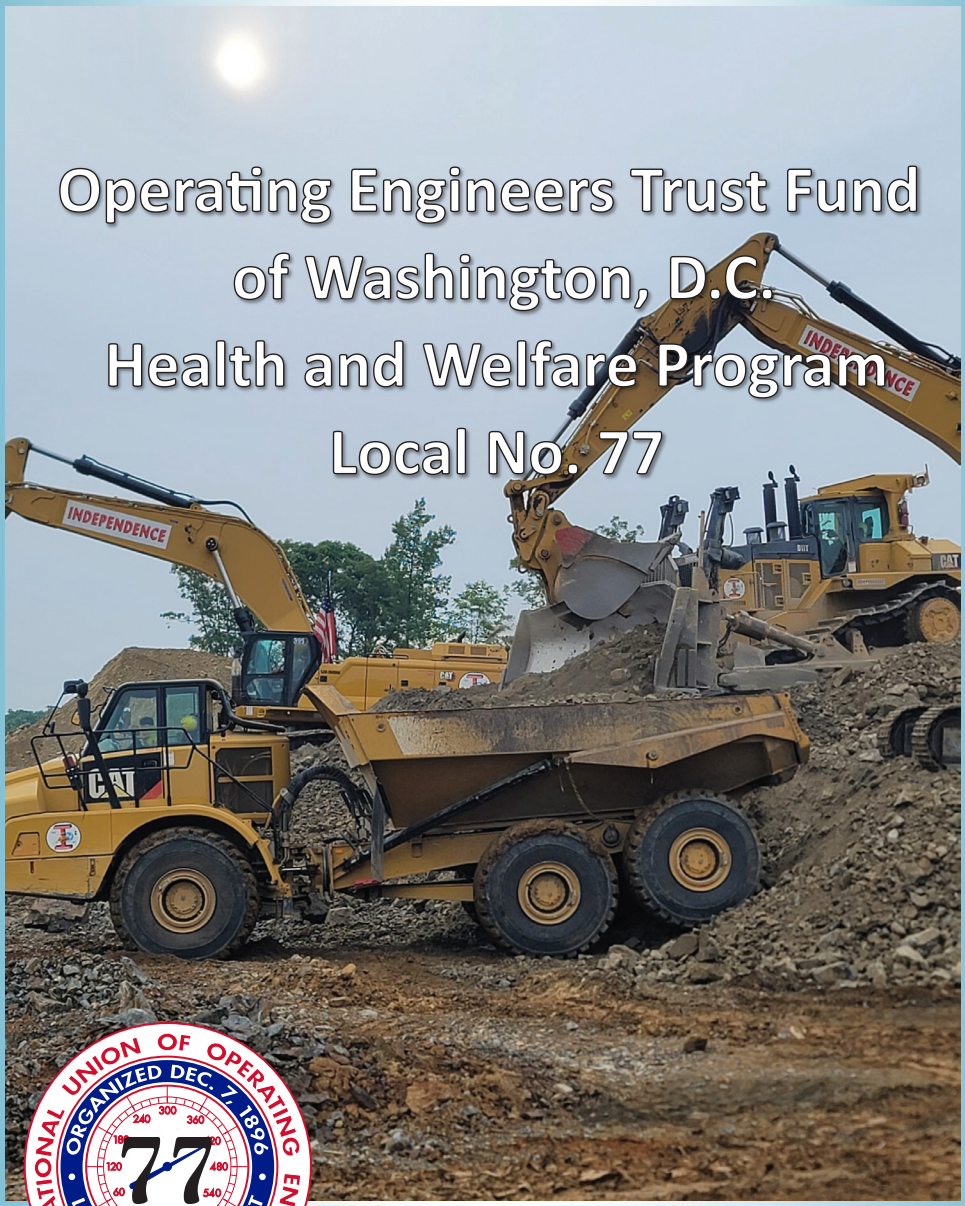
Operating Engineers Trust Fund of Washington, D.C. Health and Welfare Program Local No. 77



INTERNATIONAL UNION OF OPERATING ENGINEERS
ORGANIZED DEC. 7, 1896
77
LABOR OMNIA VINCIT

SUMMARY PLAN DESCRIPTION

January 2025

[INSERT BELOW INSIDE JACKET COVER]

The Administrative Manager (the "Fund Office" and "Plan Administrator"):

• Receives Participating Employer/employee contributions
• Keeps eligibility records
• Processes claims
• Provides information about the Fund

The Administrative Manager is
Associated Administrators, LLC

Website
www.associated-admin.com

Participant Services
(877) 850-0977

Sparks Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451
(877) 850-0977

Landover Fund Office
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
(877) 850-0977

Hours: 8:30 a.m. to 4:30 p.m., Monday through Friday

Interactive Voice Response System

You can check the status of your claims 24 hours a day, 7 days a week by using the automated phone system. Call (800) 638-2972 and press "1" at the prompt.

There are terms used throughout this booklet which have special meaning in relation to your Plan benefits. Such terms are defined in the "Definitions" section on page 15.

Dear Participant:

The Trustees of the Operating Engineers Trust Fund of Washington, D.C. ("Fund") are pleased to present this Summary Plan Description or "SPD" booklet. The SPD booklet describes your Health and Welfare benefits under the Fund. There is no competing Plan document. Please read it carefully to become familiar with its contents and keep it readily available so you will have it when you need to refer to it.

The Fund was established as a result of collective bargaining between the union ("Local 77") and the participating employers. The governing documents setting forth the applicable rules and terms resulting from the collective bargaining process are the Collective Bargaining Agreement and the Agreement and Declaration of Trust document. The contribution rate paid by your participating employer determines the benefits you receive. An equal number of Trustees have been appointed by the union and the participating employers. The Trustees administer the Fund and serve without compensation. Their authority, established under a trust agreement, includes the right to make rules about your eligibility for benefits and the level of benefits provided. The Trustees may amend the rules and benefit levels at any time. You will be notified of any material modifications (changes) to this booklet — the Summary Plan Description — as required by federal law.

The Trustees delegate authority to professionals who help them manage the Plan.

- **Administrative Manager**: Often referred to as the "Fund Office" or "Administrator," the Administrative Manager receives employer contributions, pays claims, keeps eligibility records, and ensure the proper administration of benefits, in part, by assisting Plan participants in getting their benefits. Some benefits are paid directly from the Fund's assets while others are provided by insurance carriers or other providers to whom the Fund pays premiums. Benefits are limited to Plan assets for all Fund-provided benefits. The Fund Office is not an insurance company but is hired by the Trustees to carry out its instructions in administering the Plan in accordance

with Fund rules. The Administrative Manager is Associated Administrators, LLC.

- **Investment Manager**: Investment managers invest the Fund's assets to achieve a reasonable rate of investment return.
- **Investment Advisor:** An Investment Advisor assists the Board of Trustees in selecting Investment Managers and monitors the investment performance of the Trust Fund.
- **Consultant/Actuary:** The Consultant and Actuary assist the Board of Trustees in determining the benefits to be provided under the Plan, help to identify medical and service providers to be used by the Plan, and make actuarial calculations to project future trends and expenses.
- **Fund Counsel**: Fund counsel provides legal advice and services to the Fund.
- **Certified Public Accountant**: An independent accountant audits the Fund each year. Periodic payroll audits are also performed for each participating employer.

The Trustees are always interested in providing increased benefits for the Operating Engineers of Local 77 and their dependents, when it is economically sound to do so. To protect the interests of all Fund participants and beneficiaries, the Trustees reserve the right to terminate, suspend, amend or modify the Plan in whole or in part at any time. In the event the Plan is terminated, Plan assets will be allocated, and benefit claims paid, in the manner determined by the Trustees.

We encourage you to take full advantage of the benefits provided for you and your dependents. If you have any questions about your benefits after reading this booklet, please contact Associated Administrators, LLC.

At all times, the Trustees of the Fund have discretion to determine eligibility for benefits and to interpret the terms of the Trust Agreement and this Booklet — the Summary Plan Description. The decision of the Board of Trustees shall be final and binding on all parties, including participants, employers, unions, claimants, and beneficiaries.

Se le presentarán servicios de traducción e interpretación:

Este documento titulado Summary Plan Description, explica los beneficios de salud para usted y su familia. Estos beneficios están disponibles a través de su empleador y el Fondo Fiduciario de los Ingenieros Operadores of Washington, DC, Local No. 77. Se le ayudará con la traducción e interpretación de este documento a través de la Oficina del Fondo Fiduciario. Para mas información, favor de llamar al (410) 683-6500.

Cualquier confusión con la información contenida en este documento será interpretada y resuelta acuerdo con la versión de estos documentos escrita en inglés.

Sincerely,

Board of Trustees

IMPORTANT NOTE REGARDING BENEFITS

At all times, the Trustees of the Fund have discretion to determine eligibility for benefits and to interpret the terms of the Trust Agreement and this Plan of Benefits also known as the Summary Plan Description.

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FACTS ABOUT THE PLAN

Plan Name
Operating Engineers Trust Fund of Washington, D.C. Health and Welfare Plan. Other known names for the Health and Welfare Plan include: Operating Engineers Local No 77 Trust Fund of Washington, D.C. Health and Welfare Plan; Operating Engineers Local No 77 Trust Fund of Washington, D.C. Health and Welfare Program.

Plan Sponsor
Joint Board of Trustees, Operating Engineers Trust Fund of Washington, D.C., 911 Ridgebrook Road, Sparks, MD 21152-9451.

Participants and beneficiaries may, upon written request, receive information from the Plan Administrator about whether an employer or employee organization is a sponsor of the Plan, and if so, the sponsor's address.

Employer Identification Number	**Plan Number**
52-6038508	501

Type of Plan
This is a welfare plan designed to provide health care benefits subject the plan terms. Benefits may include life, accidental death and dismemberment, hospitalization, medical, mental health, accident & sickness, prescription drug, vision, and dental benefits. The Trustees have the discretion to amend the plan at any time to alter, add, or eliminate benefits.

Type of Administration
Contract administration. The Board of Trustees has contracted with Associated Administrators, LLC to provide administrative management services.

Name of Plan Administrator
Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, MD 21152-9451, (877) 850-0977, (410) 683-6500.

Agent of Service for Legal Process
Charles Fuller of McChesney & Dale, P.C., 15736 Crabbs Branch Way, 2nd FL, Rockville, MD 20855.

Sources of Contribution
Contributions are made to the Welfare Fund by participating employers pursuant to the terms of the applicable Collective Bargaining Agreement and, optional self-payments made by participants and/or dependents.

Funding Medium
The Plan is financed by contributions by employers and those who opt to self-pay, as well as income derived from these contributions. Payments made by employers and participants are paid to a Trust, which is distributed to an interest bearing Trust account at a custodian bank where the money is held. The Trust also accrues interest or other income because of the investment of contributions. When a medical bill needs to be paid, the cost of services by providers — a doctor or hospital, for example — is paid either directly from the Trust, or the Trust pays premiums to an insurance company who in turn pays the doctor or hospital. All monies are used exclusively for providing benefits to eligible employees, the spouses of employees, or their dependents, and for paying the expenses incurred with respect to the operation of the Plan.

Plan Year and Fiscal Year
January 1 — December 31.

Overview of Plan Benefits
This booklet describes your health Plan. Members and eligible dependents of the International Union of Operating Engineers Local No. 77 may be eligible for health benefits. Generally, you and your family become eligible for benefits under the Plan if your employer

has paid for at least 400 hours of your work in the last three months or 1200 hours in the past 12-month period. You will remain eligible unless you work less than 400 hours in any three-month period and less than 1200 in the past 12-month period, or unless your employer fails to pay for your hours, in which cases your benefits will be terminated.

If you are eligible under this Plan, you and your family will be entitled to the health benefits payable in accordance with the Schedule of Benefits and Rates, including any exclusions and limitations, as amended from time to time.

NOTICE - NO FUND LIABILITY

Use of the services of any hospital, clinic, doctor, or other provider rendering health care is the voluntary act of the participant or dependent, even in cases where the Fund limits coverage to certain providers. Some benefits may only be obtained from providers designated by the Fund. This is not intended to serve as a recommendation in favor of any specific provider.

You should select a provider or course of treatment based on all appropriate factors. However, coverage will be provided in accordance with the benefit limitations set forth in the Plan. Providers are independent contractors, not employees of the Plan. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with the benefits covered under the Plan. The provider is solely responsible for the services and treatments rendered.

BOARD OF TRUSTEES

Union Trustees	Employer Trustees
Joshua VanDyke International Union of Operating Engineers Local 77 4546 Brittania Way Suitland, MD 20746	Christopher Burke Extreme Steel Crane and Rigging, LLC 4515 Whiting Road Marshall, VA 20115
Jose Ventura International Union of Operating Engineers Local 77 4546 Brittania Way Suitland, MD 20746	John Knowles Clark Construction Group, LLC 6407 Dowerhouse Rd Upper Marlboro MD 20722
Ray Dennison International Union of Operating Engineers Local 77 4546 Brittania Way Suitland, MD 20746	Richard Mazzella Crane Service Company 9310 D'Arcy Road Upper Marlboro, MD 20774
James Berry Gilroy 2114 Fiddler Lane Accokeek, MD 20607	Brian Mazzella Crane Service Company 9310 D'Arcy Road Upper Marlboro, MD 20774
Alternate: Steve Faulkner International Union of Operating Engineers Local 77 4546 Brittania Way Suitland, MD 20746	Brandon Horne Titan Crane Inc. 12230 Pulaski Highway Joppa, MD 21085

SCHEDULE OF BENEFITS

Benefit levels and rates are subject to change. Please contact the Fund Office to determine the current rates and benefits.

Benefit		Persons Eligible
Death Benefit	$5,000	Participant Only
Accidental Dismemberment	$5,000	Participant Only
Weekly Accident & Sickness Benefits	$450/ week for a maximum of 13 weeks.	Participant Only (not available for retirees)
Major Medical Benefit	Fund pays 80% of eligible medical/hospital expenses up to the Allowable Charge after satisfying annual deductible. There is a $4,000 out-of-pocket cost per person, per year. Eligible expenses are covered at 100% after participant payment of annual out-of-pocket maximum in a calendar year, up to $200,000, subject to the annual maximum benefit. Payment for Essential	Participants & Dependents

	Health Benefits covered at 50% after $200,000 has been paid.	
Annual Deductible	Individual: $300.00 Family: $1,000.00	Participants & Dependents
Annual Out-of-Pocket Maximum, per individual	$4,000.00	Participants & Dependents
Lifetime Major Medical Maximum Benefit, per Individual	No lifetime limit for Essential Health Benefits; no payments for non-Essential Health Benefits above $2,000,000	Participants & Dependents
Prescription Drug Benefits	Brand prescriptions provided through CVS Pharmacy or through CVS Caremark Mail Service Pharmacy are paid at 60% (participant co-payment is 40%) up to $2,500 per year. Generic prescriptions provided through Caremark are paid at 100%, subject to $10.00 co-payment for a 90-day supply if purchased through Caremark's mail order program or CVS pharmacy, or to a $5.00 co-payment per prescription at retail.	Participant & Dependents

	Maintenance drugs must be supplied via Caremark's mail order program or through a CVS pharmacy (mandatory).	
Annual CDL License Physical Exam	$125 paid per person per year. Deductible does not apply.	Participant only. (Not available for retirees)
Ambulance Benefit	$100 per incident paid at 100% with no deductible; remaining expenses covered at 50% after satisfying deductible if medically necessary life support services are provided by ambulance.	Participant & Dependents
Orthotics	$500 per three-year period paid at 100%. Maximum benefit is $500 per patient every 3 years. Deductible does not apply. If approved by Conifer Health Solutions ("Conifer"), $500.00 per one-year period at 100%.	Participant & Dependents

Dental Benefit	$25 deductible per individual and $75 deductible per family. $1,500 maximum per calendar year. Preferred Provider benefit provided through Delta Dental.	Participant & Dependents
Vision Benefit with a VSP Doctor	Once every 12 months, a WellVision Exam (focused on eye health and wellness). No cost other than a $10 co-pay. Once every 12 months, eyeglass lenses, and eyeglass frames up to a $150 allowance. **or** Once every 12 months, a combined $130 allowance for contacts and contact lens exam (fitting and evaluation) and contact lenses. No co-pay. 15% savings on a contact lens exam (fitting and evaluation).	Participant & Dependents
Vision Benefit with a non-VSP Doctor	Exam: Up to $52 Single vision lenses: up to $34 Lined bifocal lenses: up to $50 Lined trifocal lenses: up to $66 Progressive lenses: up to $66 Eyeglass Frame: up to $70 Contacts: up to $105	Participants and Dependents

DEFINITIONS

Accidental Injury. A bodily injury sustained solely through violent, external and accidental means. Treatment in the emergency room of a hospital or doctor's Office is not considered an accident unless an injury has occurred. Treatment for an accident must be performed within a 72-hour period to be a covered expense, except for *No Surprises Services*. Injuries sustained in the course of criminal activity are not considered to be accidental.

Administrative Manager. Associated Administrators LLC, the Third Party Administrator hired by the Fund.

Allowable Charge. The fee, as determined by the Fund, that is the lowest of: (1) the health care provider's actual charge; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the maximum amount that the Fund has determined it will pay for the service or supply; or (4) the amount that is reasonable and customary for the locality in which incurred. Notwithstanding the above, for CareFirst in-network claims, the *Allowable Charge* is the CareFirst allowed amount.

Ancillary Services. With respect to an in-network *Health Care Facility*, (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Board of Trustees. Those persons and their successors who are appointed in accordance with the Operating Engineers Trust Fund of Washington, D.C., and who administer the Fund.

COBRA. Consolidated Omnibus Budget Reconciliation Act. This Act provides for continuation of benefits under certain circumstances when benefits are lost.

Collective Bargaining Agreement. The agreement or agreements between a participating employer and the Operating Engineers Union Local No 77 which require contributions to the Operating Engineers Trust Fund of Washington, D.C.

Co-payment or Co-insurance ("Co-Pay"). The out-of-pocket amount of the *Allowable Charge* that a participant or dependent is responsible for paying for a covered benefit at the time the benefit is provided. Effective January 1, 2022, the *Co-insurance* or *Co-payment* applicable to *No Surprises Services* is based on the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the *"Qualifying Payment Amount" ("QPA"),* or the amount billed by the provider.

Concurrent Care. Care that was approved by the Board of Trustees. Ongoing course of treatment to be provided over a period of time or number of treatments.

Concurrent Care Claim. A pre-service claim related to an ongoing course of treatment or a number of treatments over time.

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

Coordination of Benefits. Coordination of Benefits or COB applies when a participant has coverage under two or more group plans. COB is intended to prevent duplicate payments or overpayments for the same service by different insurers.

Deductible. The deductible is the first amount of eligible expenses incurred during each calendar year, which must be paid by you. There is a separate deductible for each individual, as well as one for the entire family. The amount of these deductibles is listed in the Schedule of Rates and Benefits. You should submit all claims *as they are incurred* so that the Fund can apply covered claims to your deductible.

A new deductible will apply each calendar year. However, if during one calendar year, you or your dependents do not satisfy the Deductible, medical expenses incurred during the last three months of that calendar year which *would have been* applied toward the deductible may instead be applied toward the deductible for the next calendar year.

The deductible <u>will apply to</u> the Major Medical Benefit and the 50% Ambulance Benefit (after the amount paid listed in the Schedule of Rates and Benefits, if medically necessary services are provided,)

The deductible <u>*will not apply*</u> to: annual physical benefits, vision benefits, dental benefits, weekly accident and sickness benefits (available for the employee only), orthotics benefits, or prescription drug benefits.

Dependent. Effective January 1, 2011, the term "dependent" means the lawful spouse residing with you and your natural children, stepchildren, adopted children or children placed for adoption who are under the age of 26. It is a further requirement for dependent eligibility that a valid Social Security Number be provided to the Fund Office for each dependent.

