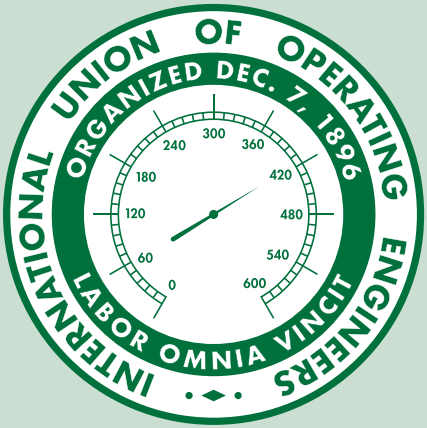
Locals 302 & 612
International Union of



Operating Engineers
Construction Industry

HEALTH AND SECURITY FUND

2010

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 •
Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 31, 2019

TO: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: Upcoming Changes to Dollar Bank Deduction for Monthly Coverage

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Trust is primarily funded with contributions required under collective bargaining agreements between the IUOE 302 and 612 and signatory employers in Washington and Alaska. When those collective bargaining rates change, monthly amounts required for continued eligibility in the health plan also change.

Effective with June 2019 hours for August 2019 coverage, the following changes have been made to the eligibility provisions that apply to Hourly Employees:

The $100 and/or $200 monthly credits that have been applied to participant dollar banks will be eliminated **effective with June 2019 hours. Participant dollar banks will receive the May 2019 credits**. Any monies in excess of the Dollar Bank Maximum that a participant has in the bank on June 30, 2019 will be grandfathered and available for use if needed. For example, a participant would use the "grandfathered" bank money to maintain coverage when active hours are not adequate. As the grandfathered bank monies are used, they cannot be replenished beyond the newly established Dollar Bank Maximum (see below).

Initial Eligibility

The minimum contribution required to establish initial dollar bank eligibility:

- Washington will decrease from $1,752 to $1,509, and
- Alaska will decrease from $2,097 to $1,852

(Contribution amount must be accumulated within a consecutive three-month period).

Continued Coverage

The monthly dollar bank deduction for coverage will change as follows for Bargained Hourly employees whose employers remit contributions for ALL hours worked, with **June hours for August coverage**:

- from $1,168 to $1,006 per month in Washington
- from $1,398 to $1,235 per month in Alaska

The monthly dollar bank deduction for coverage will change as follows for Bargained Flat Rate employees with **July hours for September coverage:**

- from $1,264 to $1,347 per month for Washington
- from $1,469 to $1,575 per month for Alaska

The new Associate monthly contribution rates will be:

- $1,347 for Washington associate employees, and
- $1,575 for Alaska associate employees.

Any participant covered by a collective bargaining agreement that has an hourly contribution which is not at least equivalent to the AGC Master Labor Agreement and whose employer remits contributions on less than all of participants' hours worked in a month, will be charged the higher Bargained Flat Rate deduction factor, for a month of coverage.

Dollar Bank Maximum

Effective August 1, 2019, the maximum dollar amount that can accumulate in an hourly employee's dollar bank is:

- $8,048 in Washington, and
- $9,880 in Alaska

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Sincerely,

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

October 31, 2018

TO: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: Changes to Dollar Bank Deduction – Effective October 1, 2018

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Trust is primarily funded with contributions required under collective bargaining agreements between the IUOE 302 and 612 and signatory employers in Washington and Alaska. When those collective bargaining rates change, monthly amounts required for initial and continued eligibility in the health plan also change. As a result of the recently finalized collective bargaining agreements in Washington, the dollar bank deduction for monthly eligibility has also been adjusted.

Effective with October 2018 hours for December 2018 coverage, the following changes have been made to the eligibility provisions that apply to Hourly Employees:

Initial Eligibility

The minimum contribution required to establish initial dollar bank eligibility in Washington will increase from $1,703 to $1,752 and in Alaska from $1,989 to $2,097(amount must be accumulated within a consecutive three-month period).

Continuing Coverage

The dollar bank deduction will increase as follows:

- from $1,135 to $1,168 per month in Washington
- from $1,326 to $1,398 per month in Alaska

Maximum Bank

The maximum dollars that can accumulate in your dollar bank are $9,344 in Washington and $11,184 in Alaska.

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Sincerely,

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

7525 SE 24th Street Suite 200 Mercer Island, WA 98040 •
P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 29, 2018

To: All Plan Participants and Dependents of the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification – Dollar Bank Eligibility Applicable to Hourly Contribution Rate Participants ONLY

Please be sure that you and your family read this notice carefully.
It should be kept with your benefit booklet or insurance records for future reference.

Last year we notified you of new dollar bank subsidies for hourly participants for hours worked from January 1, 2017 through May 31, 2018. The purpose of this notice is to advise you that those subsidies will continue through May 31, 2021.

Eligible hourly participants as described in the February 28, 2017 Notice receive two $100 subsidies in their dollar bank (a total of $200). One of these $100 subsidies was scheduled to sunset May 31, 2018, but it has been extended three years.

Plan provisions and benefits are not guaranteed and may be amended at any time by the Trustees. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet). Please keep this and all notices of Plan changes with your Plan Booklet.

If you have any questions regarding the information in this Notice or you want a copy of the February 28, 2017 Notice referenced above, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4. You may also obtain a copy of the notice on the Trust's website: www.engineerstrust.com, Health and Welfare tab, then click on Plan Booklet.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

JPE/LJ/TB:CJ/jwg
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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124 Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

June 30, 2017

TO: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: Changes to Dollar Bank Deduction – Effective July 1, 2017

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Effective with July 2017 hours for September 2017 coverage, the following changes have been made to the eligibility provisions that apply to Hourly Employees:

Initial Eligibility

The minimum contribution required to establish initial dollar bank eligibility in Washington will increase from $1,621 to $1,703 and in Alaska from $1,895 to $1,989 (amount must be accumulated within a consecutive three-month period).

Continuing Coverage

The dollar bank deduction will increase as follows:

- from $1,081 to $1,135 per month in Washington
- from $1,263 to $1,326 per month in Alaska

Maximum Bank

The maximum dollars that can accumulate in your dollar bank are $9,080 in Washington and $10,608 in Alaska.

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Sincerely,

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

JPE/CR/TB/WPAS
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F12\F12-02 - Mailing - 2017 - 06.30 - SMM - Dollar Bank Deductions.doc

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

February 28, 2017

To: All Plan Participants and Dependents of the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification—Dollar Bank Eligibility Changes Applicable to Hourly Contribution Rate Participants ONLY

Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

We previously notified you of new dollar bank subsidies for hourly participants for hours worked from January 1, 2017 through May 31, 2018. The Trustees approved the new subsidies in response to action being taken by some bargaining parties to redirect $1.00 of the hourly employer contribution from the Health Plan into the Retirement Plan. The intent of the new subsidies was to enable participants to qualify for dollar bank eligibility on a basis similar to the qualification levels in place before redirection of $1.00 from health to pension.

The redirection of contributions has not yet been negotiated under all collective bargaining agreements. Accordingly, the Trustees have taken further action so that effective for hours worked from May 1, 2017 through May 31, 2018, the new subsidies will only continue to apply to participants working under a collective bargaining agreement that has the contributions redirected. The amended action is described below.

No Change in Dollar Bank Subsidy for Hourly Eligible Participants Working Under a Collective Bargaining Agreement that HAS Redirected Health Contributions

There is no change in the dollar bank subsidies that were effective January 1, 2017 for participants working under a collective bargaining agreement which has redirected the $1.00 in Health Plan contributions to the Retirement Plan. These subsidies are described as follows:

- **Eligible participants:** In addition to the $100 monthly subsidy in effect before January 1, 2017, eligible hourly participants who work at least one hour in the month coverage is earned (e.g., hours earned in May provide July coverage) under a collective bargaining agreement which has redirected the $1.00 in hourly contributions will continue to receive the new monthly subsidy of $100 that became effective January 1, 2017, so that the total monthly subsidy will be $200. To qualify, a participant must be eligible for coverage before the subsidy is credited. This additional $100 subsidy will cease on May 31, 2018.

- **Participants earning initial eligibility:** Effective with hours worked on and after January 1, 2017, hourly participants earning initial eligibility receive a $100 dollar bank subsidy after accumulating $700 in their dollar bank, provided the participant worked at least one hour under a collective bargaining agreement that redirected the $1.00 in the month the $700 was reached. Once hourly participants accumulate $1,500 in their dollar bank, another $100 subsidy will be credited, provided the participant worked at least one hour under a collective bargaining agreement which redirected the $1.00 in the month the $1,500 was reached.

  If the participant did not work at least one hour under a collective bargaining agreement which redirected the dollar in the month his dollar bank reached $700 or $1,500, the participant will not thereafter receive the additional $100 subsidy until he/she works at least one hour under such a collective bargaining agreement. This subsidy will cease on May 31, 2018.

Change in Dollar Bank Subsidy for Hourly Eligible Participants Working Under Collective Bargaining Agreement that has NOT Redirected Health Contributions

Effective May 1, 2017, hourly participants who work under a collective bargaining agreement that has not redirected $1.00 in hourly contributions will not receive the additional subsidies described above. However, eligible hourly participants will continue to receive the $100 monthly dollar bank subsidy that was in effect prior to January 1, 2017. This subsidy is scheduled to continue after May 31, 2018 for all hourly eligible participants, provided the Trust's unallocated reserves do not fall below 11 months.

Plan provisions and benefits are not guaranteed and may be amended at any time by the Trustees.

