar. Esperamos estar a su servicio.*

If you need an additional identification card please call **1-855-295-9140** or log on to your online account on OptumRx.com and request a new card.

Sincerely, | *Atentamente,*
OptumRx

Refill orders should arrive in about four business days and new prescriptions should arrive within seven business days from the date OptumRx® receives the completed order. | *Los pedidos de resurtidos deberían llegarle aproximadamente en cuatro días hábiles y las nuevas recetas deberían llegarle dentro de los siete días hábiles a partir de la fecha en que OptumRx® reciba el pedido completo.*

Once your coverage begins: | *Una vez que comience su cobertura:*

Where will I fill my prescriptions? | *¿Dónde surtiré mis recetas?*

OptumRx home delivery | *Envío a domicilio de OptumRx*

Order up to a 90-day supply of the medication you take regularly for less. There's no charge for standard shipping to U.S. addresses. Set up home delivery online, with the app or by calling OptumRx. | *Pida un suministro de 90 días del medicamento que toma habitualmente y pague menos. El envío estándar a direcciones de los EE. UU. es sin cargo. Puede programar el envío a domicilio en línea, con la aplicación o por teléfono al número de OptumRx.*

If you choose to call, please have the following items ready: | *Si prefiere llamar, tenga preparado lo siguiente:*

— Your doctor's contact information | *La información de contacto de su médico*

— Names and strength of current medications | *Los nombres y las concentraciones de sus medicamentos actuales*

— Payment information | *Información sobre pagos*

Network retail pharmacies | *Farmacias de venta al por menor de la red*

Show your member ID card at any OptumRx network retail pharmacy. Sign in to your account, call customer service or use the app to find network pharmacies. | *Muestre su tarjeta de identificación de membresía en cualquier farmacia de venta al por menor de la red de OptumRx. Inicie sesión en su cuenta, llame al Servicio al Cliente o use la aplicación para buscar farmacias de la red.*

Questions? | *¿Preguntas?*

Once your coverage begins: | *Una vez que comience su cobertura:*

Log in to **optumrx.com.** | *Inicie sesión en* ***optumrx.com.***

Open the OptumRx app. | *Abra la aplicación OptumRx.*

Or call customer service at the number on your member ID card. | *O bien, llame al Servicio al Cliente al número que se encuentra en su tarjeta de identificación de membresía.*

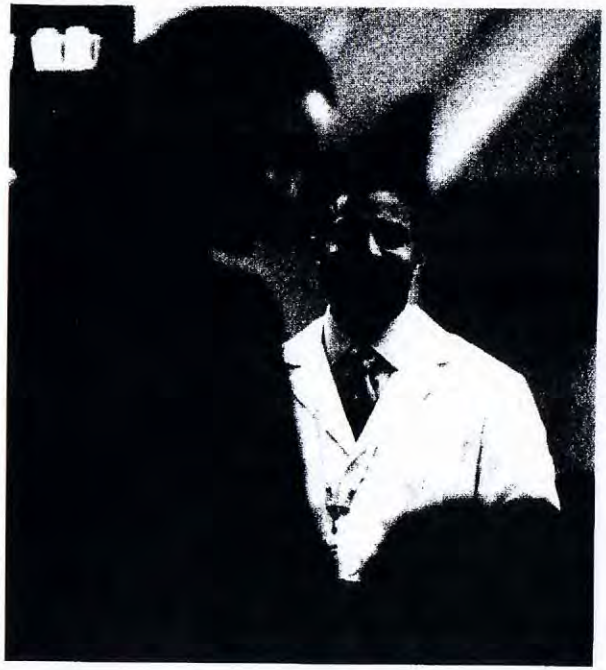
OPTUM®

OPTUMRx®

Welcome to OptumRx
Bienvenido a OptumRx

OptumRx® is your plan's pharmacy care services manager. | *OptumRx es el administrador de servicios de atención farmacéutica de su plan.*

Who is OptumRx?
¿Qué es OptumRx?



