

International Union of Operating Engineers



Local 825 Welfare Plan

**OPERATING
ENGINEERS
LOCAL 825
WELFARE PLAN**

OPERATING ENGINEERS LOCAL 825 WELFARE PLAN

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I. INTRODUCTION

A. General Information

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

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

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

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

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

I. INTRODUCTION

(Continued)

B. Claim Information

Claims for reimbursement must be submitted to:

*Operating Engineers Local 825
Fund Service Facilities
65 Springfield Avenue
SECOND FLOOR
Springfield, NJ 07081
(973) 921-1661*

Whether a claim is filed by you or by a service provider filing a claim on your behalf, to be eligible for payment, bills must include an itemization of charges with CPT codes (uniform identification codes for reporting physician procedures and services) and diagnoses codes. Claims for all professional, durable medical equipment and ambulance services should be submitted on a HCFA-1500 form, claims for dental services should be submitted on a HCFA-1500 Dental form and claims for facility charges (hospital/surgery centers) should be submitted on a HCFA-1450 or UB-92 form. These forms are generally furnished by service providers. Submission of receipts, cancelled checks and/or bills indicating balance forward is not acceptable. A single claim cannot include services for more than one individual. All claims must be submitted within 12 months after the date services are rendered to be considered for payment.

If you wish, you may arrange to have benefits paid directly to a service provider by assigning these benefits. Inpatient hospital services will be paid directly, and no assignment by you is necessary.

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

In order to avoid delay in the payment of a benefit, you must make sure that information on your status is kept up to date in the Fund Office. Any change in marital status, dependents, name or address must be reported promptly. Also, your death benefit is payable to your last named beneficiary, unless otherwise assigned pursuant to a Qualified Domestic Relations Order (QDRO). A copy of the Plan's QDRO procedures will be provided free of charge upon receipt of a written request.

In the case of a claim involving urgent care, as defined below, you or your representative may submit a request for an expedited determination. Such request may be made orally or in writing. In such a case, all information, including the Fund's benefit determination, may be transmitted between the Fund and you or your representative by telephone, facsimile or other similarly expeditious method.

I. INTRODUCTION

(Continued)

A claim involving “urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could jeopardize your life or your ability to regain maximum function, or, (b) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.

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

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

C. Claim Determination

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

In the case of a claim that does not involve urgent care, the Plan Administrator shall notify you of the Fund’s benefit determination within a reasonable period of time appropriate to the circumstances, taking into account any pertinent medical circumstances, but not later than 15 calendar days after receipt of a pre-service claim or 30 calendar days after receipt of a post-service claim by the Fund, unless the Plan Administrator determines that an extension of the period for the Fund’s benefit determination is necessary for reasons beyond the control of the Plan, or if you or your representative fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Fund, in which case the period for notifying you of the Fund’s benefit determination may be extended for a period not to exceed 15 days after expiration of the relevant period applicable to the Fund’s initial benefit determination (15 calendar days for pre-service claims or 30 calendar days for post-service claims). You shall receive written notice of any extension indicating the circumstances requiring an extension and the date by which a decision is expected to be

I. INTRODUCTION (Continued)

rendered or specific information necessary to complete your claim prior to expiration of the relevant period applicable to the Fund's initial benefit determination (15 calendar days for pre-service claims or 30 calendar days for post-service claims). For incomplete claims, you shall be afforded not less than 45 days after receipt of notice to furnish the specified information to the Fund. You shall be notified of the Fund's benefit determination within a reasonable period of time, but in no event later than 15 days after the Fund's receipt of the specified additional information.

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

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

D. Review of Adverse Benefit Determination

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

The Fund has established a procedure to provide you with a reasonable opportunity to appeal a denied claim. Within 180 calendar days after you receive notice of denial, you must make a written request to the Plan Administrator to have the Board of Trustees review your claim. Upon request and free of charge, you will be provided reasonable access to, and copies of, documents and other information relevant to your claim and be apprised of the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether such documents and other information or advice were relied upon in making the determination. You may also submit any additional written comments, documents and other information for the Board of Trustees to consider. The Board of Trustees or a Review Committee comprised of members of the Board will look at the claim as if it is being originally submitted,

I. INTRODUCTION **(Continued)**

and will not simply defer or ratify the initial denial of your claim. All comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination, will be taken into account. The object of the review procedure is to provide a fair and complete review of all information concerning the claim.

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

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

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

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

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

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

II. ELIGIBILITY

A. Introduction

In order to become eligible for benefits under the Plan, you must work as an operating engineer for an employer who is party to a collective bargaining agreement with the Union, which agreement requires the employer to make contributions to the Fund on your behalf.

Under each eligibility package there are four levels of benefit coverage for which a participant can become eligible. These levels provide the following benefits:

LEVEL OF BENEFIT PROGRAM

Level 1

Death benefits, survivor benefits, accidental death and dismemberment, inpatient hospital, outpatient pre-admission testing, outpatient emergency room, outpatient surgicenter convalescent care, ambulance, home health care, surgical, anesthesia, doctor visits, X-ray and laboratory, maternity, EAP, mental health, substance abuse, cancer medications, diabetic supplies, Medicare, PPO chiropractor, PPO podiatrist

Level 2

Includes all benefits in Level 1 plus vision, accident and sickness, non-PPO chiropractor, non-PPO podiatrist

Level 3

Includes all benefits in Levels 1 & 2 plus Dental

Level 4

Includes all benefits in Levels 1, 2, & 3 plus Prescription Drugs

B. Eligibility And Termination

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

1. Basic Eligibility

a. Employees Working Under Construction Contracts (Quarterly Eligibility)

Your eligibility is determined by the amount of fringe benefit contributions paid by your employer(s) on your behalf. However, you do not become eligible upon the initial date of your employment. There is a six- to nine-month lag between the date contributions are earned and the date you become eligible for benefits. Eligibility for the current year January, February and March is based upon contributions for periods worked April, May and June of the previous year. Eligibility for the current year April, May and June is based upon contributions for periods worked July, August and September of the previous year. Eligibility for the current year July, August and September is based upon contributions for periods worked in October, November, and December of the previous year. Eligibility for the current year October, November and December is based upon contributions for periods worked in January, February and March of the current year.

II. ELIGIBILITY **(Continued)**

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

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

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

b. Employees Working Under Shop Contracts (Quarterly Eligibility)

Your eligibility is determined by the amount of fringe benefit contributions paid by your employer(s) on your behalf. However, you do not become eligible upon the initial date of your employment. There is a three- to six-month lag between the date contributions are earned and the date you become eligible for benefits. Eligibility for the current year January, February and March is based upon contributions for periods worked July, August and September of the previous year. Eligibility for the current year April, May and June is based upon contributions for periods worked October, November and December of the previous year. Eligibility for the current year July, August and September is based upon contributions for periods worked in January, February, and March of the current year. Eligibility for the current year October, November and December is based upon contributions for periods worked in April, May and June of the current year.

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

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

II. ELIGIBILITY

(Continued)

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

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

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

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

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

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

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

2. Continuation of Coverage

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

II. ELIGIBILITY **(Continued)**

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

a. Level of Benefit Buy-In Provision

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

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

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

b. COBRA Coverage

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

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

1. Your hours of work in covered employment for which contributions are paid on your behalf are reduced to a level where you are no longer eligible for benefits or you are eligible for a reduced level of benefits, or
2. Your covered employment ends for any reason other than your gross misconduct.

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

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

II. ELIGIBILITY (Continued)

3. Your spouse's covered employment ends for any reason other than his or her gross misconduct; or
4. You become divorced from your spouse.

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

1. The parent-participant dies;
2. The parent-participant's hours of work in covered employment for which contributions are paid on his or her behalf are reduced to a level where he or she is no longer eligible for benefits or is eligible for a reduced level of benefits;
3. The parent-participant's employment ends for any reason other than his or her gross misconduct;
4. The parents become divorced; or
5. The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event. The COBRA continuation coverage period will run from that date even if coverage under the Plan continues immediately after the qualifying event due to operation of other terms of the Plan (i.e., the run-out of your eligibility based upon employer contributions made to the Welfare Fund, the exhaustion of any carried forward excess contributions in accordance with the Plan, your self-purchase of coverage under the Plan's Level of Benefit Buy-In Provision, and your continuation of coverage in accor-

II. ELIGIBILITY **(Continued)**

dance with the Uniformed Services Employment and Reemployment Rights Act). COBRA extends health benefits only and does not extend death, accidental death and dismemberment, survivor, and supplemental accident and sickness benefits.

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

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

Disability Extension of 18-month Period of Continuation Coverage

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

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can obtain up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension is available to the spouse and dependent

II. ELIGIBILITY **(Continued)**

children receiving continuation coverage if the former participant dies or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Operating Engineers Local 825 Fund Service Facilities, Attention: COBRA Continuation Coverage, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081.