Disabled Employee. An employee who is not able to perform all of the material duties of his regular occupation due to sickness or injury

and whose current monthly earnings are reduced, due exclusively to the disability, 80% or more than the employee's average monthly salary for the last twelve months. The Board of Trustees may take determinations of disability by the Social Security Administration into account when deciding whether a disability exists under the terms of this Plan.

Durable Medical Equipment. Equipment which (1) can withstand use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a person in the absence of a sickness or injury and (4) is appropriate for use in the home.

Effective/Eligibility Date. According to the Eligibility Rules, the date on which coverage for a participant or dependent begins.

Emergency Medical Condition. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services. Any of the following, with respect to an *Emergency Medical Condition*:

- An appropriate medical screening examination that is within the capability of the emergency department of a *Hospital* or *Independent Freestanding Emergency Department*, including *Ancillary Services* routinely available to the emergency department to evaluate such *Emergency Medical Condition*;
- Such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the

hospital in which such further examination or treatment is furnished); and

- Services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:
    - The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;
    - The patient is supplied with a written *Notice*, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and
    - The patient gives informed *Consent* to continued treatment by the nonparticipating provider, acknowledging that she or he understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

Employee. Any person employed by an Employer in a job category covered by the Collective Bargaining Agreement on whose behalf the Employer is required to make contributions to the Fund and any other employee of an Employer who satisfies the requirements for participation established by the Board of Trustees and who makes, or on whose behalf an Employer is required to make or makes, contributions to the Fund.

Employment. Employment in a job category for which the Employer is required to make contributions to the Fund pursuant to the Collective Bargaining Agreement.

ERISA. The Employee Retirement Income Security Act of 1974, and regulations thereunder, as amended from time to time.

Essential Health Benefits. Benefits including items and services covered within the following general categories: ambulatory patient services; *Emergency Services;* hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care, as defined in Federal regulations.

Experimental. Any service, care or treatment that is experimental in nature or which is not considered a generally accepted medical practice. A determination of whether service, care or treatment is experimental in nature or not considered a generally accepted medical practice shall be solely within the discretion of the Board of Trustees, whose determination on that issue shall be final and binding on all concerned. In addressing whether any service, care or treatment comes within the terms of this exclusion, the Trustees will consult and consider such sources available to the Board within the medical community as the Trustees shall deem in their sole discretion to be reliable, reasonable, up to date and independent of influence by parties who may have a proprietary or economic interest in the outcome.

Explanation of Benefits. **("EOB"**), A statement which shows the billed amount of a claim and how much and to whom payment was made. Any other explanation required (such as if certain charges were not covered or only partially covered) will also be shown on the EOB.

FMLA. The Family Medical Leave Act of 1993, and any regulations, as amended from time to time.

Fund. The Operating Engineers Trust Fund of Washington, D.C., established by collective bargaining agreements between Operating Engineers Local Union No. 77 and contributing employers.

Fund Office. The Administrative Manager of the Fund is also referred to as "the Fund Office." Associated Administrators, LLC, the Third Party Administrator hired by the Fund, is the Administrative Manager of the Plan and acts as the Fund Office.

Health Care Facility. For non-*Emergency Services*, a: (1) hospital; (2) hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

Hospital. An institution which is approved by the Trustees and is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets all of the tests set forth in (a) or (b) or (c) below:

(a) It is a hospital accredited by the Joint Commission on Accreditation of Hospitals.

(b) It is a hospital, a psychiatric hospital, or a tuberculosis hospital, as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.

(c) It is an institution which fully meets all of the following conditions:

- 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 duly licensed physician; and

- It continuously provides on the premises 24 hours a day nursing service by or under the supervision of registered graduate nurses; and

- It is operated continuously with organized facilities for operative surgery on the premises.

This Fund will also recognize an institution accredited by the following:

1. the Joint Commission on Accreditation of Hospitals; or

2. the Accreditation for Ambulatory Health Care or Free-Standing Ambulatory Surgical Association and licensed by appropriate regulatory authorization; or

3. Ambulatory and Surgical Centers that are licensed by the State; approved by Medicare, or in the event not approved by Medicare, an institution which is recognized for payment by major insurance companies that provide health benefits.

Hospital Services and Supplies. Services and supplies furnished to an individual and required for treatment, other than Room and Board, the professional services of any physician and any private duty, or special nursing services (including extensive nursing care by whatever name called), regardless of whether such services are rendered under the direction of the hospital or otherwise, as approved by the Trustees.

This does not include assisted living facilities, nursing homes or nursing institutions or institutions for convalescence, rest, the aged, or care of drug addicts or alcoholics.

Illness. Illness means any disease or disorder resulting in an unsound condition of the mind or body.

Independent Freestanding Emergency Department. A facility that is geographically separate and distinct from a *Hospital* under applicable state law, provides *Emergency Services*, and is licensed under state law to provide *Emergency Services*.

Injury. This means any loss to the body sustained accidentally or by external means.

Medical Care. Charges incurred by an individual covered the Plan for medically necessary treatment, services and supplies

Medically Necessary Services or Supplies. Those services or supplies provided by a hospital, physician, or other provider of health care to identify or treat the sickness or injury which has been diagnosed or is reasonably suspected and is 1) consistent with the diagnosis and treatment of your condition, 2) in accordance with standards of good medical practice, 3) required for reasons other than convenience to you, your physician, or another provider, and, 4) the most appropriate supply or level of service which can safely be provided to you. When applied to inpatient care, medically necessary means that your symptoms or condition require that those services or supplies cannot be safely provided to you on an outpatient basis. The fact that a service or supply is prescribed by a physician or another provider does not automatically mean it is medically necessary.

Medicare. The term Medicare means Title XVIII of the Social Security Act, as amended.

Month. The term Month means, for the purposes of determining a Participant's eligibility for benefits under the Plan, the payroll month, as reported by the Participant's Employer.

No Surprises Act. The No Surprises Act enacted under the federal Consolidated Appropriations Act of 2021.

Notice and Consent. With respect to out-of-network services provided at an in-network *Health Care Facility*, *Notice and Consent* means: (1) you are provided with a timely written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment, any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and (2) you give informed consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you.

Non-Essential Health Benefits. Any item or service that is not considered an Essential Health Benefit under federal law.

Participating Employer. An employer who is a party to a Collective Bargaining Agreement or other similar arrangement with Operating Engineers Union Local No. 77 and which requires contributions to Operating Engineers Trust Fund of Washington, D.C.

Plan. The Plan of Benefits adopted by the Trustees of the Operating Engineers Trust Fund of Washington, D.C. for eligible Plan Participants and Dependents.

Plan Participant. An Employee who meets the eligibility rules for coverage under the Plan.

Physician. A duly licensed Doctor of Medicine (MD) or a duly licensed Doctor of Osteopathy (DO). A duly licensed dentist for dental treatment where such services are covered. A duly licensed Podiatrist (Chiropodist or DSC) for purposes of conditions of the feet. A duly licensed Psychiatrist (PSY). A Psychologist (Psych) for services approved by the Board of Trustees. A duly licensed Chiropractor (DC). A registered Physical Therapist (RPT). A social worker and drug and alcohol counselor as long as there is a letter of medical necessity

received in the Fund Office from the patient's physician requesting treatment by such provider prior to treatment being rendered.

Post-Service Claim. A claim for which the treatment or service has already been rendered.

Pre-Service Claim. A claim which requires pre-authorization, such as a hospital stay or mental health services.

Qualified Medical Child Support Orders (Including National Medical Child Support Orders) or "QMCSOs." A medical child support court order which requires a child to be covered under a Plan, which permits the child to receive benefits from the Plan and which complies with the requirements for a QMCSO under ERISA.

Qualifying Payment Amount ("QPA"). The median of the in-network rates payable for the same or similar service in the same geographic region, for purposes of *No Surprises Services*.

Room and Board. Room, board, general duty nursing, and any other services regularly furnished by the hospital but not including professional services of physicians or intensive nursing care by whatever name called.

Serious and Complex Condition. A condition that requires specialized medical care over a prolonged period of time, and that, (1) in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, is life-threatening, degenerative, potentially disabling, or congenital.

Spouse. Spouse shall mean, with respect to an individual, the person to whom such individual is lawfully married in a binding marriage in accordance with the laws of a State of the United States or the District of Columbia, or, in the case of a marriage outside the United States, the person to whom such individual is lawfully married in a binding

marriage in accordance with the laws of such foreign jurisdiction that the Trustees determine to be consistent with the public policy of the United States.

The Welfare Plan will therefore look to the law of the State in which a marriage was performed in order to determine whether a participant is married, whether the participant's spouse can be an eligible dependent and for all other purposes of administration of the Plan of Benefits.

Subrogation. The contractual right of a health plan to recover payments made to or for the benefit of a member for health care costs from a payment for damages in a claim or a legal action either directly from the member or from any third-party payer.

Subacute Care. Comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process. It is an inpatient alternative to acute care or continued hospitalization that is non-emergency, non-urgent, and non-surgical.

Urgent Claim. A pre-service claim for treatment of illness or injury which involves an *Emergency Medical Condition.*

Urgent Concurrent Care Claim. An urgent pre-service claim related to an ongoing course of treatment or a number of treatments over time.

USERRA. The Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), which provides for the continuation of participants and their eligible dependent(s) who are absent from work due to military service.

ELIGIBILITY

Initial Eligibility

You become eligible for health coverage for yourself and your dependents when you have worked (and your employer has made contributions for) 400 hours in a 3-month period or 1200 hours during the previous 12-month period. Coverage will begin on the first day of the month following the time both you and your employer have met these requirements. Because your employer's contributions are made the month after you have performed work, the 3-month "look back" period for each eligibility month is as follows:

Eligibility Month	Look-back Period
January	September, October, November
February	October, November, December
March	November, December, January
April	December, January, February
May	January, February, March
June	February, March, April
July	March, April, May
August	April, May, June
September	May, June, July
October	June, July, August
November	July, August, September
December	August, September, October

Coverage will continue month-to-month as long as you have worked, and your employer has paid, 400 hours in any previous consecutive three-month period or 1200 hours in the previous 12-month period. If contributions are not paid for any reason, or if you have worked less than 400 hours in the last three months and less than 1200 hours in the previous 12-month period, then coverage will stop immediately.

If coverage stops, then you can become eligible again when you have worked 400 hours and your employer has paid 400 hours in the last three-month period.

Notification Requirements – Participant's Responsibilities
Once you become eligible for benefits, it is important that you keep the Fund Office updated on any changes in your status. You must notify the Fund Office of:

- Any changes in marital status;
- The names and birth dates of newborn children, stepchildren, adopted children or children placed for adoption;
- The date that any dependent child reaches his or her 26th birthday, or if over age 19, becomes eligible for other coverage through employment or through spouse's employment.
- Any change of address; and,
- Any change in beneficiary.

You must notify the Fund Office when any of the foregoing information changes. The Fund Office needs this information to be sure there is no delay in handling your claims. Your eligibility for benefits may depend on whether you have kept the Fund Office informed of these changes.

Enrollment Form
To enroll for your Health and Welfare benefits, you must complete a Health and Welfare enrollment form and send it to the Fund Office. You can get an enrollment form from the Fund Office or the Union.

ID Cards
Once you have become eligible for benefits, the Fund will send you a Fund ID card(s). You will receive two cards if you have dependent coverage. Show the card to the provider of care (doctor/hospital) each time you go for services.

Continued Eligibility
Once you are initially eligible, you become and remain a participant as long as you are employed by a Participating Employer that makes contributions to the Fund on your behalf and work the required number of hours. A participant is considered to be employed:

1. during periods of active work
2. during paid vacations
3. while on jury duty
4. while collecting Weekly Accident & Sickness pay
5. while collecting Workers' Compensation benefits for a period of up to 12 months
6. during periods of leave covered under the Family and Medical Leave Act

Termination of Eligibility
A participant and any covered dependents will cease to be eligible for benefits upon:

1. Failure to work 400 hours within the 3 month "look-back" period preceding the eligibility month, or 1200 hours in the preceding 12 months.
2. Failure of employer to pay for 400 hours within the during the 3 month "look-back" period and 1200 hours within the 12 months immediately preceding the first day of any month.
3. Working in employment covered by Local 77's Collective Bargaining Agreement for an employer who is not signatory to the agreement.
4. Termination of the Plan

In certain circumstances, a participant may continue eligibility by making self-payment (see section on Self-Payments on page 40).

Date Coverage Terminates
If you lose eligibility, your medical and hospital benefits will terminate on midnight on the last day of the month in which eligibility ceased.

If you/your covered dependent are an inpatient in the hospital on the date you lose eligibility, the Fund will pay for hospital expenses through the date of discharge or for 30 days following the date of termination, whichever is earlier.

DEPENDENT ELIGIBILITY

Dependents include your lawful spouse residing with you and your natural children, stepchildren, adopted children or children placed for adoption who are under the age of 26. It is a further requirement for dependent eligible participants that a valid Social Security Number be provided to the Fund Office for each dependent and that the dependent has been properly enrolled under the rules of the Plan.

Eligibility for your legal spouse who is defined as a Dependent will begin on the same day as your coverage begins. Coverage for your eligible child(ren) will also begin on the same date as your coverage.

To be eligible for plan coverage, an adult child (age 19 to age 26) must not be eligible for health coverage through his/her employment or the employment of his/her spouse.

Adding New Dependents

To add a ***newly eligible*** dependent, contact the Fund Office for an enrollment form. Your spouse and eligible stepchildren can be added for coverage on the first of the month following the date of marriage. Biological children can be added effective on the date of their birth, and legally adopted children and children placed for adoption may be added effective the date of adoption or placement for adoption. In order for a new dependent to be covered, a valid Social Security Number must be provided to the Fund Office.

NOTE: Only those eligible dependents listed on your most recent enrollment form and for whom a valid Social Security Number is provided will receive dependent coverage.

In order for a new dependent's coverage--including a newborn's coverage--to begin on the earliest date of eligibility, you must inform the Fund Office within 30 days from the date he or she first became your dependent. Otherwise, coverage will begin on the first of the month following the date the Fund Office receives the required information.

Eligible adult children that enroll (or re-enroll) will receive coverage that begins on the first of the month following the date of enrollment.

Special Note for Newborns: Newborns will be covered from the date of birth until six months of age without a Social Security Number. However, if a Social Security Number is not provided to the Fund Office by the time the child is six months old, coverage will be terminated on the first day of the month following the date the child turns six months of age.

The participant must submit evidence acceptable to the Fund Office to certify the eligibility status of each dependent. **Only eligible dependents listed on the most recent enrollment form will be entitled to dependent benefit coverage.**

Decedents

If you die, your covered dependents may continue eligibility by making self-payments to the Fund. The out-of-work member rate will apply as long as the deceased participant had at least five years vesting in the Operating Engineers Local 77 Pension Fund. Your spouse may continue to make self-payments until he or she remarries or upon his/her death. If/when the spouse becomes eligible for Medicare, he/she may continue at the Retiree Medicare rate in effect and dependents may continue coverage at the dependent rate in effect.

Qualified Medical Child Support Order ("QMCSO")

The Fund will provide dependent coverage to a child if it is required to do so under the terms of a QMCSO. The Fund will provide coverage to a child under a QMCSO even if the child does not meet restrictions

which otherwise may exist for dependent coverage. If the Fund receives a QMCSO and the participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the Fund Office, free of charge.

Coverage for Children Adopted or Placed for Adoption

The Fund will provide dependent coverage for a child who is adopted or placed for adoption with a participant regardless of whether the adoption is finalized. A child will be considered to be placed for adoption if the participant assumes a legal obligation for the total or partial support for the child in anticipation of adopting that child. The child's placement with the participant will be considered terminated when the participant no longer has a legal obligation to support the child. The participant will be required to supply evidence to the Fund that the child for whom dependent coverage is requested has actually been placed for adoption with the participant.

Coverage of Disabled Dependents

If a dependent child is incapable of self-support due to a mental or physical disability, the age limit for dependents does not apply. Coverage for disabled children beyond age 26, dependent coverage will continue if: (1) the child is unmarried; (2) the child is financially dependent on the participant for support; (3) the child was the participant's dependent before the child turned age 26; (4) the disability began before age 19; (5) the disability is certified by a physician and found by the Board of Trustees to be a qualifying disability; and, (6) the child continues to be eligible for dependent coverage under the Plan (the Fund Office may require evidence of the dependent's continuing disability).

CONTINUATION OF COVERAGE

You may be able to continue coverage under the Plan after you would lose eligibility due to your failure to work (or your employer fails to pay for) sufficient numbers of hours to meet the Plan's eligibility rules. The circumstances that may permit you to continue eligibility include the following:

A. Continuing Care Patient under the No Surprises Act
B. "COBRA" Continuation Coverage
C. Family Medical Leave Act
D. Uniform Services Employment and Re-Employment Rights Act
E. Unemployment
F. Disability
G. Retiree Coverage

The rules for continuing your coverage are set forth below.

A. CONTINUING CARE PATIENT UNDER THE NO SURPRISES ACT

Continuing Care Patients

If an in-network provider leaves the CareFirst network, a *Continuing Care Patient* who is receiving care with that provider will be notified, and may elect to continue to receive such care at the same in-network *Co-Payment* and *Co-Insurance* rate for up to 90 days after receiving the notification of termination, or earlier if the patient no longer requires continuing care or begins treatment with another provider or facility.

A *Continuing Care Patient* is an individual who is:

1. receiving a course of treatment for a *Serious and Complex Condition*;
2. scheduled to undergo non-elective surgery (including any post-operative care);

3. pregnant and undergoing a course of treatment for the pregnancy;
4. determined to be terminally ill and receiving treatment for the illness; or
5. is undergoing a course of institutional or inpatient care from the provider or facility.

B. CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that the Plan offer eligible participants and their eligible dependents the opportunity to pay for a temporary extension of health coverage at group rates in instances where coverage under the Plan would otherwise end, in accordance with the provisions of federal law.

Participant's Rights
Eligible participants who lose eligibility for either of the following reasons can continue coverage:

1) Termination of employment (except for gross misconduct)
2) Reduction in hours of employment

A participant who qualifies for COBRA continuation coverage may elect the coverage individually or for the participant's family. Each dependent also has an individual right to elect COBRA coverage following a qualifying event.

If a participant obtains health coverage, including Medicare, after he or she has elected COBRA under the Fund, COBRA coverage through the Fund may be terminated.

Spousal Rights
The dependent spouse of an eligible participant will have the right to continue coverage for himself or herself if he or she loses coverage under the Plan for any of the following reasons:

1. the death of the participant
2. termination of the participant's employment, other than for gross
3. misconduct, or reduction in the participant's hours of employment
4. divorce or legal separation from the participant, or
5. the participant becomes eligible for Medicare.

Dependent Children's Rights
The dependent child of a participant will have the right to continue coverage for him/herself if he or she loses eligibility under the Plan for any of the following reasons:

1. the death of the participant
2. termination of the participant's employment, other than for gross
3. misconduct, or reduction in the participant's hours of employment
4. divorce or legal separation of the participant
5. the participant becomes eligible for Medicare, or
6. the dependent child ceases to satisfy the Fund's eligibility rules for dependent coverage.

Coverage may be continued for any eligible dependent who is properly enrolled on the day before the qualifying event resulting in loss of eligibility (listed above). Even if the participant rejects COBRA continuation coverage, each eligible dependent has the **independent** right to elect or reject *COBRA* continuation coverage. An election on behalf of a minor dependent child can be made by the child's parent or legal guardian.

Notification Requirements

The Participating Employer must notify the Fund, in writing, within 30 days of the participant's death, termination of the participant's employment, reduction in working hours, the participant's entitlement to Medicare, or the Participating Employer's initiation of bankruptcy proceedings.

