

PROGRAM OF INSURANCE BENEFITS

HEALTH AND WELFARE TRUST FUND

FOR

INTERNATIONAL UNION OF OPERATING ENGINEERS

LOCAL 99 AND 99A

ACTIVE EMPLOYEES

The Trustees believe this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”) and can interpret and administer this Plan in a manner to preserve its grandfathered status. 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 the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (410) 254-9595. A Participant 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.

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Baltimore, MD 21222

January 1, 2016

(410) 254-9595
1(800) 367-7848

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We urge you to read the booklet carefully and share it with your family members who are included in your coverage. Please keep in mind that this handbook is a summary of an official legal document and, if it conflicts with the wording of the actual plan document, the plan document will govern.

SUMMARY OF BENEFITS

JANUARY 1, 2016

Please Note: This chart outlines the amount of Charges that could be paid by the Fund. Any portion of the charges not paid by the Fund and amounts in excess of the covered Charges will be your responsibility. All Charges are generally subject to a deductible.

	AMOUNT OF BENEFIT PARTICIPANT & DEPENDENT	
<u>THE MEDICAL PLAN</u>	PPO	NON-PPO
BASIC MEDICAL BENEFITS		
Plan Year Deductible	\$220	\$220
Plan Year Deductible for a Family of 3 or More	\$660	\$660
INPATIENT HOSPITAL CARE		
<i>(Pre-Certification Required)</i>		
Maximum Room and Board Charges	First 20 Days Paid at 100% at average semiprivate rate ¹	First 20 Days Paid at 100% at average semiprivate rate ¹
In Excess of 20 Days	100%	80%
Miscellaneous Charges	First 20 Days Paid at 100%	First 20 Days Paid at 100%
In Excess of 20 Days	100%	80%
OUTPATIENT HOSPITAL CARE		
Hospital Charges for Sudden & Serious Illness	100%	100%
Facility Fees for Outpatient Surgery	100%	100%
Outpatient Physical Therapy	80%	80%
Miscellaneous Outpatient Care	Depends on Itemized Charge	

There is a \$50 co-pay on all ER Facility Fees if not admitted. (If admitted, 100% paid.)

¹ The Plan Administrator reserves the right to establish the acceptable semiprivate rate if not otherwise available.

BENEFITS	AMOUNT OF BENEFIT	
	PARTICIPANT & PPO	DEPENDENT & NON-PPO
GLOBAL CASE CHARGES	100%	100%
SURGICAL CARE		
Maximum Physician Charge not to Exceed URC		
Inpatient ²	100%	80%
Outpatient ²	100%	80%
Assistant Surgeon Charges	50%	50%
Anesthesia	100%	100%
PHYSICIAN CHARGES		
(All PPO Physician Charges are subject to a \$10 Co-Pay per Visit)		
Inpatient Doctor's Visit	100%	80%
Outpatient Doctors' Visit	100%	80%
Home Visit	100%	80%
DIAGNOSTIC EXAMS		
Independent Labs	100%	70%
(All PPO independent labs are subject to a \$10 co-pay per date of service.)		
X-ray Examinations	100%	70%
DURABLE MEDICAL EQUIPMENT ("DME") ³		
	80%	80%
HEARING AIDS ⁴		
(\$1,000 Lifetime Limit)	80%	80%
HOME HEALTH CARE		
(RN, LPN Charges Only)		
100 Visits Per Plan Year	100%	80%
HOSPICE CARE		
180 Days Maximum	100%	80%

² Pre-certification is required for all in-patient admissions, out-patient surgical procedures & out-patient IV Therapy.

³ All DME benefits are subject to medical necessity review.

⁴ Specific criteria must be satisfied to qualify for Benefit.

BENEFITS	AMOUNT OF BENEFIT PARTICIPANT & DEPENDENT	
	PPO	NON-PPO
EXTENDED CARE/SKILLED NURSING FACILITY (180 Days Per Plan Year)		
First 20 Days Inpatient	100%	100%
In Excess of 20 Days	100%	80%
ORTHOTICS		
Annual Maximum 70% of Charges (Not to Exceed \$700)	70%	70%
PROSTHETICS, effective 9/9/16 (Maximum 80% of charges not to Exceed \$7,500 every seven Plan Years)	80%	0%
WELL BABY CARE TO AGE 24 MONTHS (All PPO Well Baby Care Visits are subject to a \$10.00 Co-Pay per visit)	100%	80%
PRIMARY MAJOR-MEDICAL BENEFIT	80%	80%
RECONSTRUCTIVE JAW SURGERY (Lifetime Limit of \$20,000)	80%	80%
WELLNESS BENEFIT (All benefits, including hair prosthetics, are combined and subject to a \$1,500 lifetime max but there is a separate lifetime max of \$350 on hair prosthetics.)	\$1,500 Lifetime Max	\$1,500 Lifetime Max
Nutritional Counseling		
Hair Prosthetics	\$350 Lifetime Max	\$350 Lifetime Max
OPTICAL EXPENSE BENEFITS		
Calendar Year Maximum ⁵	\$250	\$250
SECONDARY MAJOR-MEDICAL BENEFITS ⁶		
Plan Year Deductible	\$200	\$200
Lifetime Maximum Payment	\$25,000	\$25,000
Outpatient	80%	80%

⁵ Optical charges for Dependent Children under age 19 are not subject to the Calendar Year Maximum. Benefits are paid according to a separate Fee Schedule available upon request from the Administrator.

⁶ All expenses for acupuncture and chiropractic care are payable under the Secondary Major-Medical Benefit part of the Plan. None of these expenses are covered under the Basic Medical Benefit.

BENEFITS**AMOUNT OF BENEFIT****DENTAL/ORTHODONTIC BENEFITS****Dental Benefit⁷**

Preventive Services	100%
Annual Deductible	\$50
Basic Services	80%
Major Services	50%
Maximum Calendar Year Benefit	\$2,500

Orthodontic Benefit***(Dependent Children Only)***

Basic Services Annual Deductible	None
Basic Services	80%
Lifetime Maximum	\$1,000

DEATH, ACCIDENT AND DISABILITY BENEFITS (Active Employees Only)

DEATH BENEFIT	\$50,000
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	\$50,000

**SHORT-TERM WEEKLY DISABILITY & LONG TERM DISABILITY BENEFITS
(Active Employees Only)****WEEKLY DISABILITY BENEFIT**

Weekly Indemnity	\$600
Waiting Period – Accident	0 Days
Waiting Period – Sickness	7 Days
Maximum Period of Benefit	26 Weeks

LONG TERM DISABILITY BENEFIT

Monthly Indemnity 60% of Base –	Maximum \$2,500
Waiting Period	180 Days
Maximum Period of Benefit	To Age 65

⁷The annual dental maximum may not apply to Eligible Dependent Children as required under the Essential Benefit Provision of Health Care Reform.

NOTE:

1. The Stop-Loss Limit - Plan Year Out-of-Pocket maximum for Basic Medical Benefits is \$1,500 for an individual, \$3,000 for two people and \$4,500 for a family of three or more, after the cash deductible has been met.
2. Non-PPO Professional Fees Rendered at a PPO Hospital - Charges for professional fees from Non-PPO professionals (Emergency Room Physicians, Radiologists, Pathologist, etc.) will be paid at the PPO rate providing that (1) services were rendered while an eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider, and (3) the services provided were a covered benefit under the Plan.
3. The Plan is intended to be a grandfathered plan. The Trustees believe this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”) and can interpret and administer this Plan in a manner to preserve its grandfathered status. 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 the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (410) 254-9595. A Participant 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.

Current Contact List – January 1, 2016

Prescription Benefit Manager

CVS Caremark
1-866-282-8503
www.caremark.com

Pre-certification is required for all in-patient admissions, out-patient surgical procedures & out-patient IV-Therapy

American Health Holding
1-800-641-5566

CareFirst PPO Network:

Carefirst Network Leasing
P. O. Box 981633
El Paso, TX 79998
Group #: W29L
www.carefirst.com
1-800-235-5160

PPO Networks for Select Members residing outside of the CareFirst Area Effective: 2-1-2016:

InterGroup Services Green Network
Members in: PA - NJ - DE

Intergroup Services
P.O. Box 981806
El Paso TX 79998-1806
www.IGS-PPO.com
1-800-537-9389

First Health – All Other States

Plan Administrator – call for Benefits/Registration and Eligibility Claim Payment

Decision Science, Inc.
3615 North Point Blvd., Suite C
Baltimore, MD 21222
1-410-254-9595 / 1-800-367-7848

Short-Term Disability Benefits Provided Through IUOE Local 99 & 99A Health & Welfare Plan

Please Contact the Benefit Fund Office
IUOE Local 99 & 99A
Health & Welfare Plan
1-410-254-9595 / 1-800-367-7848

Long-Term Disability, Life, Accidental Death & Dismemberment Benefits Provided Through Reliance Standard Life Insurance Company

Reliance Standard Life Ins. Co.
2001 Market Street
Philadelphia PA 19103
Please Contact the Benefit Fund Office
For More Information
1-410-254-9595 / 1-800-367-7848

PRESCRIPTION DRUG BENEFITS

Caremark's Drug Savings Review

Prescription drugs covered by your health plan are reviewed under this program. The program identifies patients who may be at risk for drug interactions or drug induced illnesses. It also identifies a risk situation or a cost savings opportunity, a letter is sent to your doctor with recommendations for alternate treatment. Your doctor is not required to change your prescription and your benefits are not reduced if your prescription is not changed.

Mandatory Generic Program

Generic Step Therapy on any new prescription. Any new prescription must first be filled as a Generic or Generic Alternative before a Brand can be filled.

Mail Order for Maintenance Drugs

Any prescription taken on a regular basis for a chronic condition is considered a maintenance drug. After your 2nd 30-day fill of a maintenance drug at any store, you are required to use either the Mail Order program or your local CVS Pharmacy. When using the mail order program, you must have a prescription written for 90 days. Your medication will be mailed directly to the address you specify.

Retail and Mail Order Co-Pays	<u>Retail Employee Cost</u>	<u>Mail Order Employee Cost</u>
Generic	\$10	\$20
Preferred Brand	\$30	\$48
Non-Preferred Brand	\$48	\$72
Value Generics	\$3.33	\$9.99
Specialty Medications	20% co-pay	20% co-pay
Categories		
Crohn's		
Hepatitis C		
Subdermal Contraceptives		
Inflammatory Bowel Disease		
Multiple Sclerosis		
Oncology		
Osteoarthritis		
Psoriasis		
Psoriatic Arthritis		
Rheumatoid Arthritis		
Renal Disease		
Transplant		

<u>Retail and Mail Order Co-Pays</u>	<u>Retail Employee Cost</u>	<u>Mail Order Employee Cost</u>
Other Injectables	20% co-pay	20% co-pay
Cancer Support for the following:		
Anemia		
Neutropenia (low white cells)		
Injectable Anti-Nausea Medications		
IV Antibiotics	20% co-pay	20% co-pay
Migraines (currently Imitrex)	Normal Co-Pays	Normal Co-Pays
Anticoagulant Injectables	20% co-pay	20% co-pay
 Diabetic Treatment		
Non-Insulin Injectables	Covered After Prior Authorization at 20% co-pay	
Insulin	Normal Co-Pay	
Non Insulin Oral Drugs	Normal Co-Pay	
Supplies	90-Day Supply at Normal Co-Pays (Mail Order or CVS Pharmacy)	
Devices	Free Meter Program Only	
 Prescription Vitamins	Normal Co-Pays	Normal Co-Pays
Pre-Natal Vitamins		
Vitamin D		
Iron		
 Contraceptives		
Oral Medicine	Normal Co-Pays	Normal Co-Pays
Injectable Medicine	Normal Co-Pays	Normal Co-Pays
Patches	Normal Co-Pays	Normal Co-Pays
Subdermal Implants	20% co-pay	20% co-pay
 Vaccinations		
Flu	(Available August through April) - 0% Co-Pay when filled or administered at pharmacy	
Shingles	20% Co-Pay when filled or administered at pharmacy	
Pneumonia	20% Co-Pay when filled or administered at pharmacy	

Note: A Medical prescription is not required for any of the above vaccinations. Just present your Medical/RX ID Card to the pharmacist.

Please visit the Caremark Website for further Information at www.caremark.com

Smoking Cessation Products - 3 months supply - once yearly for 3 years

Prescription

Normal Co-pays

Over the Counter

\$0 Co-pay with a Medical Prescription.

You must present your Medical/RX ID Card to the pharmacist.

Non-Covered Prescriptions

Present your Caremark RX Card to the pharmacy even when obtaining non-covered drugs to qualify for applicable discounts. You will be billed the cost of the medication minus the discount.

SECTION A

GENERAL PROVISIONS

Unless the Summary of Benefits pages state otherwise, the following provisions apply to all Participants and their Dependents covered under this Plan:

ELIGIBLE INDIVIDUALS:

Those employees of a contributing employer who are in a collective bargaining unit represented by Local Union 99 and 99A of the International Union of Operating Engineers will be eligible for coverage under this Plan.
--

1. GENERAL INFORMATION.

- A. Definition of Employee – Those employees of an employer for whom contributions are required to be made to the Fund.
- B. Employer Contributions - Will be made in accordance with the rates and terms contained in the applicable collective bargaining agreement, for any month or a portion thereof in which an employee is employed by an employer.
- C. Disabled Participants – If a Participant is temporarily disabled, and is receiving either Weekly Income Benefits from the Plan or Workers’ Compensation, no contribution needs to be made on his behalf for the six consecutive month period, beginning with the month following the last month in which all required contributions were made on the Participant’s behalf. During the period in which the Participant qualifies for the Weekly Disability Benefits under the Plan, the Participant (and Dependent covered prior to disability) will remain covered under the Plan and receive the same benefits that were provided prior to the disability.

If the employee is temporarily disabled for longer than six consecutive months, he may continue his coverage in accordance with the COBRA rules by paying on his own behalf the necessary contributions. See the COBRA Section of the Plan (Section D).

When an employee is disabled due to an occupational injury or illness, he/she must submit a completed physicians statement or other satisfactory proof to be properly credited for the time disabled.

Disabled Participants. If you become disabled you may be able to continue your benefits during the following period:

Up to six months from the date of disability (1st of month after you stopped working) if you remain disabled* and

Your COBRA continuation period for 18 months (if you pay the required premiums). Note that insurance benefits (STD, LTD, AD&D and life insurance) are not available during COBRA; and

Extended COBRA of 11 months if you qualify for Social Security disability and timely notify DSI. See the COBRA Section of the Plan (Section D).

* The six month period may be eight months if you had a two or three month waiting period when you were initially eligible.

2. EMPLOYEE ELIGIBILITY.

General Rules.

Hired or rehired on and after November 1, 2014:

Any Employee hired or rehired on and after November 1, 2014 will become eligible for coverage on the first day of the month immediately following a period of two consecutive months for which the established contributions are received.

If two months of contributions are remitted before an Employee becomes eligible for coverage, the Employee will remain eligible for continuation coverage for two calendar months after he terminates employment. The two month coverage period shall be at the same level of coverage that existed prior to termination. Such employee does not have the option to change his coverage level. During the two month post-termination continuation period a Participant receives all benefits available to Active Employees, including AD&D and Life Insurance, but excluding Short and Long Term Disability.

Hired or rehired prior to November 1, 2014:

If you had contributions made on your behalf for a three month period prior to Plan eligibility, you are also eligible for two months of post-termination coverage.

Special Rules.

In special situations, the two month eligibility period can be waived when a new Employer Group joins the Plan. When a new Employer Group joins the Plan, only those individuals who qualify as Employees under the new Employer Group receive immediate coverage. If the two month eligibility period is waived for a new Employer Group, the Employees of the new Employer Group will not remain eligible for a period of two consecutive calendar months after employment termination.

3. ELECTING COVERAGE.

General. Once you become eligible to participate in the Fund, you should contact the Fund Office and elect in writing whether you want single or family coverage. As a courtesy to members the Fund will try to initiate contact with you.

If you fail to make a timely written election within 30 days of the date of the Fund's mailing, you will be treated as having elected single coverage.

In order to elect family coverage you must:

provide a written election to the Fund Office within 30 days of the Fund's mailing, and identify the Dependents who should be covered.