OptumRx is your plan's pharmacy care services manager. Our pharmacy care experts are committed to providing safe, easy and cost-effective ways to help you get the medication you need. | *OptumRx es el administrador de servicios de atención farmacéutica de su plan. Nuestros expertos en atención farmacéutica tienen el compromiso de ofrecerle maneras seguras, simples y eficientes en costo de ayudarle a obtener el medicamento que usted necesita.*

Things to do before your coverage begins | *Lo que debe hacer antes de que comience su cobertura*

1 Let your doctor know your pharmacy benefit is moving to OptumRx. | *Avísele a su médico que su beneficio de farmacia pasará a OptumRx.*

2 Check to see if you have refills remaining on your prescriptions. | *Revise si tiene resurtidos restantes en sus recetas.*

3 If currently using home delivery, make sure you have at least a one-month supply of medication on hand during the transition. | *Si actualmente está usando el envío a domicilio, asegúrese de tener al menos un suministro de un mes de un medicamento durante la transición.*

Things to do after your coverage begins | *Lo que debe hacer después de que comience su cobertura*

1 Set up your online account at **optumrx.com** or download the OptumRx app | *Configure su cuenta en línea en **optumrx.com** o descargue la aplicación OptumRx*

2 Review your formulary: | *Revise su Formulario:*
- Find out if you need to take action before filling your first prescription | *Averigüe si necesita hacer algo antes de surtir su primera receta*
- Check for lower-cost options | *Revise si hay opciones de menor costo*

3 Fill your prescriptions: | *Surta sus recetas:*
- Have your member ID card ready | *Tenga preparada su tarjeta de identificación de membresía*
- Select a network pharmacy | *Seleccione una farmacia de la red*
- Use home delivery for maintenance medication, refill reminders, and more. | *Use el envío a domicilio para sus medicamentos de mantenimiento, recordatorios de resurtidos y mucho más.*

Helpful tips | *Consejos útiles*

Know your plan | *Conozca su plan*

Your plan may require one or more of the following before you can fill your prescription: | *Es posible que su plan tenga uno o más de los siguientes requisitos para que usted pueda surtir su receta:*

Prior authorization — Your plan's approval to get a medication | ***Autorización previa*** — *El permiso de su plan para obtener un medicamento*

Step therapy — Trying one or more lower-cost medications before another | ***Terapia escalonada*** — *Probar uno o más medicamentos de menor costo antes que otro*

Quantity limits — Getting a certain amount of each prescription | ***Límites de cantidad*** — *Obtener una cierta cantidad de cada medicamento de venta con receta*

Talk to your doctor | *Hable con su médico*

When you talk with your doctor, use our app to confirm coverage and costs. You can also talk about what you need to do to get your medication. | *Cuando hable con su médico, use nuestra aplicación para confirmar la cobertura y los costos. También puede hablar sobre lo que tiene que hacer para obtener su medicamento.*

Save money on medication | *Ahorre dinero en medicamentos*

Your formulary is a list of covered medications. The list is broken into sections called tiers (or cost level you pay). | *Su Formulario es una lista de los medicamentos cubiertos. La lista está dividida en secciones llamadas niveles (niveles de costo que usted paga).*

- Choosing medications in lower tiers may save you money. | *Si elige medicamentos de los niveles más bajos, podría ahorrar dinero.*
- Generic medications usually have a lower copay than brand-name medications. Ask your doctor if a generic is right for you. | *Los medicamentos genéricos generalmente tienen un copago más bajo que los medicamentos de marca. Pregúntele a su médico si un medicamento genérico es adecuado para usted.*

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

IMPORTANT NOTICE TO ALL PARTICIPANTS OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 825 WELFARE FUND

Please keep this letter with your Summary Plan Description

April 1, 2020

Dear Participant:

This document is a Summary of Material Modifications ("SMM") intended to notify you of an important change made to the Operating Engineers Local 825 Welfare Plan (the "Plan"). You should take the time to read this SMM carefully and keep it with the copy of the summary plan description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office at 973-671-6800.