This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet). Please keep this and all notices of Plan changes with your Plan Booklet. If you have any questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

MRBC/TSG/R&L:cj/ag/jg
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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

January 13, 2017

To: All Plan Participants and Dependents of the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification--Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

The Trustees have adopted the following changes to the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund ("Plan"). The changes in this notice are effective for coverage on and after **January 1, 2017**. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet).

Dollar Bank Eligibility Prior to January 1, 2017

For participants with hours worked prior to January 1, 2017, the Plan provides a monthly dollar bank subsidy for all eligible hourly participants in the amount of $100, provided the Trust's unallocated reserves remain above eleven months.

Dollar Bank Eligibility On and After January 1, 2017

- **For eligible participants**: Effective January 1, 2017, the monthly subsidy for hourly participants who have achieved initial eligibility will increase by $100 so that the total monthly subsidy will be $200. A decrease in the Trust's unallocated reserve levels below eleven months will not automatically terminate the subsidies during the period from January 1, 2017 through May 31, 2018. This additional $100 subsidy will cease on May 31, 2018.

- **For participants who are earning initial eligibility:** Effective January 1, 2017, a participant earning initial eligibility who accumulates $700 in his or her dollar bank will be credited with a $100 subsidy towards eligibility. When the participant's bank reaches $1,500 the participant will be credited with another $100 subsidy. This will enable a participant qualifying for initial eligibility to do so on a basis that is similar to the qualification levels in place prior to January 1, 2017. This subsidy will cease on May 31, 2018.

Plan provisions and benefits are not guaranteed and may be amended at any time by the Trustees. Please keep this and all notices of Plan changes with your Plan Booklet.

If you have any questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

MRBC/TSG/R&L/WPAS:jwg
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Conditions We Treat

SwiftMD can be the first call you make at the onset of illness or injury. In fact, many routine and non-urgent cases may be safely treated by a SwiftMD physician over the phone or videoconference.

Please feel free to call with any medical concern or question. However, if you believe you're experiencing an emergency, call 911 immediately.

Telemedicine is appropriate for many common medical conditions, including:

- Allergies and rashes
- Arthritis pain
- Back pain or injury
- Bone or joint pain, strain or injury
- Chickenpox
- Cold sores
- Diarrhea
- Earache
- Eczema
- Eye problems, conjunctivitis or pink eye
- Fever and Flu
- Headache
- Insect bites and stings
- Lice
- Lyme Disease
- Nasal or respiratory congestion
- Prescriptions, when appropriate
- Respiratory problems, infections, asthma
- Sinusitis
- Soft tissue and muscle injuries or pain
- Sore throat
- Stomach problems, nausea, vomiting, diarrhea
- Upper respiratory infection
- Upset stomach
- Urinary tract infection
- Vomiting
- Your individual medical concerns

Member website:

mySwiftMD.com

Questions? Concerns? Lost login information?
Trouble accessing the member website?

SwiftMD is available to help:

1-877-999-7943

support@swiftmd.com

SWIFT MD®
Talk to a Doctor 24/7!

INTERNATIONAL UNION OF OPERATING ENGINEERS
ORGANIZED DEC. 7, 1896
LABOR OMNIA VINCIT
TRADE MARK REGISTERED

All SwiftMD systems and processes are HIPAA compliant. Your SwiftMD member information is maintained on secure servers, and encryption technology is used to protect your personal information during data transmission. SwiftMD is committed to protecting the privacy, security, and integrity of individually identifiable health information received from or on behalf of our clients.

SwiftMD Member Guide

SwiftMD doctors are available 24/7
AT NO COST TO YOU!

SWIFT MD®
Talk to a Doctor 24/7!

Welcome to SwiftMD

SwiftMD is a telemedicine service that delivers quality health care directly to patients in need. Services available through SwiftMD include:

- 24/7/365 nationwide access to U.S.-trained and Board-Certified physicians from your home, office, or on the road.
- Consults with doctors via phone or videoconference; doctor makes diagnosis and recommends treatment.
- Doctor calls in prescription when appropriate.
- SwiftMD's Personal Health Record allows participants to store, update and manage personal health information.
- Access to Treatment Guidelines for 30+ common medical conditions.
- Avoiding unnecessary visits to the ER, or long waits for an appointment at your doctor's office.

SwiftMD Physicians

Quality physicians are at the core of what we do. We employ excellent, board-certified Emergency and Family Practice doctors. Our doctors:

- Are U.S.-trained in Emergency or Family Medicine, and are board-certified.
- Are trained in telemedicine.
- Are experienced at diagnosing a range of illnesses and injuries.
- Have a minimum of ten years practicing medicine.

Your SwiftMD program

SwiftMD telemedicine services are provided through your I.U.O.E. Locals 302 & 612 - Construction Industry Health & Security Plan, at no cost to you.

Our U.S. Board-Certified doctors are available for consults over the phone or videoconference, from your home, office, or on the road. SwiftMD physicians can diagnose, recommend treatment, and submit prescriptions to your pharmacy of choice.

With SwiftMD, you can talk to a doctor 24/7!

- Call toll free 877-999-7943.
- Go online at www.mySwiftMD.com.

Getting started

- Remember you can use SwiftMD anytime, simply by calling toll free 877-999-7943, or online at mySwiftMD.com.
- To use SwiftMD online, go to mySwiftMD.com/activate to retrieve your username and password. You can use Group Passcode: IUOE302&612.
- Log in to mySwiftMD.com with the username and temporary password provided.
- Once you log in, enter an email address that you would like SwiftMD to use to communicate important information about your care. SwiftMD complies with all patient privacy regulations to protect your personal health information.
- Take a few minutes to enter your medical history before talking to a SwiftMD doctor. After a consultation you will be able to review the visit notes in your Personal Health Record online.

Your Family Members

- Each adult family member (age 18 and over) has an individual profile with a unique SwiftMD username and password.
- Parents or Guardians are required to oversee the telemedicine consults of dependents under the age of 18, and adult wards.
- Young children under age 3 are not eligible for telemedicine consults. When a child is unable to describe his or her symptoms, it is important to see a pediatrician or family doctor who can provide a physical examination to diagnose the patient.
- Please visit SwiftMD.com and click the Members tab for more information.

If you have any questions, or need assistance scheduling a telemedicine consult, call us at 1-877-WWW-SWIFT (1-877-999-7943) or use the "Contact Us" link at mySwiftMD.com.

Safe Practice of Telemedicine

SwiftMD physicians have skill and experience diagnosing a range of illnesses and injuries. Even so, there are a number of conditions that are unsafe to treat exclusively with telemedicine.

True emergencies should be treated in a hospital Emergency Department.

While SwiftMD can provide many healthcare services to you at your convenience, it is not designed to replace your Primary Care Physician or Specialists managing chronic illnesses or serious medical conditions. For more information, please refer to the *Exclusionary Criteria* posted on mySwiftMD.com.

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 441-9110 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

August 8, 2016

To: All Active and Retired Plan Participants and Beneficiaries of the Locals 302 and 612 l.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification--Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

The Trustees have adopted the following changes to the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund ("Plan"). The changes in this notice are effective for coverage on and after August 1, 2016. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet).

Dollar Bank Provisions - Active Employees

The Plan's dollar bank provisions have been updated to address eligibility and use of the dollar bank when an active employee goes to work for a non-contributing employer. The following language is added to the Summary Plan Description, at page 10:

Work for a Non-Contributing Employer - Eligibility Freeze and Forfeiture

Notwithstanding any other provision or rule of this Plan, if you are eligible for benefits your coverage will be frozen if you work:

- In the industry, which means work for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and
- In a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or as an employee.

While your coverage is frozen, no benefits or claims are payable with respect to any expenses incurred by you or your dependents during the "freeze" period. For each subsequent month in which you continue to work for a non-contributing employer, you will permanently forfeit one month of coverage from your dollar bank.

To reinstate frozen eligibility, you must return to work for a contributing employer and earn at least the amount of employer contributions required by the Plan to maintain continuing eligibility. If you do not reinstate dollar bank eligibility before your dollar bank is exhausted, you will be required to satisfy the initial eligibility rules to again be covered.

The forfeiture provisions do not apply if you are temporarily employed under a written agreement with any of the Operating Engineers local unions participating in the Plan. Nor do the forfeiture provisions affect your or your dependent's COBRA rights.

Retiree Coverage - Eligibility when the Covered Retiree Works for a Non-Contributing Employer

The Plan has been modified to require that a retired employee refrain from any employment with a non-contributing employer in the industry in order to be eligible for retiree coverage.

The following eligibility requirement is added to the Summary Plan Description at pages 98-100 for "Retirees Age 60 and Older," "Retirees Under Age 60" and "Disabled Retirees":

- You refrain from employment which is: in the industry, which means working 50 or more hours per month for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and in a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or as an employee.

In addition, the section entitled "When Coverage Ends" has been updated as follows:

When Coverage Ends

If you commence retiree benefits, your coverage will end on the last day of the month following the month in which you work 50 or more hours during the month:

- In the industry, which means work for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and
- In a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or an employee.

In addition, retiree coverage ends when:

- You die;
- The Plan terminates;
- You fail to make any required contributions.

Following termination of coverage, you will not be allowed to re-enroll in such coverage. Your dependents' coverage ends on the last day of the month in which:

- Your coverage ends (unless your surviving spouse elects to continue coverage by self- pay as described in the next section).
- You become divorced.
- A dependent child no longer meets the definition of an eligible dependent.
- You terminate your dependents' coverage. You may terminate your dependents' coverage by contacting the Administration Office.

If your dependents' coverage ends, your dependents may be eligible to continue coverage as described in the next section.