AND

provide proper verification of the status of your Dependents by providing documents within 60 days of the Fund's request

If the Fund asks you to provide verification of your Dependents and you do not respond in a timely and complete manner, the Fund has the right to deny or terminate your Dependent coverage. Effective January 1, 2015, the requested required documentation must be provided within 60 days from the date of the Fund's request. Benefits for Dependents will be suspended pending receipt of documentation deemed inadequate by the Plan Administrator. If you provide documentation and it is not sufficient, you must supplement the documentation within the original 60 day period.

Once you are covered under the Fund, you will have an annual opportunity to change your coverage. Your existing coverage remains in effect (from year to year) until you make a change.

Failure to timely Add Dependents. If you do not timely elect dependent coverage (see above), you will have to wait until the next annual open enrollment period to add your dependents as of the following January 1st. The only exception would be if you qualify under the Mid-Year Changes discussed below.

Annual Open Enrollment. In December of each year, the Fund will allow you to change your existing coverage under the Plan effective as of the following January 1st. To make a change, you need to complete a new registration form and indicate either individual or family coverage. The card needs to be forwarded by the date designated by the Plan Administrator to the following address:

Decision Science, Inc.
3615 North Point Boulevard, Suite C
Baltimore, MD 21222

If you are changing to family coverage, Dependents must be listed on the registration document. Also include copies of marriage certificates, birth certificates or other information required to establish the validity of a Dependent to receive health coverage. Please contact the Fund Office at 1-800-367-7848 or (410) 254-9595 if you have any questions.

You need to also inform the employer of a change in coverage by the date your employer needs to process the information by the payroll and benefits paying department. You may have a payroll deduction for your share of family coverage and your employer can inform you of the amount if any.

Mid-Year Changes. If you have certain “changes in family status”, you may be allowed to change your health coverage in the middle of a calendar year. If you have a “change of family status” and the Fund is notified of the change within 30 days from the date of the change, you can make a coverage change which will be generally effective the 1st day of the month following the day of the change. Remember: in order for you to make a mid-year change, you must notify the Fund within 30 days of the date of the change and provide documentation within 60 days of the date of the change.

A “change in family status” would include a marriage, the birth or adoption of a child, your spouse’s loss of coverage from another source, or a divorce. There are other events which could constitute a “change in family status”. Please see the Administrator for more information as to whether or not your situation constitutes a “change in family status”.

REMEMBER: The Fund needs to be notified of the change in family status within 30 days from the date of the change. The date of the change counts as day 1 of the 30 days. For example, if your son is born at 1:15 p.m. on May 1, 2015, you would need to contact the Fund office by midnight on May 30, 2015, to enroll him as a Dependent.

Special Enrollment Rule. The Plan complies with the Special Enrollment requirements of the tax law:

(1) If an Employee is declining enrollment for himself or his Dependents (including his spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, unless a special time period is available, as detailed below, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage). In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption counting the date of birth, marriage, adoption or placement for adoption as day one.

(2) The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(3) An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (*i.e.*, part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area,

(whether or not within the choice of the individual), and no other benefit package is available to the individual.

(f) If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(4) Dependent beneficiaries.

(a) General Rules. If:

(i) the Employee is a Participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(ii) a person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

(b) The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

(c) The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(i) as of the date of application for coverage;

(ii) in the case of a Dependent's birth, as of the date of birth; or

(iii) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Special Rules for Special Enrollment Rights Effective On and After April 1, 2009. A federal law provides an Employee and his Dependents with a special enrollment period if either of the following situations occurs and the Employee requests enrollment in the Plan within the time period specified below:

(1) the Employee or his Dependents loses coverage under a Medicaid plan or a state sponsored children's health insurance plan and the Employee requests coverage under this Plan within 60 days after the termination of the other coverage; or

(2) the Employee or his Dependent's becomes eligible for assistance under this Plan from the Medicaid plan or a state sponsored children's health insurance plan and the Employee requests coverage under this Plan within 60 days after the Employee is determined to be eligible for assistance.

4. REMAIN ELIGIBLE.

To continue to be eligible for coverage as of the first day of each succeeding month, an Employee must remain employed with a contributing employer and must be represented by Local 99 and 99A.

If the Fund asks you to provide verification of your Dependents and you do not provide all the requested information within 60 days, the Fund has the right to terminate your Dependent coverage.

5. TERMINATION OF COVERAGE.

All coverage to which a Participant and his Dependents are entitled will be terminated on the last day of the month in which the first of the events listed below occurs, subject to the COBRA coverage rights set forth in Article VIII. Notwithstanding the previous sentence, the Trustees have the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Trustees may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Trustee's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Trustees will refund all contributions paid for any coverage rescinded if required by law; however, claims paid will be offset from this amount. The Trustees reserve the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Your coverage under this Plan will be terminated on the last day of the month in which the first of the following events occur:

You cease to be covered by the bargaining agreement between the contributing employer and by Local 99 and 99A.

You are no longer eligible for coverage.

You or your Employer do not timely make a required contribution.

The Plan is terminated.

Your Dependent no longer qualifies as a Dependent

Your Dependent coverage can terminate if you do not timely respond to a Plan audit or information request.

Your Prescription Drug coverage can terminate if, in the opinion of the Plan's Medical Consultant, you are purchasing an excessive amount of drugs so that it is likely that you are reselling the drugs.

6. TERMINATION OF ELIGIBILITY RESULTING FROM EMPLOYER WITHDRAWAL FROM PARTICIPATION.

In the event that an Employer or group of Employers shall cease to contribute to or otherwise cease to participate in the Local 99 and 99A Health and Welfare Trust Fund, for reasons other than cessation of operation, the eligibility of Participants employed by such Employer(s), and their Dependents, shall terminate upon the date that their Employer shall cease to contribute to or participate in the Fund. Such termination of coverage for Employees and their Dependents shall be without regard to whether the initial eligibility of such Employees had commenced immediately upon contributions being made on their behalf or had commenced following a two month period of contributions being made on their behalf.

7. REINSTATEMENT OF COVERAGE.

Subject to the requirements of the law, an Employee who had a two or three month waiting period will have coverage reinstated on the first day of the month following the month in which he returns to active employment with a contributing employer for which the established contributions are received, providing he is re-employed within two calendar months of termination.

8. CONTRIBUTION TOWARD PREMIUM BY EMPLOYEE.

Contributions may be required by Participants.

9. DEPENDENT ELIGIBILITY.

General Rule. A Dependent's coverage will be effective on the date he or she becomes eligible as long as the Participant is covered on that date. (Also see Notice of Continuation of Coverage)

10. PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

The Health Insurance Portability and Accountability Act (HIPAA) privacy rules generally allow the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules. The Plan may also disclose your health information without your written authorization to your Employer for plan administration purposes.

11. DEFINED TERMS.

Included below are certain defined terms which are used throughout this document. For more information, please ask to see a copy of the Plan document.

Active Employee. An “*Active Employee*” is a current Employee who is regularly employed. An individual on COBRA is not an Active Employee.

Benefits “*Benefits*” under the Plan may include the benefits as outlined in Section B and such other insured and non-insured health and welfare benefits as may be selected by the Trustees, or by an employer pursuant to an adoption agreement. The Plan does not create vested rights in the Participants or Dependents to receive Benefits, and all Benefits under the Plan are subject to amendment at the discretion of the Trustees.

Charges. The term “*Charge*” or “*Charges*” means the usual, customary and reasonable fees for payment for services or items for which Benefits are payable under the Plan as follows:

- (a) **Usual** means the fee that is usually charged for a given service by a physician to his or her private patient (*i.e.*, his or her own usual fee).
- (b) **Customary** means the fee within the range of usual fees charged by physicians of similar training and experience for the same service within the same specific and limited geographical area.
- (c) **Reasonable** means the fee which meets the definitions for both usual and customary, or in the opinion of the responsible medical association’s review committee, is justifiable considering the special circumstances of the particular case in question.

Excessive charges will be the responsibility of the Participants or Dependents.

Dependent. The term “*Dependent*” may include the following individuals, depending upon the coverage elected by the Participant: the Participant’s Spouse (if not divorced) and each child of the Participant who has not attained his or her twenty-sixth (26th) birthday. Benefits will be provided for each child until the end of the month in which he or she turned twenty-six (26). After such time, eligibility for additional Benefits will cease.

For purposes of this definition, children shall include:

- (a) a natural child;
- (b) a legally adopted child;
- (c) a child placed with a Participant for adoption;
- (d) a child for whom the Participant serves as a legal guardian (as documented in a court order which is presented to the Plan Administrator prior to the effective date

of Dependent Coverage), if the child permanently resides in the household of which the Participant is the head and if the child is actually being supported solely by the Participant; or

- (e) any unmarried child age twenty-six (26) or over who is incapable of self-support because of mental retardation or physical incapacity that commenced prior to such child's attaining the age of twenty-six (26) and who is dependent upon the Participant for support, provided that proof of such child's incapability is furnished to the Plan Administrator no later than thirty (30) days after the child attains the maximum age limit and the child was listed as a Dependent prior to age twenty-six (26). Proof of the continued existence of such incapacity may be requested by the Plan Administrator from time to time, and subject to the Plan Administrator's determination.

If an individual is classified as a Dependent because he is disabled and satisfied the requirements in paragraph (e) above, he is eligible for Dependent coverage beyond age twenty-six (26).

Note: A stepchild qualifies as a Dependent of a nonbiological parent only if the nonbiological parent has adopted the child or been appointed the legal guardian of the child.

Legal documentation of a decree or pending proceeding to establish a Participant's status as a legal guardian of a child must be presented to the Plan Administrator before the child will be considered a Dependent of the Participant.

Newborn children shall be eligible as Dependents for Benefits under the Plan from the date of birth. You have 30 days to change your coverage level to include a newborn child. The 30 day period is measured from the date of birth and the day the newborn is born counts as a full day regardless of the time the child is born on that day.

If a Participant has no Dependents on the day he or she becomes eligible for benefits provided herein, his or her Dependent Benefits will become effective upon the date he or she does have an eligible Dependent, provided that the Participant is then still eligible for benefits and the Participant adds the Dependents during an Open Enrollment period or within 30 days of a Dependent's birth, adoption or placement for adoption. Notwithstanding the above, any child of a Participant who is named as an Alternate Recipient in a Qualified Medical Child Support Order shall be deemed to be Dependent during the period to which the Qualified Medical Child Support Order applies.

This is a technical provision that remains in the law but has little impact because a Dependent remains eligible for coverage until age 26, regardless of whether he qualifies as a student.

Special Rule for College Students. A Dependent child who is enrolled in the group health coverage who ceases to qualify as a full-time student (without regard to this paragraph) because of a change in student status that results from a "medically necessary leave of

absence” (as defined for purposes of Code § 9813) from a postsecondary educational institution will continue to be treated as a full-time student until the earlier of (a) one year from the date the “medically necessary leave of absence” began or (b) the date the child would cease to qualify as a Dependent if the child had not experienced the medically necessary leave of absence.

Special Rule for Members who Qualify as a Participant and a Dependent.

An individual who is entitled to Benefits as a Participant will not also be treated as a Dependent under this Plan. This means if a Participant and his spouse are working and receiving benefits under the Plan, the Plan will not pay 80% of a claim because the Participant is covered as a member and the remaining 20% of a claim because a Participant is also covered as the Dependent of his spouse. The Plan will not coordinate benefits against itself.

** It is your responsibility to determine whether individuals qualify as Dependents and can be provided coverage under this Plan. If the Plan covers family members who do not qualify as Dependents, the Plan has the right to terminate your Dependent coverage and seek reimbursement of any claims that were improperly paid. The Plan does not provide coverage for ex-spouses (except for the COBRA period) regardless of the terms of a court order.

Disability. “***Disability***” means you are unable to perform each and every duty pertaining to your regular job because of an illness or accidental injury, or are unable to perform a light duty reasonable accommodation job.

Employee. An “***Employee***” means:

- (a) any person who is represented by the Union and who is working for an Employer, or any other person working for an Employer for whom contributions are made to the Trust Fund;
- (b) an officer or employee of the Union who shall have been proposed for benefits under the Trust Fund by the Union and who shall have been accepted by the Trustees and for whom the Union agrees in writing to contribute to the Trust Fund at the rate fixed for contributions for other Employers;
- (c) a full-time Employee of an Employer on whose behalf such Employer is required to make payments or contributions to the Trust Fund at a rate fixed for other Employers; or
- (d) a person represented by or under the jurisdiction of the Union, who shall be employed by a governmental unit or agency, and on whose behalf payment of contributions shall be made at the time and at the rate of payment equal to that

paid by an Employer, in accordance with a written agreement, ordinance or resolution.

Employer. An “*Employer*” means:

- (a) an employer (1) which is in good standing with the state in which it was formed or incorporated, (2) which has duly executed or is bound by a collective bargaining agreement with the Union providing for the making of payments to the Trust Fund with respect to employees represented by the Union and (3) effective on and after January 1, 2015, has two or more employees for at least three consecutive months in each Plan Year. Notwithstanding the foregoing, an existing Employer as of December 31, 2014 is grandfathered and not subject to the third requirement in this paragraph until its existing collective bargaining agreement is renewed;
- (b) the Union, which for the purpose of making the required contributions to the Trust Fund, shall be considered as the Employer of the Employees of the Union for whom the Union contributes to the Trust Fund; or
- (c) an employer which does not meet the requirements in paragraph (a) or (b), but which is required to make payments or contributions to the Trust Fund by any law or ordinance applicable to the District of Columbia and the surrounding states, or to any political subdivision, corporation thereof or pursuant to any written agreement entered into by such employer with such state or any political subdivision or municipal corporation thereof.
- (d) Employers as described in this Section shall, by the making of payments to the Trust Fund pursuant to such collective bargaining or other agreements, be deemed to have accepted and be bound by the Trust Agreement.

Extended Care/Skilled Nursing Facility. An “*Extended Care/Skilled Nursing Care Facility*” means an institution which is primarily engaged in providing skilled nursing care, or extended care, and related services or rehabilitative services to residents.

Hospice. The term “*Hospice*” means a facility, agency or service that:

- (a) is licensed, accredited or approved by the proper regulatory authority to arrange, coordinate and/or provide programs to meet the special physical, psychological and spiritual needs of dying individuals (including terminally ill individuals) and their families (collectively “Hospice Care Services”); and
- (b) maintains records of Hospice Care Services that are provided and bills for such services on a consolidated basis.

Hospital. The term “*Hospital*” means:

- (a) a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Care Organizations;

- (b) a hospital, psychiatric hospital, or a tuberculosis hospital, as those terms are defined in the Medicare Laws, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;
- (c) an institution which fully meets all of the following tests: (1) it maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians, and (2) it continuously provides on the premises twenty-four (24) hours a day nursing service by or under the supervision of registered graduate nurses, and (3) it is operated continuously with organized facilities for operative surgery on the premises; or
- (d) for purposes of substance abuse treatment, the term “Hospital “ also includes a legally operated institution which is accredited by the Commission on Accreditation of Rehabilitation Facilities (“CARF Accreditation”).

The term “*Hospital*” does not include a nursing home or any part of an institution which (1) is primarily a facility for convalescence, nursing, rest, or (2) furnishes primarily domiciliary or custodial care, including training in daily living routines, or (3) is operated as a school.

Medically Necessary. The term “*Medically Necessary*” means services which are

- (a) appropriate medical treatment for the Participant’s or Dependent’s condition;
- (b) expected to provide benefits that outweigh the potential risks; and
- (c) necessary to protect or restore the physical health and/or necessary to protect or restore the mental or physical health of the Participant or Dependent. The determination of what services are Medically Necessary shall be made by the Plan or an agent designated by the Trustees under the Plan. In the event of any conflict of opinion between the Plan and the provider of care, the decision made by the Plan (or its agents) in its discretion shall be final.

The Plan will generally consider a Cardiac CT Scan to be Medically Necessary in the following cases:

- (1) where a diagnosis of chest pain exists;
- (2) where the patient has a family history of heart disease but not current symptoms;
- (3) in cases where the test is being done as a pre-operative assessment for a planned non-coronary surgical procedure; or
- (4) in cases for persons under 30 who have suggestive symptoms (e.g., angina, syncope and arrhythmia, failure to thrive, etc.).

Mental Health Benefit. Mental Health Benefits are included under the rules for Basic Medical Expenses and are not separately stated as a category of Benefits.