The participant or eligible dependent must inform the Fund, in writing, within 60 days of a divorce or legal separation, or a dependent child's loss of dependent status under the Fund. The participant or eligible dependent who is determined to have been disabled at the time of or within the first 60 days of continuation coverage must notify the Fund Office within 60 days of the date that the Social Security Administration determines that he or she is disabled and within 30 days of any final determination that he or she is no longer disabled.

If the participant or eligible dependent fails to notify the Fund Office within 60 days of the date that coverage would otherwise cease, the right to elect COBRA continuation coverage will be forfeited.

The Fund Office will notify the participant or eligible dependent within 14 days of receipt of notification of any of these events of the right to continue coverage. The participant or eligible dependent must elect COBRA continuation coverage within 60 days of the date that coverage would otherwise end, or if later, within 60 days from the date that the Fund Office first sent notice of the right to elect COBRA continuation coverage to the participant or eligible dependent. This election must be made in writing and returned to the Fund Office within the 60 day election period. Failure to notify the Fund on time will result in forfeiture of COBRA rights.

Length of Coverage

You must make all premiums due for COBRA continuation coverage to the Fund Office by the due date. Failure to pay the required premium by the due date will result in termination of COBRA coverage.

Coverage may continue under COBRA as follows:

1. Coverage for you and your dependent(s) may be continued for up to 18 months

2. The 18-month period of continuation coverage may be extended an additional 11 months for you and your eligible dependent(s) if, within 60 days from the date of the event described in (a) or (b) above, the Social Security Administration determines that you were disabled. The self-pay premium for the 11 month extension will be increased by about 50%. Proof of disability must be provided to the Fund within 60 days from the date the Social Security Administration makes the determination and within the initial 18-month period of continuation coverage. If, during the initial 18 month period, the Social Security Administration determines that the person is no longer disabled, the 11 month extension does not apply. If the Social Security Administration determines that the person is no longer disabled after the initial 18 month period, the period of continuation coverage ends with the first month that begins more than 30 days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed 29 months.

3. Other NON-DISABLED family members are also eligible for the 11-month extension. Newborn children, children placed for

adoption, and newly adopted children will be treated as individual qualified beneficiaries.

4. Coverage for your eligible dependent may be continued up to a maximum of 36 months, if coverage terminated due to:
    a. the participant's death
    b. the participant's divorce or legal separation; or
    c. a dependent child's ceasing to satisfy the Fund's rules for dependent status.

5. If a participant becomes entitled to Medicare, and within 18 months of becoming entitled to Medicare, he/she becomes entitled to COBRA due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the participant's dependent may be continued for up to 36 months from the date the participant became entitled to Medicare.

To get an extension of COBRA continuation coverage as described above, you must notify the Fund Office.

Termination of Coverage
Continuation coverage will terminate on the first of the following dates:

1. The date a required premium is due and is not paid on time by you;
2. The date you or your eligible dependent becomes covered by another group health plan;
3. You or your dependent becomes covered by Medicare benefits;
4. In the event of divorce, you remarry and are enrolled for coverage under your spouse's plan;
5. The Fund no longer provides group health plan coverage for similarly situated participants or dependents;
6. Your participating employer ceases to maintain the group health plan for its employees through this Fund.
7. The date the applicable period of continuation coverage is exhausted, including any disability extension; or

You or your eligible dependent must notify the Fund Office immediately if you become covered by any other plan of group health benefits. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund Office of any other health coverage.

Under COBRA, the participant or eligible dependent may continue coverage for **Medical, Drug, Vision, and Dental benefits** (you cannot continue the Life Benefit, the Accidental Dismemberment Benefit, or the Weekly Accident & Sickness Benefit). You must continue every one of those benefits for which you were eligible prior to your loss of coverage (in other words, you cannot choose to continue only optical and medical, for example, or any other combination.)

Cost
The cost that you must pay for COBRA coverage is 102% of the cost of coverage as determined annually by the Fund. The Trustees will determine the premium for the continuation coverage. If the premium changes while you are on COBRA, you will be notified by the Fund Office of the new premium.

The COBRA premium for an 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage

Payment of Premiums
You must make the initial payment either at the time of your election of continuation coverage or within 45 days of the election. **Ongoing payments are due by the first day of the month for which coverage is to be continued** (for example, if you want coverage for October, payment is due on October 1st). If you fail to make your premium payment within 30 days of the due date, COBRA coverage is terminated.

You will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments will result in termination of coverage. You are responsible for the payment of any required premium.

Important! When you elect COBRA continuation coverage, full and timely retroactive payments must be made to the date of loss of eligibility.

Claims incurred following the date of the event which resulted in the loss of eligibility, but before the eligible participant or dependent has elected continuation coverage, will be held until the election has been made and premiums have been paid in full. If the participant or eligible dependent does not make a timely election and pay the premiums, no Fund coverage will be provided. Coverage under this Plan will remain in effect only while the monthly premiums are paid fully and on time.

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp. This program is offered by the federal government and the Fund Office has no role in its administration.

Contact for Additional Information

If you have questions or wish to request additional information about COBRA coverage or the health plan, please contact the Fund Office as follows:

Operating Engineers Local No. 77
Health and Welfare Fund
Attn: COBRA Department
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
(877) 850-0977

C. CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 ("FMLA") requires participating employers with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the

employee to care for his/her own sickness or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the FMLA, your participating employer is required to maintain pre-existing coverage under the Plan during your period of leave under the FMLA just as if you were actively employed. Your coverage under the FMLA will cease once the Fund Office is notified or otherwise determines that you have terminated employment, exhausted your FMLA leave entitlement, or do not intend to return from leave. Your coverage will also cease if your participating employer fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect to continue your coverage under the COBRA continuation rules, as described in the previous section. The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

If you fail to return to covered employment following your leave, your participating employer shall have the right to recover and/or withhold from you the value of the contributions it paid to maintain your health coverage during the period of FMLS leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the FMLA. In addition, if you fail to return from FMLA for impermissible reasons, the Fund may offset payment of benefits, other than medical claims, payable under this Plan against the value of the costs paid to maintain your health coverage during the period of FMLA leave.

Military Family Leave under the FMLA

An eligible employee with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use his/her 12 week leave

entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits an eligible employee who is the spouse, son, daughter, parent or next of kin of a covered service member to take up to a combined total of 26 weeks of leave to care for a covered service member. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious illness or injury incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list. This military caregiver leave is available during a single 12 month period during which an eligible employee is entitled up to a combined total of 26 weeks for all types of FMLA leave.

D. CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 ("USERRA")

As required under the Uniformed Services Employment and Re-Employment Rights Act ("USERRA") the Fund provides you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence from employment begins due to military service, including Reserve and National Guard Duty, as described below. Contact the Fund Office for more information if this may apply to you.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent(s) under the provisions of USERRA. The period of coverage for you and your eligible dependent ends on the earlier of:

1. the end of the 24-month period beginning on the date on which your absence begins; or
2. the day after the date on which you are required but fail to apply under USERRA for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

Cost

After 31 days, you must pay the cost of coverage unless your participating employer elects to pay for your coverage pursuant to the Plan provision described below or your participating employer elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of USERRA by the same method the Fund uses to determine the cost of COBRA continuation coverage.

If your military service is considered an approved Leave of Absence, your participating employer must pay the cost of the coverage for the first 12 months that you are eligible for coverage. After the first 12 months, you must begin paying for the cost of your coverage.

You must notify your participating employer or the Fund Office that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact the Fund Office and elect continuation coverage for yourself or your eligible dependent(s) under the provisions of USERRA within 60 days from the date your military service begins. Payment of the USERRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of the election of your USERRA coverage. If your participating employer is obligated to pay but does not, or ceases making voluntary payment for the cost of the coverage, the Fund Office may require you to pay the required premiums.

Ongoing payments must be made by the last day of the month for which coverage is to be provided. You will not be billed; it is your responsibility to send payments to the Fund Office. Late payments can result in termination of coverage. You are responsible for payment of the required premiums.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under USERRA.

Death Benefits under USERRA
If you elect USERRA continuation coverage under the provisions of this Plan, your death benefit will not be continued for the duration of your USERRA continuation coverage.

Reinstatement after Discharge
If you become employed by a contributing employer based upon an application for employment made in accordance with the timelines established under USERRA, you and your eligible dependents will continue to be fully eligible subject to the regular eligibility rules set forth in this booklet. In the event you are not employed by a contributing employer based upon an application for employment made in accordance with the timelines established under USERRA, your eligibility will be terminated and will be reinstated only upon your completion of the normal eligibility requirements.

The timelines established under USERRA are:

- Service of 1 to 30 days: You must report to work by the first regularly scheduled work period on the first full calendar day that falls eight (8) hours after the completion of military duty leave.

- Service of 31 to 180 days: You must submit an application for reemployment no later than fourteen (14) days after the completion of service.
- Service of 181 days or more: You must submit an application for reemployment not later than ninety (90) days after the completion of service.

Weekly Accident and Sickness Benefits. If you become employed by a contributing employer based upon an application for employment made in accordance with the timelines established under USERRA (see above) you will be reinstated for Weekly Accident and Sickness benefits immediately upon return to work.

E. SELF-PAYMENTS

If you are eligible for benefits, but will lose eligibility because you are unemployed, because your employer is not paying contributions for your hours worked, or because you are disabled, the Fund will allow you to maintain your eligibility for a certain period of time by making self-payments to the Fund. The Fund offers this Self-Payment method as an alternative to COBRA or USERRA. Once you elect self-payment instead of COBRA, you will have waived COBRA continuation coverage and cannot thereafter elect it.

In order to be eligible to self-pay, the following requirements apply:

1. You must be eligible for benefits at the time you become unemployed or at the time your employer became delinquent with respect to contributions to the Fund for your hours worked.
2. You must file an application to Self-Pay with the Fund Office no later than one month following the month in which you lost eligibility.
3. You must pay the monthly amount established by the Board of Trustees for Self-Payment starting with the first day of the calendar month in which you would lose eligibility.

4. Unless you qualify for a disability self-payment, you must remain available for immediate employment in the jurisdiction of Local Union No. 77 during the entire time you are making Self-Payments. If you are not available for covered employment, or if you decline covered employment, you will not be eligible for Self-Payment. (See the Section of this Booklet regarding COBRA coverage for information on continuation coverage during periods when you are not employed and not eligible for covered employment).

Timely Payments

The Fund Office must receive payments prior to the first day of the month for the month in which you desire coverage. **Failure to make timely payments will result in loss of coverage at the end of the last month for which payment was received. Your initial payment may not be made retroactively in excess of thirty days. Payments may be made quarterly or monthly, in advance.**

Self-Payment Reimbursement

If you make self-payments to maintain your eligibility because your employer is not making contributions on your behalf, and your employer then makes those contributions, your self-payments will be refunded.

Self-Pay Reporting Form

The Fund Office will send you a self-payment and reporting form. This form must be completed for each month that a self-payment is made. The Business Agent must sign the form certifying that employment was not available or that a delinquency occurred.

You may make Self-Payments for a maximum of 18 months. After 18 months, you must return to active employment. The Board of Trustees reserves the right to determine if you are eligible for benefits including additional periods of self-payment.

Eligibility While Disabled

If you are disabled and unable to work, you will receive a credit of eight hours for each day you are disabled to a maximum of 40 hours in any one week. The Fund requires a statement of disability from your physician. The maximum credit for periods of disability is twelve months for any one disability. After the 12-month period, you may be eligible to continue your eligibility by making Self-Payments for up to 18 months, for a total of 30 months of extended disability coverage. See the Self-Payment section on page 40 for more information.

Multiple concurrent disabilities may not be added to extend the twelve-month limitation. Non-concurrent disabilities caused by or resulting from the same injury, accident, disease or illness are not covered for an additional twelve month period of eligibility.

Non-concurrent disabilities wholly unrelated to a prior disability are covered for an additional twelve-month period as long as there is a period of fourteen (14) days between the end of one period of disability and the beginning of the next period of disability.

SELF PAYMENTS
MONTHLY CO-PAY RATES

Monthly rates are subject to change at the discretion of the Board of Trustees. Contact the Fund Office at 1-877-850-0977 to determine the current rates.

Category	Monthly Rate
Out of Work Participants and for Participants Who Are Eligible for Self-Payment -- Rate includes both Participant and Eligible Dependents	$350

Limitation on Coordination of Self-Payment and COBRA Coverage
Because the Fund offers Self-Payment as an alternative to COBRA coverage, there are certain limitations, in addition to the ones listed in this section, which apply to situations in which COBRA rights are available.

1. A participant cannot combine COBRA and Self-Payment. Therefore, when you begin Self-Payments, you must sign a form which includes a provision which notifies you that you are partially waiving your right to COBRA coverage.

2. If you are not available for work, then you cannot make Self-Payments and you are therefore only eligible for COBRA coverage.

The maximum period of Self-Payment and COBRA coverage, combined, is 18 months, or 30 months if a disability is involved.

Return to Work after a Period of Self-Payment
When you leave work for a period of Self-Payment, you will be credited with the number of hours you have in your "bank" on the date you stopped working. During the period of Self-Payment, your employer-paid hours will be frozen in your "bank" while you make Self-Payments. When you return to work, you will be credited for all hours service in your previous 12 months (starting on the date you stopped working to go on Self-Pay), just as if you had never left employment. You will not be credited for hours in your "bank" for Self-Paid hours. When you return, you must continue to Self-Pay until you have earned 400 employer-paid hours in the last 3 months, or 1200 hours in the last 12 months.

F. RETIREE COVERAGE

In order to be eligible for Retiree Health and Welfare coverage, you must meet the following conditions:

1. You must be covered by the Plan (including COBRA and self-pay) at the time you apply for retiree health coverage; and,
2. You must be eligible for a full pension under the Operating Engineers Local No. 77 Pension Plan or the Central Pension Fund; and,
3. You must have been covered by this Plan (including COBRA or self-pay) for a minimum of five consecutive years immediately prior to retirement (including retirement due to disability), or meet the special rules noted below.

You are **not** entitled to coverage if:

1. You are not a Participant in the Plan at the time you apply for retiree coverage; or,
2. You are not entitled to a full pension from the Local No. 77 Pension Plan or the Central Pension Fund; or,
3. You have not been covered by the Plan for five full consecutive years prior to retirement (including retirement due to disability), unless the special rules below apply.

Special Eligibility Rules for a Retiree Who Does Not Have Five (5) Consecutive Years of Eligibility Immediately Prior to Retirement
If you were not covered by the Plan for any period during the five consecutive years immediately prior to retirement, in order to be eligible for retiree Health and Welfare benefits, you have to meet all of the following requirements:

1. You must be covered by this Plan (including COBRA and self-pay) at the time you apply for retiree health coverage; and,
2. You must be eligible for a full pension under the Operating Engineers Local No. 77 Plan or the Central Pension Fund; and,
3. You must have returned to employment and regained eligibility for health benefits during the nine consecutive years immediately prior to retirement, and you must:

a. be 100% vested in the Local No. 77 Pension Plan or Central Pension Fund prior to regaining your eligibility for health coverage at any time during the nine consecutive years prior to retirement; and,

b. have five cumulative years of health coverage under this Plan at any time during the nine consecutive years prior to retirement; and,

c. have been covered by this Plan for a period immediately prior to retirement which is equal to or greater than the last period that you were not an eligible participant in this Plan during the nine consecutive year period immediately prior to retirement.

Example: Joe works in covered employment for five years and becomes 100% vested in the Local No. 77 Pension Plan, then goes to work for a non-union employer for ten years, then returns to union employment and becomes eligible for health benefits. If he wants to retire three years after his return, he cannot get retiree health coverage because he has not been covered by the Plan for five of his last nine years leading up to retirement. Joe would have to work for five years at which point he would be eligible for retiree coverage as long as he was eligible to receive his pension and was covered by the Plan for those five years.

If Joe returns and works three years, then takes three years off, then wants to work two more years before retiring, he will not be eligible for retiree health benefits. This is so because even though he has five years of health coverage in his last nine years, he also has a three-year gap in that nine year period, after which he only worked two years prior to retirement. His last period of work — two years — wasn't as long as his most recent gap — three years. If Joe has a three-year gap, then he has to work for as long as his most recent gap right before retirement; in other words, Joe has to work and have health coverage for three years before he is

eligible. Note, however, that these "gaps" are not cumulative during the last nine years, and no "gap" can exceed five consecutive years.

Procedure for Starting and Maintaining Retiree Health Coverage
Each retiree must make a self-payment in advance in order to receive coverage. If timely payment is not received in advance by the first day of each calendar quarter (January 1, April 1, July 1, and October 1), then you will no longer have coverage.

1. Get and fill out the forms prior to retirement. Prior to retirement, contact the Fund Office to determine if you may be eligible for retiree health coverage. The Fund Office will provide the necessary forms for you to fill out.

2. Find out the amount of the premium. If it is determined that you are eligible, contact the Fund Office to confirm the amount of your monthly premium.

3. Pay the premium immediately after you lose eligibility under the health plan. Do not wait until you are formally retired. Self-payment must begin immediately upon satisfaction of retirement requirements.

4. If you draw a pension from the Operating Engineers Pension Plan, tell the Fund Office in advance that you would like your monthly payment deducted from your pension check. If you are receiving pension benefits from the Operating Engineers Local No. 77 Pension Fund and you wish to receive or continue health and welfare benefits as a retiree, your payment for health and welfare benefits must be made monthly. The monthly payment may be made by having the appropriate amount deducted from your pension check.

5. If you do not draw a pension from the Operating Engineers Pension Plan, then you must make self-payments quarterly by

January 1, April 1, July 1, and October 1 of each year. If you are not receiving a pension benefit from the Operating Engineers Local No. 77 Pension Fund and you wish to receive or continue Health and Welfare benefits as a retiree, your payment for Health and Welfare benefits must be made monthly. Payments must be received by the Fund Office no later than the first of the month for which coverage is desired.

Failure to make payment in timely fashion will result in loss of benefits. Benefits will NOT be reinstated except under the special circumstances listed below.

One Time Reinstatement of Retiree Coverage

A retiree may make a one-time election to suspend coverage because the retiree is covered under the terms of another plan, but only if the following conditions are met. If you drop Fund retiree health and welfare coverage because you have health coverage through another group plan (perhaps another job or under a spouse's plan), you MAY be able to reinstate it—**one time only**—if you meet the following qualifications:

a. Fill out an election form provided by the Fund Office and include proof of the other insurance in the 60-day period **before** you terminate coverage through the Fund.
b. When you wish to reinstate your Fund retiree coverage, you must fill out a "Reinstatement of Eligibility" form ***within 30 days after the other coverage ends*** and provide proof that the other coverage has terminated.
c. Pay the monthly premium to the Fund Office.

Points to Remember

This one-time reinstatement option is not available to you if your Fund retiree health and welfare coverage lapsed due to lack of payment, even if you provide proof that you were covered under another plan. If you do not resume Fund retiree coverage within 30 days from the time the other coverage terminates, you may not reinstate Fund

retiree health and welfare. **This option is available one time only for any retiree.** The Trustees reserve the right to investigate whether the retiree has complied with these terms before allowing the retiree to reinstate coverage. The retiree will be eligible for the same level of dependent coverage as is available to other retirees of the Plan.

Enroll in Medicare if you are Eligible. Regardless of whether a participant enrolls in the Medicare program, the Health and Welfare Fund will not pay any benefits that are available under the Medicare Program. Any pensioner receiving an Occupational Disability Pension from the Operating Engineers Local 77 Pension Fund who is later awarded a Disability Award from the Social Security Administration must enroll in the Medicare Program when he/she is eligible to do so.

Limitations on Retiree Health Benefits

If you (and any eligible dependents) choose retiree Health and Welfare coverage, the benefits provided by the Plan through the Medicare Advantage Program will be provided when you retire. When you choose retiree Health and Welfare coverage:

1. Weekly Accident & Sickness benefits are not provided to retirees;
2. No expense will be paid that is available under Medicare whether or not you and/or your spouse elected to enroll in Medicare.