COBRA Continuation Coverage Not Extended Due to Other Continuation of Coverage

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

Termination of COBRA Coverage

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

1. The Plan ceases to provide group health coverage to any participants.
2. The premium for COBRA continuation coverage is not received by the Fund Office on a timely basis.
3. After the qualified beneficiary has elected to continue coverage, he or she initially becomes covered under any other group health plan, and that other plan does not contain any exclusion or limitation for any of his or her preexisting conditions, such preexisting condition does not apply to him or her, or if he or she has satisfied any applicable preexisting condition provisions.
4. After the qualified beneficiary has elected to continue coverage, he or she initially becomes entitled to Medicare benefits. Entitlement to Medicare benefits occurs upon the earlier of the effective date of enrollment in Part A or Part B.
5. COBRA coverage has been extended to 29 months due to a disability of you or a family member and you or your family member is deemed no longer disabled. Coverage will end the month that begins 30 calendar days after the date of the final determination that you are no longer disabled.
6. Upon the expiration of the maximum coverage period, as set forth above.

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

II. ELIGIBILITY **(Continued)**

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

c. USERRA Coverage

If you are absent from work in covered employment by reason of your service in the Uniformed Services, you shall be entitled to elect continuation of coverage for yourself and your covered dependents in accordance with USERRA. The maximum period of continued coverage for you and your dependents under such an election shall be the lesser of (a) the 18-month period beginning on the date on which your absence from covered employment begins; or (b) the day after the date on which you are required under USERRA to apply for return to a position or employment and fail to do so. To avail yourself of USERRA continuation coverage, you must notify the Fund Office that you are leaving covered employment for military service. USERRA coverage provides the same health benefits available to a covered participant under the Plan.

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

Your entitlement to USERRA continuation coverage is concurrent with your entitlement to COBRA continuation coverage, meaning that if you elect USERRA continuation coverage, at the expiration of your coverage under USERRA you will have no entitlement to continued coverage under COBRA (similarly, if you elect COBRA continuation coverage instead of USERRA continuation coverage, you will not be entitled to elect USERRA continuation coverage upon the expiration of your COBRA coverage). However, if your spouse or dependent children might lose USERRA continuation coverage as the result of a qualifying event such as your death, your divorce, or a cessation of dependent status, your spouse and/or dependent children must be given an opportunity to elect COBRA continuation coverage, with a maximum coverage period of 36 months measured from the date of such qualifying event.

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

II. ELIGIBILITY (Continued)

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

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

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

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

3. Termination of Benefits

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

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

II. ELIGIBILITY (Continued)

4. Certificates of Creditable Coverage

Certificates of Creditable Coverage are automatically issued along with COBRA notices following the occurrence of a qualifying event. In addition, if COBRA continuation coverage is elected and purchased, the Fund shall issue an updated Certificate of Creditable Coverage upon termination of such COBRA continuation coverage. Additional copies of Certificates of Creditable Coverage may be obtained by calling the Fund Office.

C. Eligibility of Dependents of Active Employees

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

The Plan covers a legal spouse as a dependent. Once a divorce occurs, your ex-spouse is no longer eligible for coverage under the Plan, except that continued coverage can be purchased by or for your ex-spouse for 36 months under COBRA. Upon the expiration of COBRA coverage, all benefits cease.

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

The Plan covers your unmarried children less than 19 years of age and unmarried children less than 25 years of age for whom proof is furnished that they depend wholly upon you for support and maintenance and are full-time day students in an institution of higher education or other institution offering degree or certificate upon program completion. A letter from the registrar's office verifying that a child is a full-time student or a tuition paid receipt verifying full-time status is required each semester. To avoid any temporary lapse in coverage, either one of these verification forms should be sent to the Fund Office no later than three weeks prior to the start of each semester. To continue coverage between the spring and fall semesters, call the Fund Office in early May and request that a letter verifying registration for the upcoming fall semester be sent to you for completion. It is the member's responsibility to insure that verification of full-time status is received by the Fund Office in a timely manner.

If your child is employed where other group coverage of a non-contributory nature is available, the Plan provides secondary coverage only.

A child who is physically or mentally incapable of self-support may be continued under the Plan past the age of 19 up to age 25 while remaining incapacitated and unmarried, provided your own insurance continues in effect. To continue a child under this provision, proof of incapacity must be received by the Fund Office within 30 days prior to a child's 19th birthday. Additional proof will be required from time to time. ***IF A CHILD BECOMES ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME, MEDICAID AND/OR MEDICARE BENEFITS, IT IS MANDATORY THAT YOU AVAIL YOURSELF OF THESE BENEFITS.***

Children are eligible from birth, but subject to the limits set forth under the Plan in Section XIV, Subsection A.

II. ELIGIBILITY **(Continued)**

Stepchildren, legally adopted children or children placed for adoption, grandchildren and children born out of wedlock will be eligible for coverage as dependents provided you have the primary responsibility for their support and maintenance. You will be required to supply proof of primary responsibility through a court order, judgment or decree, adoption certificates, federal tax returns or birth certificates. Affidavits may be required annually to provide proof of continued dependency. For children born out of wedlock, the Fund will require proof of paternity.

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

1. Procedures For Qualified Medical Child Support Order (QMCSO)

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

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

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

- Promptly notify you as well as any alternate recipient of receipt of the MCSO. This notice will include a copy of these procedures. An alternate recipient may designate a representative to receive copies of all notices to be sent to the alternate recipient. Notice shall be sent to the addresses set forth in the MCSO.
- Determine within a reasonable period of time after receipt of the MCSO whether it qualifies as a QMCSO and notify you and the alternate recipient (or his/her designated representative) of its determination.

To qualify as a QMCSO, a MCSO must:

- Be made pursuant to a state's or administrative court's directive to provide medical coverage.
- Recognize the existence of an alternate recipient's right to medical coverage under the Plan.
- Specify the name and last known mailing address of yourself and each alternate recipient (or his/her designated representative).
- Specify the type and period of medical coverage. *(An alternate recipient's eligibility for coverage is based upon your eligibility. An alternate recipient will be considered eligible for medical benefit coverage only during periods you are eligible. If employer contributions are insufficient to provide you with a level of coverage specified in an order, you are responsible for making the necessary self-payment required by the Plan.)*

II. ELIGIBILITY (Continued)

- Specify the Operating Engineers Local 825 Welfare Plan as the plan to which the order applies.
- Must not require the Plan to provide any type or form of benefit or option not otherwise provided under this Plan.

D. Eligibility of Retired Members

Over the years, the rules governing eligibility of retired members have changed. The information, which follows under this section, describes the rules currently in effect.

The coverage described herein is not vested and may be changed before or after you retire.

Members who retire under the Union’s Pension Plan with at least 10.00 years of credited service and with an average level of coverage during their last three years of employment immediately preceding their retirement date of at least Level 1 or with at least one hour of service in covered employment during each of the three years immediately preceding their retirement date are eligible to purchase continued health coverage as a retiree for a period of time which is based upon years of credited service at retirement as outlined below. If coverage under the Level of Benefit Program is extended as described later in this section, then the length of time a member is eligible to purchase continued health coverage as a retiree will be reduced by the period coverage under the Level of Benefit Program has been extended on and after a member’s retirement effective date.

Years of Credited Service	Maximum Years of Welfare Coverage For Each Year of Credited Service
Less than 10 years	No Coverage
10 years up to 20	1/2 Year Welfare Coverage
20 years and over	Lifetime

The costs for continued health coverage as a retiree for the four levels of benefit coverage provided under the Plan are established by the Board of Trustees. In order to be eligible for death benefits, you must purchase at least Level 1. Also, a retired member is not eligible for survivor benefits and supplemental accident and sickness benefits. Once you choose your benefit coverage level, it cannot be changed at any time. If you cancel your coverage, you will not have the opportunity to reinstate it at a later date.

If a retiree expires prior to exhausting his or her maximum years of welfare coverage, his or her surviving spouse will be eligible to purchase coverage up to the retiree’s level of benefit coverage prior to the retiree’s death, excluding death benefits, for the unused portion of the retiree’s welfare coverage period up to a maximum of 36 months. A surviving spouse who is employed where there is other group coverage of a non-contributory nature will only be considered for secondary coverage under the Plan. If a surviving spouse remarries, all welfare benefits terminate under the Plan.

II. ELIGIBILITY **(Continued)**

A retiree who expires while eligible for benefits will have death benefit coverage, the amount of which is determined based upon the retiree's pension effective date. Members who retire on or after September 1, 1988, will have death benefit coverage in the amount of \$1,000 per year of credited service up to a maximum of \$25,000, subject to Section V.

Members who retire from September 1, 1973 to September 1, 1988, will have death benefit coverage in the amount of \$12,000. Members who retire prior to September 1, 1973, will have death benefit coverage in the amount of \$3,000.

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

1. Eligibility Upon A Return To Covered Employment

A retiree who returns to covered employment, but works less than 40 hours per month, will continue to receive retiree welfare benefits earned as of his or her retirement date. The retiree cannot earn any additional years of welfare coverage as a result of reemployment.

A retiree who returns to covered employment and works 40 or more hours per month will have his or her welfare benefits (including death benefit) suspended. Such retiree will be permitted to purchase welfare benefits on a monthly basis until eligibility for welfare coverage has been established through sufficient employer contributions made on his or her behalf.