Participant. The term “*Participant*” means a current Employee who has satisfied the eligibility provisions in the Plan or a former Employee who makes an election to continue coverage either as a retiree or through COBRA.

Plan Year. The term “*Plan Year*” means the twelve-month period ending on the 31st day of December of each year.

Retiree Coverage and Retiree Opt-Out. Once you qualify for retiree coverage, you are subject to the provisions of the SPD that is specific to retirees. There is a retiree opt-out provision. Please see the Administrator for more details.

Spouse. Prior to January 1, 2015, the term “*Spouse*” did not include a person who was validly married to a Participant of the same sex. Effective on and after January 1, 2015, the term “*Spouse*” is a person who is validly married to a Participant in accordance with the laws of the state in which such individuals were married, and could include a person validly married to a Participant of the same sex.

12. CONTINUATION DURING FAMILY AND MEDICAL LEAVE.

If you take a leave of absence under the Family and Medical Leave Act of 1993 (“FMLA”), benefits shall continue to be paid under the Plan as if you remained in active employment. You will be considered to have terminated your employment on the earliest to occur of:

- (a) the date you notify your Employer that you are not intending to return to work;
- (b) the date you fail to return to employment at the end of leave; or
- (c) the effective date of termination of the Plan.

SECTION B

THE MEDICAL PLAN - SUMMARY OVERVIEW

How the Medical Plan Works

Generally, Basic Medical Benefits are paid according to the Summary of Benefits set forth in the front of this Summary Plan Description. In some cases, the scheduled payment is not intended to cover the full cost of all of your medical care. Therefore, the Medical Plan provides Primary Major-Medical Benefits as well.

There is no Basic Medical Benefit for treatment for chiropractic care or acupuncture. These expenses are covered only under the Secondary Major-Medical Benefit.

Usual, Reasonable and Customary Charges

In the description of medical benefits, you will find the word, "Charges". This is a defined term which refers to the necessary, usual, reasonable and customary charge for a covered service.

The Medical Plan pays all or a percentage of the necessary, usual, reasonable and customary charge, depending upon the treatment or service provided. Please refer to the Summary of Benefits for specific details. Some doctors or physicians charge more than the usual, reasonable and customary amount or perform services that are not Medically Necessary. If your doctor or physician does so, you will have to pay your deductible and those excess fees.

No Vesting of Benefits

The Benefits offered under the Plan do not vest and may be amended by the Trustees from time to time.

SECTION C

THE MEDICAL PLAN - DETAILED EXPLANATION

How the Medical Plan Works

Six Parts of the Medical Plan

The Medical Plan is divided into six parts: Basic Medical Benefit, Secondary Major-Medical Benefit, Prescription Drug Benefit, Dental/Orthodontic Benefit, Optical Expense Benefit, and Insurance Benefits.

1. The Basic Medical Benefit covers basic medical services like inpatient hospital care, outpatient hospital care, surgical care, anesthesia charges, doctors' or physicians' services, diagnostic laboratory and x-ray examinations, mental health benefits, home health care, well baby care, extended care/skilled nursing care, hospice care, orthotics, and other miscellaneous services.
 2. The Secondary Major-Medical Benefit provides coverage for chiropractic care and treatment by acupuncture, subject to the tax law limitations.
 3. The Prescription Drug Benefit provides prescription drug coverage for Participants and their Dependents.
 4. The Dental/Orthodontic Benefit helps defray part of the cost of a wide range of dental services, including orthodontics for Dependent children.
 5. The Optical Expense Benefit provides coverage for vision care.
 6. The Death, Accident and Disability Benefit provides Life Insurance, Accident Insurance, a Weekly Disability benefit for temporarily disabled ill or injured Participants and a Long Term Disability Benefit for totally disabled ill or injured Participants.
- * ***Items 1-5 apply to Participants and their eligible Dependents. Item 6 applies to Active Employee Participants only.***

SECTION C

I. Basic Medical Benefit. Except for select Lifetime Limits on certain non-essential benefits (*i.e.*, Reconstructive Jaw Surgery Benefit and the Hearing Aid Benefit) there is no lifetime limit on Basic Medical Benefits under this Section C.I. The Basic Medical Benefit includes a plan year out-of-pocket maximum and a cash deductible, and, in certain instances, a co-payment. These are set forth in the Summary of Benefits. If you receive a Global Bill (which is a bill that does not include an itemized line-by-line breakdown of the separate charges), you will not be subject to a co-payment for the bill.

(A) Inpatient Hospital Care. **Note:** Inpatient Hospital Care requires pre-authorization.

(1) Covered Charges. Inpatient Hospital Care Charges will be subject to the applicable deductible, the limitations contained in subsection (3) below, the exclusions in subsection (2) below and in C-III on page 43 and pre-authorization. A Participant or Dependent who is admitted to a Hospital for treatment or sickness of a non-work related accidental injury as a bed patient and who obtains treatment through a PPO provider or a non-PPO provider shall generally be entitled to payment or reimbursement of a percentage of the required Hospital Charges set forth in the Summary of Benefits. Hospital Charges shall include:

- (a) Administration of blood, blood plasma and plasma substitutes.
- (b) Admissions for diagnostic studies when the studies are directed toward the definite diagnosis of a disease or injury.
- (c) Anesthetic materials.
- (d) Basal metabolism tests.
- (e) Blood processing.
- (f) Coronary and intensive care units.
- (g) Dressing and bandages, casts and splints.
- (h) Drugs and medicines which are officially accepted for general use at the time of hospitalization.
- (i) Electrocardiograms.
- (j) Electroencephalograms.
- (k) Laboratory examinations, including tissue examinations.

- (l) Medical services and supplies which are customarily provided by a Hospital, unless otherwise specifically excluded by this Plan.
 - (m) Occupational therapy while in a Hospital.
 - (n) Oxygen as provided by a Hospital.
 - (o) Physicians' visits which are billed by a Hospital.
 - (p) Physiotherapy, hydrotherapy and occupational therapy when performed by duly qualified therapists.
 - (q) Professional ambulance service used locally to a Hospital for a covered inpatient admission.
 - (r) Room and board, delivery room, recovery room and miscellaneous medical services for a female Participant or a Participant's spouse who is confined to a Hospital because of a pregnancy or resulting childbirth, spontaneous abortion or miscarriage up to the maximum, if any, as set forth in the Summary of Benefits.
 - (s) Room and board (including meals, special diets and general nursing services) for "semi-private accommodations," up to the daily maximum, if any, as set forth in the Summary of Benefits. Private room at the most common "semi-private" rate. Intensive or coronary care unit at twice the most common "semi-private" rate. To the extent the Hospital is an all-private room facility, room and board for "private accommodations" up to the daily maximum, if any, set forth in the Summary of Benefits.
 - (t) Use of operating, treatment and/or recovery room.
 - (u) X-ray examinations.
 - (v) X-ray radium and radioactive isotope therapy.
 - (w) Treatment for alcoholism.
 - (x) Treatment for drug dependency.
- (2) Exclusions From Coverage. Charges for Basic Medical Benefits for Inpatient Hospital Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C-III, on page 43
- (3) Coverage Limitations.
- (a) Coverage During Hospital Confinements.

- (i) Limitation on Hospital Confinement. As detailed in the Summary of Benefits, Inpatient Hospital Care provided as a Basic Medical Benefit shall be covered beyond the twentieth (20th) day of confinement for Participants and their Dependents (including newborn children) but, the Plan's payment percentage will decrease if the care is provided by a non-PPO provider.
 - (ii) Successive Confinements - Participants and Dependents. In the event a Participant enters the Hospital, is later discharged upon complete recovery and/or returns to active work on a full-time basis for an Employer for at least one full working day, and then enters the Hospital again, the second hospitalization is considered separate from the first. If the Participant does not completely recover or return to active work on a full-time basis for an Employer for at least one full working day after the first Hospital stay, the second Hospital stay will be considered part of the first, and the Hospital time under both visits will be aggregated in determining the maximum coverage limitation set forth in the Summary of Benefits.
- (b) Costs After Discharge. The Plan shall not be responsible for any Charges for Hospital services rendered after the day for which discharge has been authorized by the confined person's physician. Moreover, if the Hospital, pursuant to such an authorization, shall request the Participant or Dependent to vacate the room in which he has been a bed patient and such person fails or refuses to do so upon request or within two hours after such request, whichever occur later, the Plan shall not be responsible for any Charges for care rendered by the Hospital thereafter.
 - (c) Reserve Costs. Notwithstanding anything herein to the contrary, Hospital benefits shall be paid or reimbursed only for days of actual confinement, and shall not include any Charges for holding or reserving space, or for pass or therapeutic leave days.
 - (d) Non-PPO Professional Fees Rendered at PPO Hospital. Charges for professional fees from Non-PPO professionals (emergency room physicians, radiologists, pathologists, etc.) will be paid at the PPO rate providing that (1) services were rendered while an eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider and (3) the services provided were a covered Benefit under the Plan.

(B) Outpatient Hospital Care.

- (1) Covered Charges. There are different types of Covered Charges under the category of Outpatient Hospital Care and each is subject to an applicable deductible and the exclusions on page 43.
- (a) Outpatient Surgery. Facility fees for Outpatient Surgery Charges will be subject to the applicable deductible, the limitations outlined below and the exclusions in C-III on page 43. A Participant or Dependent who goes to the Hospital for an outpatient surgery that is not work related shall generally be entitled to payment or reimbursement of a percentage (as set forth in the Summary of Benefits) of the required Hospital Charges for both PPO and non-PPO providers.
- (b) Dental Care in Hospital. Notwithstanding the foregoing, upon the receipt of a letter of Medical Necessity from the Dependent's doctor and the written recommendation from the Fund's Medical Consultant, the Plan will pay or reimburse a percentage (based on the percentage for Facility Fees for Outpatient Surgery, as set forth in the Summary of Benefits) of the facility charges billed by a Hospital to perform dental work in a Hospital setting for a Dependent child age six or younger or for a Participant of any age or Dependent of any age who has a physical or mental impairment.
- (c) Sudden and Serious. Sudden and Serious Condition Charges will be subject to the applicable deductible, the limitations outlined below and the exclusions in C-III on page 43. A Participant or Dependent who is treated for a non-work related sudden and serious condition which does not result in an inpatient admission to a Hospital shall generally be entitled to payment or reimbursement of a percentage (as set forth in the Summary of Benefits) of the required Hospital Charges for a PPO or non-PPO provider but will be subject to a co-pay on the ER Facilities, as set forth in the Summary of Benefits. This category includes observation time billed by the Hospital.
- (i) The Fund covers Hospital charges for treating certain sudden and serious illnesses. Benefits are payable if the illness had a sudden onset, and is considered as life endangering. Benefits are only for care received during the first visit to the emergency room of a Hospital, provided the illness is treated within 48 hours of its onset and the treatment is billed by the Hospital.
- (ii) Examples of Serious and Sudden Outpatient Hospital Care:
- Acute Abdominal Pain
 - Acute Chest Pains

- Acute Coronary
- Allergic reactions, Acute (except allergy tests)
- Appendicitis, Acute
- Asthmatic Attack
- Bronchitis, Severe
- Chest Pains
- Colitis
- Coma
- Convulsions and/or Seizures
- Diabetic Coma
- Diarrhea, Severe
- Drug Reaction
- Epistaxis, Severe
- Fecal Impaction, Severe
- Food Poisoning
- Foreign Body in Eye, Ear, Nose or Throat
- Gall Bladder, Acute Attack
- Heart Attack, Suspected
- Hemorrhage
- High Fever (102 degrees F – child,
104 degrees F - adult)
- Hysteria
- Insertion of Catheter (for acute urine retention)
- Insulin Shock (overdose)
- Kidney Stones
- Pleurisy
- Pneumonitis
- Poisoning (including overdose, subject to
exclusions)
- Pyelitis
- Pyelonephritis
- Shock
- Spasms, Cerebral or Cardiac
- Spontaneous Pneumothorax
- Strangulated Hernia
- Stroke
- Sun Stroke
- Tachycardia
- Thrombosis and/or Phlebitis
- Unconsciousness
- Urinary Retention, Acute
- Vision Loss, Sudden Onset
- Vomiting, Severe

This is not a complete list of covered conditions. Benefits are payable only for emergency treatment, not for treatment that can be provided at home or in your doctor's and/or physician's office. The Fund also will pay or reimburse the charges for professional ambulance service used

locally to an emergency room of a Hospital in connection with a covered condition. The opinion of the attending doctor or physician will normally decide whether an illness was sudden and serious. The Fund will pay Hospital Charges per the Summary of Benefits. Other related services, including doctors and physicians charges, may constitute covered expenses under other parts of the Medical Plan.

(d) Miscellaneous Outpatient Hospital Care.

(i) This category includes all other services rendered as an outpatient that would not be considered surgery or sudden and serious. This is subject to the applicable deductible, the limitations outlined below and the exclusions in C-III on page 43. Charges for non-work related services or illnesses are generally entitled to payment or reimbursement of a percentage of the charges, based on the Summary of Benefits.

(ii) Non-PPO Professional Fees Rendered at PPO Hospital. Charges for professional fees from Non-PPO professionals (emergency room physicians, radiologists, pathologists, etc.) will be paid at the PPO rate providing that (1) services were rendered while an eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider and (3) the services provided were a covered Benefit under the Plan.

(2) Exclusions From Coverage. Charges for Basic Medical Benefits for Outpatient Hospital Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C-III, on page 43.

(C) Surgical Care.

(1) Covered Charges. Surgical Care Charges will be subject to the applicable deductible, and the exclusions contained in subsection (2). The Plan will pay or reimburse a percentage (as set forth in the Summary of Benefits) of the Charges (subject to the URC standards of this Plan) made by a duly qualified surgeon, depending on whether the surgeon is or is not a member of the Preferred Provider Organization. This section covers physician charges for performing a surgical operation on account of a Participant's or Dependent's accidental injury, sickness, or as necessary for pain management, subject to the following:

(a) Charges will be covered regardless if the surgery is done in a Hospital, physician's office, outpatient surgical center or the home of a Participant or Dependent.

- (b) Charges made by an Assistant Surgeon will be paid or reimbursed at the percentage set forth in the Summary of Benefits.
- (c) Surgery includes the treatment of fractures and dislocations.
- (d) Charges for obstetrical procedures or operations performed by a Physician due to the pregnancy of a female Participant or Dependent spouse which results in childbirth, spontaneous abortion or miscarriage are also payable or reimbursable at the level set forth in the Summary of Benefits under the Plan.
- (e) The Plan will pay the cost of a second surgical opinion if it is rendered and billed by a provider other than the physician who performed the surgery or provided the first opinion.
- (f) In certain instances, the Plan will pay some or all of the charges for services and supplies in connection with pre-approved transplant procedures which are deemed to be Medically Necessary based on the review and approval of the Fund's Medical Consultant, and subject to the Plan's cost containment procedures. Please see the Plan Administrator for more details.

- (2) Exclusions from Coverage. Charges for surgical care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C-III on page 43.

(D) Anesthesia.

- (1) Covered Charges. Anesthesia Charges will be subject to the applicable deductible and the exclusions contained in subsection (2) below. The Plan will pay or reimburse the percentage set forth in the Summary of Benefits of the Charges made by a duly qualified anesthesiologist for administering anesthetics on account of an accidental injury, sickness, surgery, or pain management involving a Participant or his Dependents.
- (2) Exclusions from Coverage. Charges for Anesthesia are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43.

(E) Diagnostic Examinations.

- (1) Covered Charges. Diagnostic Charges at PPO Independent labs will be subject to the applicable deductible, a co-payment, and the exclusions contained in subsection (2) below. A Participant or Dependent will be subject to a co-payment detailed in the Summary of Benefits per PPO date of service. A Participant or Dependent who incurs Charges rendered for Diagnostic Laboratory Examinations to diagnose a non-occupational

illness or injury will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Charges for a PPO provider after paying the co-payment. A Participant or Dependent who incurs Charges rendered for X-Ray Examinations to diagnose a non-occupational illness or injury will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Charges for a PPO provider. In the event the treatment is obtained through a non-PPO provider, the Participant or Dependent shall be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Charges. Treatment for Cardiac CT Scans if Medically Necessary may be covered if provided by PPO providers or by non-PPO providers if there are extenuating circumstances and the member appeals.

- (2) Exclusions from Coverage. Charges for Diagnostic Laboratory and X-Ray Examinations are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43.

(F) Durable Medical Equipment.