If you have any questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4 if you are an active employee or extension 3322 if you are retired.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

JPE:CJ:HC:KB: jwg
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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 441-9110 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

July 1, 2016

TO: All Active Participants, Non-Medicare Retirees, Medicare Retirees and Dependents of the Locals 302 and 612 of the I.U.O.E. Construction Industry Health and Security Fund

RE: Summary of Material Modification – Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully.
It should be kept with your benefit booklet or insurance records for future reference.

The Trustees adopted the following changes to the Locals 302 and 612 of the I.U.O.E. Construction Industry Health and Security Fund ("Plan"). Unless otherwise stated, the changes are effective for services received on and after **September 1, 2016**. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet).

Pre-authorization Requirements (does not apply to Medicare Retirees or Medicare eligible Dependents)

Currently, the Plan requires preauthorization of all inpatient hospitalizations, in-patient or residential behavioral (chemical dependency/mental health) and skilled nursing facility admissions, as well as certain outpatient services. Effective September 1, 2016, the Plan is expanding the list of services requiring preauthorization.

It is important to note, the Plan only provides benefits for services that are determined to be medically necessary. Preauthorization is a determination of medical necessity. You must contact the Administration Office to confirm eligibility for coverage and that the requested service is a covered benefit.

Note: If you have Medicare or other insurance as your primary insurance, preauthorization through First Choice Health is not required.

The following list of services require preauthorization effective September 1, 2016. (Refer to page 36 of the 2010 Plan Booklet):

- Applied Behavioral Analysis
- Clinical Trials (any interventions provided under a clinical trial)
- Durable medical equipment, medical supplies and prosthetics
    - Bone Growth Simulators
    - Specialized Hospital Beds and Traction (standard semi-electric bed for transition of care and rental for up to 3 months does not need precertification)
    - Custom Fabricated Braces
    - Dynamic Splinting Systems
    - Electrical Stimulators – Spinal – External
    - Neuromuscular Stimulators
    - Prosthetics
    - Speech Generating Devices

    - Custom and power operated wheelchair and supplies (standard manual wheelchair for transition of care and rental for up to 3 months does not need preauthorization)
    - Scooters
- Wearable defibrillators
- Dialysis – all types (for chronic kidney disease)
- Home health care services
    - Home health visits for wound therapy only
    - Home infusion therapy (enteral and IV)
    - Hospice
- Hyperbaric Oxygen therapy
- Imaging - PET scans
- Inpatient admissions, residential and partial hospital programs (excluding routine maternity deliveries)
    - Inpatient hospice
    - Inpatient rehabilitation admissions
    - Long-term acute care facility
    - Skilled nursing admissions
- Organ and bone marrow transplants
    - Notification only for evaluation
    - Services for recipient and donor
- Radiation Therapy
    - Proton Beam or Helium Radiation Therapy
    - Stereotactic radiosurgery (Gamma knife, Cyber knife)
- Surgery Inpatient or Outpatient locations
    - Abdominoplasty/panniculectomy
    - Bariatric surgery
    - Breast Surgeries – selected (pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer.)
        - Implant removal
        - Mastectomy for gynecomastia
        - Prophylactic mastectomy
        - Reduction mammoplasty
    - Cosmetic or reconstructive surgery
    - Cochlear implants (surgical benefit applies)
    - Deep brain stimulation
    - Eyelid surgery (i.e. blepharoplasty)
    - Fetal/intrauterine surgery
    - Spinal surgery – selected
        - Lumbar fusions
        - Cervical fusions
        - Artificial intervertebral disc
    - Rhinoplasty
    - Surgical interventions for sleep apnea
    - TMJ surgery
    - Varicose Vein procedures
    - Outpatient total knees
    - Outpatient total hips
    - Ventricular assist device
- Experimental and investigational services are not covered, except as outlined under the Clinical Trials benefit, if a service could be considered experimental and investigational for a given condition, the Trust recommends a determination in advance.

To obtain preauthorization of medical necessity, your provider or you should contact First Choice Health (FCH) as follows:

- For hospital admissions, surgical services, skilled nursing facility and other services, call FCH at (800) 986-9156.
- For chemical dependency and mental health services, contact FCH at (800) 640-7682.

To confirm your eligibility or whether the service you are pre-authorizing is a covered benefit, contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 1.

Elimination of Total Disability Extension of Benefits

Effective September 1, 2016, the Plan will no longer offer continued coverage based upon total disability. (Refer to pages 24-25 of the 2010 Plan Booklet.)

If you commenced continuation of coverage prior to September 1, 2016 based upon total disability, you will be allowed to continue medical and prescription drug coverage for covered expenses related to the accidental injury or illness that that caused the disability through the calendar year in which your dollar bank eligibility ended and during the next calendar year. However, the coverage will terminate earlier if you are no longer totally disabled, or you become covered under any group, individual, or governmental plan.

COBRA self-pay coverage will continue to be available under the Plan.

Mandatory Enrollment and Dependent Verification Audit

Beginning in August, 2016, the Administration Office will be conducting a mandatory enrollment and dependent verification audit. All eligible employees will be required to submit an enrollment form listing all dependents to be enrolled in the Plan. Dependent verification documents will be required, such as a marriage certificate for a spouse, or birth certificates for dependent children. Please watch your mail for this important information.

If you have any questions regarding the information outlined in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

June 1, 2016

TO: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: Changes to Dollar Bank Deduction –Effective July 1, 2016

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Effective with July 2016 hours for September 2016 coverage the following changes have been made to the eligibility provisions that apply to Hourly Employees:

Initial Eligibility
The minimum contribution required to establish initial dollar bank eligibility in Washington will increase from $1,540 to $1,621 and in Alaska from $1,800 to $1,895, which must be accumulated within a consecutive three month period.

Continuing Coverage
The dollar bank deduction will increase as follows:

- The dollar bank deduction will increase from $1,200.00 **to $1,263.00** per month in Alaska.
- The dollar bank deduction will increase from $1,027.00 **to $1,081.00** per month in Washington

Maximum Bank
The maximum dollars that can accumulate in your dollar bank are $10,104 in Alaska and $8,648 in Washington.

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

May 13, 2016

TO: Medicare Eligible Retirees
Locals 302 and 612 I.U.O.E Construction Industry Health and Security Fund

RE: Change of Prescription Drug Coverage Effective July 1, 2016

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Effective July 1, 2016, your prescription drug coverage is changing. Prescription drug coverage for Medicare Eligible Retirees in the Locals 302 and 612 of the International Union of Operating Engineers-Employers Construction Industry Health and Security Fund ("Trust") will be administered by UnitedHealthcare®. Medicare Retirees will be automatically enrolled into the *UnitedHealthcare MedicareRx℠ for Groups (PDP),* and the Express Scripts coverage will end on June 30. You will be eligible for this prescription coverage if you are entitled to Medicare Part A and/or purchase Part B. If you have Part B, you must continue to pay your Medicare Part B monthly premium to the government.

UnitedHealthcare
Below, you can find highlights of the UnitedHealthcare coverage. UnitedHealthcare will also be providing more details to you in the mail the first week of June. Please be advised that the **UnitedHealthcare Medicare Rx for Groups (PDP)** Plan Information brochure you will be receiving is a summary of the UnitedHealthcare prescription drug plan which applies to all of their insured groups, as well as this group. Even though the Trustees have changed the prescription drug coverage vendor, as a Medicare eligible participant in this Trust's health plan, your prescription drug co-pays and deductibles will remain the same as currently apply.

The **UnitedHealthcare MedicareRx℠ for Groups (PDP)** helps protect you from unexpected changes in your prescription drug costs. Some of the highlights include:

- The UnitedHealthcare Medicare Rx for Groups PDP formulary covers 100% of Medicare Part D eligible drugs. There is additional coverage for certain drugs not covered by Medicare Part D.
- There are over 65,000 pharmacies in the network, including national and regional retail chains as well as independent neighborhood pharmacies.
- Home delivery is available through OptumRx Mail Service Pharmacy, which provides convenience as well as savings.
- Customer Service is available from 8 a.m. – 8 p.m. local time, 7 days a week

How This Change Affects You
The Trust has selected the *UnitedHealthcare MedicareRx for Groups (PDP)* for your prescription drug coverage. You and your Medicare-eligible dependents will be automatically enrolled in the Trust's prescription drug coverage. Please note however that for automatic enrollment to work, UnitedHealthcare needs a physical address (street address) for you – a P.O. Box will not suffice. Your P.O. Box will work for mail order delivery, however in order to enroll in the coverage, a physical address is required – if one is not on file, you will receive a separate letter from UnitedHealthcare requesting this information (see the "Special Note," below). If a physical address is on file, you do not need to do anything to enroll.

You may only have coverage in one prescription drug plan at a time. If you do not wish to be enrolled in the Trust's UnitedHealthcare prescription drug coverage, please contact the Administration Office at the number below. Please note, if you choose to opt-out of this coverage, you will no longer be eligible for prescription drug benefits through the Trust nor will your monthly premium for coverage be lowered. If you have questions on this, please contact the Trust Administration Office, at (800) 441-1212 x3322.

You will only be required to pay the co-pay amount for the tier of prescription you are purchasing – this has not changed. However, the formulary (list of medications) may differ from the current formulary. When you receive the formulary (see list below for additional mailings), you should check for your prescriptions to make sure there is no change in the co-pay tier (generic, preferred brand, non-preferred generic/brand). If there is a change in copay tier, please don't hesitate to contact UnitedHealthcare (see number below) for assistance.

Mail Order
OptumRx is the mail order provider for the UnitedHealthcare MedicareRx Groups (PDP). UnitedHealthcare will transfer open refills that are on file with the current mail order provider (Express Scripts) and that are eligible for transfer, so that in many cases new prescriptions will not be needed. UnitedHealthcare will be mailing you more information about the mail order program, including OptumRx contact information.