The following clarifications are made to Section X. EXCLUSIONS AND LIMITATIONS in the SPD:

- **The text describing GENETIC TESTING (page 32) is amended with the addition of the underlined text below:**

GENETIC TESTING

Coverage for 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, BRCA 1 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.

- **The following clarifying exclusion for GENE THERAPY is added immediately following GENETIC TESTING (page 32):**

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 and Luxturna and Zolgensma. This list is not exhaustive, and new applications for gene therapies are submitted to the FDA every year.

If you have any questions regarding the above, please feel free to contact the Fund Office staff.

Sincerely,

Board of Trustees
International Union of Operating Engineers
Local 825 Welfare Fund

Notice of Grandfathered Health Plan

The Trustees of the International Union of Operating Engineers Local 825 Welfare Fund, believes that the International Union of Operating Engineers Local 825 Welfare Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 718-459-5800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

IMPORTANT NOTICE TO ALL PARTICIPANTS OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 825 WELFARE FUND

Please keep this letter with your Summary Plan Description

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes being made to the plan of benefits (the "Plan") of International Union of Operating Engineers Local 825 Welfare Fund (the "Plan"). You should take the time to read this SMM carefully. If you have any questions regarding these changes to the Plan, please contact the Fund Office at 973-671-6800.

April 8, 2020

Dear Participant:

IMPORTANT CORONAVIRUS UPDATES

Covid-19 Related Benefit Changes
Effective for services received on or after March 18, 2020 and through the end of the emergency period in which the federal government has announced a National Emergency

If you and/or your dependents think you have been exposed to COVID-19 and develop a fever and/or symptoms of respiratory illness, such as a cough or shortness of breath, call your healthcare provider immediately. We encourage you to please call your healthcare provider before presenting to an emergency room for treatment, to both ensure you have the quickest access to the specific services you need as well as to prevent the unnecessary exposure of yourself and any other patients or providers in the emergency room to the coronavirus without having taken appropriate protective measures.

Waiver of Cost Sharing for Detection of COVID-19

Effective March 18, 2020 and through the end of the national emergency as declared by the federal government, the Fund will now cover the following services **from either an in-network or out-of-network provider at 100% of the Allowed Charge, with no cost sharing to you:**

- Diagnostic tests that are approved or authorized by the FDA to detect the virus that causes COVID-19, including the administration of such tests, for the following types of tests:
  - Tests to detect the virus that are approved, cleared or authorized by certain sections of the Federal Food, Drug and Cosmetic Act (the Drug Act)
  - Tests for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied)
  - Tests developed in and authorized by a state that has notified HHS of its intention to review tests to diagnose COVID-19
  - Tests determined appropriate by HHS
- Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

This means that there will be no deductibles, copayments or coinsurance, as applicable, for COVID-19 testing.

Additionally, effective March 18, 2020 and through the end of the national emergency as declared by the federal government, the above services and products are not subject to any medical management requirements. This means that you do not have to get precertification/prior authorization from the Fund to have the tests or those visits covered.

It is important to make sure you are getting your information from a reputable source. Additional information that you and your family may find helpful can be obtained from the Centers of Disease Control and Prevention (CDC) on COVID-19 at https://www.cdc.gov/coronavirus/2019-ncov/about/index.html

Of course, if any claim is denied in whole or in part, you have the right to appeal that denial based on the procedures detailed in the Summary Plan Description.

If you have any questions regarding the above, please feel free to contact the Fund Office staff.

Sincerely,

Board of Trustees
International Union of Operating Engineers
Local 825 Welfare Fund

Notice of Grandfathered Health Plan

The Trustees of the International Union of Operating Engineers Local 825 Welfare Fund, believes that the International Union of Operating Engineers Local 825 Welfare Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 973-671-6800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

IMPORTANT NOTICE TO ALL PARTICIPANTS OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 825 WELFARE FUND

Please keep this letter with your Summary Plan Description

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes being made to the plan of benefits (the "Plan") of International Union of Operating Engineers Local 825 Welfare Fund (the "Plan"). You should take the time to read this SMM carefully. If you have any questions regarding these changes to the Plan, please contact the Fund Office at 973-671-6800.