- (1) Covered Charges. Durable Medical Equipment will be subject to the applicable deductible and the exclusions contained in Subsection (2) below. For this purpose, “Durable Medical Equipment” will be defined as medical equipment (e.g. walker, wheelchair) ordered by a Doctor for use in the home to assist in performing certain tasks that are not possible due to medical conditions or illnesses, and will include medically necessary acquisition, repair and replacement costs which may be subject to the written recommendation from the Fund’s Medical Consultant and/or other medically necessary review and approval processes established by the Fund.
- (2) Exclusions from Coverage. Charges for Durable Medical Equipment are not payable or reimbursable by the Plan under the conditions referenced in Section C-III on page 43.

(G) Hearing Aids.

- (1) Covered Charges. Charges for a hearing aid, a hearing exam or related expenses necessitated by a functional defect caused by a congenital disease or an accidental injury or surgery resulting from a disease will be subject to the lifetime maximum and the exclusions contained in subsections (2) and (3) below.
- (2) Coverage Limitations. Each Participant and Dependent shall be subject to a lifetime limit set forth in the Summary of Benefits on the amount paid or reimbursed for Charges for Hearing Aids.

- (3) Exclusions from Coverage. Charges for the purchase of or examination for the fitting of hearing aids that are required for any condition, disease or accident arising out of or in the course of a Participants or Dependent's employment will not be covered by the Plan.

(H) Home Health Care.

- (1) Covered Charges. Home Health Care Charges will be subject to the applicable deductible, and the limitations and exclusions contained in subsections (2) and (3) below. A Participant or Dependent who incurs Home Health Care Charges will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Home Health Care Charges rendered by a member or a non-member of the Preferred Provider Organization. This section covers Charges incurred for private duty nursing services for a Participant or Dependent which (i) require the skills of a Licensed Practical Nurse (LPN) or Registered Nurse, (ii) are rendered in the Participant's or Dependent's home, (iii) are medically necessary as determined by the Plan's Medical Consultants and (iv) are prescribed by the patient's physician and such prescription is documented in the medical record.
- (2) Coverage Limitation. Coverage for Home Health Care is provided as a Basic Medical Benefit but is limited to a maximum number of visits per Plan Year as set forth in the Summary of Benefits. Charges in excess of the maximum visits will not be covered under any other Plan provisions. Generally, other charges associated with home health care (*i.e.*, intravenous charges, durable medical equipment) will be eligible for coverage in accordance with the rules for the Primary Major-Medical Benefits.
- (3) Exclusions from Coverage. Charges for Home Health Care are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43.

(I) Hospice Care.

- (1) Covered Charges. Hospice Care Charges will be subject to the applicable deductible, and the limitations and exclusions contained in subsections (2) and (3) below. This section covers Hospice Care benefits rendered to a Participant or Dependent who (i) has a confirmed diagnosis of terminal illness; (ii) has a life expectancy of six months or less; (iii) has no further use nor desire for other curative therapy; and (iv) has signed an informed consent indicating an acceptance and understanding of Hospice Care. A Participant or Dependent who incurs Hospice Care Charges will generally be entitled to payment or reimbursement of a percentage as set forth in the Summary of Benefits of the required Hospice Care Charges rendered by a member of the Preferred Provider Organization or through a non-Preferred Provider Organization.

Hospice services can be rendered on an inpatient or outpatient basis. If rendered on an inpatient basis, all treatment must be under the direction of a physician. If rendered on an outpatient basis, the services must be (i) rendered in the Participant's or Dependent's home, (ii) billed by a Hospice provider, and (iii) include services from the following list:

- (a) Nursing care by a registered nurse or licensed practical nurse.
- (b) Services of a home health agent who provides non-skilled personal care to the Participant or Dependent while under the supervision of a registered nurse or a licensed member of the Hospice Care team.
- (c) Homemaker services for the Participant or Dependent only.
- (d) Services of a licensed or certified physical, respiratory, occupational or speech therapist or social worker.
- (e) Nutritional services provided by a dietician.
- (f) Rental of durable medical equipment, such as hospital beds, respirators, oxygen tents, crutches and wheelchairs when billed by the Hospice providers.
- (g) Medically Necessary surgical and medical supplies.
- (h) Drugs and medicines listed in the official forms billed by the Hospice providers.
- (i) Radiation therapy and chemotherapy.

(2) Coverage Limitation. Charges for Hospice Care provided as a Basic Medical Benefit is limited to the Charges incurred for the maximum days set forth in the Summary of Benefits. Charges for Hospice Care in excess of the maximum days set forth in the Summary of Benefits will not be covered under any other Plan provisions.

(3) Exclusions from Coverage. Charges for Hospice Care are not payable or reimbursable from the Plan for the services or items or under the conditions listed in Section C-III on page 43. Notwithstanding the foregoing, the exclusions in Section C-III pertaining to Hospice Services shall not apply to Hospice Care.

(J) Extended Care/Skilled Nursing Care.

(1) Covered Charges. Extended Care/Skilled Nursing Care Charges will be subject to the applicable deductible and the exclusions in subsection (2)

below. The Plan will generally pay or reimburse a percentage as set forth in the Summary of Benefits of the Charges incurred by Participants or Dependents for medical services while confined in an Extended Care/Skilled Nursing Care facility, subject to a maximum of 180 days in a Plan Year. Charges shall be covered in this section only if ineligible for coverage elsewhere under the Plan. Covered charges for Extended Care/Skilled Nursing Care expenses include the following medical services and supplies:

- (a) Room and board, except private room charges in excess of the Extended Care/Skilled Nursing Care Facility's (the "Facility") average charge for semi-private accommodations.
 - (b) Routine nursing care provided by the Facility on other than a private duty basis.
 - (c) Physical or speech therapy provided by the Facility or others under arrangement with the Facility.
 - (d) Medical social services provided by the Facility.
 - (e) Such drugs, biological supplies, appliances and equipment which are normally provided by the Facility for the care and treatment of its inpatients.
 - (f) Diagnostic and therapeutic services furnished by the Hospital, including medical services of a Hospital intern or resident-in-training under the teaching program of a Hospital, with which the Facility has a transfer agreement, but not including any other medical care or treatment by a doctor, resident doctor, or intern.
 - (g) Such other services necessary to maintain the health of the patients as are generally provided by the Facility.
- (2) Exclusions From Coverage. Charges for Basic Medical Benefits for Extended Care/Skilled Nursing Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C-III on page 43. Notwithstanding the foregoing, the exclusions in Section C-III for Custodial Care shall not apply to Extended Care/Skilled Nursing Care Benefits.

(K) Orthotics.

- (1) Covered Charges. Charges for Orthotics will be subject to the applicable deductible and the limitations and exclusions contained in subsections (2)

and (3) below. A Participant or Dependent who incurs Orthotics Charges will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Orthotic Charges regardless of whether the service is rendered by a member or non-member of the Preferred Provider Organization. This section covers Charges for Orthotics which is defined as medical devices (such as leg, arm, back or neck braces) which are used to activate or supplement a weakened limb or function, and are recognized by Medicare. This category excludes prosthetics.

- (2) Coverage Limitation. Each Participant and Dependent shall be subject to an annual limit as set forth in the Summary of Benefits on the amount paid or reimbursed for Charges for Orthotics.
- (3) Exclusions from Coverage. Charges for Orthotics are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43.

(L) Prosthetics.

- (1) Covered Charges. Effective September 9, 2016, Charges incurred by a Participant for Prosthetics will be subject to the applicable deductible, and the limitations and exclusions contained in subsections (2) and (3) below. If the requirements in subsection (2) below are satisfied, a Participant will generally be entitled to payment or reimbursement as set forth in the Summary of Benefits of the required Prosthetic Charges where the service is rendered by a member of the Preferred Provider Organization. This section covers Charges for Prosthetics as defined in subsection (2) below. The Plan does not cover Charges for Prosthetics for a Participant's Dependent, a Retiree or a Retiree's Dependent.
- (2) Coverage Limitations. If a Participant satisfies the circumstances below, each Participant shall be subject to the limit as set forth in the Summary of Benefits on the amount paid or reimbursed for Charges for Prosthetics in the circumstances described below.
 - (a) The Covered Charges are for the purchase, repair or replacement of an artificial limb or device which is:
 - (i) designed to support a weakened or missing body part (specifically excluding specialized footwear);
 - (ii) custom-fitted or manufactured to a Participant;
 - (iii) manufactured solely for medical use;

- (iv) limited to basic equipment necessary for all activities of daily living and specifically excludes deluxe models, or equipment specific for exercising or sporting events; and
 - (v) qualifies as a Prosthetic under Medicare.
 - (b) The Covered Charges are determined to be Medically Necessary as determined by the Plan's Administrator; and
 - (c) Within the past seven Plan Years, the Participant has not exceeded the limit for Prosthetic benefits as set forth in the Summary of Benefits.
 - (3) Exclusions from Coverage. Charges for Prosthetics are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Article VII.
- (M) Well Baby Care.
- (1) Covered Charges. Well Baby Care Charges will be subject to the applicable deductible, a co-payment and the exclusions in subsection (2) below. A Participant or Dependent will be subject to a co-payment as set forth in the Summary of Benefits per PPO Well Baby Care visit. After paying the co-payment, a Participant or Dependent who incurs Well Baby Care Charges during the twenty-four month period following birth will generally be entitled to payment or reimbursement of the required Well Baby Care Charges at the percentage set forth in the Summary of Benefits rendered by a member of the Preferred Provider Organization. For this purpose, Well Baby Care Charges include routine preventive tests, immunizations, and services that monitor the baby's physical and mental development.
 - (2) Exclusions from Coverage. Charges for Well Baby Care are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43.
- (N) Primary Major-Medical Benefit.
- (1) Covered Charges. Charges for Primary Major-Medical Benefits will be subject to the applicable deductible, and the exclusions set forth in subsection (2) below. The Plan shall provide payment for or reimbursement of a percentage (as set forth in the Summary of Benefits) of the Charges incurred by Participants or Dependents for the following Medically Necessary services, treatment or confinement, to the extent they exceed Charges covered under subsections (A) through (L) above:
 - (a) Services of physicians and specialists provided on an outpatient basis.

- (b) Private duty nursing services in a Hospital which require the skills of a Registered Nurse (RN) or Licensed Practical Nurse (LPN); provided:
 - (i) The services are Medically Necessary as determined by the Plan's Medical Consultant(s), and are of such an intensive skilled level that they cannot be provided by the Hospital's general nursing staff (intermediate, custodial or personal care is not covered); and
 - (ii) The services are prescribed by the patient's attending physician and such prescription is documented in the medical record.

- (c) Medically Necessary services in a Hospital, including the following:
 - (i) Room and board (including meals, special diets and general nursing service) for "semi-private accommodations," up to the daily maximum, if any, as set forth in the Summary of Benefits. Private room at the most common "semi-private" rate. Intensive or coronary care unit which exceeds two times the most common "semi-private" rate.
 - (ii) Use of treatment rooms.
 - (iii) Cost of oxygen and its administration.
 - (iv) X-ray radium and radioactive isotope therapy.
 - (v) Blood transfusions, including the cost of blood plasma and blood plasma expanders.
 - (vi) Drugs, medicines and dressings used in a Hospital.
 - (vii) Physicians' visits.
 - (viii) The Charges for room and board (as described in subsection (i)) beyond the twentieth day of confinement for Participants and Dependents when the care is provided by a non-PPO provider.

- (d) Medical supplies and surgical dressings including:
 - (i) Casts and splints.
 - (ii) Catheters.

- (iii) Colostomy bags and supplies required for their use which are not readily available under the prescription mail order program.
 - (iv) Dressings when medically necessary for such conditions as cancer, burns or diabetic ulcers.
 - (v) Injectable drugs which are required to be administered by a doctor and are bought and billed by a doctor. The Fund reserves the right to request a medical review and approval by the Fund's Medical Consultant.
 - (vi) Rental of an artificial respirator and other durable medical or surgical equipment necessary for temporary treatment to improve functions of a malformed body member or to prevent or retard further deterioration of the Participant's or Dependent's condition.
 - (vii) Syringes, needles and insulin when medically necessary for conditions such as diabetes, which are not readily available under the prescription mail order program.
- (e) All other items and Charges not previously addressed.
- (2) Exclusions from Coverage. Charges for Primary Major-Medical Benefits are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43.
- (O) Reconstructive Jaw Surgery and Related Treatment.
- (1) Covered Charges. Reconstructive Jaw Surgery and Related Treatment Charges will be subject to the applicable deductible, the lifetime maximum, and the exclusions set forth in subsections (2) and (3) below. A Participant or Dependent who incurs Reconstructive Jaw Surgery and Related Treatment Charges will generally be entitled to payment or reimbursement of the percentage (set forth in the Summary of Benefits) of the required Charges for medical and dental treatment (including orthodontic treatment, if necessary), regardless if the services are rendered by a member or non-member of the Preferred Provider Organization. Such Charges will be covered under the section if they relate to reconstructive jaw surgery which results from any reason other than a birth defect or an accident.
 - (2) Exclusions from Coverage. Charges for Reconstructive Jaw Surgery are not payable or reimbursable by the Plan under the conditions referenced in Section C-III on page 43.

- (3) Coverage Limitations. Each Participant and Dependent shall be subject to a lifetime maximum set forth in the Summary of Benefits for Reconstructive Jaw Surgery. The lifetime limit will include, but not be limited to, medical, dental, orthodontic treatment, surgery fees, facility fees, office visits and x-rays.

(P) Routine Foot Care.

- (1) Covered Charges. Charges for Routine Foot Care as detailed below provided by a Physician to a Participant or Dependent who has a chronic condition (*i.e.*, chronic circulatory disorder or diabetic with diabetic sensory neuropathy) will be subject to the applicable deductible, and the limitations contained in subsection (2) below. For this purpose “Routine Foot Care” will be limited to (a) local care of superficial wounds, (b) debridement of corns and calluses and (c) trimming and debridement of nails. Other conditions could constitute chronic conditions, subject to receipt of a letter of Medical Necessity which explains the causation between the circulatory disorder and the condition and approval of the Fund’s Medical Consultant.
- (2) Exclusions from Coverage. Charges for Routine Foot Care are not payable or reimbursable by the Plan under the conditions listed in Section C-III on page 43.

(Q) Wellness Benefits.

- (1) Covered Charges. Charges for Wellness Benefits will be subject to the applicable deductible, an aggregate Lifetime Maximum on a specific benefit category and the limitations and exclusions contained in subsections (2) and (3) below. Wellness Benefits include the following two categories of Benefits:
- (a) Hair Prosthetics (wigs). A separate Lifetime Maximum as set forth in the Summary of Benefits will apply for a Hair Prosthetics when loss occurred as a result of illness or treatment of an illness such as radiation therapy for cancer patients.
- (b) Charges for Nutritional Counseling where deemed medically necessary. Nutritional Counseling is counseling for the management of any medical condition for which diet and eating habits are essential to the overall treatment program. Nutritional Counseling will be deemed medically necessary if it is prescribed by a health care professional, offered at Hospital settings and provided by registered dietitians. Conditions for which Nutritional Counseling may be considered medically necessary include but are not limited to the following:
- anorexia nervosa/bulimia

- celiac disease
- cardiovascular disease
- Crohn's disease (CD)
- diabetes mellitus (DM)
- disorders of metabolism (e.g., inborn errors of metabolism, inherited metabolic diseases, amino acid disorders)
- hyperlipidemia
- hypertension
- liver disease
- malabsorption syndrome
- metabolic syndrome X
- multiple or severe food allergies
- nutritional deficiencies
- obesity (*i.e.*, body mass index [BMI] 30 or 95th percentile)
- post-bariatric surgery
- prediabetes
- renal failure
- ulcerative colitis (UC)

- (2) Coverage Limitations. Each Participant and Dependent shall be subject to a Lifetime Maximum as set forth in the Summary of Benefits on all amounts paid or reimbursed for Charges for Wellness Benefits (and a separate Lifetime Maximum on Hair Prosthetics).
- (3) Exclusions from Coverage. Charges for Wellness Benefits are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43.