Non-Medicare Eligible Dependents
Effective July 1, 2016, OptumRx will administer the Trust's prescription drug coverage for actives and non-Medicare eligible retirees and dependents. Therefore, if your dependents are not Medicare eligible, they will have coverage administered under the OptumRx program. A notice similar to this one is being sent to all participants describing the coverage for active and non-Medicare eligible persons – please refer to that notice for more information on the OptumRx coverage.

What to Expect Next
You will be receiving more information from UnitedHealthcare. Here is what you can expect.

When will materials be mailed?	What will I receive?
Early June	• UnitedHealthcare Plan Information
Mid-June	• UnitedHealthcare Confirmation of Enrollment Letter and ID card, if enrolled • UnitedHealthcare MedicareRx[SM] for Groups (PDP) Welcome Packet

Still Have Questions?
If you still have questions, please do not hesitate to call.

Contact…	To…	How…
UnitedHealthcare	Learn about Rx plan benefits Look up prescription drugs	1-866-628-4715, TTY 711, 8:00 am – 8:00 p.m. local time, 7 days a week www.UHCRetiree.com
Administration Office	Ask about eligibility Make changes in coverage Ask about your retiree health coverage	1-877-441-1212, ext. 3322 8:00am – 5pm M – F www.engineerstrust.com

Special Note:
The Centers for Medicare & Medicaid Services (CMS or Medicare) requires a permanent residential street address for all enrollment processing. You may continue to use an alternative mailing address or P.O. Box to receive your plan materials and communications. If you do not have a permanent residential street address on file with the Trust, UnitedHealthcare will send you a letter to obtain your permanent residential address. It is important for you to respond to this request for information by following the instructions in the letter.

Sincerely,

Board of Trustees,
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

May 13, 2016

TO: All Plan Participants
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

RE: Change of Prescription Drug Benefit Manager – Effective July 1, 2016

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Board of Trustees of the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund ("Plan") selected OptumRx to replace Express Scripts as the Plan's Pharmacy Benefit Manager (PBM) effective **July 1, 2016.** OptumRx will administer the retail, mail-order and specialty drug benefits for ***active participants and non-Medicare eligible retirees and dependents***. Medicare Retirees are receiving this mailing to make them aware of the change. However, effective July 1, 2016, their coverage will be provided through UnitedHealthcare, which will be described in a separate mailing. OptumRx will administer the **mail-order** prescription drug benefits for Medicare eligible Retirees, in partnership with UnitedHealthcare.

Retail Pharmacies
You can locate a complete list of OptumRx participating pharmacies by registering and using the **Locate a Pharmacy** tool at Optumrx.com on and after July 1, 2016 or by calling 1 (866) 887-0234 effective June 20, 2016. There are over 67,000 pharmacies in the OptumRx network. When using a participating pharmacy, you will make the required co-payment at the pharmacy counter and your claim will be submitted on-line directly to OptumRx. If you use a non-participating pharmacy and are submitting a claim for a prescription drug you will need to pay in full for the prescription at the counter and submit the claim to OptumRx on the approved claim form, which you can obtain by contacting the Trust Administration Office.

Mail Order
OptumRx offers home delivery with up to a 90-day supply of your long-term medications shipped right to your door. Long term medications often cost less through home delivery than they do through a retail pharmacy and there is no charge for standard shipping to US addresses. Express Scripts will transfer most current open mail order prescriptions to OptumRx as part of this transition. Some prescriptions cannot be transferred, due to the type of drug prescribed or lack of fills remaining on the current prescription. Please contact OptumRx to verify if your prescription is transferred or if you will need to contact your doctor to submit a new prescription. You can manage your medication online at optumrx.com or by calling 1 (866) 887-0234.

(over)

Specialty Drugs
BriovaRx is the OptumRx specialty pharmacy, and will be the Plan's exclusive specialty pharmacy effective July 1, 2016. Specialty Drugs are prescription medications that require special handling, administration or monitoring. Plan Participants will require preauthorization from BriovaRx for all new Specialty Drug prescriptions. If you are currently preauthorized for the use of a Specialty Drug and quantity limit, you do not require preauthorization through BriovaRx.

If you are currently taking a Specialty Drug medication, you will receive a notice from BriovaRx or you can call them at 1-855-4BRIOVA (1-855-427-4682) to enroll right away. A Patient Care Coordinator can get you started by coordinating your order with your doctor.

New Medical and Prescription Drug Identification Card (ID)
New ID cards identifying you as a Premera and OptumRx network member will be mailed to you directly from Premera by June 30, 2016. **Use your new Medical/Prescription Drug ID card for services provided on or after July 1, 2016**. If you find errors on your newly issued ID cards or do not receive your cards prior to June 30, 2016, please contact the Administration Office at (877) 441-1212.

OptumRx Website
You can access a list of participating pharmacies, request home delivery refills, compare medication costs and find helpful information on the OptumRx website by registering online at optumrx.com. The online registration will open July 1, 2016.

Medicare Retirees
Changes are also being made to the prescription drug coverage for Medicare Retirees, which effective July 1, 2016 will be administered by UnitedHealthcare. If you are a Medicare eligible retiree, a separate notice from the Trust is being sent to you and you'll receive more information about your new coverage, as well as a new Prescription Drug ID card directly from UnitedHealthcare. Your medical claims should continue to be submitted directly to Medicare. The Trust will continue to pay as your secondary coverage.

If you have any questions regarding the information outlined in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Sincerely,

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

August 13, 2015

To: All -Medicare Retiree Plan Participants and Beneficiaries of the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification--Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

The Trustees adopted the following changes to the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund ("Plan"). Unless otherwise stated, the changes are effective for services received on and after **September 1, 2015**. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet).

Coverage of Preventive Care

The Plan has been amended to cover recommended preventive care services required by the Affordable Care Act. The covered preventive services include well baby and well child care visits at specified intervals; immunizations for infants, children, adolescents, and adults as recommended by the Federal Centers for Disease Control and Prevention; and colorectal cancer screening at specified intervals for adults age 50 to 75.

Additional preventive care and screenings will be covered for women as required by the Affordable Care Act, and as supported by applicable guidelines, including: well-women visits; mammograms; and cervical cancer screenings. However, coverage for pregnancy of a dependent daughter is limited to those routine prenatal services listed under the Women's Preventive Care Act.

Contraceptives and contraceptive devices for dependent children are covered as required by the Affordable Care Act.

Covered preventive care now also includes a limited number of over-the-counter pharmaceuticals when prescribed by your physician. Please check with Express Scripts (the Pharmacy Benefit Manager) at (866) 493-9201 for limitations that may apply.

This is only a summary of the recommended preventive care required by the Affordable Care Act. If you have questions about specific services, including whether the services are recommended preventive services under the Affordable Care Act, you may contact the Administration Office or review the list of recommended preventive services at:

http:/www.healthcare.gov/preventive-care-benefits/

Out-of-Pocket Maximum

To comply with the Affordable Care Act, effective September 1, 2015, the Plan has implemented an Out-of-Pocket Maximum for covered Medical expenses of $6,600 per person and $13,200 per family. This Out-of-Pocket Maximum is the most you will pay toward covered expenses during the Plan Year. The following items do not apply to this Out-of-Pocket Maximum:

- Medical services you receive that are not covered by Medicare
- Registered Naturopath
- Registered Certified Hypnotherapists
- Acupuncturists
- Registered Dietician
- Certified Nutritionist
- Hearing Care

Coverage for Costs Associated with Certain Clinical Trials

The Plan does not provide benefits for services and supplies which are Experimental or Investigational. However, the Plan has been amended to provide that routine patient costs for items and services furnished in connection with an approved clinical trial will not be considered Experimental or Investigational if the item or service would otherwise be a covered expense for an eligible individual who is *not* enrolled in the clinical trial. An approved clinical trial is a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The eligible individual must be eligible to participate in the approved clinical trial according to the trial protocol. The following are not covered:

The actual clinical trial or the investigational team;

Items and services solely for data collection that are not directly used in the clinical management of the patient; or

Services that are clearly inconsistent with widely accepted and established standards of care for a particular condition.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

Routine patient costs for items and services furnished in connection with an approved clinical trial must be preauthorized by the preauthorization/utilization review organization. If you do not obtain preauthorization, the preauthorization/utilization review organization will determine medical necessity when the claim is submitted. If it is determined that the care you received was not medically necessary, benefits will not be provided.

Outpatient Dialysis Treatment Benefits for ESRD

If you or your eligible dependents are diagnosed with end-stage renal disease ("ESRD") you may be eligible for Medicare coverage by nature of the diagnosis. You are not obligated by the Plan to apply for and enroll in Medicare Part A and/or Part B if you have ESRD. However, enrolling in Medicare when eligible may offer some protection from balance billing by the provider of ESRD services. Balance billing means the difference between the billed amount and the amount allowed by the Plan and/or Medicare.

Benefits for outpatient kidney dialysis for treatment of ESRD have been amended. Benefits are now provided by the Plan as follows:

- If you or your eligible dependents are not yet eligible to enroll in Medicare, benefits are provided for dialysis pursuant to the plan provisions described in the Medical Benefits section of the Plan booklet (beginning on page 32). There is no change from current benefits.

- If you or your eligible dependents are enrolled in, or are eligible to enroll in Medicare, and Medicare becomes or is eligible to become the secondary payer for ESRD services and supplies (regardless of whether you are actually enrolled in Medicare), benefits for kidney dialysis are provided at 150% of the current Medicare allowed amount.