Remember, once you and your spouse both reach age 65, and become Medicare-eligible, your monthly premium will decrease to the level shown in the Schedule of Benefits.

Cost for Retiree Coverage

The cost for retiree coverage varies depending on when you retired, whether you (or your dependents) are eligible for Medicare, and on the number of dependents you cover. See the Schedule of Benefits for the rate which applies to you.

When you retire, if you are eligible for Retiree Health and Welfare, the Fund Office will send you a letter giving you the rates.

Rates for Spouses and Dependents upon Death of Retiree
Upon the death of a retired participant who is making payment and eligible for retiree benefits, the surviving spouse and eligible dependents may remain eligible for benefits by continuing to make payments at the Member's rate prior to death until the surviving spouse dies or remarries.

CO-PAY RATES FOR RETIREES EFFECTIVE JANUARY 1, 2024	
Retiree Under Age 65 Not Medicare-Eligible (Single)	$550
Retiree and Spouse Not Medicare-Eligible	$650
Additional $100 per month for each covered child	
Retiree on Medicare (Single)	$100
Retiree and Spouse on Medicare	$200
Additional $100 per month for each covered child	
Medicare-Covered but Not Retired (Single) or Medicare-Eligible Retiree (Single)	$125
Medicare-Covered and Spouse or Medicare Eligible and Spouse	$250
Additional $100 per month for each covered child	

IMPORTANT NOTE REGARDING PREMIUM RATE CHANGES AND THE AVAILABILITY OF BENEFITS

The monthly premiums stated above are subject to change. Retiree Health and Welfare benefits are not guaranteed and are subject to change. The Trustees reserve the right to modify or eliminate Retiree Health and Welfare benefits entirely should future circumstances warrant such action. At all times, the Trustees of the Fund have discretion to determine eligibility for benefits and to interpret the terms of the Trust Agreement, and the Plan of Benefits, also known as the Summary Plan Description.

COORDINATION OF BENEFITS

General Information

Coordination of Benefits applies when a participant or dependent is entitled to benefits under any other kind of group health coverage in addition to the Fund. When duplicate coverage exists, the "primary" plan typically pays benefits according to its Schedule of Benefits and the "secondary" plan pays a reduced amount. **The Fund will never pay, either as primary or secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed the *Allowable Charge* or *Qualifying Payment Amount*.** This provision applies whether or not a claim is filed under Medicare or any other group plan. The Fund is authorized to obtain information about benefits and services available from Medicare or other plans in order to implement this rule.

1. The plan which covers you as an employee provides your "primary" coverage; plans which cover you as a dependent provide "secondary" coverage. The primary plan normally pays benefits to the full extent set forth in its Schedule of Benefits, and the other plan pays a reduced amount for eligible remaining balances.

2. Coordination of benefits saves the Fund money by making sure other plans pay benefits when they are available.

Benefit Coordination

If a person is covered by two or more group plans, the order in which benefits are paid is determined as follows:

1. The plan which covers the person as an employee pays before the plan which covers the person as a dependent.

2. If you are covered under two group plans, the plan which has covered you the longest pays first. There are two exceptions to this rule: (1) a group policy that covers a person for reasons

other than being laid off or retired will determine the benefits that are paid first and (2) a group policy that covers a person as a laid-off or retired employee will determine the benefits that are paid second.

Benefits are coordinated between plans based on these rules. You may not "choose" which plan to use as primary.

Coordination of Benefits for Children

1. If your child is covered under two plans (both you and your spouse's plan, for example), the plan covering the parent whose birthday falls earlier in the year pays first (except children of legally separated or divorced parents--see following section). This is known as the "birthday rule."
2. If neither plan follows the birthday rule, then the father's plan will be the primary plan.
3. When a determination cannot be made, the plan that has covered the patient for a longer period of time will be the primary plan.

Coordination of Benefits for Children Covered under Two Plans—Separated or Divorced Parents

If a court determines financial responsibility for a child's health care expenses, the plan of the parent with that responsibility will pay first ("primary"). If such determination has NOT been made or if the responsibility is divided equally, benefits are paid in the following order:

1. The plan of the natural parent with legal custody pays first;
2. the plan of the step-parent (if any) who is married to the custodial parent pays second;
3. the plan of the natural parent who does **not** have legal custody pays third;
4. the plan of the step-parent (if any) who is married to the **non-custodial** parent pays last.

You Must Follow Rules of Primary Plan
If you or your dependent has primary coverage elsewhere, you must follow the rules of the other carrier in order for this Plan to pay as secondary. For example:

1. You must use a participating or specified provider if the rules of the other plan require it for balances to be considered under this Plan;
2. You must file your claim with the other carrier on time;
3. You must respond to requests for information from the other carrier on time; and,
4. You must comply with all other requirements for coverage or eligibility established by the other carrier.

This Fund will not make payment for services that would have been paid by the other Plan had you followed the other Plan's rules.

Military Personnel
Participants who are retired from active military service are entitled to benefits from this Plan for themselves and their eligible dependents even though they may be provided benefits under the CHAMPUS Program. Participants married to active duty military personnel are entitled to benefits from this Plan for themselves and any eligible dependents not in active military service. Notwithstanding the foregoing, benefits will be provided to participants and eligible dependents as required under federal law.

Coordination of Benefits with Medicare
If you are a **retired** participant eligible for benefits under Medicare as well as the Fund, Medicare is primary. This means Medicare pays first. The Fund will process balances remaining after Medicare has paid its portion. If you are an **actively working** participant eligible for Medicare, the Fund is primary. If you do not file with Medicare and submit your claim to the Fund Office, the Fund Office will process the balances which *would have remained* if Medicare had processed your claim as primary.

The deductible does not apply when the Fund is paying secondary to Medicare, however any co-payments or Plan limits do apply. Medicare premiums are not reimbursed under this Plan.

Medicaid and Medicaid Reimbursements

The Plan complies with the requirements of ERISA §609(b) regarding participants and beneficiaries eligible for Medicaid. The Plan shall not reduce or deny benefits for any participant or dependent to reflect the fact that such an individual is eligible to receive medical assistance under a state Medicaid plan. Under state and federal law, should a participant or dependent covered under the Plan be entitled to payment of a claim under the Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the participant or dependent's right to payment under the Plan to the extent of the amount paid by Medicaid, and reimbursement under the Plan will be made in that amount directly to the state.

RECIPROCITY

A Reciprocity Agreement is an agreement between Local No. 77 and another local outside this area. The agreement applies when you work outside the Local No. 77 area and it requires the other local to transfer contributions made on your behalf for Health and Welfare coverage to this Plan so you can maintain coverage here. The Trustees of the Operating Engineers Trust Fund have entered into reciprocity agreements with the Trustees of other Welfare Funds to assure your continuing eligibility in the event Local 77 is your Home Local. Check with the Fund Office to determine with whom the Fund has local reciprocity agreements.

You must notify the Fund Office if you are working outside Local 77's jurisdiction. Contact the Fund Office for the proper form.

In the event you are temporarily employed in any of these areas, please promptly notify the Fund Office in writing, advising:

1. The Local where you are working;
2. Starting date; and
3. On termination, notify the date of termination.

The Fund Office will correspond with these Locals and attempt to obtain your hours employed and the contribution, and upon receipt of the contributions paid on your behalf in these areas, the hours of employment will be credited to your record in this Fund as if you were employed here.

When you are working in another local jurisdiction, the contributions on your behalf are not transferred back to this Fund on a monthly basis. They are usually paid quarterly and sometimes semi-annually. As a result of this arrangement, your eligibility status with this Fund may not be current. If you find yourself in this situation, please notify the Fund Office. We will do everything possible to help bring your eligibility status to a current standing.

RECOVERY FOR THIRD PARTY LIABILITY (SUBROGATION)

The Plan does not cover injuries arising as a result of the fault of a third-party, or for which damages or medical expenses are the obligation of a third party. The Fund will advance benefit payments that are otherwise covered by the Plan, subject to the repayment obligations set forth in this section.

Purpose of Third Party Liability Provisions

In some instances, you may be injured on the job or in a car accident or other accident. When injuries and/or death occurs in those situations, an employer's worker's compensation carrier, your own or someone else's car insurance company, may be responsible for paying your medical bills as well as your weekly accident and sickness expenses. Under those circumstances, the Fund is not responsible for paying your medical bills and accident and sickness expenses because some other person is at fault or some other company is responsible for paying your bills.

Waiting for some other insurance company to pay for your injuries can be difficult, particularly in situations where your doctor or hospital requires pre-authorization of payment. Recovery may take a long time. This Fund is not responsible for paying your bills in these circumstances, but the Board of Trustees recognizes the problem and has developed a program to try and resolve this problem. The program is called Third Party Liability Recovery. This program provides you limited coverage which would otherwise be unavailable and saves the Fund money by making sure that the responsible party pays for your injuries.

How Third Party Liability Recovery Works

The Third Party Liability provisions of the Plan entitle the Fund to collect any money it advances to pay your benefits directly from any third party or insurance carrier, including uninsured motorist policies, which owes or provides you money. In exchange for your written promise to pay the Fund back in full from any recovery you receive,

the Fund will advance you benefits for medically necessary treatment which the Fund would otherwise not cover. In effect, the Fund "advances" benefits to you and acceptance of these benefits by the participant, dependent or provider constitutes their agreement to repay the Plan in the event a recovery is made from any other person or party.

To ensure that people repay the advance to the Fund, the Fund takes a lien on your right of recovery from any third party. The Fund shall be entitled to recover its lien directly from any third party, regardless of the reason for the recovery and regardless of whether your recovery from a third party is through a separate insurance policy unrelated to medical expenses and weekly accident and sickness expenses, including an uninsured motorist policy. You shall be required to repay, and the Fund will be entitled to that payment, for a recovery from any third party or entity who pays you for any reason, even if the basis for the Third Party Recovery is characterized as being a recovery for damages other than medical expenses.

Please note that the Fund requires a written promise that you will repay the entire amount advanced by the Fund regardless of why, where or from whom you receive money. The Fund has no obligation to share in the legal costs and fees of obtaining a third-party recovery in a common Fund. Also, the Fund's right of recovery matures without regard to whether you are made whole economically for injuries you sustain. Thus, the Fund can regain, by legal action if necessary, benefits paid by it to the participant or that person's insurance company or plan from the participant or parties responsible for the injury.

What You Need to Do

Under the Plan's third party liability provisions, a participant must fulfill the following obligations in order to be entitled to receive the advance which is provided under this Section.

1. You must sign the Application for Payment of Subrogated Benefits and Repayment Agreement, provided by the Fund. However, even if a participant or dependent has not signed the Repayment Agreement, he/she will still be responsible to repay the Plan in the event of a recovery.

2. You must file a claim with the Fund Office on time.

3. You must cooperate with Plan representatives as may be necessary or appropriate to recover from any third party, which includes any recovery you may obtain from uninsured motorist coverage and recovery from any person, firm, corporation or other entity as relating to your illness or injury, as damages, those payments made by the Plan.

4. You must immediately reimburse the Plan for any expenses paid by the Fund with money recovered from a Third Party.

5. You must not do anything to impair, prejudice or discharge the Plan's right to subrogation, or obtain recovery of the amounts advanced.

6. You must assign to the Plan the right to bring an action against any third party responsible for the injuries sustained if you fail to bring such action. Recovered payment will be credited against any yearly or lifetime limits on a participant's benefits.

The Plan can withhold future benefits to a Participant for failure to comply with these rules.

Failure to Comply with Third Party Liability Procedures

If you fail to comply with the terms of these Third Party Liability Recovery procedures or if you fail to comply with the Application for Payment of Subrogated Benefits and Repayment Agreement, the Plan may recover the full amount of the benefits advanced from you through institution of a legal action, and the Fund will be entitled to

recover its legal expenses and fees for doing so. Furthermore, the Plan can withhold future benefits to a participant for failure to comply with these rules. If any participant or dependent has any questions or if you are asked to waive any rights covering any conditions for which you have received or expect to receive payment from the Plan, contact the Fund Office as soon as possible.

Express Limitations

This Plan conclusively disavows and overrides the judicially created "make whole" doctrine. This Plan's right to recovery matures without regard to whether the injured party is made whole economically for his or her injuries. The Plan's right of subrogation shall apply regardless of whether the member is made whole. This Plan also conclusively disavows and overrides the judicially created "common fund" doctrine. This Plan has no obligation to share in the legal costs and fees incurred by a member or dependent in securing a third-party recovery.

Expenses Not Covered – Workers' Compensation

This Plan does not provide benefits if the medical expenses are covered by workers' compensation or occupational disease law. Since the resources of the Plan are limited, no benefits are payable with respect to any treatment, service or supply not specifically provided for in the Plan or for any expense, charge, or fee incurred in connection with any of the following:

(1) any injury or illness resulting from or arising out of any employment or occupation for compensation or profit; or

(2) any injury or illness for which benefits are payable under any workers' compensation law, occupational disease law or similar legislation.

In the event the Plan pays any expenses or charges described under this section, it is entitled to recover those payments from any third party liable for such charges or from the participant.

CAREFIRST PPO

Call CareFirst at 800-235-5160 or visit www.carefirst.com to Find a Physician or Medical Facility

The Trustees have contracted with CareFirst, (Blue Cross/Blue Shield) -- a network of hospitals, physicians, and other health care providers which offer medical and hospital services at reduced rates. As long as the Fund is your primary coverage, when you use a CareFirst preferred doctor or hospital for your medical benefits, you'll get lower out-of-pocket expenses, and the Fund's costs will also be reduced. Although using CareFirst providers is not "required," you will receive the best discounts by using a CareFirst provider. When the amount of the bill is less, it means balances remaining which are your responsibility are also less. CareFirst saves both you and the Fund money.

CareFirst discounts claims when you use a participating provider, but **CareFirst is not your insurance!** Your coverage is provided through the Fund.

Finding a CareFirst Provider

Call CareFirst at (800) 235-5160 to find a participating provider. You may also go online at **www.carefirst.com**. If you call CareFirst, be sure to identify yourself as a Local 77 participant. Be sure the provider still participates with CareFirst at the time of your appointment, since information changes frequently.

At your appointment, show your Fund ID card and tell the doctor or hospital you participate with CareFirst. Tell the doctor's Office personnel to **write your group number on the bill.** This number tells CareFirst exactly who you are and where to send your claim after they have discounted it.

You or your medical provider should send the claim to CareFirst at:

CareFirst/Network Leasing
P.O. Box 981633
El Paso, TX 79998-1633

CareFirst will discount the claim and forward it to the Fund Office for processing. **If you do not use a CareFirst provider**, send your claim directly to the Fund Office for processing at:

Operating Engineers Local No. 77
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Claims must be received by the Fund Office within one year from the date of service in order to be paid. Remember, you must certify your inpatient hospital stays and elective procedures with Conifer Health Solutions at (844) 739-8913.

Medicare Primary Participants

If your primary coverage is through Medicare, your claim will be sent to and processed by Medicare. Ask your provider to also send the claim to the Fund Office. The Plan may provider secondary benefits after the payment by Medicare. If Medicare is secondary, send your claim to Medicare after the Plan has paid its benefits, as you may be entitled to secondary Medicare benefits.

Participants whose primary coverage is Medicare are not eligible for CareFirst discounts because Medicare benefits are priced at Medicare's schedule. Your benefits do not change when you use CareFirst providers. What is excluded under your Plan coverage continues to be excluded even if a CareFirst provider, such as a cosmetic surgeon, provides that service.

A CareFirst provider should **not** require payment at the time of service. If the provider attempts to collect payment at the time of your visit, remind the provider that payment will be made by the Fund after CareFirst discounts the billing.

CONIFER HEALTH SOLUTIONS
UTILIZATION MANAGEMENT (CERTIFICATION OF CARE SERVICE)

Conifer Health Solutions ("Conifer") is a cost containment program designed to control costs by reducing unnecessary hospital admissions and certifying the length of certain treatments. Conifer reviews admissions and treatments to determine medical necessity and to find treatments in alternative settings if appropriate.

For example, suppose your physician recommends a procedure for you on an inpatient basis. Conifer may find that the procedure is regularly performed on an outpatient basis. They would review your records to determine if outpatient treatment is an option for you.

You must contact Conifer Health Solutions at (844) 739-8913 to certify all inpatient hospital admissions (and within 24 hours of an emergency admission). This number is also shown on the front of your Fund ID card.

Other Treatments That Must Be Certified with Conifer Health Solutions:

The following procedures/treatments must be certified by Conifer in order to be covered.

1. sub-acute care;
2. outpatient surgery;
3. surgery performed at a hospital on an outpatient basis;
4. inpatient rehabilitation;
5. physical therapy (for more than 8 visits)
6. skilled nursing facilities

7. home health care
8. chiropractic care (for more than 8 visits)

Medical Necessity
In order for claims to be paid under this Plan, all medical care must be medically necessary. The Plan has the right to require that you receive a second opinion by another physician chosen by Conifer Health Solutions to determine the medical necessity of the proposed care.

Certifying Care -- Emergency Admissions
If you or your eligible dependent are admitted to the hospital for *Emergency Services* or due to a *Emergency Medical Condition*, you (or a family member), the hospital, or your physician should contact Conifer Health Solutions after your admission. The Fund will only cover treatment in an emergency or urgent care setting that is medically necessary, as consistent with applicable law. Emergency Room visits do not require certification, and *Emergency Services* do not require prior authorization.

Certifying Care -- Surgical/Non-emergency Inpatient Admissions (Scheduled Hospital Stays).
If you, your spouse or your children are scheduled for a hospital stay, call Conifer at (844) 739-8913 ten (10) days before your stay before your stay to get pre-authorization. If you are calling after hours, leave a message on the answering machine.

Conifer will send you an approval letter for a certain number of days. Bring this letter with you when you are admitted to the hospital.

If your medical condition warrants an extension of your hospital stay, Conifer will authorize it. Authorization is not required for purposes of post-stabilization treatment in connection with *No Surprises Services.*

You MUST contact Conifer prior to any non-emergency admission! If you don't the Fund will not pay for your care, except as otherwise necessary with applicable law. Conifer verifies the medical necessity

and authorizes the length of your hospital stay. However, **Conifer does not certify that you are eligible for benefits or that a given procedure or hospital stay is covered under the Plan. A procedure excluded under the Plan will be excluded from coverage regardless of Conifer's determination of medical necessity.** If you are not sure if a proposed procedure will be covered, please contact the Fund Office.

Concurrent Care

Conifer will also monitor your stay while in the hospital to assure appropriate length of confinement. Conifer acts in its position as adviser to the Fund to recommend the number of days of your hospital stay the Fund should pay under your Schedule of Benefits. If your medical condition requires an extension of your hospital stay, Conifer will authorize it, except that authorization is not required for post-stabilization treatment in connection with *No Surprises Services.*

Conifer Appeal Procedures

If the appropriate length of hospitalization determined by Conifer is different from the time recommended by your physician or if Conifer denies your hospital admission, either you, your physician, or the hospital may submit an appeal.

Standard Appeals

All appeals must be made within 30 days from the date you are notified of Conifer's decision. Appeals must be in writing, and should include all relevant medical information or records. If your appeal does not include the necessary medical information and/or records, Conifer will request that you sign a record release so that they may obtain the information necessary to make a decision.

The appeal will be reviewed by the Medical Director at Conifer and, in cases where the Medical Director is unable to make a decision, a board-certified physician reviewer in the same specialty as your attending physician will render a decision. Notification of Conifer's decision will be sent to you, your physician, and the hospital within 45 days following the receipt of your appeal and all necessary documentation. The clinical

basis for a denial of your appeal will be made available to your attending physician upon his/her request. Write to:

Conifer Health Solutions
Attn: Appeals
1596 Whitehall Road
Annapolis, MD 21409

Expedited Appeals

If you are receiving acute services, your physician may appeal Conifer's decisions on an expedited basis by calling Conifer's Utilization Review Department. A board-certified physician in the same specialty as the attending physician will review the appeal. He/she will be made available to the attending physician by phone and by fax to facilitate the appeal process. Your physician will be notified of the decision by telephone within 24 hours. Written verification will be sent to the physician, hospital, patient and the Fund within one business day of the decision. If your attending physician disagrees with the outcome of an expedited appeal, he/she may initiate a standard appeal within 30 days from the date of Conifer's **original** decision.