A retiree who returns to covered employment and becomes eligible either from employer contributions or from optional purchase shall be entitled to receive survivor benefits if he or she dies. However, the benefit amount will be calculated based upon years of service earned upon return to covered employment; pre-retirement years will not be included in this calculation of survivor benefits.

If a retiree returns to covered employment and becomes eligible (working 40 or more hours per month), the amount of death benefit coverage will remain set as of the date of retirement, except that it will increase at the rate of \$1,000 for each additional year of employment to a maximum of \$25,000.

II. ELIGIBILITY (Continued)

If a retiree returns to covered employment but does not become eligible, either because of insufficient employer contributions received on the retiree's behalf or because of the retiree's failure to purchase benefits on a monthly basis, ***NO DEATH BENEFIT WILL BE PAYABLE.***

2. Eligibility Upon Re-Retirement

In determining the amount of welfare coverage to which a member is entitled upon re-retirement, years of credited service earned as a result of reemployment will be combined with credited service at the time of original retirement. From the total number of years will be subtracted the period of welfare coverage already used by a member during the period of original retirement.

E. Special Enrollment Rights

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

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

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

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

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

- in the case of marriage, not later than the first day of the first month beginning after the date the written request for enrollment is received;
- in the case of a dependent's birth, as of the date of such birth; or
- in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

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

III. COORDINATION OF BENEFITS

A. Introduction

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

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

In coordinating benefits, only reasonable fees will be considered. Also, the yearly deductible and any applicable copayments still apply.

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

B. Exceptions

1. If the other group plan claims to provide excess coverage only, the Plan will only consider 20% of reasonable fees as primary carrier. Following payment under the Plan, the remaining balance should be submitted to the other plan for payment.
2. Where other coverage is provided by any program sponsored or arranged through a school, a league association or victims of violent crimes, the Plan will only reimburse up to 50% of reasonable charges as the primary carrier.
3. Where another group plan is primary, the Plan will not pay for charges denied by the primary plan because of a failure to follow the primary plan's prerequisites for coverage, including, but not limited to, failure to obtain prior authorization or failure to participate in clinical pathways or wellness programs.

III. COORDINATION OF BENEFITS (Continued)

C. Member and Spouse Coverage

The Plan provides primary coverage for an eligible member. A claim for expenses incurred by a member should be submitted to the Fund Office first. Secondary benefits are provided for a spouse who is employed and is eligible to participate in a group health plan of a non-contributory nature at his or her place of employment. In such a situation, the spouse's group plan is primary; and a claim for expenses incurred by the spouse should be submitted to the spouse's group plan first. If a member or spouse is actively working while the other has retired, the plan of the person who is actively employed is the primary plan for both.

D. Dependent Coverage

The Plan has adopted the Birthday Rule for coordinating benefits when a claim is made for an eligible dependent child covered by both this Plan and your spouse's plan. This rule stipulates that the plan of the parent whose birth date (month and day, not year) falls earlier in the calendar year will pay first. If the parents have the same birthday, the plan of the parent who has had coverage longer is primary.

If one of the two plans has not adopted the Birthday Rule, the rules of the plan without the Birthday Rule will determine which group plan is primary and which is secondary.

Where a dependent is a stepchild, the natural parent's insurance plan is primary.

E. Plan's Limit of Payments

When the Plan is secondarily liable, it will provide a reduced benefit which, when added to the benefits under other group plans, will equal 100 percent of reasonable expenses. In no event will the Plan's liability as a secondary carrier exceed its liability as a primary carrier.

IV. SUBROGATION AND REIMBURSEMENT

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

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

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

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

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

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

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

This provision shall apply to recoveries for current, as well as future, expenses estimated to be incurred. If a settlement has been reached which includes payment for future medical expenses, any later arising claims relating to the injury or illness which were part of the settlement will not be considered for payment under the Plan.

IV. SUBROGATION AND REIMBURSEMENT

(Continued)

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

V. DEATH BENEFITS

If you expire while eligible for benefits, the Plan will pay a death benefit to your beneficiary.

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

Your death benefit will be paid to the beneficiary you have named. You may name anyone as your beneficiary and you may change a designation from time to time; however, the benefit will be paid to your last named beneficiary, unless otherwise assigned pursuant to a Qualified Domestic Relations Order. It is important that you make any changes immediately so that your current wishes are properly reflected. If at the time of your death you have not designated a beneficiary, or if designated, your beneficiary is not living, the death benefit will be paid to your estate. Upon your initial enrollment, you will be asked to complete an enrollment card, which includes an area for you to designate a beneficiary for your death benefit. If at any time thereafter you wish to change your beneficiary designation, it will be necessary for you to complete a Notice of Change in Dependent Status and/or Change of Beneficiary Form (Sec. 2).

The amount of your death benefit coverage will be determined by multiplying your years of Plan participation by \$1,000, to a maximum of \$25,000. Years of Plan participation will be based upon years of credited service under the Pension Plan. For those members who are not participants in the Pension Plan, years of Plan participation will be based upon years of eligibility for coverage under the Welfare Plan. If your Plan participation is not continuous, then upon your return as a Plan participant, your years of Plan participation prior to your break in participation will not be counted towards your years of Plan participation unless your return as a Plan participant occurs within three years from the last time you were an active participant, in which case your years of Plan participation prior to your break in participation will be combined with your years of Plan participation after your return as a Plan participant.

Members who retire and who are not eligible to purchase lifetime coverage will have the option of extending their death benefit coverage for a longer period of time by accepting a reduced amount of coverage. The amount of coverage is based on the member's age at retirement.

VI. SURVIVOR BENEFITS

This benefit is only available to your spouse or dependent children when you die in the status of an active employee who is eligible for benefits under the Plan. Any member who is receiving pension benefit payments at the time of death, whether or not such member has returned to covered employment and continues to receive a pension benefit because he or she is working under the maximum 40 hours per month allowed by the Plan, is not eligible for this benefit. Moreover, the survivor benefit is not available in connection with the death of a dependent.

In the event you die while eligible for benefits, in addition to your death benefit, the Plan will make payments of \$15 per month for each year of Plan participation, as defined above in Section V, up to a maximum of \$300 per month.

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

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

VII. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

The loss must take place within 90 days after the accident and must be a direct result of the accident and may not be caused by war, narcotics, drugs, alcohol or intentionally self-inflicted injuries or injuries sustained in the commission of a crime. Loss of eyesight means the entire and permanent loss of sight.

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

VIII. SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFIT

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

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

Accident and sickness benefits are payable to active, eligible members. These benefits do not apply to retired members who do not work or who work less than 40 hours per month while collecting a pension benefit.

If you are unable to work because of an accident, you will receive a weekly payment of \$180 starting with the first day of disability. Payment will continue for as long as you are disabled up to a maximum of 26 weeks.

If you are unable to work because of an illness, you will receive a weekly payment of \$180 starting with the eighth day of disability. In the event that your illness continues through the twenty-second day of disability, you may then apply for benefit payment for the first seven days of your disability. Payment will continue for as long as you are disabled up to a maximum of 26 weeks.

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

IX. OVERVIEW OF HEALTH COVERAGE

As outlined in Section II, there are four levels of benefit coverage, each of which provides for specific benefits. You must be eligible for a particular level in order for the Plan to consider a claim for benefits for you or your dependents. Once it has been determined that you are eligible for benefits, the Plan will pay benefits as outlined in this booklet for participating providers or non-participating providers. Certain expenses are excluded from coverage under the Plan. These exclusions are set forth in Section X. In addition to these exclusions, overall limitations apply to some benefits. Whenever the term treatment is referred to in this booklet, it shall mean medical care, services or supplies, including, but not limited to, advice, consultation, the prescribing of drugs or medicines or surgery. To be covered, treatment must be medically necessary, meaning that (1) treatment is ordered by a physician, (2) treatment is consistent with the diagnosis and treatment of a patient's condition, (3) treatment is generally recognized by the medical community as safe and effective or appropriate for a patient's condition, (4) treatment is approved by the Food and Drug Administration for the particular use for which coverage is sought, (5) treatment is approved for reimbursement by the Centers for Medicare and Medicaid Services for the particular use for which coverage is sought, (6) treatment is not experimental or provided in connection with medical or other research, (7) treatment is rendered by a provider licensed or certified to provide the treatment under the laws of the state where the provider practices, and (8) treatment duration does not exceed the appropriate length of care as determined by the Fund's Medical Director. If a particular treatment is not outlined in this booklet, call the Fund Office.