August 20, 2020

Dear Participant:

IMPORTANT CORONAVIRUS UPDATES

Covid-19 Related Benefit Changes

As previously advised, effective March 18, 2020, and through the end of the national emergency as declared by the federal government, the Fund will cover diagnostic tests that are approved or authorized by the FDA to detect the virus that causes COVID-19, including the administration of such tests, from either a PPO or Non-PPO provider at 100% of the Allowed Charge, with no cost sharing to you.

Based on new guidance regarding COVID-19 antibody (Serological) testing issued jointly by the Department of Labor, Department of Health and Human Services, and the Department of Treasury, as well as guidance issued by the Centers for Disease Control and Prevention and the Food and Drug Administration, the following changes are effective August 1, 2020:

- **Beginning with claims received on or after 8/1/20**, claims for Serological testing **will only be covered if accompanied by proof that an individualized health assessment was performed by the ordering clinician, acting within their scope of licensure.** However, since CDC guidelines indicate that Serological testing may be appropriate with respect to Multisystem Inflammatory Syndrome in Children, which is associated with COVID-19, **for those patients less than 21 years of age, proof of an individualized health assessment is not required.**

Claims for Serological testing from either a PPO or Non-PPO provider that are deemed eligible for reimbursement pursuant to the above requirements will still be covered at 100% of the Allowed Charges, with no cost sharing to you.

It is important to make sure you are getting your information from a reputable source. Additional information that you and your family may find helpful can be found from the Centers of Disease Control and Prevention (CDC) on COVID-19 located at https://www.cdc.gov/coronavirus/2019-ncov/about/index.html.

Of course, if any claim is denied in whole or in part, you have the right to appeal that denial based on the procedures detailed in the Summary Plan Description.

If you have any questions regarding the above, please contact the Fund Office staff.

Sincerely,

Board of Trustees
International Union of Operating Engineers
Local 825 Welfare Fund

Notice of Grandfathered Health Plan

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Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 973-671-6800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Operating Engineers Local 825 Fund Service Facilities

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(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

IMPORTANT NOTICE TO PARTICIPANTS OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 825 WELFARE PLAN

Please keep this letter with your Summary Plan Description

This document is a Summary of Material Modification ("SMM") intended to notify you of important changes being made to the plan of benefits (the "Plan") of the Local 825 Welfare Fund. You should take the time and read this SMM carefully and keep it with the copy of the summary plan description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office.

February 5, 2021

To all Participants, Dependents and COBRA Beneficiaries:

This Notice is to advise you as to the Plan's coverage for the new COVID-19 vaccine.

Coverage for the COVID-19 Vaccine

Effective January 1, 2021, and for so long as the COVID-19 Public Health Emergency remains in effect, the Plan will cover an item, service, or immunization that is intended to prevent or mitigate coronavirus disease (COVID-19) and that is, with respect to the individual involved: (i) an evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force or (ii) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC, (a "Qualifying Coronavirus Preventive Service") on an in-network and out-of-network basis, without participant cost sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements.

The Plan will reimburse an out-of-network provider for the item or service in an amount that the Plan determines is reasonable, as determined in comparison to prevailing market rates for such services. A reasonable amount shall include the amount that the provider would be paid under Medicare for the item or service.

At time of vaccine administration, you may be asked to present either your OptumRx or Horizon BCBSNJ identification card, so make sure both cards are in your possession. If you have any questions concerning this Notice or your Welfare Fund benefits, please contact the Fund Office.

Sincerely,

Board of Trustees
International Union of Operating Engineers
Local 825 Welfare Plan

Notice of Grandfathered Health Plan

The Operating Engineers Local 825 Welfare Plan believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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You should keep this Notice together with your Summary Plan Description at all times. The two documents should be read together for an accurate depiction of your current health plan benefits. If you have any questions, contact the Welfare Fund.

The Board of Trustees reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or eligibility for such benefits), in whole or in part, at any time and for any reason.