II. Secondary Major-Medical Benefit.

- (A) Covered Charges. Each Participant and his Dependents covered under the Plan shall be subject to a deductible and lifetime limit set forth in the Summary of Benefits on all Secondary Major-Medical Benefits under this C-II. This section will cover the Charges listed below. Secondary Major-Medical Benefits will be subject to the exclusions in subsection II(B) below. There is no Inpatient Hospital Care for this benefit.
- (1) Categories of Secondary Major-Medical Benefits. This section will cover medical care and services for Participants and their Dependents (whether provided on an inpatient or outpatient basis) as follows:
- (a) Chiropractic care.
 - (b) Treatment by acupuncture.
- (2) Outpatient Hospital Care. A Participant or Dependent who incurs Secondary Major-Medical Charges which are incurred for outpatient

treatment will generally be entitled to payment or reimbursement of a percentage, as set forth in the Summary of Benefits of the required Charges, regardless if the Charges are rendered by a member or non-member of the Preferred Provider Organization.

- (B) Exclusions from Coverage. Charges for Secondary Major-Medical Benefits are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 43. Notwithstanding the foregoing, the exclusions in Section C-III pertaining to Chiropractic Care or Services, and Acupuncture will not apply to Secondary Major-Medical Benefits.

III. Exclusions from Coverage. Except where specifically stated otherwise and except where required under the Health Insurance Portability and Accountability Act, the Basic Medical Benefit and the Secondary Major-Medical Benefit portion of the Plan will not pay or reimburse charges for the following treatment (including, but not limited to, examinations, hospitalizations, services, supplies and surgery) or under the conditions outlined below:

- (A) Acupuncture. Acupuncture, anesthesia by hypnosis, or anesthesia for non-covered services. Notwithstanding the foregoing, the exclusion for Acupuncture will not apply to the Secondary Major-Medical Benefit.
- (B) Ailments of the Foot. Treatment of corns, bunions (except capsular or bone surgery), calluses, nails of the feet (except surgery for ingrown nails), or symptomatic complaints of the feet (except when surgery is performed). Notwithstanding the foregoing, the exclusion for Ailments of the Foot will not apply to Routine Foot Care.
- (C) Artificial Insemination. Artificial insemination, in vitro fertilization, chromosome studies, fertility studies, reversal of sterilization and like procedures.
- (D) Behavior Modification Techniques. Smoking cessation programs except for physician visit to obtain a prescription for a smoking cessation product, weight loss programs or treatment for obesity (including gastric by-pass surgery and similar like procedures and/or services at a health spa, gymnasiums or similar facility) and like programs. This exclusion will not apply to the benefit for nutritional counseling under the Wellness Benefit.
- (E) Braces, Prosthetic Appliances, Etc. Procurement or use of special braces, appliances or equipment, except as may be required on account of accidental injury to natural teeth. Notwithstanding the foregoing, the exclusion for Braces, Prosthetic Appliances, etc. will not apply to the Orthotic Benefit.
- (F) Chiropractic Care or Services rendered by a Chiropractor. Notwithstanding the foregoing, the exclusion for Chiropractic Care will not apply to the Secondary Major-Medical Benefit.

- (G) Claim Processing. Services for completing claim forms or for providing other records or reports.
- (H) Contraceptive Materials. Contraceptive materials and devices such as IUDs. Coverage for these items may be available under the Prescription Plan.
- (I) Cosmetic Surgery and Related Charges. Cosmetic surgery and related charges except when accident related or required under the Women's Health and Cancer Rights Act of 1988 including but not limited to breast reduction (except as deemed medically necessary by the Plan), and breast augmentation.
- (J) Coverage Under Another Plan. Any services or treatment to the extent available from or provided by any other coverage, except that the Plan will coordinate the payment of Charges with any other coverage where permissible under the existing laws and regulations in the manner set forth in Section E.
- (K) Custodial Care. Domiciliary, intermediate or custodial care or services in rest homes, health resorts, homes for the aged, infirmaries, or places primarily for domiciliary or custodial care or similar institutions providing primarily non-medical care. This exclusion does not apply to Home Health Care Benefits, as provided in Section C-I (H), Hospice Benefits (as provided under Section C-I(I), or Extended Care/Skilled Nursing Care benefits, as provided under Section C-I(J)).
- (L) Dental Care or Treatment. Services and supplies for dental care, including dental X-rays or treatment, dental prosthetic appliances or the fitting of any thereof, except when necessary to treat an accidental injury to natural teeth and a dentist's or oral surgeon's charges for certain cutting procedures in the oral cavity. Coverage for these items may be available under the Dental Plan. Notwithstanding the foregoing, the exclusion will not apply to the facility fee for dental work performed in a Hospital setting which satisfies the requirements of a Sudden and Serious Outpatient Hospital Care or when care is required to be rendered in a hospital setting as set forth in Section C-I(B)(b).
- (M) Drug or Alcohol Impairment. Examinations, hospitalization, services, supplies, surgery and/or treatment incurred by a Participant or Dependent in connection with any injury resulting from the impairment or intoxication of such person from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol. The impairment, intoxication, or influence shall be determined by the attending medical personnel, or in accordance with the applicable laws of the state in which the Participant or Dependent resides, and shall include all impairment, influence or intoxication caused by ingestion or administration of drugs or alcohol other than according to a physician's prescription. To the extent the evidence indicates that the Participant or Dependent was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits. This exclusion can be applied even if a Participant or Dependent is not formally charged with or convicted of driving while intoxicated.

- (N) Education or Training. Any class, service or treatment incurred by a Participant or Dependent to educate or train a Participant or Dependent regarding a medical treatment, condition, disease or a healthy lifestyle. This exclusion does not apply to nutritional counseling or training for basic medical home care services such as wound care IV administration.
- (O) Experimental Procedures and Drugs/Clinical Procedures. Procedures or operations not recognized by the American Medical Association, and drugs not approved by the U. S. Food & Drug Administration. Notwithstanding the foregoing, the Plan may pay (i) the minimum costs that would have been incurred by the Participant or Dependent regardless of whether the Participant or Dependent received conventional or experimental treatments if the Participant or Dependent appeals and obtains the Trustees' pre-approval to participate in a clinical trial and (ii) coverage for the off-label use for medications which are medically appropriate for treatment of the patient's diagnosis, standard of care and not experimental/investigational, as determined by the Fund's Medical Consultant, in conjunction with the prescription drug manager in connection with the Fund's third party administrator.
- (P) Eye Care or Treatment. Eye refraction or eyeglasses, except as may be required on account of accidental bodily injury to physical organs or parts sustained by a Participant or Dependent while eligible for Benefits under this Plan. Coverage may be available under the Optical Benefit of C-VI.
- (Q) Free Services. Treatment for which a Participant or a Dependent do not have to pay.
- (R) Genetic testing. Genetic testing, includes but is not limited to, BRAC testing, COLARIS testing, MELARIS testing, and similar chromosome testing or DNA testing. The previous exclusion notwithstanding, the Plan will allow for Medically Necessary diagnostic, DNA, genetic and chromosome testing. The determination of being Medically Necessary will be based on the guidelines for that particular test, the clinical judgment of the provider and the standard of care. The exclusion will also not apply when testing is ordered to determine the most effective course of treatment for a previously documented medical condition. A letter documenting that a test is Medically Necessary may be required in cases where the condition is not evident upon receipt of the request. This provision will apply to the medical and prescription benefits. Preauthorization is required for panels and series of tests which in the aggregate exceed \$1,000.
- (S) Government Owned Hospital Care. Confinement in, or treatment received from (including surgery), a sanitarium, state or federal hospital, any state or political subdivision thereof, or the Veterans Administration Hospital owned or operated by the U.S. Government, unless such confinement or treatment is not covered by any other government sponsored health insurance, entitlement or benefit program or for which a Participant or Dependent would not be required to pay anything if there were no coverage provided under this Plan; provided, however, that nothing herein shall cause the exclusion of charges incurred by an individual who is

eligible for coverage under this Plan while simultaneously eligible for coverage under a State plan for medical assistance approved under Title XIX of the Social Security Act.

- (T) Hospice Services. Hospice Services rendered at an inpatient facility or at the residence of a Participant or Dependent. Notwithstanding the foregoing, this exclusion does not apply to Hospice Care, provided under Section C-I(I).
- (U) Imaging Not Preserved on Film or Digital Images. X-ray examinations made where the image is not preserved on film or digital images.
- (V) Reserved.
- (W) Injuries While Committing a Felony. Services or treatment for injuries sustained while participating in or attempting to commit a felony, regardless of whether the Participant or Dependent is convicted. This exclusion does not apply if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- (X) Injuries While Employed or Engaged in any Activity For Profit. Services or treatment in connection with injuries sustained while doing any act or thing pertaining to any occupation or employment for compensation or profit.
- (Y) Non-Listed Charges/Expenses. Any service or item not specifically listed as a covered Charge under other sections of the Plan and services, supplies or treatment of any complications arising from non-covered services to the extent such exclusion does not negate grandfathered status.
- (Z) Non-Medically Necessary Care. Services, supplies or treatment deemed not to be medically necessary for the diagnosis or treatment of an injury, illness or symptomatic complaint. The Plan shall have the right to submit disputed cases to a medical review committee appointed by the Trustees. Charges for medical care deemed not medically necessary, in whole or in part, shall not be payable or reimbursable by the Fund. Notwithstanding the foregoing, charges for voluntary sterilization shall be an allowable Plan charge.
- (AA) Obstetrics for Dependent Children. Obstetrical procedures or operations provided to Dependent children are not payable or reimbursable under this Plan.
- (BB) Occupational Illness or Injury. Treatment or services for an occupational illness or injury.
- (CC) Participation in Voluntary Reckless Activity. Services, supplies or treatment for injuries sustained while participating in any reckless activity voluntarily, which is unnecessary and for recreational purposes, and which, in the opinion of the Trustees, constitutes “reckless endangerment”.

- (DD) Pre-Paid Providers. Services and supplies provided by or available from a health maintenance organization (“HMO”), preferred provider organization or association (“PPO”/“PPA”) or similar arrangement to which a Participant or Dependent subscribes individually or through a group unrelated to the Union or Plan, and Charges which result from failure to use the health management provisions of such organizations, such as second opinions for surgical procedures.
- (EE) Prescription and Non-Prescription Drugs that are separately purchased by the Participants and/or their Dependents, Vitamins, and Minerals, except generally accepted standard of care vaccines are not excluded.
- (FF) Radiokerotomy, Laser Eye Correction, or Like Procedures.
- (GG) Self-inflicted Injuries. Services or treatment for self-inflicted injuries, including those associated with or resulting from suicide attempts. This exclusion does not apply if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- (HH) Specified Examinations or Hospitalization for Examinations. Eye refractions; examinations for the fitting of eyeglasses or hearing aids; dental examinations; diagnostic study relating to routine physical examinations or checkups, as required by a job, recreational activity or school, or to obtain insurance.
- (II) Sex Therapies. Services related to sex transformation or sexual dysfunctions or inadequacies. This exclusion will not apply to the office visits and related diagnostic charges associated with organic impotence.
- (JJ) Take Home Items. Take home drugs and personal items such as admission kits, TV, telephone, cots and visitors’ meals at any institution.
- (KK) Therapies. Activity, recreational or family therapy, or marriage, pastoral, or financial counseling or similar services. Notwithstanding the foregoing, the exclusion for therapies will not apply for counseling that is Medically Necessary for Mental Health parity requirements or for the benefit of a minor child with a letter of medical necessity.
- (LL) Travel. Travel, whether or not recommended by a physician, other than the local use of an ambulance.
- (MM) Treatment and Supplies Rendered by Non-Qualified Physicians.
- (NN) Treatment Not Approved by a Qualified Physician. Examination or treatment (including surgery) furnished without a physician’s approval.
- (OO) Treatment of Participants as Dependents. Examination or treatment of a Dependent if such Dependent is simultaneously entitled to Benefits as a Participant. If an individual can have simultaneous coverage both as a Participant and as a Dependent, the Plan will not recognize the dual coverage. The Plan will

recognize the individual's coverage as a Participant and, when that ceases, the Plan will recognize the individual's coverage as a Dependent, to the extent applicable.

- (PP) Treatment Rendered Outside the United States. Treatment for care rendered outside the United States which exceeds the allowable Charge for comparable services in the United States. Notwithstanding the foregoing, non-emergency care rendered outside the United States will not be paid by the Plan without detailed documentation and services for sudden and serious outpatient care will be reimbursed by the Plan (consistent with the coverage that would have been provided if the services had been performed in the United States) if an itemized bill is received and approved by the Fund's Medical Consultant.
- (QQ) Treatment, Services, or Supplies Rendered before a Participant or Dependent's Effective Date or after Coverage Ended.
- (RR) War. Services for diseases contracted or injuries sustained as a result of war, declared or undeclared or of any act of war, or of any act of international armed conflict or conflict involving armed forces of any international authority, if such war or act occurs after the Participant or Dependent becomes eligible for Benefits under the Plan.
- (SS) Workmen's Compensation. Services for any condition, disease, or accident arising out of, or in the course of a Participant's or Dependent's employment (whether by the Employer, or by any other employer) for which benefits are payable to the Participant or Dependent under any workmen's compensation law or similar legislation.
- (UU) Supplies Provided by a Third Party Provider and Separately Billed. Supplies (regardless of whether they are classified as supplies, orthotics, durable medical equipment or otherwise) used for In-Patient Care, Out-Patient Care, Surgical Care or to provide Primary Major Medical Benefits, which are provided and separately billed by a third party provider are excluded under the Plan unless the third party provider receives written approval by the Plan in advance of the procedure.

IV. Prescription Drug Benefit.

- (A) Covered Charges. Subject to the Prescription Drug Co-Payment Feature and the rules set forth in this paragraph (A), the Plan shall pay for or reimburse all costs for prescription drugs for Participants and their Dependents as follows:
 - (1) Maintenance Prescriptions. Drugs which are to be taken on an ongoing basis for a chronic condition (90 days or more) are "Maintenance Prescriptions." With this definition as a guide, the registered pharmacist receiving the prescription request will initially determine whether it is a Maintenance Prescription. "Maintenance Prescriptions" can be ordered on-line or in person from the pharmacy designated by the Trustees. The Plan will only cover Maintenance Prescriptions including diabetic supplies

that are filled through the mail order program or at the Prescription Benefit Manager's pharmacy.

- (2) Non-Maintenance Prescriptions. Drugs which are to be taken for a definite period for a non-chronic condition are "Non-Maintenance Prescriptions." Subject to the Co-Payment feature, the Plan will pay in full the cost for such drugs when the Participant or Dependent submits a prescription drug card to a pharmacist participating in the Plan.
- (3) Mandatory Generic. Subject to the Co-Payment feature, to the extent generically equivalent FDA-approved drugs are available, the maximum cost of "Maintenance Prescriptions" or "Non-Maintenance Prescriptions" which the Plan will pay for or reimburse will be limited to the cost of the generically equivalent drug, regardless of whether the Participant or their Dependents elect to receive the generically equivalent drug. To the extent that generically equivalent drugs are not available, the Plan will pay for or reimburse the brand name cost of "Maintenance Prescriptions" and "Non-Maintenance Prescriptions", subject to the Co-Payment feature.

To the extent the Fund receives written notification from a physician that medical reasons prohibit a Participant or their Dependents from receiving generic drugs, the Plan will pay or reimburse the brand name cost of the "Maintenance Prescription" or "Non-Maintenance Prescriptions."

- (4) Non-Participating Pharmacies. To the extent prescription drugs are purchased at non-participating pharmacies, the Trustees have the discretion to pay a reduced percentage (lower than that currently shown in the Summary of Benefits) of the Charges for the prescription drugs.
- (5) Specialty and Non-Specialty Injectibles. Injectibles may be covered with a co-payment as set forth in the Summary of Benefits.
- (6) Special Rules for Diabetic Supplies. Diabetic supplies (*i.e.*, test strips, lancets and needles) are covered only if purchased from the mail order program or at the Prescription Benefit Manager's pharmacy. This means you must purchase a 90 day supply..
- (7) Off-label Drug Use. Coverage for the off-label use should be provided for medications which are medically appropriate for treatment of the patient's diagnosis, standard of care and not experimental/investigational, as determined by the Fund's Medical Consultant, in conjunction with the prescription drug manager in connection with the Fund's third party administrator.
- (8) Vaccine Program.