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

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

X. EXCLUSIONS AND LIMITATIONS

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

1. Treatment provided by any federal, state or local government.
2. Treatment made necessary by any motor vehicle accident, including services rendered to anyone injured by a motor vehicle. Motor Vehicles include automobiles, trucks, vans, and motorcycles. **IF YOU RESIDE IN A STATE WHERE YOU ARE GIVEN THE OPTION OF ELECTING A PIP DEDUCTIBLE, REMEMBER THAT THE PLAN WILL NOT PAY FOR ANY TREATMENT, INCLUDING TREATMENT NOT PAID BY YOUR INSURANCE CARRIER. THEREFORE, THE DEDUCTIBLE UNDER YOUR PIP IS EXCLUDED FROM COVERAGE.**
3. Treatment for any sickness, disease or injury arising out of or in the course of employment, whether or not there is Workers' Compensation available.
4. Treatment not ordered by a physician (the term "physician" solely refers to a duly licensed Doctor of Medicine (M.D.), Osteopath (D.O.), Podiatrist, Chiropractor, Dentist, and Optometrist) and treatment not rendered by a provider licensed or certified to provide treatment under the laws of the state where the provider practices.
5. Treatment which is not approved by the Food and Drug Administration or approved for reimbursement by the Centers for Medicare and Medicaid Services for the particular use for which coverage is sought.
6. Treatment which is not considered medically necessary as defined in this Plan.
7. Medical expenses you are not legally required to pay.
8. Any charges in excess of reasonable fees as defined in this Plan.
9. Sickness, disease or injury resulting from war or an act of war or incurred during military service.
10. Intentionally self-inflicted injuries.
11. Injuries incurred while committing an act which constitutes a crime, whether or not the injury is caused by an unintentional event.
12. Private nursing care, whether in a hospital or at home, rendered by a relative. Also, to be eligible for private duty nursing rendered by a non-relative, you must submit a letter of medical necessity from your attending physician for preauthorization by the Fund's Medical Director.
13. Care or treatment rendered in a rest facility, a nursing facility or a facility for the aged.
14. Care or treatment of alcoholism, drug addiction or psychiatric treatment in other than an accredited facility.

X. EXCLUSIONS AND LIMITATIONS **(Continued)**

15. Custodial care or treatment, even if rendered in an accredited hospital. Custodial care includes, but is not limited to, assistance in daily living activities, such as walking, bathing, feeding; preparation of special diets; and supervision of medication which is usually self-administered.
16. Cosmetic surgery which does not directly result from an accident suffered while an eligible participant or dependent or, if direct result of an accident, does not occur within 12 months of accident's occurrence.
17. Cardiac rehabilitation, cardiac physical therapy, and post-heart attack exercise programs, including all equipment and supplies, unless preauthorized by the Fund's Medical Director.
18. Any treatment for weight control, except treatment for morbid obesity and co-morbid conditions associated with morbid obesity, which treatment has been preauthorized by the Fund's Medical Director.
19. Non-emergency ambulance service or air transport service.
20. Standby surgeon.
21. Reduction mammoplasty, with the exception of post-mastectomy patients. For other than post-mastectomy patients, the Fund's Medical Director must approve medical necessity.
22. Removal of breast implants, except post-mastectomy.
23. Treatment for impotence, including penile implants or any MEDICATION or devices.
24. Intersex surgery and any related charges.
25. Blepharoplasty performed on lower eyelid.
26. Testing and therapy for learning disabilities and testing for psychiatric disabilities as well as psychiatric evaluations.
27. Drugs available without a prescription, even if a prescription has been issued by a doctor, or drugs dispensed by anyone other than a licensed pharmacist.
28. Food supplements.
29. Any donor expenses associated with a body organ transplant.
30. Genetic testing, except for amniocentesis and BRCA1 and BRCA2 gene mutations preauthorized by the Fund's Medical Director.
31. Services to a child-dependent related to childbirth, miscarriage or abortion.

X. EXCLUSIONS AND LIMITATIONS **(Continued)**

32. Personal expenses incurred during a hospital confinement, such as guest meals and television rental.
33. Specially molded shoes.
34. Occupational therapy, except following a stroke, a spinal cord injury or surgery. Treatment must be rendered by a certified Occupational Therapist. Treatment must be ordered by a M.D. and be preauthorized by the Fund's Medical Director.
35. Visual therapy.
36. Radial keratotomy or any other surgical procedure to correct vision.
37. Medical treatment of eye disease or injury rendered by an optometrist who does not hold a therapeutic license to treat ocular diseases.
38. Sterilization reversal.
39. Bras, cranial prosthesis and specialty clothing.
40. Lamaze classes.
41. Durable medical equipment for non-medical purpose, including, but not limited to: specialty beds (including waterbeds), chairs, air conditioners, humidifiers, dehumidifiers, whirlpool baths, heating pads, and exercise equipment.
42. CPM (Continuous Passive Motion Machine).
43. Supportive care.
44. Expenses incurred by a child age 25 or older.
45. If you elect not to take part 'B' Medicare and Medicare is your primary carrier, any charges that would be covered under part B are not eligible.
46. Blood pressure monitoring machines.
47. Biofeedback.
48. Moh's surgery, other than face.
49. Treatment for complications relating to an excludable treatment under the Plan.
50. Acupuncture treatment rendered for other than pain management.
51. Charges for missed appointments, interest on late payments, and collections.

X. EXCLUSIONS AND LIMITATIONS (Continued)

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

AIDS/HIV

\$50,000 LIFETIME

GENETIC

TESTING

Coverage for genetic testing is limited to amniocentesis testing and up to three counseling sessions during pregnancy and, when preauthorized by the Fund's Medical Director, a \$3,000 maximum lifetime benefit for BRCA1 and BRCA2 gene analysis and counseling.

INFERTILITY

\$2,000 per 12-month period, including all expenses related to surgical procedures, drugs and expenses associated with a spouse's participation.

JAW JOINT DISORDERS

\$2,500 LIFETIME

MAGNETIC RESONANCE IMAGING

(Except for brain, brain stem and cervical spinal cord, which are covered in accordance with the Plan's reasonable fee)

\$500 PER SITE

MOH'S SURGERY

(Coverage provided for face only)

\$1,000

WEIGHT CONTROL TREATMENT FOR MORBID OBESITY AND CO-MORBIDITIES ASSOCIATED WITH MORBID OBESITY

Benefits for treatment preauthorized by the Fund's Medical Director are subject to a maximum lifetime payment of \$50,000. Benefits shall include preoperative evaluation, consultation, facility charges, surgery, anesthesia, charges related to complications, nutritional counseling, and prescription drugs (Level 4 eligible). No benefits are payable for food supplements, special foods, exercise programs, and medications which do not require a prescription. Complications include, but are not limited to, (1) Immediate complications - wound infection, wound dehiscence, bleeding, blood clot formation and pulmonary embolism; and (2) Long-term complications - excessive skin of abdominal wall leading to panniculitis, abdominal hernias, chronic wound infections and draining sinuses, and metabolic complications due to lack of absorption.

X. EXCLUSIONS AND LIMITATIONS **(Continued)**

MOTORIZED RECREATIONAL VEHICLES

Benefits provided for injuries sustained in connection with a motorized recreational vehicle accident are subject to a non-renewable lifetime aggregate maximum of \$50,000 for all claims. Motorized Recreational Vehicles include, but are not limited to, any of the following:

- * Moped
- * Mini-bike
- * Dirt-bike
- * Go-cart
- * Motor-assisted bicycle
- * All terrain-vehicle
- * Snowmobile
- * Boat
- * Personal watercraft

When other coverage is available, payment of benefits under this Plan will be determined only after payment of benefits under such other coverage.

NEONATAL

(Care rendered during first 30 days of birth)

\$50,000 LIFETIME

ORGAN TRANSPLANTS

Benefits provided for recipient expenses to a maximum of \$100,000 per procedure for kidney, liver, heart, and bone marrow transplant surgeries and to a maximum of \$40,000 per procedure for corneal transplant surgery. Donor expenses are not covered. Charges for immunosuppressant medications following surgeries are covered under Level 4 in accordance with the Plan's prescription drug program in addition to transplant procedure maximums.

PAIN MANAGEMENT

Coverage for injection therapies and implantable interventions rendered on an outpatient basis which has been approved by the Fund's Medical Director is subject to a maximum payment of \$600 per visit and \$6,000 per calendar year (professional and facility combined). Acupuncture treatment for management of pain must be rendered by a medical doctor (M.D. or D.O.) certified to perform acupuncture or by non-medical practitioner holding license to practice acupuncture in the state where services are rendered. Acupuncture benefit payments are applied towards and are subject to the \$6,000 calendar year maximum.

PHYSICAL THERAPY

When prescribed by a M.D. or D.O. and rendered by a physician or licensed physical therapist working under the orders of a physician, up to 36 sessions per illness or injury are covered. Any treatment beyond the Plan's limitation is subject to approval by the Fund's Medical Director.

SPEECH THERAPY

When needed following a stroke, or when preapproved by the Fund's Medical Director for other conditions, up to 36 sessions per illness or injury are covered. Any treatment beyond the Plan's limitation is subject to approval by the Fund's Medical Director.

XI. PRECERTIFICATION

The purpose of precertification is to review medical necessity, to assist you in understanding Plan benefits, and to provide guidance in obtaining the most appropriate treatment at reasonable cost. The decision to proceed with a particular treatment, however, lies with a patient and his or her physician. ***Precertification does not guarantee eligibility or payment.*** Following is a list of services which require precertification (or prior authorization). In addition, where noted in the Plan, approval of the Fund's Medical Director is required for specific treatment. Precertification requests may be made by you (or a family member) or a service provider by calling 1-800-677-3237 prior to scheduled treatment. Precertification calls should be made as soon as possible prior to scheduled treatment. For emergency treatment, precertification requests should be received within two (2) two working days following such treatment. At the time a precertification call is received, basic information regarding the scheduled treatment will be requested. If necessary, additional information will be obtained from the service provider. If the particular treatment being precertified is not covered under the Plan, the patient and/or his or her attending physician will receive written notification.