DEATH BENEFIT

The Death Benefit is payable to a beneficiary in the event of your death. It is only payable if you are eligible for health coverage at the time of your death.

The Death Benefit will be paid in a lump sum to any beneficiary you designate. Contact the Fund Office to request a beneficiary designation form which you will complete and return to the Fund Office. You may change your beneficiary at any time by completing a new beneficiary form with the Fund Office. **No designation or change is effective until received by the Fund Office.**

Order of Payment

If your designated beneficiary dies before you, that beneficiary's right to the death benefit terminates. If there is no beneficiary designation on file with the Fund Office, or if your designated beneficiary dies before you, your death benefit will be paid in the following order, if living:

1. Legal Spouse;
2. Children (Equal Shares);
3. Parents (Equal Shares);
4. Brothers and Sisters (Equal Shares); or
5. Your Estate.

The Death Benefit terminates upon your termination of eligibility.

Exclusions

The Fund will not pay the Death Benefit if your death is caused, directly or indirectly, by criminal activity, occurs during the course of criminal activity or results from criminal activity or as a result of suicide or an attempted suicide.

Claims Procedure

Your beneficiary must file a written claim with the Fund Office within one year from the date of your death in order to receive the Death Benefit. Claims filed more than one year from the date of death will not be paid. The Fund Office must be provided with:

a. a certified copy of the death certificate;
b. if the estate is the beneficiary, certified letters of administration or comparable state document designating the party as executor of the estate;
c. proof of identity requested by the Fund Office;
d. completed and signed copies of the claim form provided by the Fund Office; and
e. any other documentation requested by the Fund Office.

Special Limitation for Participants Disabled by ULICO

Participants who were approved as permanently and totally disabled by ULICO, a prior disability insurance carrier, for an accident or illness that occurred prior to April 1, 1974 will receive the death benefit which was in effect at the time the accident or illness occurred.

ACCIDENTAL DISMEMBERMENT BENEFIT

The Accidental Dismemberment Benefit provides benefits for the accidental loss of limbs and sight while you are eligible.

You must be eligible for health coverage at the time of your loss. The full amount shown in the Schedule of Benefits will be paid for the accidental loss of:

1. Both hands;
2. Both feet;
3. One hand and one foot;
4. Sight of both eyes;

One-half the amount shown in the Schedule of Benefits will be paid for the accidental loss of one hand, one foot, or the sight of one eye.

Payments will be made directly to you, if living; otherwise, to your beneficiary.

Claims Procedure
You must file a written claim with the Fund Office within one year from the date of the injury which caused the dismemberment occurred. Benefits will not be paid for claims filed more than one year from the date of death or more than one year from the date of the injury which caused the dismemberment.

You must provide copies of medical or investigative reports establishing, in the opinion of the Board of Trustees, that:

1. the dismemberment occurred;
2. the dismemberment was accidental;
3. the dismemberment was the result of the accidental injury
4. The Fund Office must receive a completed and signed copy of its claim form; and
5. any other documentation requested by the Fund Office.

Exclusions/Limitations
This benefit does not cover injuries caused by acts of war, injuries occurring during the course of criminal activity, injuries caused by suicide of attempted suicide, or any loss that occurs more than 90 days after the date of the accident.

WEEKLY ACCIDENT AND SICKNESS BENEFITS

If you are disabled due to a non-occupational accident or illness and unable to work, the Fund will pay you the Weekly Accident & Sickness benefits as shown in the Schedule of Benefits. The benefits are paid weekly and will include payments for a portion of a week.

In order to receive Weekly Accident and Sickness pay, the following conditions must be met:

1. The disability must be a result of a non-occupational accident or disease for which benefits are not payable under the Workers' Compensation law; and
2. The disability begins
   a. after commencement of a hospital confinement; or
   b. from an accident or illness involving a fracture procedure; or
   c. for periods certified to by a physician or surgeon following surgery, provided all other requirements are met; and
3. You are not being paid by your employer.

Weekly Accident & Sickness benefits are payable for a maximum of 13 weeks for any one disability. If you cease being disabled you are required to notify the Fund Office.

Special Circumstances: Payment of Benefits for Six Weeks
If you are taking a prescribed medication which prevents you from operating machinery, you may be eligible for Weekly Accident & Sickness benefits for a maximum of six weeks (or the length of time you take the medication, whichever is less). To be eligible for benefits

under this provision, the Fund Office must receive a doctor's note—contact the Fund Office for more information if this applies to you.

Taxes on Benefit
As required by the government, FICA (Social Security) taxes are withheld from your Weekly Accident & Sickness benefit. You may request that federal taxes also be withheld from your benefit check provided that you send a properly executed IRS form to the Fund Office and comply with IRS rules for such withholding. Contact the Fund Office if you have any questions. Your employer will be responsible for payment of the Employer portion of FICA and Medicare taxes.

Date Benefits Begin
Weekly Accident and Sickness benefits will begin on the first day of disability if the disability is the result of an accident or on the eighth day of your disability if your disability resulted from illness.

Successive Periods of Disability
Payment will be made for as many separate and distinct periods of disability as may occur. Your physician must certify that each disability is separate and distinct. However, if you recover from a disability and again become disabled after less than two weeks of active work on a full time basis, both disabilities will be considered as one period of disability ***unless*** the more recent disability is due to an injury or sickness entirely unrelated to the causes of the first disability.

In order to receive this benefit, you must be disabled within the meaning of this Plan. It is not necessary to be confined to your home to collect benefits, but you must be under the care of and seen by a doctor during the period of disability.

Claims Filing Procedure
See the section of this booklet entitled "Claims Filing Procedures" on page 122.

Amount of Benefit
You will receive the amount shown in the Schedule of Rates and Benefits, as amended from time to time. If the Schedule of Benefits is amended to increase or decrease the rate, those already receiving Accident and Sickness Benefits will have their benefits increased or decreased as of the effective date of the amendment.

Claims must be filed within 60 days of your doctor's certification of your disability! This is very important!

MAJOR MEDICAL BENEFITS

Once you have become eligible for benefits, the Fund will send you a Fund ID card(s). You will receive two cards if you have dependent coverage. Show the card to the provider of care (doctor/hospital) each time you go for services. Covered expenses generally include inpatient hospital services, medical-surgical services, and medically necessary services and treatments. Services must be provided by a licensed, legally qualified physician.

Benefit Amount
Covered medical expenses under Major Medical are payable at 80% up to the *Allowable Charge*. You must satisfy a $300 annual deductible per person or a $1,000 annual deductible per family before the Fund will begin paying benefits.

Out-of-Pocket Maximum
After you have reached the out-of-pocket maximum of $4,000 per person, per calendar year, expenses for the reminder of that year for that individual will be covered at 100% of covered expenses up to the Allowable Charge, up to $200,000 per calendar year and at 50% above that amount, up to any annual maximum.

What You Should Do
For treatment that requires pre-authorization, contact Conifer Health Solutions. For treatment that does not require pre-authorization, contact the Fund Office to determine what is required for coverage. Always show your ID card to the provider of care (doctor/hospital) each time you go for services.

Treatment Must be Medically Necessary
All treatment must be medically necessary as determined by the Board of Trustees in order to be eligible for coverage. Care must be provided by a licensed physician or physician's assistant legally qualified to practice medicine.

Inpatient Hospital Admissions
Hospital admissions, including room and board, are covered under the Major Medical benefit. Benefits are payable only if the hospital makes a charge for room and board unless surgery is performed or *Emergency Service* is received, in which case a room and board charge is not required.

Alcohol and Substance Abuse Benefits
Treatment of alcohol and substance abuse is covered if the participant/covered dependent meets the following conditions:

1. Prior approval is required, as consistent with applicable law.
2. You must submit a letter of medical necessity from the legally qualified physician requesting non-emergency treatment by a social worker and/or a drug and alcohol counselor. With Fund approval, the Fund will pay for the treatment of drug and alcohol addiction.
3. The Fund will pay 100% for inpatient and outpatient care up to the *Allowable Charge* and subject to the other limits of the Plan. No other benefits are payable under the Plan for drug and alcohol addiction, consistent with applicable law. Inpatient treatment (including at a drug and alcohol treatment facility) must be approved by the Fund Office prior to your admission, except for *Emergency Services* and *No Surprises Services*.

Contact Conifer Health Solutions to pre-authorize non-emergency treatment. You must submit a request in writing prior to undergoing treatment in order to be covered for this benefit, except for *Emergency Services*.

Bariatric Surgery
The Plan will cover the cost of Bariatric Surgery, subject to all other appropriate Plan provisions, provided the surgery is determined to be medically necessary, and consists of one of the following surgeries:

- Gastric Bypass (Roux-en-Y)
- Adjustable Silicone Gastric Banding
- Biliopancreatic Diversion with Duodenal Switch
- Vertical Gastrostomy (Sleeve Gastrectomy)

and is subject to the following conditions and procedural guidelines along with such additional guidelines as the Board of Trustees shall deem medically appropriate in accordance with nationally published medical guidelines at the time of the surgery.

Requirements

- The individual should be at least 18 years old or should have reached full expected skeletal growth.
- Body Mass Index (BMI) of 40 or greater OR
- **BMI** of at least 35 or more with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease or pulmonary hypertension.
- Documentation of a motivated attempt of weight loss through a structured diet program, prior to bariatric surgery, which includes physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program for a minimum of six months.
- Active participation in an integrated clinical program that involves guidance on diet, physical activity and behavioral and social support prior to and after the surgery.
- Psychological evaluation to rule out major mental health disorders which would contraindicate surgery and determine patient compliance with post-operative follow-up care and dietary guidelines.
- Limit to in-network benefits for contracted Carefirst providers and facilities, but limited to facilities that are certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center or are certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence

- Exclude any procedure that is considered experimental or investigational, in the medical community at the time the surgery is to be performed.

The benefit is limited to a $100,000 lifetime maximum benefit under the plan.

Cataract Surgery
Lenses required following cataract surgery are included under the surgical benefit.

Chiropractic Care
Your Plan covers up to 8 visits to a chiropractor per calendar year. More than 8 visits must be certified by Conifer Health Solutions in order to be covered.

Cochlear Implants – Cochlear Implants are covered under Major Medical and not under the hearing aid benefit. A cochlear implant (CI) is a surgically implanted electronic device that provides a sense of sound to a person who is profoundly deaf or severely hard of hearing.

Dental Extractions – Impacted Wisdom Teeth Only
Extraction of impacted wisdom teeth will be covered under Major Medical. Simple extractions will be covered under your dental benefit with Delta Dental.

Diagnostic Laboratory and X-Ray
The Fund covers expenses for laboratory tests or x-ray examinations for diagnosis of a disease for which benefits are not payable under any Workers' Compensation law, or an accidental bodily injury which does not arise out of or in the course of employment. A holter monitor and other similar testing devices will be covered under this benefit when their use is recommended by the attending physician.

Dietician/Nutritionist
The Fund covers services rendered by a dietician provided the Fund Office receives a letter of medical necessity from a Medical Doctor (M.D.). Services of a nutritionist are not covered.

Durable Medical Equipment
Rental of Durable Medical Equipment is covered on a case by case basis, subject to the approval by the Board of Trustees, but you must contact Conifer Health Solutions to arrange the equipment rental. If you do not coordinate your rental with Conifer, it will not be covered.

Emergency Room Visits
The Fund covers visits to the emergency room provided that your (or your dependent's) condition meets the definition of an *Emergency Medical Condition*. Examples of medical emergencies include heart attack, severe chest pains, cardiovascular accidents, poisoning, loss of consciousness or respiration, convulsions and other acute conditions.

Medical emergencies usually do not include less acute medical conditions, which your own physician or other outpatient provider could treat during regular office hours. If you use the emergency room for a condition which did not meet the definition of an *Emergency Medical Condition*, it will not be covered, consistent with applicable law.

Hepatitis Injections
The Fund covers self-injections for the treatment of hepatitis (only) under Major Medical. You must submit a letter from your doctor stating that you have hepatitis, that the injections are necessary for treatment of your illness, and that your doctor recommends home injections in lieu of Office visits. You cannot go the pharmacy to pick up the injection—it must be obtained through your doctor's Office or through a mail-order program. The cost will be paid at 80% after satisfying the annual deductible. All other covered injectable drugs must be administered in a physician's Office in order to be covered.

Home Health Care

Home Health Care services are covered ***following a hospital confinement only.*** The home health care must have been recommended by your doctor and must have been approved by the Fund Office. You must certify Home Health Care services with Conifer in order to be covered. Services are subject to Fund approval. Services under Home Health Care include:

- Registered nurse services and licensed practical nurse services;
- Physical, respiratory and occupational therapist services;
- Rental of durable medical equipment;
- Hemodialysis services and equipment;
- Medical/surgical supplies;
- Professional ambulance services to or from a hospital, up to the limit set forth in the Schedule of Benefits for Ambulance Services.
- Amputation Therapy
- Colostomy Care

Hospice Care

The Fund will cover inpatient and outpatient hospice care for terminally ill participants and dependents whose life expectancy is six months or less and who are receiving palliative, not curative, care. If the terminally ill patient survives beyond the six months, care must be re-certified in order for benefits to continue.

Benefits for hospice care include:

- Inpatient care at a hospice facility
- Intermittent nursing care by a registered or licensed practical nurse
- Services of a licensed medical social worker
- Home health aide visits
- Radiation for palliative purposes only
- Medical-surgical supplies
- Oxygen

- Physician home visits
- Ambulance and wheelchair transportation to and from the hospital for palliative treatment or for admission as an inpatient hospice level of care.

Hospice treatment will be covered under Major Medical at 80% after satisfying the annual deductible, up to the out-of-pocket maximum. After you have reached the out-of-pocket maximum ($4,000 per calendar year) benefits will be paid at 100% of the *Allowable Charge* for the remainder of that calendar year.

Hospice care must be certified with Conifer Health Solutions in order to be covered! Call Conifer Health Solutions at (844) 739-8913 to certify hospice treatment. Failure to certify care may result in loss of benefits.

Limitation for Two or More Procedures
When two or more surgical procedures are performed through the same abdominal incision, the one of greater indemnity will be paid.

Mammograms & PAP Tests
Mammograms are covered for **eligible participants and spouses only**. Dependent daughters do not have coverage for mammograms. PAP tests are covered for participants and dependents.

You may use any participating CareFirst laboratory. To locate a CareFirst lab, go online at www.carefirst.com or call CareFirst at (800) 235-5160.

Maternity Care (Length of Hospital Stays)

Pursuant to federal law, this Plan covers any hospital length of stay in connection with childbirth for the mother or newborn child for 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn

earlier than 48 or 96 hours, as applicable. In any case, Plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 (or 96) hours.
Dependent daughters are not covered for obstetrical or maternity services.

Mental Health Benefits
Mental health treatment is covered up to the *Allowable Charge* and subject to the other limits of the Plan. All care must be certified through Conifer Health Solutions in order to be covered.

Notice of Coverage for Reconstructive Surgery following Mastectomy (Women's Cancer Rights Act)
This Plan provides coverage for (1) reconstruction on the breast on which a mastectomy was performed (2) surgery and reconstruction on the other breast to provide a symmetrical appearance and (3) prostheses and (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

The benefits are subject to the Plan's usual deductible and co-insurance provisions. Federal law requires that all participants be notified of this coverage annually.

Organ Transplants
All organ transplant services must be medically necessary and pre-approved by Conifer Health Solutions in order to be covered, consistent with applicable law. Covered transplants are:

- Liver transplants in children under the age of eighteen (18) with biliary atresia;
- Kidney transplants;
- Cornea transplants; and,
- All non-experimental bone marrow transplants.

All services related to covered transplants must be approved by the Plan. If the Participant or eligible dependent does not meet the basic screening criteria for a facility or if the transplant service is not covered, the Plan will not cover any charges related to the transplant evaluation. Organ transplants and related services not described in this section of the Plan are not covered.

Some services related to organ transplants are covered, others are not. Covered services include:

- Physician and Hospital charges associated with covered organ transplants, and any related complications, will be covered only as follows:
- Services for, or related to, the following transplantation of an organ into a participant or eligible dependent of the Plan including pre-transplantation and post-transplantation services approved by the Plan are covered for the participant or eligible dependent.
- Services for, or related to, the removal of an organ from a Participant or eligible Dependent for the purposes of transplantation into another person are covered when the following conditions apply (1) transplant recipient is covered by the Plan; (2) transplant recipient is undergoing a covered transplant; and (3) the services are not payable by another plan.
- Services for, or related to, the removal of an organ from a non-participant or non-eligible dependent for the purposes of transplantation into a covered participant or eligible dependent of the Plan when such participant or eligible dependent is undergoing a covered transplant, and the services are not payable by another plan.
- The cost of services related to the screening of organ donors will be covered for the actual organ donor only.

Organ Transplant Exclusions
The following services for or relating to the transplantation of an organ <u>are not covered</u>:

- Charges associated with complications resulting from the removal of an organ from a non-participant or eligible dependent.
- Services for, or related to, the removal of an organ from a participant or eligible dependent for the purposes of transplantation into a non-participant or eligible dependent.
- Any services related to or associated with any non-covered transplant.
- Any services associated with complications resulting from a non-covered transplant.

All services relating to organ transplants must be pre-approved by Conifer Health Solutions in order to be covered, consistent with applicable law.

Physical Therapy
Up to 8 visits for physical therapy per calendar year are covered. More than 8 visits must be certified by Conifer Health Solutions in order to be covered.

Physician's Assistants and Nurse Practitioners
The charges of a Physician's Assistant or a Nurse Practitioner are covered, subject to Allowable Charge limits of the Plan, provided the Physician's Assistant or Nurse Practitioner is under the supervision of a Physician and further provided that the treatment is properly undertaken by a Physician's Assistant or Nurse Practitioner.

Preventive Care
Medical Benefits are payable for the preventive care as follows:

- Routine care and check-ups for eligible children;
- Routine lab and lab facility charges;
- Measles, mumps and rubella injections for eligible participants and eligible dependents at any age;
- Immunizations and well child care;

Prosthetic Appliance Benefits
The Fund will pay you for expenses incurred by you or your dependents for prosthetic appliances when the loss of the body part occurs and when initial purchase is made to replace a natural body part if medically necessary. A replacement is not covered when it is reasonable to assume that medical necessity was not a factor (i.e., the recent replacement was purchased because it had superior enhancement over the old model).

A replacement may be given consideration when it is shown that:

- Major growth of the user is a factor (e.g. a 10 year old child who was fitted for an artificial leg at 5 years old);
- Major pathological change has occurred at the affected site (e.g., an amputee who has had further amputation of the limb in question);
- Reimbursement for replacement breast prostheses will be made when a new prosthesis is necessary due to additional disease.

Rehabilitation
You must certify all inpatient rehabilitation with Conifer. Outpatient rehabilitation does not require pre-authorization. If you obtain pre-authorization, and it is medically necessary, the Plan covers acute intensive physical rehabilitation services such as physical, occupational, speech or cognitive therapy when medically necessary for coordinated interdisciplinary rehabilitative services. Services may be provided by a free-standing hospital, a distinct unit of an acute hospital or skilled nursing facility, or outpatient setting.

Rehabilitation due to an Injury or Sickness will be covered only to the extent of restoration to the pre-trauma level. Speech therapy will be covered only to the extent of restoration to the level of the pre-trauma, pre-sickness, or pre-condition speech function. Rehabilitative care is to be terminated when further progress toward the established rehabilitation goal is unlikely or it is appropriate to assume progress can be achieved in a less intensive setting. Treatment will only be

covered as long as sustainable, measurable progress is demonstrated. Treatment to maintain an existing level of function is not covered.