- (a) Flu vaccines can be provided at a pharmacy without the necessity of a prescription and without having a Participant pay a co-pay; and
 - (b) Vaccines for Shingles and/or Pneumonia can be provided at a pharmacy without a prescription but subject to a co-pay as specified in the Summary of Benefits.
- (9) Pre-approval for Compound Drugs. Effective on and after January 1, 2015, pre-authorization is required for compound drugs for amounts exceeding \$300 based on the Plan's discussion with its Prescription Benefit Manager and limited to one fill per month.
- (10) Specialty Medications.
 - (a) Subject to a coinsurance feature set forth in the Summary of Benefits, and the rules detailed in (b) below, the Plan will pay or reimburse a percentage set forth in the Summary of Benefits of the cost of the bio-tech medicines that are purchased through the Plan's Specialty Pharmacy to treat the conditions or procedures identified on the Specialty Medication page of the Summary of Benefits.
 - (b) Additional rules regarding Specialty Medications:
 - (i) The reimbursement rate identified in the Summary of Benefits will apply to oral or injectible drugs.
 - (ii) A Participant receiving oral specialty medicine identified above as of December 1, 2008 will be grandfathered so that the Plan will continue to reimburse or pay for his current level of coverage as long as the coverage is continuous.
 - (iii) The approved Specialty Medications must be reviewed through the Prescription Benefit Manager Specialty Guidelines Management Program ("SGM") or such other program approved by the Trustees to ensure a prescription is the most cost effective type and quality. If SGM determines a lower cost alternative, the Plan will cover the cost of the lower cost alternative.
- (B) Exclusions From Coverage. The Plan will not pay for or reimburse a Participant or Dependent for the following Charges for prescriptions:
 - (1) Prescriptions that are not taken pursuant to orders given by a physician.
 - (2) The cost of prescriptions required by a Participant or Dependent in connection with any injury resulting from the impairment or intoxication

of that individual from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol. The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the state in which the Participant or Dependent resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a physician's prescription. To the extent the evidence indicates that the Participant or Dependent was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits.

- (3) Prescriptions for the following items are not covered under the Prescription Drug Benefit portion of the Plan:
- (a) Abdominal supports, trusses, or oxygen.
 - (b) Any drug labeled, "Caution - Limited by Federal Law to Investigational Use", or experimental drugs, even though charges are made to the individual.
 - (c) Braces, splints, dressings, bandages, sick room equipment or supplies, heat lamps or similar items.
 - (d) Canes, crutches, wheelchairs or any means of conveyance or locomotion.
 - (e) Charges payable under any other benefits of the Fund to the extent that the portion of such charges are paid.
 - (f) Surgically implanted intrauterine devices and RX U486 are not covered.
 - (g) Infertility medication.
 - (h) Drugs or medicines delivered or administered to the eligible individual by the prescriber.
 - (i) Self-administered injectibles as approved by the Plan or as set forth in the Summary of Benefits.
 - (j) Immunizing agents, biological serum, blood plasma, injectibles, and any prescription directing parental administration or use, except insulin.
 - (k) Medication which is to be taken or administered to, in whole, or in part, by the Participant or Dependent while he or she is a patient in a Hospital, nursing home, rest home, sanitarium, skilled nursing care facility, convalescent hospital, or similar institution.

- (l) Non-Legend, patent or proprietary medicine or medication not requiring a prescription.
 - (m) Prescriptions not listed with the Plan Administrator as excluded Charges.
 - (n) Weight loss prescriptions.
 - (o) Prescriptions for smoking cessation aids that exceed a three month supply once a year for a maximum of three years.
 - (p) The cost of prescriptions required by a Participant or Dependent in connection with any injury incurred while the Participant or Dependent was participating in or attempting to commit a felony. This exclusion does not apply if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).
 - (q) Vitamins, vitamin prescriptions, cosmetics, dietary supplements, health or beauty aids. Notwithstanding the foregoing, the exclusion will not apply to prescription vitamins, such as prenatal vitamins and Vitamin D and Iron at the lower of the actual cost or co-pay.
- (5) Prescriptions for which a Participant or Beneficiary requests reimbursement or payment after the date the Participant's or Dependent's Prescription Drug Benefit is terminated because of misusing the Benefit.
 - (6) Prescriptions purchased for the purpose of resale for compensation.
 - (7) Excessive amounts of the same prescription as determined by the Trustees based on advice from the Plan's Medical Consultant.
 - (8) Diabetic supplies which are not purchased in a 90 day supply through the mail order pharmacy or purchased at the Prescription Benefit Manager's pharmacy.
 - (9) Prescriptions for Specialty Medications that are not included in the categories identified in the Summary of Benefits or that are not obtained in accordance with the procedures and requirements identified in Section IV(A)(10) or the Summary of Benefits.

V. Dental and Orthodontic Benefit.

(A) Dental Benefit.

- (1) Covered Charges. Subject to the annual deductible and limits set forth in the Summary of Benefits and the exclusions and limitations contained in

subsection (2) below, the Plan will pay or reimburse Charges subject to the usual, reasonable and customary “URC” fee) incurred by Participants and their Dependents for certain dental treatment and services. The allowable Charges are set forth on a separate schedule maintained by the Fund which is incorporated herein by reference. An annual limit will not be assessed on Charges for pediatric dental services that are deemed to constitute “essential health benefits” under the Patient Protection and Affordable Care Act. The list of allowable Charges includes, but is not limited to:

(a) Preventive Care.

- (i) Oral examinations, up to two per calendar year
- (ii) Cleaning, up to two per calendar year
- (iii) One full-mouth fluoride treatment per calendar year
- (iv) X-rays with a preventive exam or cleaning
- (v) Space maintainers for baby teeth

(b) Basic Care.

- (i) Oral surgery
- (ii) Periodontics
- (iii) Root canal therapy
- (iv) Bite guards
- (v) Dentures
- (vi) Restorations

(c) Major Care.

- (i) Crowns (temporary or permanent)
- (ii) Bridgework
- (iii) Inlays or Onlays

(2) Exclusions and Limitations from Coverage.

(a) The Plan will not pay or reimburse Charges for the following dental treatments and/or services for Participants and their Dependents:

- (i) Any dental procedures not started and completed while covered under the Plan.
- (ii) Charges resulting from failure to follow primary carrier’s guidelines.
- (iii) Cosmetic procedures except those required as a result of an injury which occurred while covered by the Dental Plan.

- (iv) Dental appointment charges for canceled appointments.
 - (v) Dental services performed by a non-licensed provider.
 - (vi) Non-prescription drugs, medicines or supplies intended primarily for home use, such as toothpaste and cleaning supplies, oral hygiene and nutritional counselling.
 - (vii) Replacement of full or partial dentures or bridgework more often than once every five years.
 - (viii) Replacement of a lost or stolen appliance.
 - (ix) Services rendered by pre-paid providers which will not supply an Explanation of Benefits (E.O.B.) from the primary carrier.
 - (x) Treatment of reconstructive jaw surgery. (This is covered under Section C-1.)
 - (xi) Charges in excess of the Usual, Customary and Reasonable Allowance.
- (b) Participants and their Dependents will be responsible to pay the deductible set forth in the Summary of Benefits. Subject to the annual deductible set forth in the Summary of Benefits and the limit set forth in (c), the Plan will pay a percentage set forth in the Summary of Benefits of the Usual, Reasonable and Customary Charges for inlays, onlays, gold fillings, crowns (temporary and permanent), bridgework and all other basic care services.
- (c) The maximum limit the Plan will pay for each Participant and each Dependent age 19 and older for dental preventive, basic services and major services care is set forth on a separate schedule which is incorporated by reference.
- (d) Dental and orthodontic charges for reconstructive jaw surgery will not be covered under the dental benefit portion of the Plan; it will be covered under the Reconstructive Jaw Surgery and Related Treatment section.
- (e) In the case of services rendered by pre-paid providers which will not supply an Explanation of Benefits (EOB), the Plan will reimburse charges for dental treatments for Participants and Dependents as follows, subject to the calendar year maximum and the annual deductible. Notwithstanding the foregoing, the Plan will not impose an annual limit on pediatric dental services which are deemed to be “essential health benefits” under the Patient

Protection and Affordable Care Act. If the Participant can provide the Plan with (i) an itemized bill showing the date of the service, the services which were rendered and the amount charged for each service and (ii) adequate documentation to establish that the Participant paid for dental treatment or services and that such treatment or services will not be reimbursed by the pre-paid provider, the Plan will reimburse the Participant a percentage of the amount paid based on the allowances set forth in the Plan.

- (3) Coordination with the Medical Plan. When a billed procedure involves a medical service, the Medical Plan will become the primary payer. Between the Medical and Dental Plan, the total paid amount will not exceed 80% of the total amount charged because the medical procedure is considered a basic service under the Dental Plan.

Example:

Your Oral Surgeon determines that you have two (2) impacted wisdom teeth that must be surgically removed. You undergo the oral surgery and a bill of \$1,000 is submitted.

Your Medical Plan covers charges billed for the removal of the impacted wisdom teeth. The Medical Plan requires that you meet a \$220 deductible which you have not satisfied. Therefore, payment under the Medical Plan will be calculated as follows:

<i>Billed</i>	<i>\$1,000.00</i>
<i>Medical Deductible</i>	<i>- 220.00</i>
	<i>\$ 780.00</i>
	<i>x 80%</i>
	<i>624.00</i>

You are entitled to additional benefits under the Dental Plan because your Medical deductible was taken out. Therefore, since your Dental Plan would have paid 80% or \$800 (if the Dental deductible is not met, the payment would be \$760), you are entitled to an additional benefit.

EX. 1 Dental Deductible is met.

<i>Medical Deductible Taken</i>	<i>\$220.00</i>
	<i>x 80%</i>
	<i>\$176.00</i>

EX. 2 Dental Deductible is not met.

<i>Medical Deductible taken</i>	<i>\$220.00*</i>
<i>Dental Deductible applied</i>	<i>- 50.00</i>
	<i>\$170.00</i>
	<i>x 80%</i>
	<i>\$136.00</i>

**(This is now considered under the Dental Plan)*

Had your deductible been satisfied under the Medical Plan, your Dental Plan would not have been able to provide the additional coverage because the Medical Plan would have paid \$800.

(B) Orthodontic Benefit.

- (1) Covered Charges. Subject to the lifetime maximum set forth in the Summary of Benefits, the Plan may pay or reimburse the Charges incurred by the Dependent children of Participants for services in connection with straightening and repositioning teeth.

- (2) Exclusions and Limitations from Coverage. The Plan will not pay or reimburse Charges for Orthodontic Benefits for the spousal Dependent of any Participant. The Plan will also not pay or reimburse charges for Orthodontic Benefits for Dependent children for treatment or services outlined in Section C-V(A)(2).

VI. Optical Expense Benefits.

- (A) Covered Charges. Subject to the exclusions contained in subsection (B) below, the Plan will pay or reimburse up to the limit set forth in the Summary of Benefits, Charges (subject to the Usual, Reasonable and Customary “URC” fee) incurred by Participants and their Dependents for the optical services listed below. Notwithstanding the foregoing, the Plan will not impose an annual limit on pediatric vision services which are deemed to be essential health benefits under the Patient Protection and Affordable Care Act. For pediatric vision services, the Plan will adopt the frequency limits recommended by the American Optometric Association. The annual limit imposed on Participants and Dependents age 19 and older will be determined on a calendar basis.
 - (1) Complete eye examination, including refractions. Eye examinations performed for medical reasons would be paid for or reimbursed as a Basic Medical Benefit or a Primary Major-Medical Benefit.
 - (2) Eyeglasses with prescription lenses; or
 - (3) Contact lenses.
- (B) Exclusions from Coverage. The Plan will not pay or reimburse Charges for Optical Expenses for the following treatments and/or services for Participants and their Dependents:
 - (1) Costs of cosmetic tinting, scratch guarding and lens kits.
 - (2) Non-prescription items including but not limited to eyeglass cases, care kits, solutions, protection plans and warranties.
 - (3) Medical or surgical treatment for eye disease, which requires the services of a physician. (Coverage for care/treatment may be available thru the medical portion of the Plan.)
 - (4) Elective corrective vision surgery.
 - (5) Services covered by Worker’s Compensation.
 - (6) Services or materials that are not specifically covered by the Plan.

- (7) Replacement or repair of lenses and or frames that have been lost, stolen or broken.
 - (8) Cosmetic Services or materials.
 - (9) Charges in excess of the Usual, Reasonable, Customary Allowance.
- (C) Limitations on Coverage. In the case of services rendered by pre-paid providers which will not supply an Explanation of Benefits (EOB), the Plan will reimburse charges for Optical Expense Benefits for Participants and their Dependents as follows subject to the limit set forth in the Summary of Benefits. If the Participant can provide the Plan with (1) an itemized bill showing the date of the service, the services which were rendered and the amount charged for each service and (2) adequate documentation to establish that the Participant paid for optical expense benefits and that such benefits will not be reimbursed by the pre-paid provider, the Plan will reimburse the Participant the amount paid.

VII. Insurance Benefits.

- (A) Types of Benefits. This Plan provides four categories of insurance benefits: (a) Weekly Disability Benefits, (b) Death Benefits, (c) Accidental Death, Dismemberment and Loss of Sight Benefits, and/or (d) Long-Term Disability Benefits. The insurance benefits are available only to Employees who are Participants but each of the four categories of insurance benefits may not be available to all Employees. The actual benefits provided to the different groups of Employees who are Participants will be determined based on the terms of the adoption agreement and the applicable Summary of Benefits.
- (B) Weekly Disability Benefit.
- (1) Coverage. Subject to the limitations and exclusions set forth in (3) below, the Plan will provide a “Weekly Disability Benefit” to Employees who are Plan Participants who have a Disability. The Fund will pay the Weekly Disability Benefit from the first day of the Disability resulting from an accident and from the seventh day of the Disability resulting from a sickness (including pregnancy).
 - (2) Amount and Length. The amount and length of Weekly Disability Benefit payments will be determined as set forth in the Summary of Benefits. Notwithstanding the foregoing, effective on and after January 1, 2015, the Weekly Disability Benefits will end on the earlier of (a) the date of commencement of retirement plan benefits by a Plan Participant or (b) the end of the Maximum Period of Benefits set forth in the Summary of Benefits.
 - (3) Exclusions and Limitations on Coverage. The Plan will not make Weekly Disability Benefit payments for:

- (a) Successive periods of Disability separated by less than two weeks of active full-time employment with an Employer. Such successive periods shall be considered part of the same period of Disability unless the subsequent period results from an illness or injury unrelated to the previous Disability.
- (b) Participants who are not under the care of a Physician during the period of Disability.
- (c) Injuries incurred by a Dependent.
- (d) Injuries occurring while an Employee is not a Participant or a Participant is not a current Employee.
- (e) Injuries resulting from a suicide, attempted suicide, or intentionally inflicted injury.
- (f) Injuries resulting from an occupational illness or injury.
- (g) Injuries resulting from participating in or attempting to commit a felony.
- (h) Injuries resulting from the impairment or intoxication of the Participant from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol. The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the State in which the Participant resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a Physician's prescription. To the extent the evidence indicates that the Participant was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits, regardless of whether a driving while intoxicated conviction is received.
- (i) Injuries resulting from war, any act of war, military service while a country is engaged in war or military policy duty.
- (j) Injuries sustained while the Participant was doing any act or thing pertaining to any occupation or employment for remuneration or profit, or sickness for which benefits are payable in accordance with the provisions of any workmen's compensation or similar law.
- (k) Participation in any reckless activity voluntarily, which is unnecessary and for recreational purposes, and which, in the opinion of the Trustees constitutes "reckless endangerment".

- (l) A Participant who reaches his retirement date and commences pension benefits.
 - (m) The Plan will not pay for services for completing claim forms or for providing other records or reports.
- (C) Death Benefit, Accidental Death, Dismemberment Benefit and Long-Term Disability Benefit. The Fund will provide a Death Benefit, an Accidental Death, Dismemberment Benefit and a Long-Term Disability Benefit to Participants where such coverage is provided by the terms of the applicable collective bargaining agreement. The amount of the coverage is set forth in the Summary of Benefits and the terms of the coverage as of the Effective Date is set forth in the Fund's separate contract with the insurance carrier, the terms of which are incorporated by reference. The Fund has purchased an insurance contract from an insurance company and you recently received a Certificate of Coverage detailing the various benefits. Please refer to your Certificate of Coverage for more information. Successor contracts are hereby incorporated by reference. The Plan will not pay for services for completing claim forms or for providing other records or reports.