1. Referral for all hospital activity: inpatient admissions, same-day surgeries, outpatient diagnostic and non-diagnostic procedures.
2. All surgical procedures, regardless of place of surgery.
3. Moh's surgical procedures.
4. Skilled nursing facility.
5. Infertility treatment.
6. Home health care.
7. Home I.V. therapy.
8. Diagnostic Tests: myelogram, M.R.I., C.A.T. scan, RAST testing, PET scan, sleep apnea studies, amniocentesis, or any other procedure in excess of \$600.
9. Long-term treatment plans: rehabilitation, speech therapy, physical therapy, occupational therapy and radiation therapy.
10. Private duty nursing.
11. Durable medical equipment.
12. Drug therapy: AZT, chemotherapy, injectables (except insulin and immunization), pentamidine treatments.
13. Lyme disease treatment.

XII. COPAYMENTS

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

SERVICE	COPAYMENT
Emergency Room	\$25.00 per incident
Surgery	\$25.00 per procedure where surgical fee is greater than \$100.00 \$10.00 per procedure where surgical fee is \$100.00 or less
Hospital	\$25.00 per confinement (in-network) \$500.00 per confinement (out-of-network)
Surgicenter	\$25.00 per incident
Doctor Visits (in hospital and office)	\$15.00 per visit
Second Opinion	\$15.00 per visit
Chiropractor Visit	\$15.00 per visit
Podiatry Visit	\$15.00 per visit
Laboratory Services (excluding veripuncture) rendered in outpatient department of hospital, a freestanding facility or physician office	\$10.00; if multiple laboratory services are rendered on any one day, maximum daily copayment is \$10.00
Diagnostic Testing (radiology, EKG's, echoes, etc.) rendered in outpatient department of a hospital, a freestanding facility or physician office	\$25.00; if multiple diagnostic tests are rendered on any one day, maximum daily copayment is \$25.00

XII. COPAYMENTS (Continued)

Prescription Drug

<i>Medication Type</i>	<i>Network Pharmacy</i>	<i>Mail Pharmacy Service</i>
Generic Medications	\$7	\$14
Preferred Brand (Formulary)	20% coinsurance \$75 maximum	20% coinsurance \$150 maximum
Non-Preferred Brand (Non-Formulary)	35% coinsurance \$75 maximum	35% coinsurance \$150 maximum
Non-Preferred (Non-Formulary)	50% coinsurance \$30 minimum	50% coinsurance \$60 minimum

XIII. HEALTH CARE BENEFITS

Under the Welfare Plan, you have the freedom to choose your health care providers. You will benefit most under the Plan by choosing providers from any of the medical, surgical, chiropractic, podiatric, laboratory, radiology and durable medical equipment providers which participate with the Operating Engineers Local 825 PPO. No referrals are required, although precertification requirements under Article XI of the Plan may apply. The providers who participate with the Plan are under contract to provide services at prenegotiated fees. A list of participating providers is available without charge on the Plan's website (iuoe825.org) or upon telephone or written request to the Plan. These providers must meet specific credentialing standards for acceptance into the network and periodically undergo repeat verification of their credentials. *Remember, physicians may shift into and out of the participating provider network. Therefore, it is strongly suggested that you contact the Provider Relations Department prior to scheduling your appointments to verify that a provider is still participating.*

Your share of costs is lowest when care is received through the Plan's network of participating providers. When treatment is rendered by a participating provider, the Plan will pay benefits based upon prenegotiated rates. The only out-of-pocket expense you will incur is any applicable copayment. On the other hand, when treatment is rendered by a non-participating provider, you are responsible for 20 percent coinsurance, any applicable copayment, and any charges in excess of reasonable fees, after satisfaction of the annual calendar year deductible. The deductible is \$200 per family member of eligible expenses to a maximum of \$600 per family. No more than \$200 will be applied towards the family deductible for expenses incurred by any one family member. Any other differences in coverage between participating and non-participating providers are specifically noted in Sections XIV through XVII. Although the Plan's participating provider network is designed to cover a broad range of service providers, **a high percentage of providers in certain specialties, particularly anesthesia and pathology, do not participate.** Claims for services rendered by these providers will be processed as described herein for non-participating providers. Payment of reasonable fees is based upon the Resource Based Relative Value System (RBRVS), a system utilized by the Centers for Medicare and Medicaid Services for determining the appropriateness of fees, which accounts for factors such as complexity of services, a provider's operating expenses, and geographic area where services are rendered. In no event will reasonable fees exceed billed amounts. If possible, you should always discuss billing procedures prior to receiving treatment from a non-participating provider.

Whether services are rendered by a participating or non-participating provider, the Plan will not consider payment for any charges which exceed specific maximum benefit limitations. Also, excluding accident and sickness, survivor, death, vision and dental benefits, all benefits payable under the Plan are subject to a lifetime maximum of \$1,000,000 per person. However, \$1,000 of benefits will be reinstated at the beginning of each calendar year.

XIII. HEALTH CARE BENEFITS (Continued)

In addition to the benefits described in greater detail in the sections which follow, below is a list of treatments covered under the Plan. For any treatment not addressed in the Plan, please contact the Fund Office.

1. The services of a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.), except one who is a member of your family or who ordinarily lives in your home, provided that such services are deemed necessary by the attending physician.
2. Rental or purchase of durable medical equipment such as oxygen equipment, a wheelchair and hospital-type bed prescribed by a physician and which is for a therapeutic purpose consistent with an illness or injury. You must submit a written request from the physician to the Fund Office for this equipment. The Fund Office must authorize the rental or purchase in advance. Items used for comfort and convenience and not primarily medical in nature (whether prescribed by a physician or not) are not covered.
3. Purchase of braces, artificial limbs, prostheses and medical supplies. You must submit a written request from the physician to the Fund Office for this equipment. The Fund Office must authorize the purchase in advance.
4. Dental services required as a result of accidental bodily injury, provided such services are rendered within 12 months of the date of accident.
5. Hearing aids prescribed by a medical doctor. An otologist is not a doctor. This benefit is limited to once every two years.
6. For post-mastectomy patients, reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prosthesis and physical complications of all states of a mastectomy, including lymphedemas.

XIV. LEVEL 1 BENEFITS OF HEALTH CARE

A. Inpatient Hospital Coverage

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

For mental health and substance abuse treatment, see Subsection L.

While routine care of a newborn child is covered, all treatment rendered a newborn neonatal infant is subject to a maximum benefit of \$50,000.

B. Outpatient Preadmission Testing

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

C. Outpatient Emergency Room Care

The Plan covers outpatient services that are medically necessary within 48 hours of an accident or the onset of a sudden or serious illness. This benefit does not cover routine medical care rendered in the emergency room in lieu of a visit to the doctor's office.

D. Outpatient Surgicenter Care

Services provided by a licensed freestanding surgical center will be covered for ambulatory same-day surgery. Eligible services are the same as inpatient hospital, except for room and board. Each day of care at a surgicenter is counted as part of available inpatient hospital days.

E. Convalescent Care (Subacute) Following A Hospital Stay

This benefit will help pay for a convalescence at a licensed intermediate care facility after a hospital stay of a least five consecutive days. The confinement must start within seven days after release from a hospital and must be required by your doctor for the condition causing the hospitalization. Up to 100 days per condition will be covered for expenses at a convalescent care facility. Any extension beyond 100 days is subject to approval by the Fund's Medical Director. The Plan places a 365-day limit on the payment for hospitalization and convalescent benefits combined for any one condition. **Medicare patients must be admitted to a Medicare certified facility for benefits to be paid.** For

XIV. LEVEL 1 BENEFITS OF HEALTH CARE **(Continued)**

non-Medicare patients, payment is limited to 50 percent of the standard daily semi-private room rate charge for room and board for the hospital from which the patient was transferred.

Convalescent care requires coverage on a 24-hour basis by the facility's doctor and nursing staff. Convalescent care does not mean custodial care. The Plan does not cover custodial care.

F. Ambulance

The Plan will pay 100 percent of charges up to a maximum of \$500 per trip to a maximum of \$1,500 per calendar year for all trips for emergency ambulance service.

G. Home Health Care for the Terminally Ill

This benefit is provided to a terminally ill patient in need of home health care. A terminally ill patient is one with a medical diagnosis of an end-stage disease and with a life expectancy of less than six months. The patient's physician must certify the need for home health care, the medical diagnosis and the life expectancy.

The Plan places a 365-day limit on coverage for both home health care and hospital care. If you first receive hospital care for a certain number of days, the balance of the 365 days will be available for home health care. If you receive home health care first, the balance will be available for the hospital care. The Plan will pay home health care expenses incurred up to the daily limit of \$200 (\$100 per shift and two shifts per day). Care provided by a relative is not covered.