Plan Sponsor: *Board of Trustees of the Operating Engineers Local 825 Welfare Fund*
Sponsor's EIN #: 22-6033381 Plan Number: 501 Plan Year: July 1 through June 30

Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

IMPORTANT NOTICE TO PARTICIPANTS OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 825 WELFARE PLAN

Please keep this letter with your Summary Plan Description

This document is a Summary of Material Modification ("SMM") intended to notify you of important changes being made to the plan of benefits (the "Plan") of the Local 825 Welfare Fund. You should take the time to read this SMM carefully and keep it with the copy of the summary plan description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office.

March 1, 2022

To all Participants, Dependents, and COBRA Beneficiaries:

This Notice is to advise you as to the Plan's coverage for over-the-counter (OTC) at-home COVID-19 tests purchased on or after January 15, 2022.

Coverage of OTC at-home COVID-19 tests

Effective January 15, 2022, and for so long as the COVID-19 Public Health Emergency remains in effect, the Plan will cover OTC at-home COVID-19 tests under the pharmacy benefit. The Plan will not require a note from a doctor or other authorization from a healthcare provider to receive coverage.

Options for coverage of OTC at-home COVID-19 tests include:

(1) *Point-of-Sale Purchase at a Retail Preferred Network Pharmacy.* Tests purchased at a preferred network pharmacy (see listing below) will be covered through your prescription drug coverage with OptumRx. You will not be charged any out-of-pocket costs for such tests. Present your member ID card and ask to have your OTC at-home test kits submitted to the Plan for coverage.

(2) *Reimbursement for Out-of-Pocket Purchases*. You will be reimbursed for the cost of tests purchased at other than a preferred network pharmacy or

purchased at other retailers. In order to receive reimbursement, you must file a claim for reimbursement with OptumRx online at **https://covidtest.optumrx.com/covid-test-reimbursement** or via mail using OptumRx's reimbursement form (a copy of the Form is included with this SMM). Keep your purchase receipt(s) to submit for reimbursement.

You will be reimbursed up to $12 per test for any OTC at-home COVID-19 test purchased at other than **a preferred network pharmacy or other retailer.**

The preferred retail pharmacy network currently includes any of the following pharmacies:

- Kinney Drugs
- Rite Aid (including Bartell Drugs)
- Sam's Club
- Walmart Pharmacy
- Walgreens

This list is subject to change. Visit **optumrx.com/testinfo** for the latest updates and information. Purchases at a preferred network pharmacy will be fully reimbursed.

(3) You can purchase a test through OptumRx at no cost via the Optum Store by following these steps:

- Go to **optumrx.com**
- Sign in using your Member ID
- Go to "**Get at-home COVID-19 tests with $0 copay**"
- Click the "order now" link (smartphone users will need to scroll down to find the link)

You may purchase up to 8 tests (4 kits) per household per calendar month at the Optum Store.

The Plan is only required to cover up to eight (8) tests in total per individual per calendar month (e.g., a family of 4 would be eligible for 32 tests per month). The 9th and subsequent tests you purchase during any calendar month will not be covered. In other words, you will have to pay out-of-pocket for any tests purchased beyond this 8-test limit in any given calendar month, and you will not be eligible for coverage or reimbursement for any such tests.

Each test in a multi-test kit counts as one test (e.g., one kit with two tests counts as two tests).

Only OTC at-home COVID-19 tests approved by the FDA are covered. This includes the following tests (this list is subject to change):

- BD Veritor At-Home COVID-19 Test
- BinaxNOW COVID-19 Antigen Self Test
- CareStart COVID-19 Antigen Home Test
- Celltrion DiaTrust COVID-19 Ag Home Test
- CLINITEST Rapid COVID-19 Antigen Self-Test
- Ellume COVID-19 Home Test
- FlowFlex COVID-19 Antigen Home Test
- InBios SCoV-2 Ag Detect Rapid Self-Test
- iHealth COVID-19 Antigen Rapid Test
- InteliSwab COVID-19 Rapid Test
- MaximBio ClearDetect COVID-19 Antigen Home Test

- Nano-Check COVID-19 Antigen Test
- On/Go COVID-19 Antigen Test
- QuickVue Rapid At-Home COVID-19 Antigen Test
- SD Biosensor COVID-19 At-Home Test

The Plan is not required to cover any tests purchased and used solely for employment purposes (such as periodic testing of an unvaccinated employee).