Short Term Rehabilitative Therapy
Short-term therapy is defined as inpatient and/or outpatient services which, in the opinion of the Fund, can be expected to result in significant improvement of the Member's condition. If therapy is determined to be short-term, based upon diagnosis, services are covered as long as sustainable, measurable progress is demonstrated. Short-term speech therapy is covered when judged necessary to correct an impairment of organic origin due to an Injury or Sickness, or following surgery to correct a congenital defect. Therapy performed to correct impairment resulting from a functional nervous disorder is not covered.

Skilled Nursing Services and Supplies
You must certify all skilled nursing facility care and skilled nursing supplies with Conifer Health Solutions. Coverage includes skilled nursing services and supplies and services related to skilled nursing, services provided in a skilled nursing facility, extended care facility, hospital or other acute care setting, provided the services are not for custodial care. Skilled nursing/supply coverage includes:

1. semi-private room;
2. general nursing care;
3. meals;
4. special diets recommended by a physician; and
5. miscellaneous services, supplies, medications and dressings related to Skilled Nursing care.

The maximum amount payable under the Fund for Skilled Nursing Services and Supplies is sixty (60) days per participant per contract year. Skilled nursing services received in a hospital or other acute care setting count toward the maximum benefit.

Surgical Charges
Surgical charges have coverage after satisfying the annual deductible. Charges for a physician's assistant, a surgical assistant and a certified surgical assistant are covered if the surgical assistant is used instead of a second surgeon. The Fund will only cover surgical charges and costs that are the Allowable Amount as determined by the Plan. Surgical charges in excess of the *Allowable Amount that* cannot be applied to the deductible are not payable by the Plan. Therefore, you will be solely responsible for the excess over and above the *Allowable Amount*.

Check with your physician before any non-emergency surgical procedure to get an estimate of the cost so you know what will be covered. You must certify surgeries with Conifer Health Solutions in order to be covered.

Other Covered Services/Major Medical Benefits

1. Dental services for the treatment of a fractured jaw if accidental injuries to natural teeth occur within 6 months of the accident. This does not include dental services covered under the Dental Benefit of this Plan for routine dental care.
1. Vasectomies, but only with a letter of recommendation from a physician;
2. Medically necessary tubal ligations are covered. Voluntary tubal ligations are covered for participants and spouses only; not for dependent daughters.
3. Oxygen and its administration;
4. Routine check-ups (except for the CDL exam, which covered under as specified on page 85), including annual gynecological examination, PAP tests, mammograms.
5. Extractions of impacted wisdom teeth. Simple extractions are covered under the separate Dental Benefit.
6. Treatment of glaucoma.
7. Physical therapy when accompanied by a diagnosis of accident or illness. Conifer Health Solutions must certify all physical therapy

treatment in order for it to be covered, consistent with applicable law.

8. Rental of non-motorized wheelchairs, commodes, C-PAP machines for sleep apnea, and walkers. Coverage of this equipment is subject to the discretion of the Trustees who may opt to purchase the equipment rather than rent, or who may elect to deny this medical equipment outright, as determined on a case-by-case basis;
9. Medically necessary injectibles and bandages, subject to the discretion of the Trustees; and,
10. Other medically necessary services or supplies which the Trustees deem covered on a case-by-case basis.
11. Vision coverage: with prior approval, the Fund provides coverage for treatments related to the eye by a licensed ophthalmologist or optometrist for treatment of the eye which relates to disease or illness. Coverage under Major Medical does not include eyeglasses, contacts, and eye examinations which may be covered by the Vision Benefits of this Plan.
12. Durable Medical Equipment is covered up to certain limits. You must obtain prior authorization from Conifer Health Solutions in order to be covered, and it is only covered on an approved case-by-case basis at the discretion of the Board of Trustees. Durable Medical Equipment includes (but is not limited to) handrails, ramps, telephones, air conditioners, humidifiers, hearing aids, eyeglasses, contact lenses, or contact lenses (except as may be covered under your vision benefit), walkers, commodes, or wheelchairs.
13. The Fund will pay for hearing aids up to $2,500 for every three years when medically necessary. You must satisfy the $300 annual deductible before the Fund will begin paying benefits.
14. Allergy shots and flu vaccines (Tamiflu and Relenza) are covered.
15. COVID-19 vaccines and tests, as described below.

COVERAGE OF COVID-19 SERVICES

COVID-19 Testing

During the COVID-19 national public health emergency period, the following services will be covered with no cost sharing (including *Deductibles*, *Co-payments* and co-premiums) and no requirement of prior authorization:

- Diagnosis products for the detection of SARS-CoV-2 or the diagnosis of COVID-19 and the administration of such diagnostic products. The types of tests that will be covered include:

    1. Diagnostic testing authorized by the FDA or the Secretary of HHS;
    2. Diagnostic testing that is under review, or will be submitted for review, by the FDA for emergency use; and
    3. Diagnostic testing authorized by a State, if that State has notified the Secretary of HHS.

- Items and services furnished to a Participant or Dependent during health care provider office visits, urgent care visits, and emergency room visits that result in an order for, or administration of, a diagnosis product, but only to the extent that the item or service relates to the furnishing or administration of the diagnostic test or the evaluation of whether an individual needs a diagnostic test.

COVID-19 Vaccination Coverage

During the COVID-19 national public health emergency period, the following services will be covered on an in-network and out-of-network basis with no cost sharing (including deductibles, co-payments and co-premiums) and no requirement of prior authorization:

- A COVID-19 immunization that has a recommendation from the

Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use), after such recommendation has been in effect for 15 business days; and

- items and services that are an integral part of furnishing the covered immunization, including vaccine administration.

Office Visit Coverage

During the COVID-19 national public health emergency period, there are limited situations in which an office visit is payable under this COVID-19 Vaccination Coverage. The following conditions apply to payment for office visits under the COVID-19 Vaccination Coverage.

- If the covered immunization, item or service is billed separately from an office visit, then the Fund will impose cost-sharing with respect to the office visit.

- If the covered immunization, item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of the immunization, then the Fund will pay for the office visit without cost-sharing.

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

Upon the termination of the COVID-19 national public health emergency period, the above services (including COVID-19 Testing, COVID-19 Vaccination Coverage, and COVID-19 Office Visit Coverage) will be covered in accordance with the terms of the Plan, with cost sharing (including *Deductibles*, *Co-payments* and *co-premiums*), as applicable.

ANCILLARY BENEFITS – NOT SUBJECT TO DEDUCTIBLE

In addition to your Major Medical Benefits, the Fund provides what are referred to as "Ancillary Benefits." Ancillary benefits are benefits which are **not** subject to the annual deductible. The ancillary benefits under this Fund are listed below.

Ambulance Benefit
When medically necessary, the Fund will pay for professional ambulance services to or from a hospital, up to $100 per incident, per year, paid at 100% with no deductible. When it is determined that medically necessary life support services are provided while being transported, 50% (not 80%) of the remaining cost of the ambulance service will be paid under Major Medical. You must satisfy the annual deductible before the additional 50% payment will apply.

Annual CDL Physical Exams – Participant Only
If you are required to have a physical for your Annual CDL Physical Exam, you will be entitled to reimbursement for the actual amount charged by the physician up to the amount shown in the Schedule of Benefits per person per calendar year. The annual deductible does not apply.

Orthotic Benefits
The Fund covers expenses incurred by you or your dependents for orthotic appliances. Orthopedic shoes are covered only if it is an integral part of the brace. This benefit is available once every three years for you or your dependents up to the amount shown in the Schedule of Rates and Benefits. If approved by Conifer Health Solutions , orthotics can be covered once every year. The annual deductible does not apply to this expense.

EXCLUSIONS AND LIMITATIONS

The following charges/expenses are excluded from payment under any benefit category (unless otherwise specified as being covered elsewhere in this SPD).

1. Injuries, illnesses or diseases which are payable under any Workers' Compensation law, whether or not such benefits are actually paid.
2. The Fund will not pay if a third party is responsible for your injury.
3. Expenses for any material, service, supply or device used or prescribed by a physician in connection with providing medical services not otherwise specifically included in the Plan.
4. Expenses for injuries sustained for which another party is liable. The Fund will advance payment of benefits otherwise payable provided the participant and/or dependent execute an Application for Payment of Subrogated Benefits and Repayment Agreement to repay the Plan from any recovery from such other person or party pursuant to the Subrogation section of this booklet.
5. The Plan does not cover any medical care, including examinations, procedures and treatments, which are not recommended or approved by a legally qualified physician or surgeon and which are not approved by the Board of Trustees. **All treatment must be medically necessary unless covered under preventive or otherwise specified as being covered in this booklet**.
6. Any bodily injury or illness for which care, treatment, or supplies are obtained from any federal, state, or local government agency or program or from a hospital or institution owned thereby unless required by law.
7. Injury or illness which arises out of or in the course of employment, or injury sustained in the course of any employment for remuneration or profit.

8. Services provided by volunteer organizations which you receive at no charge are not covered.
9. Services by a member of your family or household, or by a person related to you by blood or marriage are not covered.
10. The Plan does not cover any services, treatment, drugs, or supplies which are experimental or investigational in nature, including any services, treatment, drugs or supplies which are not recognized as acceptable medical practice. A determination of whether service, care, or treatment is experimental in nature or not considered a generally accepted medical practice shall be solely within the discretion of the Board of Trustees, whose determination on that issue shall be final and binding on all concerned. In addressing whether any service, care, or treatment comes within the terms of this exclusion, the Trustees will consult and consider such sources available to the Board within the medical community as the Trustees shall deem in their sole discretion to be reliable, reasonable, up-to-date, and independent of influence by parties who may have a proprietary or economic interest in the outcome. Prior to March 23, 2010, the Trustees determined that genetic testing, including any medical procedures or treatment related to genetic testing, including but not limited to gene therapy, are not covered by the Plan because they are experimental and/or investigational in nature.
11. Services provided to a participant whose place of residence is an institution which provides treatment to injured or disabled persons.
12. Private duty nursing.
13. Home Health Care visits for treatment of nervous or mental conditions.
14. Home Health Care primarily for rest or custodial care.
15. Cosmetic, plastic, or reconstructive surgery (except reconstruction resulting from mastectomy), including

surgery to correct developmental malformations, or as a result of earlier cosmetic, plastic or reconstructive surgery is not covered unless the surgery is necessary for the repair or alleviation of damage caused by accidental injury or congenital defect.

16. Treatment of learning deficiencies or behavioral problems or for special education is not covered.
17. The Plan does not cover confinement in any facility for more than one day preceding the date of surgery, unless justified as Medically Necessary by a physician and the Board of Trustees, consistent with applicable law.
18. No benefits under this Plan shall be payable for injuries, illness or death sustained in the course of, or as a result of, both misdemeanor or felonious criminal activity or any illness, injury, or death that was a result of alcohol or drug induced intoxication or the willful intent to injure himself or another, consistent with applicable law. However, the injuries, illness, or death resulting from an act of domestic violence or from a medical condition (such as depression or including a mental health condition) are not solely excluded because the source of the injury was an act of domestic violence or a medical condition. In compliance with HIPAA's anti-discrimination provisions, the Plan reserves the right to exclude certain self-inflicted injuries so long as the injury did not result from a medical condition or domestic violence and such exclusion is consistent with the other provisions in the Plan.
19. Dental x-rays are not covered under your medical benefit except in cases of accidental bodily injury. Routine dental x-rays are covered under your dental benefit.
20. Reversals of vasectomies are not covered.
21. Medical or obstetric care relating to the pregnancy of a dependent daughter.
22. Divisional or Recreational therapy is not covered.
23. Orthopedic shoes or supportive devices for the feet such as arch supports, heel lifts, etc., are not covered. Orthotics

may be covered if medically necessary and used in lieu of surgery, following surgery, or after injury to support, align, prevent or correct deformities or to improve the function of the moveable parts of the foot.

24. Callus or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain are not covered. Certain of these procedures may be covered for those with a diagnosis of diabetes. Contact the Fund Office for more information.
25. Treatment of obesity is not covered, nor are weight reduction or physical fitness programs.
26. Eye surgery for conditions which can routinely be corrected through corrective lenses is not covered.
27. Treatment or devices to enhance sexual function are not covered. Erectile dysfunction drugs such as Viagra or Cialis are covered with a limit of 9 pills per month. The Fund will cover "daily" Cialis at one (1) pill per day for 30 days if prescribed at 5 mg.
28. Trans-sexual or sex change operations or any care or services associated with this type of surgery is not covered.
29. High dose chemotherapy and/or with peripheral stem cell rescue is not covered.
30. Ongoing and routine treatment of allergies and allergic reactions is not covered; however allergy shots and treatment of urgent allergic reactions are covered.
31. Durable Medical Equipment is excluded unless prior approval is received from Conifer Health Solutions. Durable Medical Equipment is only approved on a case-by-case basis. Durable Medical Equipment includes (but is not limited to) handrails, ramps, telephones, air conditioners, humidifiers, eyeglasses or contact lenses (except as may be covered under your vision benefit), walkers, commodes, or wheelchairs.

32. Food expenses.
33. Housing or housing-related expenses.
34. Non-ambulatory transportation, whether or not recommended by a physician.
35. Prescription drugs, except as provided under the Prescription Drug benefit.
36. Computerized Tomography or computerized axial tomography, also known as whole body scans, for preventive care or wellness purposes.
37. Services or care provided in long-term care facilities, nursing homes, convalescent homes, or rest-care facility.

DENTAL BENEFITS

Provided through Delta Dental of Pennsylvania

Delta Dental PPO

The Fund has contracted with Delta Dental, a dental Preferred Provider Organization or "PPO." You are not required to use a Delta Dental provider, but doing so can save you money and stretch your dental benefit further.

To find a Delta Dental provider, call (800) 932-0783 or go online to www.midatlanticdeltadental.com.

Delta Dental dentists have agreed to provide services at specific, generally lower, rates. Using a Delta Dental dentist means the amount you must pay is generally lower as well.

Benefit Amount

The Fund will pay up to $1,500 per calendar year (per participant and dependent) for examinations, cleanings, fillings, and other dental services. There is a $25 deductible per individual and a $75 deductible per family. The deductible does not apply for routine and preventive dental services. The annual maximum does not apply to any dental benefit that is an Essential Health Benefit.

The chart below shows coverage level (to the $1,500 per year maximum) for various procedure types. Balances remaining are your responsibility to pay.

Orthodontia benefit is paid at 50% to a lifetime maximum of $1,500 per person (up to age 19).

Benefits and Covered Services	Benefit Payment Using a Delta Dental Network Dentist	Benefit Payment Using an Out-of-Network Dentist
Diagnostic and Preventive Services Oral exams, routine cleanings, x-rays, fluoride treatment, space maintainers, sealants	100%	80%
Basic Benefits Fillings	80%	60%
Major Benefits Crowns, inlays, onlays, and cast restorations	50%	50%
Endodontics Root canals	80%	60%
Periodontics Gum treatment	80%	60%
Oral Surgery Incisions, excisions, surgical removal of tooth including simple extractions (when tooth is not impacted)	80%	60%
Prosthodontics Bridge, dentures	50%	50%

When you use a Delta Dental dentist, you will only be asked to pay your portion at the time of your visit. The participating dentist will file the claim for you and receive reimbursement directly from Delta Dental.

If you go to a non-Delta Dental provider, you may be asked to pay the cost in full and you may be required to file your own claim. If you use a non-Delta Dental dentist and file your claim, payment will be made directly to you, not to the dentist. You are responsible for paying the non-Delta Dental dentist in full.

Temporomandibular Joint – **TMJ Disorders:** the Fund will cover TMJ treatment as a medical benefit up to $1,500 per year. This benefit is subject to your annual deductible and coverage is at 80%.

Temporomandibular joint and muscle disorders (TMJ disorders) are problems or symptoms of the chewing muscles and joints that connect your lower jaw to your skull.

VISION BENEFITS

The Fund uses Vision Service Plan (VSP) to provide vision care services at discounted rates. You are still eligible to receive vision care benefits if you do not go to a VSP Panel provider for services; however, your out-of-pocket expenses may be higher.

There are two ways to obtain vision coverage under the Plan.

- visit a VSP vision care professional
- select another provider not affiliated with VSP

If you use a VSP provider, you will have a $150 allowance for the purchase of prescription eyeglasses or towards the purchase of contact lenses.

VSP Provider Benefits
You may visit the VSP website (www.vsp.com) or contact VSP at 1-800-877-7195 to find a participating provider near you. When you call to make your eye appointment, provide your name and date of birth. The provider will contact VSP for authorization of your eligibility. You do not need a VSP ID card. However, if you would like one, you may print it by going to the VSP website at www.vsp.com.

When you use a VSP provider, you may have a WellVision Exam (focused on eye health and wellness) once every twelve months, at no cost to you other than a $10 co-pay.

VSP Vision Benefit Summary

The chart bellows shows the vision benefits summary when using a VSP Choice network.

Well Vision Exam	• Focuses on your eyes and overall wellness	$10	Every plan year*
Prescription Glasses			
Frame	• $150 allowance for a wide selection of frames • 20% savings on the amount over your allowance • $80 Costco allowance	Included in Prescription Glasses	Every plan year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every plan year
Lens Enhancements	• Progressive lenses • Scratch-resistant coating • Average savings of 20-25% on other lens enhancements	$0 $0	Every plan year

Contacts (instead of glasses)	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every plan year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.

*** Plan year begins in July.**

Extra Savings

Glasses and Sunglasses

• Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.

- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam

Laser Vision Correction

- **Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.**

Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

- Exam – up to $52
- Frame – up to $70
- Single vision lenses – up to $34
- Lined Bifocal lenses – up to $50
- Lined Trifocal lenses – up to $66
- Progressive lenses – up to $66
- Contacts – up to $105

If you use a non-VSP provider, you or the eye doctor should submit a detailed bill itemizing charges directly to VSP at the following address:

Attn: Out-of-Network Provider Claims
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Claims must be submitted within six months of the date of service.

Vision Benefits Not Covered

The Plan does not cover expenses in connection with the following treatments or supplies:

- non-prescription glasses
- sunglasses
- photosensitive, plastic, cosmetic tinted (other than pink 1 and 2) or oversized lenses, although you have the option of paying the difference in cost between these lenses and the cost of clear, standard lenses
- replacement or repair of lost or broken lenses or frames
- orthoptics, vision training, or vision aids for aniseikonia
- medical or surgical treatments, as these are provided for under other provisions of the Plan such as post-cataract lenses or implants
- eye surgery for conditions which routinely can be corrected through corrective lenses
- any eye examination or the fitting of glasses except as provided above

Medical Conditions Related to the Eye

Treatment for medical conditions related to the eye, other than eyeglasses, contacts and eye examinations may be covered under the Major Medical Benefit portions of this Plan. You may use any provider you choose, however, services must be provided by an ophthalmologist, optician or other doctor of medicine in order to be covered.

PRESCRIPTION DRUG BENEFIT

Provided through Caremark/CVS Rx

This section does not apply to retirees. Retirees' prescription drug benefit is covered by the Medicare Advantage Program on page 118 of this booklet.

Your prescription drug coverage is provided through Caremark/CVS Rx.

ID Card

You will be issued an ID card from Caremark/CVS ("Caremark"), which you must show to the pharmacy when you pick up a prescription. **You must have your ID card with you when you pick up your prescription in order to receive your benefit. Benefits will not be paid if you do not have your ID card at the time of pick-up. You will not be reimbursed.**

Benefit and Co-Pay

Preferred brand drugs provided through Caremark are paid at 60% (participant co-payment is 40%) up to $2,500 per year.

Generic drugs provided through Caremark are paid at 100%, subject to $10.00 co-payment for a 90-day supply if purchased through Caremark's mail order program or CVS pharmacy, or a $5.00 co-payment per prescription at retail.