H. Surgical

The Plan provides benefits for surgery performed by a physician, as the term "physician" is defined in Section X. Benefits are payable whether an operation is performed in the hospital on an inpatient or outpatient basis or in a physician's office. The Plan will consider the fee for the surgical procedure in accordance with reasonable fees for the procedure performed.

Benefits will be provided for charges by an assistant surgeon when deemed medically necessary. The assistant surgeon must be a medical doctor and charges must be billed separate from the primary surgeon. No benefits are payable for assistant services provided by hospital personnel.

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

The Plan will pay 100% of reasonable charges for anesthesia services rendered. Only one anesthesia charge per procedure will be considered for payment.

XIV. LEVEL 1 BENEFITS OF HEALTH CARE **(Continued)**

I. Maternity Care

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

Under Federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

J. Doctor Visits

The Plan will consider charges for in-hospital and out-of-hospital doctor visits up to reasonable amounts. If a surgical operation is performed, the Plan will pay for your doctor visits up to the day the operation is performed. No additional payment will be made for post-operative care.

K. X-ray and Laboratory Care

If you or your eligible dependent require diagnostic X-ray or laboratory services, charges up to the reasonable amount will be considered.

L. Mental Health/Substance Abuse Treatment

Mental health and substance abuse benefits provided under the Plan are managed through Magellan Behavioral Health. A table of mental health and substance abuse benefits for in-network and out-of-network services is below. If a referral is received to a Magellan Behavioral Health provider, the only out-of-pocket expense incurred will be the copayments listed. If you do not receive a referral to a Magellan Behavioral Health provider or you use an out-of-network provider, you will be responsible for the copayments listed plus any charges in excess of the payments outlined for out-of-network services. Active members and retirees who are not Medicare eligible are eligible to utilize the services of in-network providers.

In addition to mental health and substance abuse benefits, an Employee Assistance Program (EAP) is available for all active members through Magellan Behavioral Health. This service is available 24 hours per day at no cost by telephoning 1-800-346-5486.

XIV. LEVEL 1 BENEFITS OF HEALTH CARE (Continued)

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

Mental Health	In-Network	Out-of-Network
<i>Inpatient Facility</i>	100% after \$25 per admission* copayment up to 30 days per year, 90 days lifetime maximum	70% of average in-network allowance after \$500 per admission* copayment up to 30 days per year, 90 days lifetime maximum
<i>Inpatient Physician Visits</i>	100% after \$15 copayment per visit, up to 30 visits per year, 90 visits lifetime maximum when authorized as part of in-network admission	80% of in-network allowance after \$15 copayment per visit, up to 30 visits per year, 90 visits lifetime maximum when authorized as part of out-of-network admission
<i>Partial Hospitalization (PHP)</i>	1 inpatient day can be exchanged for 2 PHP days	No Benefit
<i>Outpatient</i>	100% after \$15 copayment per visit, up to 50 visits per year, 150 visits lifetime maximum	50% after \$15 copayment per visit, up to \$25 plan payment for services rendered by a MD or PhD only, up to 50 visits per year, 150 visits lifetime maximum
SUBSTANCE ABUSE	In-Network	Out-of-Network
<i>Inpatient</i>	100% after \$25 per admission* copayment up to 30 days per year, 60 days lifetime maximum	70% of average in-network allowance after \$500 per admission* copayment up to 30 days per year, 60 days lifetime maximum
<i>Partial Hospitalization (PHP)</i>	1 inpatient day can be exchanged for 2 PHP days	No Benefit
<i>Outpatient</i>	100% after \$15 copayment per visit, up to 50 visits per year, 150 visits lifetime maximum	No Benefit

*All inpatient services must be preauthorized for medical necessity both in and out of network. If not preauthorized, there is a 20% penalty for failure to precertify medically necessary admissions. If admission is determined to be not medically necessary, there is no benefit. **Note:** Yearly maximums are calculated on a calendar year basis. Yearly and lifetime maximums are combined for in- and out-of-network benefits.

XIV. LEVEL 1 BENEFITS OF HEALTH CARE (Continued)

M. Cancer Medications

The Plan will pay 100 percent of reasonable charges for chemotherapy medications. Chemotherapy medications purchased at a local pharmacy will be considered in accordance with the Plan's prescription drug program.

N. Diabetic Supplies

Charges for glucometers, test strips, syringes/needles and lancets will be considered up to reasonable amounts. Diabetic supplies purchased at a local pharmacy will be considered in accordance with the Plan's prescription drug program (Level 4 participants only). Glucometers are limited to one during any 36 consecutive months to a maximum of \$100.

O. Medicare

Medicare coverage consists of two parts - Part A (Hospital Insurance) and Part B (Medical Insurance). You become eligible for Medicare either when you reach age 65 or after you have been receiving Social Security disability benefits for 24 months. There is no premium for Part A. To receive Part B, you must pay a monthly premium for this coverage. Roughly three months before your 65th birthday, you should contact Medicare about applying for Medicare coverage. Medicare's enrollment rules differ depending on whether you have stopped working or remain actively employed after you turn age 65. Delaying enrollment may adversely affect the start of your Medicare coverage.

When you become eligible for Medicare and are retired, Medicare becomes your primary health insurance coverage and the Plan becomes your secondary coverage, unless your spouse is actively employed and you are covered under a group health plan through your spouse's place of employment, in which case the order of benefit determination is your spouse's group plan first, Medicare second and the Plan last. ***If you are retired and fail to obtain Medicare coverage for yourself or your spouse when eligible, claims will not be considered for coverage under the Plan.*** If you remain actively employed after 65 years of age, the Plan is primary for you and your eligible dependents. If your spouse becomes eligible for Medicare, the Plan will remain primary for both you and your spouse as long as you remain an active employee, whether or not you are over 65 years of age.

When Medicare is primary, all claims must first be submitted to your Medicare carrier, who will send you a statement of payment or rejection. This statement then should be forwarded to the Fund. The Plan will pay the difference between the Medicare approved amount and the Medicare paid amount on your Medicare statement, minus any applicable copayment, whether or not the service provider accepts Medicare assignment. If Medicare rejects your claim, other than for your failure to purchase Part B Medicare or your entering into a Medicare Private Contract with a service provider in which you agree to give up Medicare payment for services furnished by such provider, coverage will be considered under the provisions of the Plan.

When the Plan is primary, continue to send your claims to the Fund Office first. Reimbursement will be made in accordance with the Plan. Your explanation of benefits accompanying your benefit payment should then be sent to your Medicare carrier.

XV. LEVEL 2 BENEFITS OF HEALTH CARE

A. *Vision Coverage*

The Plan provides vision benefits covering an eye examination (refraction) performed by a licensed optometrist or ophthalmologist and lenses and frames ordered by them. Benefits are paid at 100 percent up to the scheduled reimbursement amounts outlined below, whether services are rendered by a participating or non-participating provider.

Vision Care Service	Benefit Amount
Complete eye examination (Refraction)	\$ 40.00
Materials - Per Lens	
Single Vision (glass)	\$ 11.00
Bifocal (glass)	\$ 18.00
Trifocal (glass)	\$ 29.00
Lenticular (glass)	\$ 50.00
Plastic Lenses - Additional Per Lens	\$ 5.00
Contact Lenses - Per Lens (following surgery for cataracts) (Lenses covered would be for long-term care)	\$101.00
Frames	\$ 35.00

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

Coverage for medical treatment of eye disease or injury by an ophthalmologist or optometrist holding a therapeutic license to treat ocular diseases is provided under the medical portion of the Plan.

XV. LEVEL 2 BENEFITS OF HEALTH CARE (Continued)

B. Chiropractic Care

Reasonable charges for chiropractic treatment will be considered and paid up to a maximum of \$1,000 per calendar year for all services rendered by a licensed chiropractor (including any X-rays).

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

1. Incomplete dislocation of vertebrae
2. Off-centering of vertebrae
3. Misalignment of vertebrae
4. Fixation of vertebrae
5. Abnormal spacing of vertebrae

C. Podiatry Care

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

Surgical procedures (open cutting procedures) performed by a podiatrist are not considered routine podiatric care, and charges for such procedures are considered as any other illness. A list of surgical procedures commonly performed by podiatrists and reimbursed under the Plan is available from the Fund Office.

No coverage is provided for specially molded shoes. Orthotics will be paid under the \$750 calendar year maximum.

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

A. Benefits

The Plan's dental program is administered by BeneCare Dental Plans. When you become eligible for benefits under the Welfare Plan, you will receive a BeneCare identification card.

The Plan provides dental benefits in accordance with an established schedule under which benefits are paid up to the dentist's actual charge or the Plan's maximum benefit allowance, whichever is lower, for each procedure, whether services are rendered by a participating or a non-participating dentist. The maximum amount payable in any calendar year for all courses of dental treatment is \$1,200 per covered person.