SECTION D

CONTINUATION OF COVERAGE

1. IN GENERAL.

Notwithstanding any Plan provision to the contrary, each Qualified Beneficiary who would otherwise lose Medical Care coverage hereunder as a result of a Qualifying Event shall be entitled to elect, within the election period, to obtain and pay premiums for Continuation Coverage. "Continuation Coverage" shall consist of Medical Care coverage which, as of the time such coverage is being provided, is identical to Medical Care coverage provided under the Plan to similarly situated Participants (and their Dependents) with respect to whom a Qualifying Event has not occurred.

Medical Care coverage includes Medical Benefits, Prescription Drug Benefits, Dental and Orthodontic Benefit and Optical Benefits. COBRA coverage does not include any of the insurance benefits (disability benefits, death benefits, AD&D and LTD).

If Medical Care coverage under the Plan is modified for any group of similarly situated Participants or Dependents, such Medical Care coverage shall also be modified in the same manner for all Participants and Dependents who are Qualified Beneficiaries with respect to such group. Any such modifications will continue to credit any Deductible, Co-Payment Feature and Lifetime Maximum in effect prior to the amendment.

2. QUALIFYING EVENTS.

For purposes of this Section, the term "Qualifying Event" means, with respect to any Participant (and his or her Dependents), any of the following events which, but for the Continuation Coverage hereunder, would result in loss of Medical Care coverage for a Qualified Beneficiary:

- (A) The death of the Participant.
- (B) The termination (other than by reason of a Participant's gross misconduct), or reduction of hours, of the Participant's employment. The term "gross misconduct" means conduct of a Participant which is (1) a deliberate and willful disregard of standards of behavior which the Employer has a right to expect, showing a gross indifference to the Employer's interest; or (2) a series of repeated violations of employment rules proving that the Participant has regularly and wantonly disregarded his or her obligations.
- (C) The divorce or legal separation (if recognized by state law) of the Participant from the Participant's spouse.
- (D) The Participant becomes entitled to Medicare benefits under Title XVIII of the Social Security Act, as amended.

- (E) A Dependent child of a Participant ceases to be a Dependent child under the specific terms of the Plan, as amended from time to time.
- (F) An Employer's filing of Chapter 11 Bankruptcy.

3. QUALIFIED BENEFICIARY.

The term "Qualified Beneficiary" means:

- (A) any Participant or Dependent who, on the day before the Qualifying Event is eligible for Benefits under the Plan on the basis of being either (i) the Participant, (ii) the Dependent child of the Participant or (iii) the spouse of the Participant. Except as set forth in (B), no Participant, Dependent spouse or Dependent child may be considered a Qualified Beneficiary if, on the date prior to the Qualifying Event, such individual was not already eligible for Benefits under the Plan.
- (B) newborn infants and children placed for adoption who become Dependents during the period of time when a Participant is eligible for COBRA coverage but who were not covered under the Plan on the day before the Qualifying Event are still treated as "Qualified Beneficiaries".
- (C) The term "Qualified Beneficiary" shall exclude nonresident aliens to the extent permitted by law.

4. PERIOD OF COVERAGE.

- (A) Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:
 - (1) The last day of the applicable "Maximum Coverage Period," as defined in Section 5.
 - (2) The first day for which a payment is not made to the Plan within 30 days of the first day of the coverage period.
 - (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
 - (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the Maximum Coverage Period that applies to the Qualified Beneficiary without regard to the disability extension.
- (B) The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

5. MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE.

- (A) The Maximum Coverage Periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.
 - (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the Maximum Coverage Period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
 - (2) In the case of a Participant's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the Maximum Coverage Period for Qualified Beneficiaries other than the Participant ends on the later of:
 - (a) 36 months after the date the Participant becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
 - (3) In the case of a bankruptcy Qualifying Event, the Maximum Coverage Period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The Maximum Coverage Period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent

child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Participant during a period of COBRA continuation coverage, the Maximum Coverage Period is the Maximum Coverage Period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
 - (5) In the case of any other Qualifying Event than that described above, the Maximum Coverage Period ends 36 months after the Qualifying Event.
- (B) Expanded Maximum Coverage Period. If a Qualifying Event that gives rise to an 18-month or 29-month Maximum Coverage Period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months Maximum Coverage Period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA Maximum Coverage Period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.
- (C) Disability Extension. A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month Maximum Coverage Period. This notice should be sent to the Plan Administrator.

6. PREMIUM REQUIREMENTS.

- (A) A Qualified Beneficiary shall be required to pay a premium for Continuation Coverage. The Plan Administrator shall cause an actuary to determine the applicable premium for each calendar year of Continuation Coverage, either on the basis of a reasonable estimate of the cost of providing such Medical Care coverage for similarly situated beneficiaries, or on the basis of actual cost for the preceding year for similarly situated beneficiaries (adjusted to reflect cost-of-living increase as measured by the GNP deflator), in a manner which complies with the Code and ERISA.
- (B) The Qualified Beneficiary may elect to pay such premium in monthly installments. Payment is due within 30 days after the first day of the coverage

period. If Continuation Coverage is elected after the Qualifying Event has occurred, the Qualified Beneficiary shall be permitted for a period of forty-five (45) days after the date of his or her election to pay the premium for Continuation Coverage during the period preceding his or her election. Payment is considered made on the date on which it is postmarked to the Plan.

7. INSURABILITY AND CONVERSION OPTION.

The availability of Continuation Coverage shall not be conditioned upon, or discriminate on the basis of, a lack of evidence of insurability. The Plan does not provide any Participants or Dependents with the right to convert to an individual policy. Therefore, the Plan also does not provide to a Qualified Beneficiary the option of enrollment under a conversion health plan when the Qualified Beneficiary's COBRA coverage would otherwise end.

8. QUALIFIED BENEFICIARY'S ELECTION.

- (A) Each Qualified Beneficiary who would otherwise lose coverage under the Plan because of a Qualifying Event shall be entitled to make an independent election, within the Election Period, to have Continuation Coverage under the Plan.
- (B) A Qualified Beneficiary may choose to purchase coverage for medical, dental and vision Benefits under the Plan, or coverage for only medical Benefits. At the time of election, the Plan Administrator will provide the cost of each option.
- (C) The "Election Period" shall be the period which:
 - (1) Is at least sixty (60) days in duration; and
 - (2) Ends no earlier than sixty (60) days after the later of:
 - (a) the date on which coverage would normally terminate; or
 - (b) the date of the notice given by the Plan Administrator to a Qualified Beneficiary with respect to a Qualifying Event.
- (D) Except as otherwise specified in an election, any election of Continuation Coverage by a Qualified Beneficiary who is either a Participant or the spouse of a Participant shall be deemed to include an election of Continuation Coverage on behalf of any other Qualified Beneficiary who otherwise would lose coverage by reason of the Qualifying Event.
- (E) A Qualified Beneficiary who waives Continuation Coverage may revoke such waiver at any time before the end of his or her Election Period, provided that no Benefits shall be payable for Charges incurred during the period commencing on the date that the Qualified Beneficiary's coverage under the Plan terminated and ending on the date the Participant revokes such waiver. Revocation of a waiver is an election of COBRA coverage. Waivers and revocations of waivers are

considered made on the date they are sent to the Plan Administrator or designee, applicable.

9. NOTICE.

The following notice requirements shall apply:

- (A) The Employer shall notify the Plan Administrator of a Qualifying Event by reason of death, or entitlement to Medicare benefits or the Employer's Chapter 11 Bankruptcy filing, within thirty (30) days of the date of any such Qualifying Event. The determination of the occurrence of a Participant's termination of employment or reduction of hours as a Qualifying Event shall be made by the Plan Administrator.
- (B) In the case of a Qualifying Event by reason of death, termination of employment, reduction of hours, or entitlement to Medicare benefits, the Plan Administrator shall notify each Qualified Beneficiary with respect to such event of such beneficiary's right to elect Continuation Coverage.
- (C) Each Participant shall have sole responsibility for notifying the Plan Administrator of a Qualifying Event by reason of divorce, legal separation, or a Dependent child ceasing to be a Dependent under the terms of the Plan, within sixty (60) days after the date of such Qualifying Event. If notice is not given within such 60-day period, any right to elect Continuation Coverage shall be terminated.
- (D) In the case of a Qualifying Event by reason of divorce, legal separation, or a Dependent child ceasing to be a Dependent under the terms of the Plan, where the Participant notifies the Plan Administrator, the Plan Administrator shall notify each Qualified Beneficiary with respect to such event of his or her right to elect Continuation Coverage hereunder.
- (E) For purposes of giving notice to Qualified Beneficiaries, any such notice shall be given within fourteen (14) days after the date on which the Plan Administrator is notified of a Qualifying Event by reason of death, entitlement to Medicare benefits, divorce or legal separation, a Dependent child ceasing to be a Dependent under the terms of the Plan, or an Employer's Chapter 11 Bankruptcy filing, provided that the Plan Administrator receives notice within the time prescribed by applicable law or regulation, as summarized above.
- (F) Any Qualified Beneficiary who believes he is disabled and therefore eligible for an extended period of continuation coverage must provide the requisite notices to the Plan Administrator as set forth in Code Section 4980B.

10. SPECIAL RULES FOR THE UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994.

Special rules exist under the Uniform Services Employment and Reemployment Rights Act of 1994 (“USERRA”) for a Participant who is on military leave. The Plan incorporates these rules by reference.

A Participant who qualifies for these special rules is permitted to continue his medical, dental and vision benefits for the lesser of

24 months from the start of the employee’s absence due to performing uniformed service; or

when the service period is less than 24 months, the period ending on the date the employee fails to return from service or to apply for reimbursement.

A person who elects to continue coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

The USERRA continuation period runs concurrently with the COBRA continuation period.

SECTION E

COORDINATION OF BENEFITS

** These rules apply based on the presumption that a family member qualifies as a Dependent. If a family member does not qualify as a Dependent, then no coverage will be provided by this Plan and this Section does not apply.

1. LIMITATION OF COVERAGE.

Benefits under the Plan will be coordinated with any other group or blanket health care coverage and limited in all cases to a maximum of one hundred percent (100%) of the actual Charges to the Participant and any Dependents for eligible Benefits. Benefits shall also be coordinated in the same manner with payments made or available under a “no-fault” statute to the maximum extent permitted by law.

2. “PRIMARY-SECONDARY” PAYMENT RULES.

(A) In processing a claim where two or more group health plans exist, the “primary-secondary” payment rule determines the provision of payment. It is applied in the following manner:

(1) The Plan will accept primary responsibility on claims in which:

- (a) The patient is a Participant; or
- (b) The patient is the covered Dependent child of a Participant and the Dependent child does not have coverage elsewhere from the Dependent’s employer, the employer of the Dependent’s Spouse or as a Dependent of the Participant’s Spouse; or
- (c) the patient is the covered Dependent child of a Participant, the Dependent child has coverage under a plan of the Participant’s Spouse, and the Participant’s birth date precedes his or her Spouse’s birth date in the calendar year.

(2) The Plan will accept secondary responsibility on claims in which:

- (a) Another health care plan is primarily responsible because the patient is covered thereunder as an employee or Spouse of an employee; or
- (b) Another health care plan is primarily responsible for a Dependent child because:
 - (i) the Dependent child is covered under this Plan without being on COBRA Coverage as a result of the Participant’s death and the Dependent child is also covered under

another plan as a Dependent of the Participant's Spouse and the Participant's Spouse has a birthday that falls earlier in the calendar year than the Participant's; or

- (ii) the Dependent child is covered under this Plan as a result of electing COBRA Coverage upon the Participant's death and the Dependent child is also covered under another plan as Dependent of the Participant's Spouse.

(B) Notwithstanding the foregoing, the following rules apply to the coverage of Dependent children:

- (1) If the Dependent child has coverage as an employee or as the Spouse of an employee, such plan will be primary and this Plan will be secondary. This rule applies regardless of the marital status of the Participant.
- (2) In the event that the Participant is divorced or legally separated from his or her Spouse and if the Dependent child does not have coverage as an employee or as the Spouse of an employee, the following rules apply.
 - (a) If there is a court decree which establishes financial responsibility for medical or other health care expenses for the Dependent child, the plan covering the parent who has that responsibility shall be primary and the plan covering the other parent shall be secondary.
 - (b) If there is no such court decree, and the parent with custody of the Dependent child has not remarried, the plan covering the parent who has custody of the Dependent child shall be primary, and the plan covering the other parent shall be secondary.
 - (c) If there is no such court decree, and the parent with custody of the Dependent child has remarried, the order of priority is:
 - (1) The plan covering the parent who has custody.
 - (2) The plan covering the Spouse of the parent who has custody (that is, the stepparent of the Dependent child).
 - (3) The plan covering the parent without custody.

3. DUPLICATE COVERAGE.

If a Participant is covered under more than one plan through two jobs, the primary plan shall be determined as follows:

- (A) If a Participant is actively employed in only one job, the plan that covers the Participant as an active Employee shall be the primary plan.

(B) In all other cases, the plan which has covered him or her for the longer period of time shall be primary.

4. LACK OF COORDINATION.

Notwithstanding any other provision of the Plan, if Charges covered hereunder are also covered in whole or in part by any group insurance plan or group health plan which does not contain provisions for coordination of benefits, payment will be made under this Plan only with respect to those Charges not covered by such group insurance or plan.

COB EXAMPLE:

Generally, if you are covered by an employer group health plan, that plan will pay first for you. This is also true if your spouse or your dependent is covered through his or her employer. When a health plan pays first the term used to describe the coverage responsibility is “primary.” All bills are required to be billed thru the primary plan first before being submitted to the secondary plan for payment.

In a case where you and your spouse have children and are both employed and have family health coverage through your employers, the order of liability is determined as follows

Local 99 member	Local 99 Plan pays primary	Spouse’s plan pays secondary
Spouse of 99 member	Spouse’s Plan pays primary	Local 99 plan pays secondary
Biological children *	The parent whose birthday Falls earliest in the year pays 1 st (month/day)	Later birthday secondary (month/day)

* Please note if the children are step children, grandchildren or adopted the rules may be different. Please contact the Fund Office for help in determining the order of liability in special circumstances.

SECTION F
THIRD PARTY RESPONSIBILITY (SUBROGATION)

1. THIRD PERSON RESPONSIBILITY.

- (A) Benefits shall be modified when a third person, other than the person for whom a claim is made, is considered responsible or liable for payment due to a sickness or injury. To the extent payment is made for such sickness or injury, or may be in the future, by or for such responsible or liable third person (as a settlement, judgment or in any other way), Charges arising from such sickness or injury are not covered and Benefits for any period of Disability resulting (in whole or in part) from such sickness or injury are not payable unless the requirements of Section F-1(B) are satisfied. Accepting Benefits under this Plan automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurers regardless of whether the Participant or Dependent chooses to pursue the claim. By accepting Benefits under the Plan, the Participant or Dependent agree to (i) repay to the Plan benefits paid on his or her behalf out of the monies paid to the Participant or Dependent by the third party or insurer in accordance with Section F-1(B) and (ii) notify the Plan Administrator of any claim, actions, rights of recovery, demands, actions or lawsuits that the Participant or Dependent ay have against a third party for Benefits covered by the Plan.
- (B) The Plan has no obligation to pay any Charges excluded from coverage under Section F-1(A) provided however, if the requirements of this Section F-1(B) are satisfied, the Plan will pay Charges excluded from coverage under Section F-1(A) in accordance with the terms of the Plan. Any bill submitted to the Plan for Charges excluded from coverage under Section F-1(A) shall be suspended for payment by the Plan pending satisfaction of the following requirements of this Section F-1(B). If the following requirements of this Section F-1(B) are not satisfied, any suspended bills for Charges excluded under Section F-1(A) will be excluded from coverage under the Plan.
- (1) Payment by or for the responsible third person has not yet been made; and
 - (2) The Participant and/or Dependent notify the Plan or its agent in writing within 90 days from the earliest of the following dates:
 - (a) The occurrence of any injury that gives rise to a subrogated claim;
 - (b) The notification or filing of any claim, action, right of recovery, demand, action or lawsuit that a Participant or Dependent may have against a third party for Benefits covered under the Plan; or
 - (c) The engagement of an attorney to handle any subrogated claim.

In the event the Participant or Dependent does not comply with the notification requirements in Section F-1(B)(2), the Plan reserves the right

to pursue any and all actions as it deems appropriate, including suspending and or denying payment of Charges, as determined by the Plan, that pertain to the injury, claim or subrogated matter.