Maintenance drugs must be supplied via Caremark's mail order program or through a CVS pharmacy (mandatory).

Specialty drugs must be filled through Caremark dedicated specialty pharmacy.

The prescription benefit limits your maximum annual out-of-pocket expense to $2,500.00 per participant.

Use a Caremark Participating Pharmacy
You must use a pharmacy which accepts the Caremark card and program in order to receive benefits. If you use a pharmacy which does not accept Caremark, the Fund will not reimburse you for the cost of your prescription. Because Caremark offers discounts to Fund participants, even if your medication is not covered under the Plan, continuing to use a Caremark pharmacy can give you the best price.

Shingles Vaccination and Chantix
The Fund will cover the Shingles vaccination for participants age 60 and older.

The Fund will also cover Chantix under the prescription plan through CVS Caremark.

CVS MinuteClinics
The Fund will cover services rendered at a CVS MinuteClinic. This is exciting news, since the average wait time in an emergency room is close to an hour. You can now avoid this by taking advantage of the services offered at a CVS MinuteClinic health care center. No appointment or pre-authorization is needed.

MinuteClinics are staffed by nurse practitioners and physician assistants and are available to provide services for the diagnosis and treatment of minor illnesses, injuries and skin conditions, administration of vaccinations, health screenings, physicals and monitoring for chronic conditions. Most services are available for those age 18 months and older, but ages for specific services may vary.

MinuteClinic Practitioners Can:
- Diagnose, treat and write prescriptions for common family illnesses such as strep throat, bladder infections, pink eye and infections of the ears, nose and throat.
- Provide common vaccinations for flu, pneumonia, pertussis, and hepatitis, among others.

- Treat minor wounds, abrasions, joint sprains and skin conditions such as poison ivy, ringworm and acne.
- Provide a wide range of wellness services, including sports and camp physicals, smoking cessation and TB testing.
- Offer routine lab tests, instant results and education for those with diabetes, high cholesterol, high blood pressure or asthma.

Services For These Minor Illnesses

- Allergy symptoms (2 years+)
- Bronchitis / cough
- Earache / ear infection
- Flu symptoms
- Mononucleosis
- Motion sickness
- Sinus infection / congestion
- Pink eye & styes
- Sore throat / strep throat
- Upper respiratory infection
- Urinary tract / bladder infection (females 12 years+)

Services For These Minor Injuries

- Blisters
- Bug bites & stings
- Corneal abrasions
- Deer tick bites
- Jellyfish stings
- Minor burns
- Minor cuts & lacerations
- Minor wounds & abrasions
- Splinters
- Sprains / strains (ankle, knee)
- Suture & staple removal

Other Services Include:

- Skin Condition Exams
- Wellness & Physical Exams

- Health Condition Monitoring
- Vaccinations, Labs & Tests – go to www.minuteclinic.com to learn more.

Some additional charges may apply for certain treatments.

IMPORTANT: Services are covered only at CVS MinuteClinics.

SwiftMD Telemedicine Benefits
SwiftMD allows participants to communicate with board-certified, emergency medicine and family practice doctors who are experts in dealing with a wide range of medical conditions.

While the list of maladies covered by SwiftMD continuously expands, here are a few of the most common:

- Back pain
- Earache
- Fever/flu
- Headache
- Insect bites and stings
- Rashes and allergies
- Sore throat
- Stomach pain

For more information, visit www.SwiftMD.com.

Generic Drugs - A Safe Opportunity for Savings
Saving money and maximizing your health care dollar is important. But, what can you do? Here is an easy way to help you save money on prescription medicines. Generic drugs are drugs for which the active ingredient is identical to a brand name drug. Generic drugs are less expensive than brand name drugs and it is to your advantage to request a generic whenever possible.

Just Ask for Generics and Save!

Each time you fill a prescription, you could save money by asking for a generic medicine. That could add up to big savings in just a short time. Research shows that plan participants can **save an average of 30% to 80%** when they fill their prescriptions with a generic drug instead of a brand-name drug. The U.S. Food and Drug Administration (FDA) ensures that your generic drug is safe and effective. All generic drugs are put through a rigorous, multi-step approval process. That's why you can count on Generics for brand-name quality at a lower cost!

How do I request a generic medicine?

- When you need a prescription, ask your doctor if there is a generic available to treat your condition and to allow generic substitution at your local pharmacy.
- When you need a refill, say, "yes," if your pharmacist asks whether you would like the generic equivalent for the brand-name drug your doctor prescribed.

The value of choosing generic medicines:

- Brand-name quality at a lower cost
- Safe, effective and FDA approved

Why do Generics Cost Less?

Discovering a new medicine costs millions of dollars in research, development and clinical studies. Since generic drug makers do not develop a drug from scratch, the costs to bring the drug to market are less, and those savings are passed on to you. But generic drug makers must show the FDA that their product performs in the same way as the brand-name drug.

Are Generics Safe and Effective?

Yes. The FDA says that all drugs must work well and be safe. Generic drugs use the same active ingredients as brand-name drugs and work the same way. So they have the same risks and benefits as the brand-name drugs. The FDA requires a generic drug to be the same as its brand-name counterpart in:

- Effectiveness (how well it works)
- Safety
- Active ingredients
- Performance (how it works in the body)
- Strength (e.g., 10 mg, 20 mg)
- Dosage form (pill, liquid, cream, etc.)

Fraudulent Use of ID card

Your prescription ID card may be used only on behalf of persons covered under the program. Unauthorized or fraudulent use of your card to obtain prescription drugs will result in immediate cancellation of your prescription drug benefit.

Formulary Medications

Caremark maintains a list of formulary medications. Formulary medications are single-source medications that have no generic equivalency. They are often less expensive than other brand medications. If your pharmacist suggests use of a formulary medication, discuss with your doctor whether switching to a formulary medication is appropriate.

Covered Prescriptions

Your prescription coverage includes:

- Medically necessary FDA approved generic or brand-name compound or legend drugs. A legend drugs is any drug which requires a prescription in order to be dispensed and a compound drug is a medication made by combining, mixing or using alien ingredients (some of which may not be subject to approval by the FDA), in response to a prescription, to create a customized drug that is not otherwise available..
- The drug is medically necessary for treatment of illness, injury, disease or condition means that the drug must be prescribed in order to treat an illness, injury, disease or condition.
- Diabetic test strips are covered under your prescription drug benefit.

Any compound drug over $300 must be pre-authorized by call the Fund Office at (877) 850-0977 and pressing "2" to speak to a representative.

Over the counter drugs are not covered under your Plan.

Maintenance Drugs--MANDATORY Mail Order through Caremark or at a CVS Pharmacy

For maintenance drugs, you must use Caremark's mail order program or fill at a CVS pharmacy. Maintenance drugs are those drugs prescribed for a long period of time and are necessary to sustain good health or are used to treat a chronic condition. Examples are drugs used to treat high blood pressure, diabetes and arthritis. You may receive a 90 day supply of these drugs at one time.

You must use the mail order program or a CVS pharmacy for maintenance drugs in order to be covered!

How to Use the Mail Order Program

1. **Get Two Prescriptions From Your Physician.**
   If you intend to use mail order rather than a CVS, pharmacy, the first time you purchase the maintenance drug, you should get two prescriptions from your physician. One prescription should be for a supply of up to 30 days, which you may fill using your prescription card at a participating Caremark pharmacy. The second prescription will be used to order a larger supply through the mail order program or through CVS pharmacy, up to a 90-day supply. Co-payments for mail order drugs will be 40% of the discounted drug cost.

2. **How to Fill a Mail Order Prescription**
   - Get a mail order form from the Fund Office or www.caremark.com. You should have received a bank mail order form at the time you received your prescription ID card.

- Complete the form and mail it, along with the prescription, and payment by check, credit card, or money order to the Caremark mail order facility at the address on the mail order form or present them to a CVS pharmacy. The first mail order prescription must be submitted by mail. Your prescription will then be sent through the mail to your home within approximately 14 days.

Caremark's mail order address is:

Caremark
P.O. Box 407009
Ft. Lauderdale, FL 33340-7009

- Get refills by returning the refill card or calling the toll-free number at the mail-order facility, which is (866) 282-8503. You may receive as many refills as your doctor indicates are necessary on the original prescription.

- If you get a maintenance drug at the pharmacy level, the pharmacy system will notify the pharmacist that you must use mail order. After your third refill, your prescription will no longer go through at the pharmacy level.

- Note your credit card number (kept confidential) or send a money order (after confirming the correct co-payment with Caremark) on the order form. Payment of your co-payment is required before your maintenance drug prescription will be shipped to you.

What if I have questions about my mail order prescription?
If you have questions about your mail order prescription, call Caremark directly at (866) 282-8503.

Maintenance Drugs Can Be Filled by Mail Order or through a CVS Pharmacy

You can have your maintenance drugs filled at a CVS pharmacy or with CVS/Caremark Mail Service pharmacy. Either way, the opportunity to get a 90 day supply offers you significant savings.

Choose what works best for you!

Whether you choose to have your maintenance drug prescription filled at a CVS pharmacy or through CVS/Caremark mail service, you pay the same co-pay.

Convenience with CVS Pharmacy

- Pick up your long-term medicine directly from the pharmacy at a time convenient for you.
- Enjoy same-day prescription availability
- Talk face-to-face with a pharmacist

Convenience with CVS/Caremark Mail Service

- Enjoy convenient home delivery
- Receive medicine in confidential, tamper-resistant and (when necessary) temperature-controlled packaging.
- Talk to a pharmacist by phone.

Learn More at www.caremark.com

- Access medicine and health information
- Investigate other cost savings opportunities
- Learn more about your prescription benefit plan

Specialty Drugs

At times, certain medical conditions call for the use of Specialty Drugs, which are extremely costly to the Plan and its participants. To manage participant's use of Specialty Drugs, the Plan has implemented Caremark's "Specialty Guideline Management Program." Under this program, all Specialty Drugs shall be filled through Caremark's dedicated pharmacies. A list of Caremark's specialty pharmacies can be found at www.caremark.com. A Specialty Drug is a drug that is

biologically derived and that is on the list of specialty drugs maintained by your prescription benefits manager, CVS Caremark. This will help insure that Specialty Drugs are only prescribed for conditions for which there is medical evidence establishing effectiveness in treatment. You will be able to obtain your Specialty Drug prescription, subject to the Specialty Guideline Management Program.

RETIREE PRESCRIPTION BENEFITS MEDICARE PART D

The Plan has elected to enroll current and future Medicare eligible Retirees and eligible dependents in a Medicare Advantage plus Prescription program called the Medicare Advantage Plan. This is a fully funded Medicare Advantage plus Prescription program that offers prescription benefit enhancements. It also offers automatic medical claims processing and adjudication, which means that you no longer need to submit your own claims or Medicare Explanation of Benefits ("EOB"). The prescription benefits available to retirees under the Medicare Advantage Plan have been determined to be equivalent to prescription benefits through Medicare Part D. This means that you do not need to purchase prescription benefits through another plan. If you do obtain prescription benefits through another plan, you will cease to be eligible for prescription benefits under the Medicare Advantage Plan. **Please contact the Fund Office before making any decision to obtain prescription benefits as a retiree from a source other than this plan**.

Exclusions

The Board of Trustees does not determine which drugs are covered under the Medicare Advantage Plan nor does it determine which drugs are excluded from coverage.

In some cases, the law does not allow any Medicare plan to cover certain drugs. In other cases, the Medicare Advantage Plan provider has decided not to cover a particular drug.

The provider maintains a "List of Covered Drugs (Formulary)" that you can view on its website. (AetnaMedicare.com/formulary).

Medicare Coverage

Actively Working & Retired Participants and their Spouses Must Enroll in Medicare If They Are Eligible. The Fund Office will automatically assume that all participants, active and retired, and

their spouses, age 65 years of age and over have enrolled with the Medicare program. The Fund will also assume that anyone receiving twenty-four months or more of Social Security Disability Payments has elected to enroll with the Medicare Program.

IMPORTANT NOTE: The Fund assumes that you are enrolled in Medicare if you are eligible. This means that the Medicare Advantage Plan will not cover anything that Medicare covers. If you are not enrolled in Medicare, and you submit a claim that Medicare would cover if you were enrolled, the Medicare Advantage Plan will not consider paying the claim. **Make certain you enroll in Medicare as soon as you are eligible to do so**.

Enrolling in Medicare — How do I sign up for Medicare Part A and Part B? Medicare has two parts, Medicare Part A and Medicare Part B.

1. What is Medicare? Medicare is a federal assistance program which provides coverage for different types of hospital and medical care to eligible Americans. It consists of two main parts:

a. Medicare Part A: Hospital Insurance. This helps pay for care in a hospital and skilled nursing facility, home health care and hospice care. It is provided to you at no charge, provided you are eligible and you enroll for coverage.

b. Medicare Part B: Medical Insurance. This helps pay for doctors, outpatient hospital care and other medical services. There is a monthly cost to you to enroll in Part B which can be deducted from your monthly Social Security check.

2. When do I enroll in Medicare? You should enroll in Medicare when you are within three months of age 65 and are getting Social Security benefits, or when you are under 65 and disabled, or if you are a kidney dialysis or kidney transplant patient.

Participants and spouses becoming 65 years of age, or who have received twenty-four months of Social Security Disability Payments must enroll with the Medicare Program during the specified enrollment period in order to avoid any loss of benefits.

a. Automatic Enrollment. If you are receiving Social Security benefits, you should automatically be enrolled in Medicare Part A when you turn 65. You will know if you are enrolled because you should receive your Medicare card three months prior to your 65th Birthday. You must choose to enroll in Medicare Part B. If you do not enroll in Part B when you are eligible, the Fund will process your claims as if you do have Part B coverage. That means the Fund will process balances which ***would have remained if your claim was first processed under Medicare Part B.***

IMPORTANT NOTE: Contact the Social Security Administration at least three months before you turn age 65 to see if you are enrolled in Social Security, Medicare Part A and Medicare Part B, and to enroll if you are not.

Medicare Part D

The Plan provides prescription benefits to Retirees through Medicare Advantage. The prescription drug coverage provided by Medicare Advantage provides coverage, on average, that is equal to or better than the standard Medicare Part D plan. **If you or a covered dependent enrolls in a separate Medicare Part D program, you will lose your prescription benefits with Medicare Advantage.**

You cannot have both Medicare Advantage prescription coverage and Medicare Part D prescription coverage at the same time. If you enroll in a Medicare Part D plan and then wish to return to Medicare Advantage prescription coverage, you may not be able to return effective immediately. It is important that you compare you current prescription Plan, including which drugs are covered, with the coverage and costs of the Medicare Part D plans being offered in your area. Under Medicare Advantage, your drug coverage is provided as

part of your Health and Welfare benefits when you make the monthly co-payment.

You should also know that if you drop or lose coverage with the Plan and don't enroll in Medicare prescription drug coverage (Medicare Part D) after your Plan coverage ends, you may pay more to enroll with a Medicare Part D plan later.

PAYMENTS TO SURVIVORS

All benefits accrued during the life of an eligible employee but actually paid after death shall be paid in the discretion of the Trustees in the following manner:

A. Providers Paid First. Accrued benefits shall first be paid to the hospital, doctor, etc., which provided the services for which a benefit payment is still outstanding, or

B. Payers Who Paid Providers Paid Second. Any benefit which is eligible to be paid to a provider, which was paid by some other party, shall be paid to the other party, or

C. Order of Payment If Providers and Payers Satisfied. Any benefit which is eligible to be paid, which is not paid to a provider for services or to a payer for payment of services, shall be paid in the following order:

1. Designated beneficiary for death benefit;
2. Surviving spouse of the employee;
3. Children of the employee;
4. Parent of the employee;
5. Grandchildren of the employee;
6. Brothers and sisters of the employee; and,
7. Personal representative of the employee's estate.

CLAIMS FILING AND APPEALS INFORMATION AND PROCEDURES

Important Note: You must file all claims within 365 days from the date of an event, except for Weekly Accident and Sickness claims, which must be filed within 60 days from your disability determination date or before you return to work, whichever is later.

An "event" is defined as the accrual of charges for medical care, the date of injury, disease or illness, the date of disability, date of accident or sickness or date of death or injury which causes dismemberment.

IMPORTANT NOTE REGARDING BENEFIT CLAIMS, DENIALS AND APPEALS: At all times, the Trustees of the Fund have discretion to determine eligibility for benefits and to interpret the terms of the Trust Agreement, Plan, and this booklet — the Summary Plan Description. The decision of the Board of Trustees shall be final and binding on all parties, including participants, dependents, providers, employers, unions, claimants, and beneficiaries.

How to File a Claim – Medical Claims

Actively Working Participants and Non-Medicare Primary Retiree

Show your ID card to the provider of service. The provider will generally file your claim for you. Virtually all claims from a CareFirst provider will be filed electronically with the Fund Office. No claim form is necessary.

If you used a non-CareFirst provider or the provider files a paper claim, send an itemized bill directly to the Fund Office at the address shown below. Be sure the participant's ID number is marked clearly on the bill. The Fund Office may have you sign an "Assignment of Benefits" statement allowing payment to be made directly to the provider

To file a claim directly with the Fund Office, send to:

Operating Engineers Local 77 Health & Welfare Fund
911 Ridgebrook Road
Sparks, MD21152-9451

If you used a CareFirst provider, the provider will file the claim electronically to CareFirst for you. If you do file a claim yourself, send to:

CareFirst/Network Leasing
P.O. Box 981633
El Paso, TX 79998-1633

Required Information for Medical Claims
If either you or your physician submitting a bill to the Fund Office or CareFirst, it must contain certain required information. You or your provider must submit an itemized bill in order to receive benefits. Bills must be fully itemized and on the letterhead or stationery of the provider of service. Bills must show the following:

a. participant's name,
b. participant's Social Security Number,
c. patient's name,
d. type of service,
e. type of diagnosis,
f. date(s) of service, and
g. charge per service.

Cancelled checks, cash register receipts, and personal itemizations **are not** acceptable.

Additional Required Information for Weekly Accident and Sickness Claims. In addition to the information required to be provided to the Fund Office for Medical Claims, for Weekly Accident & Sickness Claims, you also obtain and complete a form provided by the Fund

Office, as well as the date you became disabled and were unable to work as stated on the claim form signed by your doctor.

Remember, all Medical and Death and Dismemberment claims, must be filed within 365 days from the date of service or the date the claim.

Weekly Accident & Sickness Claims
All Weekly Accident & Sickness claims must be filed within 60 days from the date of the disability began as certified by a doctor). If you return to work before 60 days, then you have 60 days from the date your doctor certifies that you are disabled in which to file a claim. If, on the other hand, you are disabled for longer than 60 days, then you must file a claim BEFORE you return to work. In no event may a claim for Accident and Sickness Benefits be filed later that your doctor certifies that you are disabled. Also, in no event may a claim be filed after 60 days and after you return to work.

You Must Provide Information to the Fund Office Upon Request. The Fund Office has the right to request further information in order to properly process a claim under the Plan's provisions. If a claimant fails to provide the necessary information within a reasonable period not to exceed thirty (30) days, the Fund shall have no duty to pay the claim until such time as the documents are provided, but in no event later than 365 days.

Penalties for Filing False or Misleading Statements or Failure to Refund Overpayments. If a claimant makes a false statement material to his claim for benefits, the Board of Trustees shall have the right to recover any payments made in reliance on such false statement. Any participant who received payments from the Fund through error or misrepresentation must make immediate repayment to the Fund upon request. Failure to comply within 30 days will result in the following penalties:

1. 7% Interest Penalty. Interest will be added to the amount due at the rate of 7% per annum; and

2. Termination of Eligibility for Benefits under this Plan. If still not paid at the end of 90 days, the participant's eligibility will be terminated; and

3. No Reinstatement until 12 Months after Repayment. The participant's eligibility will not be reinstated until 12 months after the date of repayment, at which time he or she must work enough hours to satisfy the reinstatement rule.