You may visit any dentist you choose. Your share of costs, if any, will depend on whether you visit a participating or a non-participating dentist. Dentists who participate in the network have contractually agreed to either accept the Fund's payment as payment in full for all services with no balance billed to you or to accept the Fund's payment as payment in full for all services covered at 100 percent (examinations, X-rays, preventive services, simple fillings, and extractions other than bony impactions) and balance bill you only the difference between the Fund's payment and the lower of (1) the dentist's actual charge or (2) the maximum amount the dentist is permitted to charge above the Plan's maximum benefit allowance for all other services. To receive dental services from a participating dentist, call BeneCare at 1-800-843-4727 for assistance in locating a dentist convenient to you. Upon telephone or written request to the Plan, a list of participating dentists will also be provided to you without charge. Once you have chosen a dentist, call the dentist's office direct to schedule an appointment. Present your identification card at the time of your visit to insure that you receive the full benefits available to you.

If you choose to visit a dentist who does not participate in the network, ask your dentist to submit completed claims to:

***BeneCare Dental Plans
One Independence Mall, Suite 1001
615 Chestnut Street
Philadelphia, PA 19106-4404***

Claims for dental benefits must include member's name and Social Security number, patient's name, procedure codes, treatment description(s), date(s) of service and charge for each treatment procedure. Reimbursement for treatment will be made up to the same maximum benefit allowances for participating dentists.

B. Pretreatment Estimates

You may request a pretreatment estimate for any procedure your dentist is proposing. Whenever the cost of treatment is expected to exceed \$250.00, you should ask your dentist to submit a request for predetermination of covered benefits to BeneCare. BeneCare will review the proposed treatment and notify the dentist if the treatment is covered and the dollar amount of benefits payable, provided you are eligible for benefits at the time treatment is actually rendered. To facilitate either a predetermination or the review of completed services, BeneCare requires that all pertinent documentation be provided by the treating dentist, including, where applicable, appropriate X-rays, charting of periodontal pocket depths and a treatment narrative.

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

C. Orthodontic Treatment

In addition to the \$1,200 calendar year maximum, a \$2,500 maximum lifetime benefit is provided for orthodontic treatment for a dependent child who commences orthodontic treatment prior to age 18. Benefits for orthodontic treatment are paid in installments based on the Plan's \$2,500 lifetime maximum, with an initial benefit payment of \$1,000 and the remaining \$1,500 payable in monthly installments. You must remain eligible for dental benefits for a monthly installment to be paid.

D. Dental Fee Schedule

Following is a listing of some more commonly performed dental services and maximum benefit amounts payable for each. Upon telephone or written request to the Plan, a detailed schedule will be made available to you without charge.

AMERICAN DENTAL ASSOCIATION CODES	DENTAL PROCEDURE	MAXIMUM BENEFIT AMOUNT
00120	Periodic Examination	\$ 28.00
00150	Complete Oral Evaluation	\$ 38.00
00210	Complete X-ray Series	\$ 75.00
00220	Single Periapical X-ray	\$ 12.00
00272	Two Bitewing X-rays	\$ 21.00
00330	Panoramic X-ray	\$ 65.00
01110	Adult Prophylaxis	\$ 60.00
01120	Child Prophylaxis	\$ 50.00
02150	Two Surface Amalgam permanent tooth	\$ 80.00
02331	Two Surface Anterior Composite -perm. tooth	\$ 110.00
02386	Two Surface Posterior Composite - perm. tooth	\$ 105.00
02752	Crown Porcelain Fused to Noble Metal	\$ 550.00
02930	Stainless Steel Crown - primary tooth	\$ 140.00
03330	Molar Root Canal Therapy	\$ 500.00
04341	Periodontal Scaling and Root Planing, per quadrant, subject to the Plan's specific limitations	\$ 75.00
05110 /05120	Complete Denture	\$ 600.00
05213/05214	Cast/Acrylic Partial Denture	\$ 600.00
05421/05422	Denture Adjustment	\$ 40.00
07110	Single Tooth Extraction	\$ 90.00
08010 -08090	Comprehensive Orthodontic Treatment	\$2,500.00
09952	Complete Occlusal Adj.	\$ 100.00

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

Coverage for the removal of bony impacted teeth is provided under the medical portion of the Plan and coverage for treatment of jaw joint disorders is provided up to a lifetime maximum of \$2,500 per person under the medical portion of the Plan. Benefit payments are based upon reasonable charges and may be subject to the annual calendar year deductible, 20 percent coinsurance and copayments.

E. Coverage Exclusions

Plan payments will not be made for the following:

- Experimental procedures.
- Appliances, restorations, and procedures to alter vertical dimension, including, but not limited to, occlusal guards and periodontal splinting.
- Space maintainers for dependent children age 10 or over.
- Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance.
- Restorations which are not of any dental health benefit, but purely cosmetic in nature.
- Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including posterior composites or the use of fixed bridgework, where a removable partial denture would restore the arch. Payment of the applicable percentage of the Plan allowance for the alternate service will be made toward such treatment and the balance of the cost remains the responsibility of the patient.
- General anesthesia, except for the following reasons:
 - ◆ Removal of one or more impacted teeth.
 - ◆ Removal of four or more erupted teeth.
 - ◆ Treatment of a physically or mentally impaired person.
 - ◆ Treatment of a child under age 11.
 - ◆ Treatment of a person who has a medical problem, when the attending physician requests in writing that the treating dentist administer general anesthesia. This request must accompany the dental claim form.
- Duplicate charges.
- Services incurred prior to the effective date of coverage.
- Services incurred after cancellation of coverage, whether or not services commenced while covered.

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

Coverage Exclusions (Continued)

- More than two oral examinations in any twelve-month period.
- Services incurred in excess of the benefit year maximum.
- Services or supplies that are not necessary according to accepted standards of dental practice or are incomplete.
- Orthodontic services which did not commence prior to an eligible dependent child's eighteenth birthday, or which are provided after the loss of eligibility.
- Sealants on teeth other than the first and second permanent molars, or applications applied more frequently than every thirty-six months or a service provided outside of ages five through fourteen.
- Services such as trauma, bony impaction removal, or jaw joint treatment for which coverage is provided under the medical portion of the Plan.
- Any combination of more than four prophylaxes or periodontal maintenance appointments in any twelve-month period.
- More than one full mouth X-ray series in any period of thirty-six consecutive months.
- More than one bitewing X-ray series in any twelve-month period.
- Adjustments or repairs to dentures performed within six months of the installation of the denture.
- Services or supplies in connection with periodontal splinting.
- Expenses incurred for the replacement of a missing or stolen appliance or for an existing denture, which is or can be made satisfactory.
- Expenses incurred for a temporary denture.
- Expenses incurred for the replacement of a denture, crown, or bridge for which benefits were previously paid, if such replacement occurs within five years from the date the expense was originally benefited.
- Training in plaque control or oral hygiene, or for dietary instructions.
- Completion of reporting forms.
- Charges made by the attending dentist for the patient's failure to appear as scheduled for an appointment.

XVI. LEVEL 3 BENEFITS OF HEALTH CARE (DENTAL COVE AGE) (Continued)

Coverage Exclusions (Continued)

- Charges for services and supplies which are not necessary for treatment of the injury or disease, or are not recommended and approved by the attending dentist, or charges which are not reasonable.
- Scaling and root planing which is not followed, where indicated, by definitive pocket elimination procedures. In the absence of continuing periodontal therapy, scaling and root planing will be considered a prophylaxis and subject to the limitations of that procedure.

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

The Fund has contracted with Express Scripts to manage prescription drug benefits provided under the Plan.

You may purchase your prescription from:

- An Express Scripts network retail pharmacy
- A retail pharmacy outside the Express Scripts network
- Express Scripts Mail Pharmacy Service

Express Scripts Network Pharmacy

When you fill a prescription at an Express Scripts network retail pharmacy, present your eligibility identification card (which contains the Express Scripts logo). Up to a 30-day supply of a covered medication is covered, less the applicable copayment. For an Express Scripts network retail pharmacy in your area, call Express Scripts at 1-800-218-3051.

Out-of-Network Pharmacy

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

Mail Pharmacy Service

The mail order service may be used for medications that will be taken on a regular or long-term basis (maintenance medications). When you fill a prescription through the Express Scripts Mail Pharmacy Service, you can receive home delivery of up to a 90-day supply of a covered medication at one time, with payment of the applicable copayment.

When your physician prescribes a medication for the first time or when you exhaust all refills through the Mail Pharmacy Service, ask your physician to write one prescription for a 30-day supply and another for a 90-day supply with refills to cover you until your next physician visit. Fill the prescription for the 30-day supply at a retail pharmacy and mail the prescription for the 90-day supply to Express Scripts Mail Pharmacy Service. To obtain a Prescription Mail Order Form, call the Fund Office at 1-800-677-3237. Prescriptions submitted without a mail order form must include the member's Social Security number. The address for order submission is:

***Express Scripts Mail Pharmacy Service
POB 52123
Phoenix, AZ 85072-2123***

Shipments from the Mail Pharmacy Service will include a Refill Authorization Form, which can be used to order refills by mail. You may also phone in refills by calling 1-800-295-2956 or visiting the

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

Express Scripts' website at www.express-scripts.com. Any balance due will appear on the packing slip included with your order.