- (3) The Participant and/ or Dependent involved (or if incapable, that person's legal representative) and the Participant's and/or Dependent's attorney(ies) cooperate with the Plan's reimbursement and subrogation rights by timely executing and returning any and all documents as the Plan may require and acknowledge that:
- (a) The Plan has a 100% first dollar priority lien on any amounts recovered (whether or not designated as payment for medical expenses).
 - (b) The Subrogation Packet applies whether or not: (i) liability for the payments is admitted by the responsible persons; and (ii) such payments are itemized.
 - (c) The Plan will not process any Charges relating to the subrogated claim until:
 - (i) a complete Subrogation Packet is timely returned to the Plan within 60 days from the date of the mailing by the Plan or, if later, the date requested by the Plan. For this purpose, the Subrogation Packet for the Participant and/or Dependent consists of the following documents: (1) the Subrogation (information) Form, which must be fully completed and executed by the Participant and, if the Dependent is over 18 years of age, the Dependent, (2) the Subrogation Agreement, which must be fully completed and executed by the Participant and, if the Dependent is over 18 years of age, the Dependent, (3) the Reimbursement Agreement, which must be fully completed and executed by the Participant and, if the Dependent is over 18 years of age, the Dependent, and (4) the Acknowledgement and Consent, which must be fully completed and executed by the Participant and, if the Dependent is over the age of 18 years of age, the Dependent, and the Participant's and/or Dependent's attorney, if the Participant and/or Dependent has engaged an attorney to represent him or her in connection with the incident. The Participant and/or Dependent must also provide all supporting documentation requested by the Plan, as may be necessary for the Plan to evaluate the Participant's or Dependent's claim.
 - (ii) If the Participant or Dependent, as applicable, has not retained an attorney prior to the time that he or she returns the Subrogation Packet, but he or she subsequently retains

an attorney to handle the subrogated matter, the Participant and/or Dependent shall notify the Plan in writing within 14 days of the engagement of the attorney and shall return the fully completed and executed Acknowledgement and Consent within 30 days of the date of mailing by the Plan.

- (d) In the event the Subrogation Packet is not timely returned (as detailed in (c)(i) or (c)(ii), as applicable), all Charges for which a third party may be responsible will be denied.
- (e) While the Participant and/or Dependent and their attorneys are pursuing recovery from a third party, the Participant and/or Dependent and their attorneys agree to provide the Plan or its agent with progress reports on a quarterly basis except that in the event of settlement activity, the Participant and/or Dependent and their attorneys agree to provide the Plan with more frequent updates.
- (f) The Participant and/or Dependent and their attorneys shall obtain the written consent of the Plan (or its agents) prior to the resolution of an incident that a third party or insurer may have responsibility; and
- (g) The Participant and/or Dependent and their attorneys shall obtain the written consent of the Plan (or its agent) prior to disbursement of any proceeds received as a result of the incident, including, but not limited to, recoveries for health care expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever, by way of judgment, settlement, or otherwise to compensate for all losses caused by the incident, whether or not said losses reflect benefits covered by the Plan (hereinafter, "Proceeds"). Pending the actual receipt of the Plan's consent to disbursement of the Proceeds, the parties agree as follows:
 - (i) If the Participant and/or Dependent have engaged an attorney, the attorney shall hold the Proceeds in the Attorney's client trust fund/escrow account.
 - (ii) If the Participant and/or Dependent have not engaged an attorney or if the attorney disburses funds without first obtaining the Plan's written consent, the Participant and/or Dependent shall hold the Proceeds in a separate non-interest bearing bank account.
 - (1) The Participant and/or Dependent shall repay to the Plan the Proceeds within 15 days of receipt.
 - (2) Because all or a portion of the Proceeds represents amounts due and owing to the Plan, all or a portion

of the Proceeds constitute Plan assets; the Participant and/or Dependent is a fiduciary with respect to those Plan assets.

- (4) To the extent permitted by law, amounts due to repay Benefits as described above may be deducted from other Benefits payable under the Plan after payments by or for the responsible person are made.
- (5) The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover Benefit payments from the Participant or Beneficiary.
- (6) The Plan's right to the third party recovery/subrogation still applies if the recovery received by the Participant or Dependent is less than the claimed damage, and, as a result, the claimant is not made whole.
- (7) The Plan shall have no obligation whatsoever to pay Charges/Benefits to a Participant or Dependent if a Participant or Dependent refuses to cooperate with the Plan's reimbursement and subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and subrogation rights. Further, in the event the Participant or Dependent is a minor, the Plan shall have no obligation to pay any Charges/Benefits caused by a responsible third party until after the Dependent or his authorized legal representative obtains valid court recognition, and otherwise satisfies the requirements of Section F-1(B). In the event the Participant or Dependent becomes deceased, the Plan shall have no obligation to pay any Charges/Benefits caused by a responsible third party until after the personal representative of the Participant's or Dependent's estate obtains valid court recognition, and otherwise satisfies the requirements of Section F-1(B).
- (8) The third party right of recovery applies to all monies paid to the Participant or Dependent, including, but not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever, by way of judgment, settlement, or otherwise to compensate for all losses caused by the injury or sickness, whether or not said losses reflect Benefits covered by the Plan.

2. RIGHT OF REIMBURSEMENT/SUBROGATION.

The Plan shall have a right of subrogation to the extent of its payment to or for the benefit of any Participant or Dependent, and shall have a 100% first dollar priority lien to the extent of such recovery (whether by settlement, judgment or otherwise) whether or not designated as payment for medical expenses, where the Participant or Dependent does or may recover any amount from a third person, his or her insurance company, or any other responsible party, as a result of a covered injury or illness. The Plan may exercise its

right of subrogation either in its own name or in the name of the Participant or Dependent in order to recover payments made to such person, who shall take any such action as the Plan Administrator may reasonably require to enable the Plan to enforce its rights. Once a Participant and/or Dependent accepts a settlement or judgment, the Plan reserves the right to deny future benefit payments to the extent allowed by law. The Plan's subrogation rights mirror the Third Party Recovery rights set forth in Section F-1 and incorporated by reference.

Please note: Once you accept a settlement, if less than medical expenses paid to date, the Fund may continue to pay for care. If you accept a settlement which is more than the medial claims paid to date, the Fund will expect your future expenses to be paid from the settlement.

SECTION G

FEDERAL LAW REQUIREMENTS

NOTICE OF COMPLIANCE UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (the "1998 Law") requires the Trustees of this Plan to notify you, as a participant or beneficiary of the Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

all stages of reconstruction of the breast on which the mastectomy was performed;

surgery and reconstruction of the other breast to produce a symmetrical appearance; and

prostheses and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided under the "Basic Medical Benefits" portion of the Plan. These benefits will be subject to the applicable deductible, the lifetime maximum and the general co-payment provisions which exist in the Plan.

Keep this Notice for your records and call your Plan Administrator for more information.

NOTICE OF COMPLIANCE UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan may not set the level of benefits or out-of-pocket cost so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Plan Administrator.

SECTION H **FILING A CLAIM**

IMPORTANT INFORMATION TO KNOW

Filing a Claim

If your claim is for Hospital expenses, the Hospital will file a claim for you. Present your Medical Benefit Card when you are admitted into the Hospital. The billing instructions are printed on the back of the card.

If you need a claim form for other medical expenses, please contact the Fund Office at (410) 254-9595 or toll free 1(800)367-7848. Please note that claim forms are not mandatory but will be provided for your convenience.

Your claim must include all of the following information:

- * Member's name
- * Member's identification number
- * Member's home address
- * Patient's name and age
- * Employer's name
- * Doctor's diagnosis and surgical procedure, if applicable
- * Doctor's Federal Tax ID Number and NPI number
- * Doctor's name, address, phone number
- * Doctor's signature in original form
- * Appropriate procedure codes

If services have been rendered as a result of an injury of any kind, please provide a brief description of how, when and where the injury occurred.

If your Dependents have primary coverage through another health care plan, program, or insurance policy, please submit a copy of the itemized bill (including the information described above) and the original explanation of benefits. Payments will not be made without both of these statements.

If you want payment to be made directly to the provider of services, please submit the provider's tax identification number and complete name and address. You must also sign an authorization in order for the Fund to release benefits to the provider. Please refer to the attending physician form, a copy of which may be obtained from the Fund Office. If you wish to be directly reimbursed for a claim and the claim exceeds \$100.00, please provide the original proof of payment (paid receipt, canceled check, etc.).

Review Procedures Time Limits

1. **Urgent Care Claim:** A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. An Adverse Benefit Determination review must be completed in 72 hours. Any urgent care claim that requests extension of a course of treatment beyond the initial prescribed period of time or number of treatments must be decided and communicated within 24 hours, provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period.

2. **Pre-Service Claim:** A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits or pre-certification. A review of an Adverse Benefit Determination must be completed in 15 days, subject to a 15 day extension.

3. **Post-Service Claim:** A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant. A review of an Adverse Benefit Determination can generally occur at the next Board meeting, unless the request for review is filed within 10 days preceding the date of such meeting, in which case the review of the Adverse Benefit Determination shall be made no later than the date of the second meeting following the Plan's receipt of the review request.

Time Limit for Filing Claims

No amounts will be reimbursed and no benefits will be paid by the Fund for claims filed more than twelve (12) months following the later of (1) the date the service was rendered or (2) the date a primary carrier processed payment.

When your claim form is completed, attach original of all bills and mail to:
Operating Engineers Local 99 Benefit Fund
3615 North Point Boulevard, Suite C
Baltimore, MD 21222

Adverse Benefit Determination Defined

An “Adverse Benefit Determination” is any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in the Plan, and including a denial, reduction or termination of, or a failure to provide or make payment (in whole or part) for a benefit resulting from the application of any utilization review, as well as the failure to cover an item or service for which benefits are otherwise provided because it is deemed to be Experimental or Investigational or not Medically Necessary or appropriate.

Rights Regarding an Adverse Benefit Determination

You have the following rights with regard to an Adverse Benefit Determination:

1. You have the right to appeal an Adverse Benefit Determination in accordance with the Plan’s review procedures and the time limits applicable to such procedures, as detailed below. If your appeal is denied, you have the right to bring a civil action under Section 502(a) of ERISA. A complete copy of the Plan’s claims procedures is available for free upon written request to the Fund Office at the address below.
2. You have the right to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination. A document, record, or other information shall be considered relevant to an Adverse Benefit Determination if it:
 - (a) was relied upon in making the benefit determination;
 - (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
 - (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
 - (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.
3. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, you have the right to receive a copy of that written rule, guideline, protocol, or criterion, free of charge, upon written request to the address below.

4. If the Adverse Benefit Determination was based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, you have the right to receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances. Such explanation will be provided free of charge, upon written request to the address below.

How to File an Appeal

In the event that you or your Dependents receive an Adverse Benefit Determination, you may file an appeal to your Board of Trustees. All of the information related to the appeal must be received in the Fund Office at least ten (10) days prior to the scheduled quarterly meeting of the Trustees in order to ensure review. Appeals received after the cut-off period will be held until the next quarterly meeting. Please contact the Fund Office for the meeting dates.

The following information must accompany all formal appeals:

1. A letter from the Participant or Dependent briefly describing the situation and detailing the special request.
2. A letter from the physician who prescribed the item or service explaining that the item or service is Medically Necessary. The letter should include the anticipated benefits of using the item or service.
3. A cost quote from the supplier. The estimate must be in writing and on the company's letterhead.

Please forward all appeal requests to:

Operating Engineers Local 99
3615 North Point Boulevard, Suite C
Baltimore, MD 21222
Attn: Appeal Department

The Participant's identification number should appear on all appeal items. Please contact the Fund Office if you have any questions concerning the appeal process.

You may submit written comments, documents, records, and other information relating to the Adverse Benefit Determination. The period of time within which a benefit determination or review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Adverse Benefit Determination, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination nor a subordinate of that individual.

If the Adverse Benefit Determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional shall not be an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual.

Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

Response Time for Appealed Adverse Benefit Determinations

The Plan Administrator shall notify the Claimant in writing no later than five days after the benefit determination has been made. The final decision on an appealed claim shall contain the same information as a “Notice to Claimant of Adverse Benefit Determinations.”

Special Rules for Disability Claims

If you file a claim for disability benefits, it will be subject to the rules set forth above with the following modifications:

1. Once you file your disability claim, the Plan Administrator will notify you within 45 days of receipt if it is denied. The 45-day period may be extended an additional 30 days if you are notified in writing before the original 45-day period ends. The 30-day extension period can be extended another 30 days if you are notified in writing before the first 30-day extension expires.
2. If your claim is denied, you will receive a written notification which will contain the information identified above, plus it will include a statement notifying you about your rights to bring a civil action. It will also notify you that you will have the right to request a copy, free of charge, of any internal rule, guideline or similar criteria, or exclusion or limitation (such as medical necessity or experimental treatment) which formed the basis for the adverse determination. You will have 180 days to appeal the decision.

SECTION I

OTHER IMPORTANT INFORMATION

YOUR RIGHTS UNDER THE FUND

As a member of the Fund, you are entitled to certain rights and protections under ERISA -- the Employee Retirement Income Security Act. This section describes those rights and explains how you can put them to work for you.

Right to Information

One right entitles you to a full summary of the Fund. This booklet is designed to provide that information. In addition to the summary, you can examine without charge at the Administrator's office and at other specified locations, all Fund documents and contracts, including financial reports, the collective bargaining agreement, the latest 5500 filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, and plan descriptions. To get copies of any legal documents, write to the Fund Office. You may have to pay a small fee for copying charges.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the

administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits 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.

Assignment of Benefits

Generally, no assignment for the benefit of creditors of any benefit provided under the Fund will be valid.

Qualified Medical Child Support Order

The Plan has a procedure which details how it evaluates a medical child support order. You can obtain a copy, at no addition charge, from the Plan Administrator.

SECTION J

ADMINISTRATIVE INFORMATION

Fund Administration

The Board of Trustees sponsors the Fund described in this booklet. Decision Science, Inc. is the Administrator of the Fund.

Fund Records

All Fund records are kept on a Plan Year basis, from January 1st to December 31st.

Legal Matters

If you have a question about any legal Fund Provision, contact the Plan Administrator. You may serve legal papers on the Fund Sponsor or the Fund Administrator. The Trustees have the discretion to construe and/or interpret the terms of the Plan.

The Plan is maintained pursuant to various collective bargaining agreements. You may obtain, upon written request, a complete list of the employers participating in the Plan, the collective bargaining agreements, if any, that pertains to employers whose employees are covered by the Plan, and a list of providers included in the PPO network. Please contact the Administrator or send him a written request for more details. You may also examine the documents.

The common name for the Fund is the Operating Engineers Local 99 and 99A Health Care Fund.

Funding Medium

The Plan assets are held in a trust and contributions to the trust are made by the participating Employers. Employees may also make contributions.

Future of the Fund

The Fund expects to continue the benefits described in this booklet, but has the right to change or terminate them. Any changes must be approved by the Board of Trustees. You'll be told how the change affects your benefits, if at all.

SECTION K
IMPORTANT NAMES AND NUMBERS

Name of the Fund	Health and Welfare Trust Fund for International Union of Operating Engineers Local 99 and 99A
Fund Number	501
Employer Identification Number	52-6072849
Plan Year	January 1st to December 31st
Type of Fund	Self-Funded Health and Welfare Benefit Fund
Fund Sponsor	Board of Trustees of the Health and Welfare Fund for the International Union of Operating Engineers Local 99 and 99A 3615 North Point Boulevard, Suite C Baltimore, MD 21222 Tele: (410) 254-9595 1-800-367-7848
Plan Administrator	Contract Administrator: Decision Science, Inc. 3615 North Point Boulevard, Suite C Baltimore, MD 21222 Tele: (410) 254-9595 1-800-367-7848
Board of Trustees	<u>Union Trustees</u> Charles Erik Jewett IUOE Local 99 2461 Wisconsin Avenue, N.W. Washington, DC 20007 Tele: (202) 337-0099 Fax: (202) 625-7982 Donald Havard IUOE Local 99 2461 Wisconsin Avenue, N.W. Washington, DC 20007 Tele: (202) 337-0099 Fax: (202) 625-7982

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Baltimore, MD 21222
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