- If Medicare becomes primary payer for ESRD services, the Plan pays secondary to Medicare and coordinates benefits up to 100% of the then current Medicare allowed amount for kidney dialysis.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above or in the SPD, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, you are required to provide the Administration Office with the effective date of Medicare Part A and Part B coverage.

Appeal Procedures

Appeal Procedures

The Appeal Procedures are described in the Plan Booklet. Generally, a claimant who believes he did not receive the full amount of benefits to which he is entitled, has the right to appeal to the Board of Trustees, provided a written request for appeal is submitted within 180 days after receipt of notification of an adverse decision. A properly submitted appeal will be presented to the Trustees for review.

Amendment Effective September 1, 2015

A claimant who remains dissatisfied with the Trustees' decision on appeal, may bring a civil action under ERISA § 502(a). Effective for appeals reviewed by the Trustees on and after September 1, 2015, the Plan has been amended to allow a claimant to request external review by an Independent Review Organization ("IRO") as an alternative to filing a civil action. ***External review is only available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage.*** There is no external review for non-healthcare claims, such as weekly disability, accidental death and dismemberment, or life insurance.

A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Attn: Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the request. The preliminary review will be expedited if the request satisfies the requirements for an urgent care claim. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

Review by Independent Review Organization

If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a). A claimant must exhaust the Plan's Appeal Procedures prior to filing a civil action.

Clarification of Hearing Care Expenses

Previously, coverage for Hearing Care Expenses was available only to Active and Retired employees. Effective March 1, 2015, this benefit was modified to include coverage for any eligible dependent who has profound hearing loss due to non-occupational illness or non-occupational injury and is seeking coverage of cochlear implants. Refer to your Plan Booklet, page 44, and the Summary of Material Modifications dated June 4, 2015, for a list of covered hearing care expenses.

Non-Grandfathered Status Under Affordable Care Act

Effective September 1, 2015, the Plan is no longer considered "grandfathered" under the Affordable Care Act.

If you have any questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

July 2, 2015

To: All Active and Plan A Non-Medicare Retiree Plan Participants and Beneficiaries of the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification – Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully.
It should be kept with your benefit booklet or insurance records for future reference.

The Trustees adopted the following changes to the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund ("Plan"). Unless otherwise stated, the changes are effective for services received on and after **September 1, 2015**. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet).

Coverage of Preventive Care

The Plan has been amended to cover recommended preventive care services required by the Affordable Care Act. The covered preventive services include well baby and well child care visits at specified intervals; immunizations for infants, children, adolescents, and adults as recommended by the Federal Centers for Disease Control and Prevention; and colorectal cancer screening at specified intervals for adults age 50 to 75.

Additional preventive care and screenings will be covered for women as required by the Affordable Care Act, and as supported by applicable guidelines, including: well-women visits; mammograms; and cervical cancer screenings. However, coverage for pregnancy of a dependent daughter is limited to those routine prenatal services listed under the Women's Preventive Care Act.

Contraceptives and contraceptive devices for dependent children are covered as required by the Affordable Care Act.

Covered preventive care now also includes a limited number of over-the-counter pharmaceuticals when prescribed by your physician. Please check with Express Scripts (the Pharmacy Benefit Manager) at (866) 493-9201 for limitations that may apply on the following over-the-counter medications:

- aspirin (325 mg and 81 mg) for cardiovascular disease for men and women
- folic acid (0.4 mg and 0.8 mg) supplements for women
- smoking cessation drugs and products

This is only a summary of the recommended preventive care required by the Affordable Care Act. If you have questions about specific services, including whether the services are recommended preventive services under the Affordable Care Act, you may contact the Administration Office or review the list of recommended preventive services at:

http:/www.healthcare.gov/preventive-care-benefits/

Benefits Payable for Covered Preventive Care

The Plan will provide benefits for covered preventive care, identified above, without cost-sharing, ***when services are provided by a Preferred Provider Organization ("PPO")***. This means the deductible, coinsurance, and copays will not be applied.

Some pharmaceuticals, including some over-the-counter medications, are also included in the preventive care benefit when prescribed by a physician, and will be covered without cost-sharing when purchased through the Plan's Pharmacy Benefit Manager.

Preventive services that are received from a *Non*-PPO provider will be subject to the deductible, copay and coinsurance. In addition, a *Non*-PPO provider may bill you for the difference between the billed amount and the Usual, Customary and Reasonable Amount allowed by the Plan.

Out-of-Pocket Maximum

The annual PPO Out-of-Pocket Maximum for medical benefits is $2,300 per person / $4,600 per family. The PPO Out-of-Pocket Maximum will continue to include the deductible ($300 per person / $600 per family). The Out-of-Pocket Maximum will now also include copays and coinsurance for PPO services. Non-PPO services within the PPO service area do not apply to the Out-of-Pocket maximum.

In addition, an Out-of-Pocket Maximum limit for covered prescription drugs will be established at $4,300 per person / $8,600 per family. There is no Out-of-Pocket Maximum for non-preferred brand prescriptions or drugs not on the formulary.

The following items will not apply to the Out-of-Pocket Maximum

- Coinsurance and copays for services received from non-PPO providers or hospitals within a PPO Service Area
- Benefits for foot orthotics and other supportive devices of the feet
- Expenses that are in excess of the Plan limits
- Expenses not covered by the Plan
- Expenses in excess of UCR amounts
- Alternative Provider benefits

Emergency Services Received in a Hospital Emergency Department

Under the Plan, the PPO coinsurance rate is applied when covered emergency services are received from a Non-PPO provider or hospital within 48 hours of an emergency. After 48 hours, benefits are reduced to the Non-PPO coinsurance rate, unless the physician documents that necessary services are not available at a PPO facility.

The Plan has been amended so that benefits for covered services to treat an "Emergency Medical Condition" in the emergency department of a Non-PPO hospital will now also be provided at the PPO coinsurance rate, regardless of whether the services are provided within 48-hours of an emergency. A Non-PPO provider may still bill you for the difference between the billed amount and the Usual, Customary and Reasonable Amount allowed by the Plan.

An "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual or unborn child in serious jeopardy, to expose the individual to serious impairment of bodily functions, or result in serious dysfunction of any organ or body part.

Coverage for Costs Associated with Certain Clinical Trials

The Plan does not provide benefits for services and supplies which are Experimental or Investigational. However, the Plan has been amended to provide that routine patient costs for items and services furnished in connection with an approved clinical trial will not be considered Experimental or Investigational if the item or service would otherwise be a covered expense for an eligible individual who is *not* enrolled in the clinical trial. An approved clinical trial is a

phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The eligible individual must be eligible to participate in the approved clinical trial according to the trial protocol. The following are not covered:

- The actual clinical trial or the investigational team;
- Items and services solely for data collection that are not directly used in the clinical management of the patient; or
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular condition.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

Routine patient costs for items and services furnished in connection with an approved clinical trial must be preauthorized by the preauthorization/utilization review organization. If you do not obtain preauthorization, the preauthorization/utilization review organization will determine medical necessity when the claim is submitted. If it is determined that the care you received was not medically necessary, benefits will not be provided.

Outpatient Dialysis Treatment Benefits for ESRD

If you or your eligible dependents are diagnosed with end-stage renal disease ("ESRD") you may be eligible for Medicare coverage by nature of the diagnosis. You are not obligated by the Plan to apply for and enroll in Medicare Part A and/or Part B if you have ESRD. However, enrolling in Medicare when eligible may offer some protection from balance billing by the provider of ESRD services. Balance billing means the difference between the billed amount and the amount allowed by the Plan and/or Medicare.

Benefits for outpatient kidney dialysis for treatment of ESRD have been amended. Benefits are now provided by the Plan as follows:

- If you or your eligible dependents are not yet eligible to enroll in Medicare, benefits are provided for dialysis pursuant to the plan provisions described in the Medical Benefits section of the Plan booklet (beginning on page 32). There is no change from current benefits.

- If you or your eligible dependents are enrolled in, or are eligible to enroll in Medicare, and Medicare becomes or is eligible to become the secondary payer for ESRD services and supplies (regardless of whether you are actually enrolled in Medicare), benefits for kidney dialysis are provided at 150% of the current Medicare allowed amount.

- If Medicare becomes primary payer for ESRD services, the Plan pays secondary to Medicare and coordinates benefits up to 100% of the then current Medicare allowed amount for kidney dialysis.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above or in the SPD, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, you are required to provide the Administration Office with the effective date of Medicare Part A and Part B coverage.

Appeal Procedures

Appeal Procedures

The Appeal Procedures are described in the Plan Booklet. Generally, a claimant who believes he did not receive the full amount of benefits to which he is entitled, has the right to appeal to the Board of Trustees, provided a written request for appeal is submitted within 180 days after receipt of notification of an adverse decision. A properly submitted appeal will be presented to the Trustees for review.

Amendment Effective September 1, 2015

A claimant who remains dissatisfied with the Trustees' decision on appeal, may bring a civil action under ERISA § 502(a). Effective for appeals reviewed by the Trustees on and after September 1, 2015, the Plan has been amended to allow a claimant to request external review by an Independent Review Organization ("IRO") as an alternative to filing a civil action. ***External review is only available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage.*** There is no external review for non-healthcare claims, such as weekly disability, accidental death and dismemberment, or life insurance.

A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Attn: Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the request. The preliminary review will be expedited if the request satisfies the requirements for an urgent care claim. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

Review by Independent Review Organization

If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a). A claimant must exhaust the Plan's Appeal Procedures prior to filing a civil action.