Copayments are determined by the type of medication purchased and place of purchase. If you are eligible for Level 4 coverage at time of purchase, **per prescription** copayments are as follows:

Tier	Medication Type	Network Pharmacy 30-day supply	Mail Service Pharmacy 90-day supply
1	Generic Medication	\$7	\$14
2	Preferred Brand (Formulary)	20% coinsurance \$75 maximum	20% coinsurance \$150 maximum
3	Non-Preferred Brand (Non-Formulary)	35% coinsurance \$75 maximum	35% coinsurance \$150 maximum
4	Non-Preferred (Non-Formulary)	50% coinsurance \$30 minimum	50% coinsurance \$60 minimum

Listings of the most commonly prescribed medications which fall under Tiers 1, 2 and 4 can be obtained by calling the Fund Office or by visiting the Welfare Fund's website at www.iuoe825.org.

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

No coverage is provided for over-the-counter items, such as cold remedies and wound dressings which, even though prescribed by a physician, can be legally purchased without a prescription, as well as medications used to treat impotency and vitamins, minerals and herbs. Also, medications prescribed for weight loss, infertility, smoking cessation, migraine headaches, and pain management (other than cancer treatment) are covered with limitations.

If you are on benefit coverage level 1, 2 or 3, you are not eligible for reimbursement for your prescription drug costs; however, you can take advantage of directly purchasing your prescriptions at discounted costs through an Express Scripts network retail pharmacy or Express Scripts Mail Pharmacy Service.

XVIII. TAXATION OF BENEFITS FOR COMPANY OFFICERS

If you are an officer in a company, or an employee receiving more than \$50,000 in compensation, a portion of benefits received by you under the Plan may be taxable under Section 89 of the Internal Revenue Code (26 U.S.C.A Sec. 89). You must determine whether benefits are taxable by consulting with your employer, accountant or attorney.

XIX. AMENDMENT AND TERMINATION

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

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

XX. ERISA RIGHTS

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

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, including union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from this 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.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive this material within 30 days, you may file suit in a Federal court.

XX. ERISA RIGHTS

(Continued)

In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

XXI. CONFIDENTIALITY OF PERSONAL INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and regulations issued thereunder by the Federal Department of Health and Human Services require the Plan to protect your personal information from unauthorized use or disclosure. Towards that end:

Plan Administration has implemented physical, electronic and procedural safeguards to maintain the confidentiality and integrity of the personal information in its possession and to guard against unauthorized access. These measures include, among other things, procedures for controlling access to participants’ files, building security programs and information technology security measures.

Plan Administration continues to access new technology as it becomes available and to upgrade the physical and electronic security systems as appropriate.

The Fund’s policy is to permit Fund employees and professionals employed by the Fund to access the personal information of participants and beneficiaries only if they have a legitimate purpose for such information, such as administering the Plan, reviewing and analyzing claims and claim denial appeals, and/or providing Plan benefits. No personal information is used for any employment-related decision or action.

Information Subject to the Policy

The Fund collects information about you to help provide Plan benefits and to fulfill legal and regulatory requirements. Fund Administration considers all information about you in its possession to be personal information, even if you cease to be a Plan participant. Personal information collected may include, among other things:

- Identifying information, such as your name, age, address, phone number and social security number.
- Employment information.
- Personal health information.

Typically, this information is collected on applications and other forms you complete, through conversations you may have with the Fund’s administrative staff and health care professionals, and from reports and data provided by healthcare service providers.

Sharing Information within the Fund Office

Fund Administration shares personal information about you among its staff primarily for the purpose of providing you with Plan benefits. It is also used to assure compliance with applicable laws and regulations.

The following employees or classes of employees of the Fund shall have access to personal information maintained by the Fund: claim adjudicators, claim department manager, medical review, precertification, case management, provider relations, accounting, data processing programmers and operators, and Fund Administrator.

XXI. CONFIDENTIALITY OF PERSONAL INFORMATION

(Continued)

Fund employees' access to personal information maintained by the Fund is restricted to those plan administration functions, including treatment, payment and health care operations functions, performed by such individuals for the Fund.

Any employee of the Fund failing to comply with the privacy provisions of this Plan, with the terms of the Fund's Notice of Privacy Practices, or with the terms of the Fund's internal privacy guidelines and policies in accessing and/or using personal information maintained by the Fund, shall be subject to sanctions as described in the Fund's internal privacy guidelines and policies.

Sharing Information with Health Care Providers and Other Plan Professionals

The Fund shares personal information about you, as required or permitted by law, with third parties, such as service providers who assist in the day-to-day operations of the Plan. These third parties include health care professionals, software providers and plan professionals. The Fund requires third-party service providers to enter into confidentiality agreements prohibiting them from using any personal information they obtain for any purposes other than those for which they were retained or as required by law. The Fund may also disclose information about you, when necessary or required, in legal and arbitration proceedings and to government agencies.

It is understood that you may be especially concerned about the privacy of your personal health information. The Fund does not sell or rent your personal health information to anyone or disclose it to others for marketing purposes. Except as you have otherwise authorized, the Fund only uses and shares personal health information for the administration of the Plan and processing claims. The same holds true for any other personal information contained in, or obtained in order to process your claims.

Sharing Information with the Trustees

Personal health information is disclosed to members of the Board of Trustees only to the extent such disclosure is necessary for processing appeals of denied claims. Personal health information will only be disclosed to the Trustees once they have certified the Plan has been amended to incorporate the following provisions. The Trustees shall:

- Not use or further disclose such personal information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents of the Trustees to whom they provide personal information received from the Fund agree to the same restrictions and conditions that apply to the Trustees with respect to such information;
- Not use or disclose any personal health information they receive from the Fund for any employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
- Report to the Fund any use or disclosure of the personal health information that is inconsistent with the uses or disclosures described herein of which they become aware;
- Make available all personal health information received from the Fund to the individual to whom such information pertains, in accordance with 45 C.F.R. §164.524;

XXI. CONFIDENTIALITY OF PERSONAL INFORMATION (Continued)

- Make available all personal health information received from the Fund for amendment and incorporate any amendments to such personal health information in accordance with 45 C.F.R. §164.526;
- Make available all personal health information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
- Make their internal practices, books and records related to the use and disclosure of personal health information received from the Fund available to the Secretary of Health and Human Services;
- Ensure that adequate separation between the Plan and the Trustees is established as required by 45 C.F.R. §164.504; and
- To the extent feasible, return or destroy all personal health information received from the Fund and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Notice of Privacy Practices

The Fund maintains a Notice of Privacy Practices, which has been distributed to all participants and which provides a complete description of HIPAA's privacy rules and your rights thereunder, including your right to inspect and copy your personal information, to receive an accounting of certain disclosure of your personal information and, under certain circumstances, to amend your personal information. For a copy of this notice, write or call the Fund Office at 65 Springfield Avenue, Second Floor, Springfield, New Jersey 07081, telephone number (973) 921-1661.

The Fund reserves the right to change its privacy practices and the notice and to apply such changes to your personal information received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of the notice will be provided via first class mail within 60 days of the effective date of the change.

XXII. ADMINISTRATIVE INFORMATION

Type of Plan

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

Plan Name	Plan Number	Employer Identification Number:	Plan Year
Operating Engineers Local 825 Welfare Fund	501	22-6033381	July 1 to June 30

Plan Administrator

**Ms. Christine Medich
Operating Engineers Local 825 Fund Service Facilities
65 Springfield Avenue
SECOND FLOOR
Springfield, NJ 07081
(973) 921-1661**

Agent for Service of Legal Process:

**McAleese, McGoldrick, Susanin
& Widman, P.C.
Suite 240, Executive Terrace
455 South Gulph Road
King of Prussia, PA 19406**

-OR-

**Cohen, Leder, Montalbano & Grossman
1700 Galloping Hill Road
Kenilworth, NJ 07033**

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

XXII. ADMINISTRATIVE INFORMATION (Continued)

Contributing Employers

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

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

Plan Administration

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

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

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

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

Source of Contributions and Funding Medium

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

XXII. ADMINISTRATIVE INFORMATION
(Continued)

BOARD OF TRUSTEES

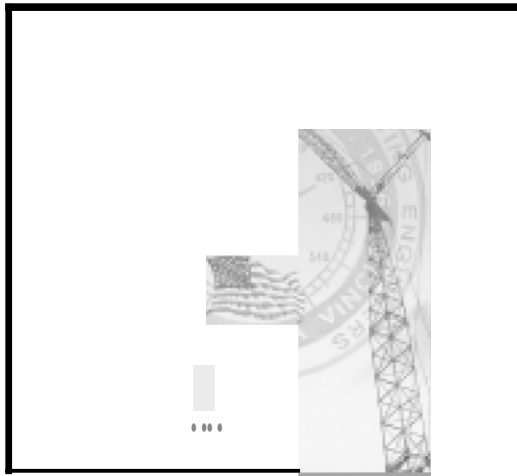
Employer Trustees	Union Trustees
Michael Paquet, Co-Chairman	Kenneth Campbell, Chairman
Robert Koch	Patrick Campbell, Secretary
Jack Kocsis	John Lynch
Ross J. Pepe	Robert Occhiuzzi

Address for all Trustees:

**Operating Engineers Local 825 Fund Service Facilities
65 Springfield Avenue
Second Floor
Springfield, NJ 07081**

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