4. Payable Claims Offset Amount Due By Repayment during 90 Day Period Prior to Termination of Eligibility. All claims presented to the Fund during the 90 day period prior to losing eligibility, if eligible for payment under the terms of the Plan, will be applied to the amount of repayment due from the employee.

5. Right to Waiver Penalties. The Trustees reserve the right to waive any or all of these provisions in whole or in part.

Time Within Which Fund Must Process Claims.
Claims shall be processed as follows:

a. Urgent Care. 72 hours for the Plan to decide, with one 24-hour extension, and 48 hours for you to respond, and 48 hours for the Plan to decide. When the request for care is of an urgent nature, the Fund Office or Conifer Health Solutions will:

i. notify you as soon as possible of the Fund Office's decision, whether adverse or otherwise, but in no event later than 72 hours after receipt of the claim by the Plan, unless

ii. you failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

iii. If there is a failure to provide the necessary information, the Fund Office will notify you within 24 hours that information is insufficient and provide claimant with the specific information necessary to complete the claim.

iv. After notifying you that you haven't provided enough information for the Fund Office to determine whether a claim is covered by the Plan, the Fund Office will give you another 48 hours to provide the information.

v. After you provide the information requested by the Fund Office or Conifer Health Solutions, the Plan will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.

b. Concurrent Care. Notification by Plan prior to the end of course of treatment with enough time to appeal, or, for urgent concurrent care, if you request more treatment within 24 hours prior to end of course of urgent care treatment, then Fund has 24 hours to decide.

When the request for care is of a concurrent nature — that is, if the plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments — then the Fund Office or Conifer Health Solutions will:

i. inform you that any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination;

ii. notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated; and,

iii. if concurrent care of an urgent nature is involved, and if you request an extension of your course of treatment beyond the period of time or number of treatments within 24 hours before the course of treatment is to end, the Fund Office will decide as soon as possible whether the care is covered by the Plan and communicate to its decision within 24 hours of receipt of the claim.

c. Pre-service Authorization Claims. 15 Days for Fund to decide with one 45-Day extension for you to respond.

In the case of a pre-service claim such as any inpatient or outpatient surgery, the Fund Office will notify you of the decision, adverse or otherwise, within a reasonable period of time but not later than 15 days. This period may be extended once if:

i. the Plan determines that an extension is necessary due to matters beyond the control of the Plan; and

ii. the Plan notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision; and,

iii. the Plan notifies you that you have failed to provide the necessary information; and,

iv. the Plan provides you with specific information about what information the Plan needs; and,

v. the Plan provides you with 45 days from receipt of the notice within which to provide the specified information.

d. Post-service authorization claims. 30 Days for Fund to decide with one 15-Day extension and 45 days to respond.

In the case of a post-service authorization claim, the Fund Office will notify you of the Plan's adverse decision within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended once if:

i. the extension if for no longer than 15 additional days; and

ii. the extension is necessary due to matters beyond the control of the Fund; and,

iii. the Plan notifies you, before the 30 days expire, of the reason for the extension and the expected date of decision; and

iv. if the extension is necessary due to your failure to provide the necessary information, the Plan notifies you of what information is needed; and,

v. the Plan gives the claimant 45 days to response.

e. Accident and Sickness Claims. Denial within 45 days after receipt of claim; two 30-day extension permissible. In the case of an Accident and Sickness claim, the plan administrator shall notify the claimant of the plan's adverse decision within a reasonable period of time, but not later than 45 days after receipt of the claim. The 45-day period may be extended twice.

This period may be extended the first time if:

i. the extension if for no longer than 30 additional days; and

ii. the extension is necessary due to matters beyond the control of the Fund; and,

iii. the plan notifies the claimant, before the 45 days expire, of the reason for the extension and the expected date of decision;

iv. the notice of extension states the standards on which entitlement to a benefit is based;

v. the notice of extension states the unresolved issues that prevent a decision on the claim;

vi. the notice of extension states the additional information needed to resolve those issues; and,

vii. the notice of extension states that the claimant has at least 45 days within which to provide the specified information.

This period may be further extended the second time if:

i. the extension if for no longer than 30 additional days; and

ii. the plan notifies the claimant, before the first extension of 30 days expires, of the reason for the extension and the expected date of decision;

iii. the notice of extension states the standards on which entitlement to a benefit is based;

iv. the notice of extension states the unresolved issues that prevent a decision on the claim;

v. the notice of extension states the additional information needed to resolve those issues; and,

vi. the notice of extension states that the claimant has at least 45 days within which to provide the specified information.

IMPORTANT NOTE: Claims for Weekly Accident and Sickness coverage under this plan are subject to all of the claims procedures contained herein except that, for Accident and Sickness Claims, the Plan need not notify you within 5 days or 24-hours of you or your representative's failure to comply with the claims procedures.

f. Calculation of Time Periods. The period of time begins at the time a claim is filed in accordance with the reasonable procedures of the plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. If an extension is necessary, the original time period for making the benefit determination is tolled beginning when the notice of extension is sent until the date on which the claimant response to the request for additional information. If urgent care is involved, notice may be oral, with written notice to follow within 3 days of oral notice.

Authorized Representative. An authorized representative may act on your behalf in pursuing a benefit claim or appeal. Medical personnel acting under urgent care situations are automatically authorized to act on your behalf. In situations involving non-urgent care, you must file a statement with the Fund Office indicating the name of your authorized representative. The Fund Office may request additional information regarding your representative in its discretion.

Denial Prohibited in Certain Circumstances. The Fund will not deny any claim based on your failure to obtain pre-authorization in situations where it is impossible to obtain authorization such as in urgent care cases over weekends and during the non-business hours during the week when representative of the Fund Office or Conifer Health Solutions are not available, or where urgent care precludes you from obtaining authorization.

Procedural Safeguards. All benefit claim determinations must be made in accordance with this Booklet.

Consistent Treatment. The Plan must make certain that similarly situated claimants are treated consistently.

No Mandatory Arbitration. No claim or appeal shall be subject to mandatory arbitration.

Failure to Comply with Claims Procedures. If you or your representative fails to comply with the requirements for filing a claim or appeal, the Fund Office will notify you in accordance with the following procedure:

1. The Fund Office will notify you of the failure to comply:

    a. For urgent care, within 24 hours of your failure to comply with claims procedures; or,

    b. For non-urgent care, within five (5) days of your failure to comply with claims procedures; or,

    c. For Accident and Sickness claims, within a reasonable period which may exceed the periods for both *Emergency Service* and non-*Emergency Service* claims.

2. Notification may be oral, unless you or your representative requests written notification.

3. The communication to you or your representative must be by the claims department.

4. The communication from claimant or representative must name a specific claimant, medical condition or symptom, and a specific treatment, service or product requested.

Notice Required for Denial of Claims

1. If a claim is denied in whole or in part, the Fund Office shall provide a written notice to the participant stating the following:

a. The specific reason for the denial;

b. Specific reference to pertinent Plan provisions, claims procedures or other evidence on which the denial is based;

c. A description of any additional material or information necessary for the claimant to perfect the claim and any explanation of why such material or information is necessary; and

d. An explanation of the Plan's claim review procedure, including:

i. A statement informing the claimant of his/her opportunity to appeal,

ii. The time limits applicable to the Plan's review and appeal procedures;

iii. The procedure by which an appeal may be made;

iv. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

v. A statement that the claimant, or his/her duly authorized representative, may review pertinent documents, setting for the times and places at which such document may be reviewed and/or obtained; and

vi. A statement that the claimant, or his/her duly authorized representative, may submit issues and comments in writing upon filing a request for review of denial of claim with the Board of Trustees.

vii. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, then a free copy of either the specific rule, guidelines, protocol, or other similar criterion that was relied,

viii. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

ix. If urgent care is involved, a description of the expedited review process applicable to such claims, which may be oral, but only if followed by written notice within 3 days of oral notice.

Appealing a Denied Claim

Appeals Procedure for Medical Claims Including Concurrent Care, Pre-Service, and Post-Service Claims.

a. Right to Appeal in Writing. If your claim is denied, in whole or in part, you may appeal the denial to the Board of Trustees. An appeal in writing may be submitted by the participant himself or by his duly authorized representative acting on the claimant's behalf;

b. Time to Appeal. You have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

c. Time for Board of Trustees to Decide. The Board of Trustees shall render a decision on review no later than the date of the meeting of the Board which immediately follows the receipt of a request for review, unless the request for review is received within 30 days preceding the date of such meeting. In that case, a decision may be made by no later than the date of the second meeting following receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the Board following the Fund Office's receipt of the request for review. If special circumstances require a delay, you will receive a written notice of the reason for the delay.

d. Right to Request Relevant Documents. You shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits;

e. Right to Comprehensive Review. Your review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

f. Right to Review. Your review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse

benefit determination that it the subject of the appeal, nor the subordinate of such individual;

g. Right to Professional Consultation. In deciding an appeal of any adverse benefit determination that is 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 Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

h. Right to have Physicians Identified. Your review will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

i. Right to Review by Person not Connected to Person Making Initial Adverse Benefit Determination. Your review will provide that the health care professional engaged for purposes of a consultation in the appeal of an adverse benefit determination above is not the 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;

j. Urgent Care Appeals Special Provision. If urgent care is involved, your review will be conducted on an expedited basis if you request an expedited appeal of an adverse benefit determination submitted orally or in writing. If you make such a request, the Plan will provide all necessary information to you, including the Plan's benefit

determination on review by telephone, facsimile, or other available similarly expeditious method.

k. Right to Limit Appeals before Action. A claimant need not file more than two appeals of an adverse benefit determination for each separate claim prior to bringing a civil action under ERISA.

Appeals Procedures for Accident and Sickness Claims Appeals.

a. Time to Appeal. The Plan will provide you with 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

b. Content of Appeal. The Plan will provide you the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

c. Right to Access Documents. The Plan will provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits;

d. Right to Comprehensive Review of Record. The Plan will provide for a review that takes into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination;

e. Right to Appeal. The Plan will provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by a fiduciary of the plan who is neither the individual who made the adverse

benefit determination that it the subject of the appeal, nor the subordinate of such individual;

f. Right to Professional Consultation. The Plan will provide that, in deciding an appeal of any adverse benefit determination that is 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;

g. Right to Identification of Experts. The Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your claim's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

h. Right to Review by Person not Connected to Person Making Initial Adverse Benefit Determination. The Plan will provide that the health care professional engaged for purposes of a consultation in an appeal of an adverse benefit determination is not the 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; and,

i. Right to Limit Appeals Before Action. A claimant need not file more than two appeals of an adverse benefit determination for each separate claim prior to bringing a civil action under ERISA.

RIGHT TO AMEND AND TERMINATE

A. Right to Amend and Terminate Entirely. The Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time to:

1. terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment may affect claims which have already accrued;

2. alter or postpone the method of payment of any benefits;

3. to amend or rescind any other provision of this Plan; and

4. to terminate this Plan in its entirety.

B. Effect of Termination of Plan. In the event this Plan is terminated, the Board of Trustees shall use any remaining funds to satisfy existing and arising claims for benefits under the terms of this Plan and to pay reasonable administrative expenses until such funds are exhausted.

GRANDFATHERED STATUS

The Trustees believe that the Operating Engineers Local No. 77 Trust Fund of Washington, D.C. is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("PPACA").

The Operating Engineers Local No. 77 Trust Fund of Washington, D.C. uses collectively bargained employer contributions to the Plan, and income from the investment of Plan assets, to provide the most generous health plan that is prudently possible given the assets of the Plan. To avoid the financial and other burdens on the Plan that would be associated with full implementation of the PPACA, the Trustees have decided to operate the Plan as a "grandfathered health plan" under the PPACA.

A health plan that was in existence on March 23, 2010, the enactment date of the PPACA, is referred to under the PPACA as a "grandfathered health plan." As permitted by the PPACA, 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 PPACA 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 PPACA, for example, coverage of dependents up to age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager at: Operating Engineers Union Local No. 77, Health and Welfare Fund, 8400 Corporate Drive, Suite 430, Landover, MD 20785-2361, (877) 850-0977. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

THE PLAN'S COMMITMENT TO PRIVACY

The Operating Engineers Local 77 Trust Fund of Washington DC (the "Plan") is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to the participants and dependents that are eligible for benefits under the Plan. **Please review carefully**.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and

regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information.

SUMMARY OF THE PLAN'S PRIVACY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;

- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- Request access to your health information in an electronic format;
- Receive notice of a breach of unsecured protected health information if it affects you;
- Choose someone to act on your behalf;
- File a complaint with the Fund Office or the Secretary of the Department of Health and Human Services if you believe that your that privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends;
- Provide disaster relief;
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment your receive;
- Run our organization;
- Pay for your health services;
- Administer your health plan;
- Help with public health and safety issues;
- Do research;
- Comply with the law;
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director;

- Address workers' compensation, law enforcement, and other government requests;
- Respond to lawsuits and legal actions

Changes in the Plan's Privacy Practices
The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information
If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan's privacy practices, please contact:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(410) 683-6500

DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES
THE PLAN'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan uses and discloses your health information only for the administration of the Plan and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** Although the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.

2. **For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with its third party administrator, Associated Administrators LLC ("Associated"), so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered under the Plan. Associated also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, Associated may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. **For Health Care Operations**. The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan. While we can use and disclose your information to run our organization or disclose information to your health plan sponsor for plan administration, we are not allowed to use genetic information to decide whether we will give you coverage and the process of that coverage. However, this prohibition does not apply to long term care plans.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its "business associates," which are third parties that assist the Plan in its operations. The Plan discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with Associated so that it may process your claims. The

Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Plan may disclose your health information to a translator; and Associated may provide names and address information to mailing services.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected. Similarly, Associated contracts with the subcontractors it uses to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information to the Plan Sponsor, which is the Plan's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan, without your authorization. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Plan that it will protect your health information and that it has amended the Plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan, may make without your authorization.

1. **Required by Law**. Your health information may be used or disclosed as required by law. Generally, we will share health information about you if state or federal laws require it, including with the Department of Health and Human Services if it want to see that we're complying with federal privacy law. We may also share your health information in the following circumstances:

- For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
- To assist law enforcement officials in their law enforcement duties.
- To notify the appropriate authorities of a breach of unsecured protected health information.

2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as:

   - Preventing or controlling disease.
   - Injury or disability.
   - Helping with product recalls.
   - Reporting adverse reactions to medications.
   - Reporting suspected abuse, neglect, or domestic violence.
   - Preventing or reducing a serious threat to anyone's health or safety.
   - To meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

4. **Active Members of the Military and Veterans**. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

6. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.

7. **Others Involved In Your Care**. Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, Associated may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. **Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults. You must provide the Fund with a copy of a properly executed Power of Attorney or other legal document before the Fund can disclose any information to your designated agent or personal representative.

9. **Treatment and Health-Related Benefits Information**. The Plan and its business associates, including Associated, may contact you to provide information about treatment alternatives or other health-

related benefits and services that may interest you, including, for example, alternative treatment, services and medication.

10. **Research**. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed. For more information regarding the use or disclosure of health information for public health and research, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

11. **Organ, Eye and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

12. **Deceased Individuals**. The health information of a deceased individual may be disclosed to alert law enforcement of the death of the individual, when there is a suspicion that death resulted from crimination conduct; to the coroners, medical examiners and funeral directors so that those professionals can perform their duties, for research that is solely on the protected health information of decedents; and to organ procurement organizations. In addition, the protected health information of a decedent to a family member, or other person who was involved in the individual's health care or payment for care prior to the individual's heath, unless doing so is inconsistent with any known prior or expressed preference of the deceased individual. This may include disclosures to spouses, parents, children, domestic partners, other relatives, or friends of the decedent, provided the information disclosed is limited to that which relevant to the person's involvement in the decedent's care or payment of care. The privacy protections do not apply to an individual that has been deceased for more than 50 years, however, if your family medical health history includes health information about a relative who

has been deceased for more than 50 years, this health information is protected as part of your own health record.

Uses and Disclosures for Fundraising and Marketing Purposes
The Plan and its business associates, including Associated, do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization
Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization. If you would like to provide your express written authorization to disclose your health information, or revoke a previous authorization, you may do so using the Fund's HIPAA Authorization Form found on the Fund Office website at www.associated-admin.com. You may also request a mailed copy of the HIPAA Authorization Form by contacting the HIPAA Privacy Officer at the address or phone number referenced below.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451

Right to Inspect and Copy Health Information
You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverage, claim records, and billing records. For health records that the Plan keeps in electronic form, you may request to receive the records in an electronic format.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Plan will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment form and is not limited to a two year period, state that in your written request, and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the Plan will charge you a fee of $.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format also may be subject to a small charge.

In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request That Your Health Information Be Amended
You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that

support your request. The Plan may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Plan, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan, including disclosures by Associated to other entities. We will not include disclosures pertaining to treatment, payment, and health care operations, and certain other disclosures, such as any disclosures requested or specifically authorized by you. The accounting covers up to six years prior to the date of your request, except, in accordance with applicable law, the accounting will not include disclosures made before April 14, 2003. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Plan may provide you with a list of business associates who make such disclosures on behalf of the Plan, along with contact information so that you may request the accounting directly from each business associate. The first accounting

that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but Associated will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is generally not required to agree to your request for such restrictions, and the Plan may say "no" to your request if it would affect your care. The Plan is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out of pocket.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. You may also submit this request by completing the Fund's HIPAA Authorization Form. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. We will not deny a reasonable request for confidential communication if disclosure by any means other than the method of communication you requested would endanger you. Generally, reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan by contacting us by using the information provided on page three (3) of this document. You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice at Associated's website, www.Associated-Admin.com.

Right to Receive Notice of a Breach of Your Protected Health Information

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured—for example, computer data that is encrypted and inaccessible without a password—or if it is determined that there is a low probability that your health information has been compromised.

CHANGES IN THE PLAN'S PRIVACY POLICIES

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be posted for review near the front lobby of Associated's Offices in Sparks, Maryland and Landover, Maryland. Any revised notice will also be available at Associated's website, www.Associated-Admin.com.

EFFECTIVE DATE

This Notice, as revised, is effective September 23, 2013. The previous notice, issued on April 14, 2013, was amended to reflect the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice will remain in effect unless and until the Plan publishes a revised Notice.

YOUR RIGHTS UNDER ERISA

As a participant of Operating Engineers Local No. 77 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Board of Trustees complies fully with this law and encourages you to first seek assistance from the Fund Office when you have questions or problems that involve the plan.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
This Plan is maintained pursuant to Collective Bargaining Agreements. A copy of these documents may be obtained by participants and beneficiaries upon written request to the Fund Office. The documents are also available for examination by participants and dependents.

Examine, without charge, at the plan administrator's Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance

contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description**.** The administrator may make a reasonable charge of the copies.

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

Continue Group Health Plan Coverage

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 your 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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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. However, if you have a denied claim or disagree with the Plan's decision regarding an order, you must appeal these decisions within the plan's time limits before you can bring suit. 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 Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, 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.

TELEPHONE NUMBERS AND ADDRESSES

Fund Office …… (877) 850-0977

Conifer Health Solutions …… (844) 739-8913

CareFirst …….. (800) 235-5160

Delta Dental …… (800) 932-0783

Caremark/CVS (Prescription Drug Plan)
P.O. Box 407009
Ft. Lauderdale, FL 33340-7009

File Claims to CareFirst (All Non-Medicare Primary Participants)
Whether or not you used a CareFirst provider, your claim should be filed to CareFirst. Be sure to show your ID card to the provider at your time of service. Paper claims may also be sent directly to CareFirst at:

CareFirst
P.O. Box 981633
El Paso, TX 79998-1633

Medicare-Primary Participants or Dependents
If your primary coverage is through Medicare, file your claim to Medicare first, then send your claim, along with your Medicare EOB, to the Fund Office at:

Operating Engineers Local No. 77
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451