Clarification of Hearing Care Expenses

Previously, coverage for Hearing Care Expenses was available only to Active and Retired employees. Effective March 1, 2015, this benefit was modified to include coverage for any eligible dependent who has profound hearing loss due to non-occupational illness or non-occupational injury and is seeking coverage of cochlear implants. Refer to your Plan Booklet, page 44, and the Summary of Material Modifications dated June 4, 2015, for a list of covered hearing care expenses.

Non-Grandfathered Status Under Affordable Care Act

Effective September 1, 2015, the Plan is no longer considered "grandfathered" under the Affordable Care Act.

If you have any questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

CR/JP/TB/RBK/CJ/HC: jwg opeiu#8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F12\F12-02 - Mailing - 2015 - 06.02 - SMM - Important Info Re Health Plan.docx

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

July 2, 2015

To: All Plan B Non-Medicare Retiree Plan Participants and Beneficiaries of the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification--Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully. It should be kept with your benefit booklet or insurance records for future reference.

The Trustees adopted the following changes to the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund ("Plan"). Unless otherwise stated, the changes are effective for services received on and after **September 1, 2015**. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet).

Coverage of Preventive Care

The Plan has been amended to cover recommended preventive care services required by the Affordable Care Act. The covered preventive services include well baby and well child care visits at specified intervals; immunizations for infants, children, adolescents, and adults as recommended by the Federal Centers for Disease Control and Prevention; and colorectal cancer screening at specified intervals for adults age 50 to 75.

Additional preventive care and screenings will be covered for women as required by the Affordable Care Act, and as supported by applicable guidelines, including: well-women visits; mammograms; and cervical cancer screenings. However, coverage for pregnancy of a dependent daughter is limited to those routine prenatal services listed under the Women's Preventive Care Act.

Contraceptives and contraceptive devices for dependent children are covered as required by the Affordable Care Act.

Covered preventive care now also includes a limited number of over-the-counter pharmaceuticals when prescribed by your physician. Please check with Express Scripts (the Pharmacy Benefit Manager) at (866) 493-9201 for limitations that may apply on the following over-the-counter medications:

- aspirin (325 mg and 81 mg) for cardiovascular disease for men and women
- folic acid (0.4 mg and 0.8 mg) supplements for women
- smoking cessation drugs and products

This is only a summary of the recommended preventive care required by the Affordable Care Act. If you have questions about specific services, including whether the services are recommended preventive services under the Affordable Care Act, you may contact the Administration Office or review the list of recommended preventive services at:

http:/www.healthcare.gov/preventive-care-benefits/

Benefits Payable for Covered Preventive Care

The Plan will provide benefits for covered preventive care, identified above, without cost-sharing, ***when services are provided by a Preferred Provider Organization ("PPO")***. This means the deductible, coinsurance, and copays will not be applied.

Some pharmaceuticals, including some over-the-counter medications, are also included in the preventive care benefit when prescribed by a physician, and will be covered without cost-sharing when purchased through the Plan's Pharmacy Benefit Manager.

Preventive services that are received from a *Non*-PPO provider will be subject to the deductible, copay and coinsurance. In addition, a *Non*-PPO provider may bill you for the difference between the billed amount and the Usual, Customary and Reasonable Amount allowed by the Plan.

Out-of-Pocket Maximum

The annual PPO Out-of-Pocket Maximum for medical benefits is $2,800 per person / $5,600 per family. The PPO Out-of-Pocket Maximum will continue to include the deductible ($800 per person / $1,600 per family). The Out-of-Pocket Maximum will now also include copays and coinsurance for PPO services. Non-PPO services within the PPO service area do not apply to the Out-of-Pocket maximum.

In addition, an Out-of-Pocket Maximum limit for covered prescription drugs will be established at $3,800 per person / $7,600 per family. There is no Out-of-Pocket Maximum for non-preferred brand prescriptions or drugs not on the formulary.

The following items will not apply to the Out-of-Pocket Maximum

- Coinsurance and copays for services received from Non-PPO providers or hospitals within a PPO Service Area
- Benefits for foot orthotics and other supportive devices of the feet
- Expenses that are in excess of the Plan limits
- Expenses not covered by the Plan
- Expenses in excess of UCR amounts
- Alternative Provider benefits

Emergency Services Received in a Hospital Emergency Department

Under the Plan, the PPO coinsurance rate is applied when covered emergency services are received from a Non-PPO provider or hospital within 48 hours of an emergency. After 48 hours, benefits are reduced to the Non-PPO coinsurance rate, unless the physician documents that necessary services are not available at a PPO facility.

The Plan has been amended so that benefits for covered services to treat an "Emergency Medical Condition" in the emergency department of a Non-PPO hospital will now also be provided at the PPO coinsurance rate, regardless of whether the services are provided within 48-hours of an emergency. A Non-PPO provider may still bill you for the difference between the billed amount and the Usual, Customary and Reasonable Amount allowed by the Plan.

An "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual or unborn child in serious jeopardy, to expose the individual to serious impairment of bodily functions, or result in serious dysfunction of any organ or body part.

Coverage for Costs Associated with Certain Clinical Trials

The Plan does not provide benefits for services and supplies which are Experimental or Investigational. However, the Plan has been amended to provide that routine patient costs for items and services furnished in connection with an approved clinical trial will not be considered Experimental or Investigational if the item or service would otherwise be a covered expense for an eligible individual who is *not* enrolled in the clinical trial. An approved

clinical trial is a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The eligible individual must be eligible to participate in the approved clinical trial according to the trial protocol. The following are not covered:

- The actual clinical trial or the investigational team;
- Items and services solely for data collection that are not directly used in the clinical management of the patient; or
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular condition.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

Routine patient costs for items and services furnished in connection with an approved clinical trial must be preauthorized by the preauthorization/utilization review organization. If you do not obtain preauthorization, the preauthorization/utilization review organization will determine medical necessity when the claim is submitted. If it is determined that the care you received was not medically necessary, benefits will not be provided.

Outpatient Dialysis Treatment Benefits for ESRD

If you or your eligible dependents are diagnosed with end-stage renal disease ("ESRD") you may be eligible for Medicare coverage by nature of the diagnosis. You are not obligated by the Plan to apply for and enroll in Medicare Part A and/or Part B if you have ESRD. However, enrolling in Medicare when eligible may offer some protection from balance billing by the provider of ESRD services. Balance billing means the difference between the billed amount and the amount allowed by the Plan and/or Medicare.

Benefits for outpatient kidney dialysis for treatment of ESRD have been amended. Benefits are now provided by the Plan as follows:

- If you or your eligible dependents are not yet eligible to enroll in Medicare, benefits are provided for dialysis pursuant to the plan provisions described in the Medical Benefits section of the Plan booklet (beginning on page 32). There is no change from current benefits.

- If you or your eligible dependents are enrolled in, or are eligible to enroll in Medicare, and Medicare becomes or is eligible to become the secondary payer for ESRD services and supplies (regardless of whether you are actually enrolled in Medicare), benefits for kidney dialysis are provided at 150% of the current Medicare allowed amount.

- If Medicare becomes primary payer for ESRD services, the Plan pays secondary to Medicare and coordinates benefits up to 100% of the then current Medicare allowed amount for kidney dialysis.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above or in the SPD, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, you are required to provide the Administration Office with the effective date of Medicare Part A and Part B coverage.

Appeal Procedures

Appeal Procedures

The Appeal Procedures are described in the Plan Booklet. Generally, a claimant who believes he did not receive the full amount of benefits to which he is entitled, has the right to appeal to the Board of Trustees, provided a written request for appeal is submitted within 180 days after receipt of notification of an adverse decision. A properly submitted appeal will be presented to the Trustees for review.

Amendment Effective September 1, 2015

A claimant who remains dissatisfied with the Trustees' decision on appeal, may bring a civil action under ERISA § 502(a). Effective for appeals reviewed by the Trustees on and after September 1, 2015, the Plan has been amended to allow a claimant to request external review by an Independent Review Organization ("IRO") as an alternative to filing a civil action. ***External review is only available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage.*** There is no external review for non-healthcare claims, such as weekly disability, accidental death and dismemberment, or life insurance.

A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Attn: Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

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Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the request. The preliminary review will be expedited if the request satisfies the requirements for an urgent care claim. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

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Clarification of Hearing Care Expenses

Previously, coverage for Hearing Care Expenses was available only to Active and Retired employees. Effective March 1, 2015, this benefit was modified to include coverage for any eligible dependent who has profound hearing loss due to non-occupational illness or non-occupational injury and is seeking coverage of cochlear implants. Refer to your Plan Booklet, page 44, and the Summary of Material Modifications dated June 4, 2015, for a list of covered hearing care expenses.

Non-Grandfathered Status Under Affordable Care Act

Effective September 1, 2015, the Plan is no longer considered "grandfathered" under the Affordable Care Act.

If you have any questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

June 4, 2015

TO: All Active and Non-Medicare Retirees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund ("the Trust")

RE: New Preferred Provider Organization (PPO) and Benefit Changes

Please be sure that you and your family read this notice and keep it with your benefit booklet or insurance information for future reference.

New Preferred Provider Organization Effective July 1, 2015
Premera Blue Cross will replace First Choice and MultiPlan as the preferred provider organization ("PPO") in Washington and Alaska. In all other areas of the United States, the Trust will use the BlueCard nationwide network, which is a network of Blue Cross/Blue Shield (BCBS) providers. The Premera network also replaces the Trust's PPO contracts with Providence Alaska Medical Center and MatSu Regional Medical Center in Anchorage (both are in the Premera network). The purpose of this change is to improve pricing for medical services for you and for the Trust—*your benefits will not be affected by this transition.*

To receive the maximum benefit and the lowest out-of-pocket amounts, you must use a hospital, physician, or other healthcare provider that participates in the Premera Blue Cross or BCBS Network. You may receive care from any provider; **howeve**r, if you use a NON PPO provider, your out-of-pocket expenses will likely be higher because the provider's charges will not be discounted by Premera and the percentage of covered expenses paid by the Plan will be less.