You may purchase an OTC at-home COVID-19 tests ***for personal use only*** (or use by a family member that has coverage under the Plan). Any covered tests that you purchase and receive coverage/reimbursement for ***may not be resold***. The resale of a covered tests constitutes fraud and can lead to criminal prosecution.

You may not knowingly submit a claim for reimbursement for an OTC at-home COVID-19 test if you have already been reimbursed from another source. This may constitute fraud and lead to criminal prosecution.

If you have any questions concerning this Notice or your Welfare Fund benefits, please contact the Fund Office.

Sincerely,

Board of Trustees
International Union of Operating Engineers
Local 825 Welfare Plan

Notice of Grandfathered Health Plan

The Operating Engineers Local 825 Welfare Plan believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

You should keep this Notice together with your Summary Plan Description at all times. The two documents should be read together for an accurate depiction of your current health plan benefits. If you have any questions, contact the Welfare Fund.

The Board of Trustees reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or eligibility for such benefits), in whole or in part, at any time and for any reason.

Plan Sponsor: *Board of Trustees of the Operating Engineers Local 825 Welfare Fund*
Sponsor's EIN #: 22-6033381 Plan Number: 501 Plan Year: July 1 through June 30

OPTUMRx®

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Member information

RxGroup *(see ID card)* | Member ID *(see ID card)*

Last name | First name | MI

Mailing street address | Apt. #

City | State | ZIP

Prescription is for O Self O Spouse O Dependent

Gender O M O F

Date of birth *(mm/dd/yyyy)* ___/___/____

2 Custodial parent information

For reimbursement requests from a parent for a child (under the age of 18) when the requesting parent meets both of the following requirements:

1. Parent is not enrolled in the same Group Health plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Group Health plan

If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.

Legal custodian's name | Legal custodian's contact phone

Custodian requesting reimbursement name | Custodian requesting reimbursement contact phone

Address payment is to be mailed to

3 Physician and pharmacy information

Prescribing physician name | Dispensing pharmacy name

Prescribing physician phone number with area code | Dispensing pharmacy phone number with area code

4 Reason for request Select appropriate options for your request

O I did not use my Prescription Drug ID card

O I used a non-participating pharmacy *(please explain)*

_____

_____

O I filled a compound prescription *(your pharmacist must complete section B on the back of this form)*

O I purchased medication outside of the United States

Country_____

Currency used _____

O My primary coverage is with another insurance carrier *(coordination of benefits claim; see section C on back for details)*

- O I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
- O I am submitting a copay receipt

O I was waiting for a drug approval

O I was retroactively enrolled with the plan

O My pharmacy billed the wrong plan

O Other *(please explain)*_____

_____

5 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ **Date:** _____

Instructions for submitting form

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
2. Read the Acknowledgement (section 4) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
3. Send completed form with pharmacy receipt(s) to: **OptumRx Claims Department, P.O. Box 29044, Hot Springs, AR 71903**

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Pharmacy receipts for reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

- O Date prescription filled
- O Name and address of pharmacy
- O Prescribing physician name or ID number
- O National Drug Code (NDC) number
- O Name of drug and strength
- O Prescription number (Rx number)
- O Quantity

Section B – Pharmacy information *(for compound prescriptions ONLY)*

(Pharmacist must complete and sign)

- List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient used in the compound prescription.
- For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.

* Individual quantities must equal the total quantity.

† Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

Rx#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee		
Total		

X _____

Signature of Pharmacist

Section C – Coordination of benefits

You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare: If you have not already done so, submit the claim to the Primary Plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

When submitting a copay receipt: If your Primary Plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

***Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

***California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通，我们提供一些免费服务，例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助，请拨打您的 ID 卡上列出的免费电话号码。