The allowed amount for non-PPO expenses will be reimbursed at the Usual, Customary and Reasonable (UCR) allowance. Unlike PPO providers, non-PPO providers can balance bill you for the difference between the UCR allowance and their billed charges.

How Do I Find a Preferred Provider?
If you currently have a provider, it's likely that they are already participating with the local Blue Cross (Premera) network. The Trust recommends that you confirm this directly with your provider, or search for other preferred providers in your area, before July 1, 2015, in one of the following ways:

- By calling Premera directly at (800) 810-BLUE (2583) between the hours of 8 a.m. and 5 p.m.
- By visiting Premera's website and following steps 1 through 3, listed below:
  1. Log onto www.premera.com and select the **Find a Doctor, Dentist, or More** option.
  2. Under **Search without Logging In**, click on the **Search All Providers** link.
  3. Type the following information into the **I'm Looking For** search bar: the type of provider for which you are looking, your location, and your network. (Note: On the network drop box menu, select the **BlueCard PPO** network.)

To receive the highest level of benefits make sure all providers involved in your medical treatment are PPO providers. For example, if you are expecting to have surgery, inform your physician that other providers involved in your surgery (such as an assistant surgeon or anesthesiologist) must be PPO providers, Also check to see that any freestanding lab or x-ray services used by your physician are covered PPO providers

New Identification (ID) Cards
New identification (ID) cards that reflect the network change to Premera will be mailed to you during the middle of June. Please be sure to present your new ID card to your providers for services received on or after July 1, 2015. If you do not receive your new ID card by July 1, please contact the Administration Office at the number listed below.

Medicare Retirees
You are receiving this notice to make you aware of the change. However, this change does not affect your medical services covered as primary by Medicare. Because you have Medicare as your primary coverage, please continue to receive care from medical providers that accept Medicare. Your medical claims should continue to be submitted directly to Medicare. The Trust will continue to pay as your secondary coverage.

Medicare retirees will NOT receive new ID cards and should continue to use their current ID cards.

Benefit Changes Effective March 1, 2015

- **Cochlear Implants –** charges for cochlear implantation are covered for adults with severe to profound hearing loss due to illness or injury and otherwise meet required medical criteria and children (under age 18) who meet required medical criteria. Preauthorization is required for cochlear implantation.

- **Hearing Care Expenses** this benefit is modified to remove the limitation on coverage to Active and Retired employees if a participant has a profound hearing loss and is seeking coverage of cochlear implants–

- **Neurodevelopmental Therapy and Therapy Services –** This section of the Summary Plan Description (plan booklet) is deleted, and replaced with the following:

  Therapy Services
  Habilitative therapy services, including occupational therapy, speech therapy, physical therapy and related therapies, to improve a mental health condition or congenital birth defect.

  Rehabilitative therapy services on an outpatient basis, including occupational therapy, speech therapy and physical therapy, to the extent that the therapy will significantly restore and improve a lost function(s) following a severe illness, injury or surgery.

  Habilitative and rehabilitative services are subject to the following conditions:
  - The service must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy.
  - The services must be prescribed by the attending physician and administered by a physician or covered licensed therapist. The Plan may periodically request a review of the services by a physician and the patient must continue under the care of the attending physician during the time the therapy is being provided; and
  - The services must not be custodial in nature.

  Rehabilitative and habilitative therapy services unrelated to a mental health condition are limited to 20 visits per calendar year. Benefits for rehabilitative and habilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of therapy.

Any questions regarding the information contained in this notice should be directed to the Administration Office at (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 877-441-1212, option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

June 24, 2014

To: All Eligible Plan Participants
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification – Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice and keep it with your benefit booklet or insurance information for future reference.

I. Medical Benefits

Effective **April 1, 2014**, the Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund (the Plan) is being amended to reflect changes that are required by the Patient Protection and Affordable Care Act (PPACA), informally known as the Affordable Care Act. The Plan changes are summarized below. This notice should be considered an insert to your 2010 edition Summary Plan Description (Plan Booklet) and Plan Document. Please take time to read it carefully and then keep it with your important plan paperwork.

Dependent Eligibility – Coverage for all dependent children who satisfy the requirements as defined by the Plan is now extended to age 26, regardless of other available coverage. This Plan will be secondary to a plan that covers a dependent as an active employee. Coverage is not automatic. You must enroll your children who are not presently enrolled. No claims will be processed until an enrollment form is on file and proper documentation has been received.

Annual Medical Maximum Benefit – The Plan's annual medical maximum benefit of $2,000,000 is being eliminated. There will no longer be any annual medical benefit maximum. This change was reflected on the Summary of Benefits and Coverage mailed to you in early March, 2014.

Vision Benefits for Children – The following services are considered "essential" for eligible dependent children up to the age of 18 only. Annual dollar limits on these vision benefits are removed if provided in network:

- Pediatric Vision Exam
- Contacts
- Frames
- Low Vision Coverage

II. Dental Benefits

Effective April 1, 2014, the Trustees made the following changes to the **Active Plan** self-funded dental benefits (these changes do not apply to participants enrolled in Willamette Dental Group):

Revised Schedule of Dental Benefits – Enclosed with this Notice is a revised schedule which replaces the benefits schedule listed on pages 68 – 71, of your 2010 Plan booklet. In most cases the allowed amounts have increased. Included with this updated schedule is coverage of dental implant services. Dental implant services include implant surgery (the implant and the crown placed thereon) and like all other dental services are subject to all plan limitations.

This is not a complete list of all dental procedures. If you would like a complete list of scheduled dental benefits, please contact the Administration Office. If you had a claim for dental benefits during April 1, 2014 and May 30, 2014, all dental claims are being reprocessed using the new dental benefits schedule.

III. Dollar Bank Eligibility

The Board of Trustees has also taken action to update certain provisions regarding maintenance of dollar banks.

A. Reinstatement of Eligibility/Forfeiture of Contributions – Covered Participants

The Trustees have extended the length of time that the Plan will carry an employee's dollar bank, when the dollar bank lacks sufficient contributions for a month of coverage. Prior to October 1, 2013, the Plan would carry a dollar bank balance which had less than the current dollar bank deduction rate for one month of coverage, for up to six months after loss of eligibility.

Effective October 1, 2013, if coverage ends because an employee's dollar bank has less than the current dollar bank deduction rate for a month of coverage, the balance of the dollar bank is carried by the Plan for a maximum of fourteen months.

If during the twelve months beginning on the first day of the month in which the Participant first loses coverage, he works and adds sufficient dollars to his account, his eligibility will be reinstated on the first day of the second month after the account has the minimum required for a month of eligibility, i.e., the first day of the fourteenth month after he had lost eligibility.

If eligibility is not reinstated by the first day of the fourteenth month following the date coverage ends, the Participant is required to satisfy the initial eligibility rules to again be covered under the Plan. In addition, beginning the first day of the fourteenth consecutive month in which a Participant does not reinstate eligibility, the oldest month of contributions in his account will be forfeited. Thereafter, on the first day of each consecutive month in which the Participant's account does not have sufficient contributions to reestablish eligibility, he will forfeit the oldest month of contributions in his account.

B. Initial Eligibility Rules for Hourly Employees

For hours worked prior to May 1, 2014, the Plan provided that each employee is assigned a dollar bank into which employer contributions are credited. An employee becomes eligible on the first day of the second month following accumulation of the minimum amount needed to establish initial eligibility as set by the Trustees.

The minimum amount of contributions needed to establish initial eligibility is $1,460 in Washington and $1,705 in Alaska, **which must be accumulated in a consecutive three-month period**.

Effective for hours worked on and after May 1, 2014, the minimum amount of contributions required to establish initial eligibility must still be accumulated in a consecutive three-month period. However, under the Plan as amended, an employee will have up to twelve months in which to have a three consecutive month period in which to accumulate the contributions required to establish initial eligibility. If by the end of the twelve months in which the Plan has received contributions on behalf of the employee, the employee has not yet accumulated sufficient contributions to achieve initial eligibility, the contributions received in the first month will be forfeited. Thereafter, the oldest month of contributions will be forfeited at the end of each twelve-month period in which the employee does not accumulate sufficient contributions to achieve initial eligibility.

Example

A Washington employee accrues total contributions of $1,250 in his dollar bank in January. February, and March 2013. He earns no contributions in April through November 2013. The employee has not yet established initial eligibility as he has not had sufficient contributions in his account within a consecutive three-month period in the past eleven months.

The employee then accrues total contributions of $1,600 in December 2013, and January and February 2014, and has sufficient contributions in three consecutive months to establish initial eligibility in April 2014. However, because he did not accumulate sufficient contributions in the twelve-month period of January 2013 through December 2013 to establish initial eligibility by February 2014, the contributions earned in January 2013 are forfeited to the Plan on January 1, 2014. The contributions earned in February 2013 are forfeited on February 1, 2014, because he did not accumulate sufficient contributions in the twelve-month period of February 2013 through January 2014 to establish initial eligibility by March 2014. He does accumulate sufficient contributions in the twelve-month period of March 2013 through February 2014 to establish initial eligibility effective April 2014, so the contributions earned in March 2013 remain in his account provided he maintains eligibility pursuant to Plan provisions.

Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding benefit changes, please contact the Administration Office at (877) 441-1212, option 1 or visit www.engineerstrust.com.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 877-441-1212, option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Locals 302 and 612 of the International Union of Operating Engineers Health and Security Fund
Schedule of Dental Benefits Effective April 1, 2014

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
	DIAGNOSTIC		
	Examinations		
0120	Periodic oral exam	$59	$71
0140	Limited oral exam	$99	$119
0150	Comprehensive oral exam	$104	$125
	Radiographs (X-Rays)		
0210	Intraoral–complete series (including bitewings)	$132	$158
0220	Single, first film	$26	$31
0230	Each additional film	$24	$29
0270	Bitewing–single film	$27	$32
0272	Bitewings–two films	$44	$53
0274	Bitewings–four films	$62	$74
0330	Panoramic film	$106	$127
	PREVENTIVE		
	Prophylaxis		
1110	Age 13 and over	$106	$127
1120	To age 13	$74	$89
	Fluoride Treatment: To age 18		
1208	Topical application of fluoride	$41	$49
	Fissure Sealants: ages 6 to 18		
1351	Topical application of fissure sealant (per tooth)	$52	$62
	Space Maintainers: To age 19		
1510	Fixed–unilateral type	$341	$409
1515	Fixed–bilateral type	$477	$572

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
	MINOR RESTORATIONS		
2140	Amalgam–1 surface	$128	$154
2150	Amalgam–2 surfaces	$166	$199
2160	Amalgam–3 surfaces	$201	$241
2161	Amalgam–4 or more surfaces	$245	$294
2951	Pin retention–exclusive of amalgam	$37	$44
2330	Resin–1 surface anterior	$116	$139
2331	Resin–2 surfaces anterior	$148	$178
2332	Resin–3 surfaces anterior	$182	$218
2335	Resin–4 or more surfaces anterior	$215	$258
2391	Resin–1 surface posterior	$136	$163
2392	Resin–2 surfaces posterior	$178	$214
2393	Resin–3 surfaces posterior	$221	$265
2394	Resin–4 or more surfaces posterior	$271	$325
	MAJOR RESTORATIONS		
	Inlays and Onlays		
2510	Inlay, metallic–1 surface	$500	$600
2520	Inlay, metallic–2 surfaces	$567	$680
2530	Inlay, metallic–3 surfaces	$654	$785
2542	Onlay, metallic–2 surfaces	$641	$769
2543	Onlay, metallic–3 surfaces	$670	$804
2544	Onlay, metallic–4 or more surfaces	$697	$836
2642	Onlay, porcelain–2 surfaces	$643	$772
2643	Onlay, porcelain–3 surfaces	$693	$832

Locals 302 and 612 of the International Union of Operating Engineers Health and Security Fund
Schedule of Dental Benefits Effective April 1, 2014

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
	MAJOR RESTORATIONS Continued		
2644	Onlay, porcelain–4 or more surfaces	$735	$882
2910	Re-cement inlay	$62	$74
	Crowns		
2720	Resin with high noble	$674	$809
2721	Resin with predominantly base metal	$632	$758
2722	Resin with noble metal	$646	$775
2740	Porcelain/ceramic noble metal	$692	$830
2750	Porcelain fused to high noble metal	$683	$820
2751	Porcelain fused to predominantly base metal	$636	$763
2752	Porcelain fused to noble metal	$651	$781
2780	¾ cast high noble metal	$655	$786
2781	¾ cast base metal	$616	$739
2782	¾ cast noble metal	$637	$764
2783	¾ cast porcelain	$673	$808
2790	Full cast high noble metal	$659	$791
2791	Full cast predominantly base metal	$624	$749
2792	Full cast noble metal	$636	$763
2930	Stainless steel–primary tooth	$170	$204
2970	Temporary crown	$154	$185
2950	Crown buildup	$163	$196
2920	Re-cement crown	$63	$76

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
	Endodontics		
3110	Pulp cap–direct	$59	$71
3120	Pulp cap–indirect	$47	$56
3220	Vital pulpotomy	$121	$145
	Root Canal Therapy (includes treatment plan, clinical procedures, follow-up care; excludes final restoration)		
3310	Single-rooted	$605	$726
3320	Bi-rooted	$742	$890
3330	Tri-rooted	$920	$1,104
3410	Apicoectomy (as a separate surgical procedure)	$693	$832
	PERIODONTICS		
	Non-Surgical Services		
4910	Periodontal maintenance	$125	$150
4341	Periodontal scaling and planing (per quadrant)	$203	$244
	Surgical Services		
4210	Gingivectomy (per quad)	$637	$764
4241	Gingival flap procedure (per quad)	$467	$560
4260	Osseous surgery (per quad)	$1,346	$1,615
	PROSTHODONTICS		
	Dentures (includes six months post-delivery care)		
5110-20	Complete upper or lower	$1,034	$1,241
5130-40	Immediate upper or lower	$1,128	$1,354
5211	Partial upper or lower, acrylic base (and conventional clasps/rests)	$873	$1,048

Locals 302 and 612 of the International Union of Operating Engineers Health and Security Fund
Schedule of Dental Benefits Effective April 1, 2014

Scheduled Dental Plan			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
5213-14	Partial upper or lower, predominantly cast base with acrylic saddles (and conventional clasps/rests)	$1,143	$1,372
	Related Denture Services		
5410-22	Denture adjustment (complete or partial)	$57	$68
5510	Repair denture damage (no teeth)	$113	$136
5520	Replace missing or broken teeth in complete denture–per tooth	$95	$114
5710	Rebase denture	$420	$504
5730-31	Reline denture–office	$237	$284
5750-51	Reline denture–lab	$316	$379
	IMPLANT CROWN		
6065	Implant supported porcelain/ceramic crown	$921	$1,105
6066	Implant supported porcelain fused to metal crown	$709	$851
6067	Implant supported metal crown	$997	$1,196
	Bridgework		
6210	Pontic–cast	$665	$798
6240	Pontic–porcelain	$657	$788
6250	Pontic–resin	$649	$779
6930	Re-cement bridge	$95	$114

Scheduled Dental Plan			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
	ORAL SURGERY		
	Extractions (includes local anesthesia, routine postoperative care)		
7140	Single tooth	$120	$144
7210	Erupted tooth–surgically removed	$209	$251
7220	Impacted tooth–soft tissue	$262	$314
7230	Impacted tooth–partially bony	$348	$418
	ORAL SURGERY		
	Extractions Continued		
7240	Impacted tooth–completely bony	$409	$491
7250	Root recovery–per tooth	$220	$264
	Related Oral Surgical Procedures		
7310	Alveoloplasty–per quadrant	$452	$542
7510	Incision, drainage of abscess intraoral	$486	$583
7960	Frenectomy (separate procedure)	$256	$307
9220	General anesthesia	$301	$361

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

April 30, 2014

To: All Eligible Active and Non-Medicare Retirees Residing in the State of Alaska
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: BridgeHealth Surgical Benefit Management Services

Exciting Enhancement to your Standard Medical Plan

Important Information – *Please be sure that you and your family read this notice carefully and keep it with your benefit booklet or important insurance papers for future reference.*

Effective May 1, 2014, the Trust is offering another option for major surgical care, in addition to using one of the Plan's PPO hospitals including Providence Alaska Medical Center in Anchorage and Mat Su Regional Medical Center in Palmer or another PPO hospital and/or facility through the Beech Street/Viant Network outside of Anchorage.

You now have access to a wide range of tools and resources through BridgeHealth Medical to help you make medical decisions -- like whether or not to have major surgery. And, it's included in your Operating Engineers Construction Industry Health and Security Plan benefits at no additional cost to you!

Many times there are viable alternatives to surgery. The BridgeHealth Medical program empowers you to understand *all* of your options. It gives you the tools to make informed decisions and confidently discuss with your doctor the treatment that is best *for you*.

If surgery is necessary, you'll have access to Centers of Excellence facilities across the country, where you get top-quality care *and* the lowest out-of-pocket costs.

With the BridgeHealth Medical program you get:

- ***Access to the BridgeHealth website.*** Use the interactive tools and resources to better understand your diagnosis and treatment options.
- ***Access to CareChex® quality ratings*** – CareChex is an independent hospital rating service available through the BridgeHealth website.
- ***Travel and surgical coordination handled on your behalf*** *(*by a BridgeHealth care coordinator) every step of the way.
- ***Travel and lodging covered at 100%*** for you *and* a companion (if medically necessary) when the network provider you need is outside your local area.
- ***Annual deductible and coinsurance/copayment*** are both waived.
- ***$50 per day*** to cover incidental expenses related to your travel.

Find out more

Visit **www.BridgeHealthMedical.com**. Look for the **Plan Member Login** button at the top of the page. Sign in using your e-mail and password. If it's your first time on the site, you'll need to register using Operating Engineers' unique company code: **PRLT2**.

Specific questions? Ready to schedule surgery?

BridgeHealth is here to help plan participants like you.
Chat online with a BridgeHealth care coordinator (accessed via www.BridgeHealthMedical.com); send an e-mail to ClientCenter@BridgeHealthMedical.com or call 1-800-680-1366.

While we hope no one will ever need this program, we want to make sure our members take advantage of the quality care and out-of-pocket savings BridgeHealth offers.

Sincerely,

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

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S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F12\F12-02 - Mailing - 2014 - 04.30 - BridgeHealth.docx

About to schedule surgery?
Wait! Make sure you get the care you deserve.

Specialty procedures | Hip | Heart | Shoulder | Knee | Spine

You may qualify for up to **100% coverage** on many planned procedures. This could significantly reduce your out-of-pocket expenses!

How it works

BridgeHealth Medical is a part of your employee benefit plan. When you use BridgeHealth to facilitate your surgery, you get top quality care *and* significant savings...**at no additional cost to you.**

Before scheduling surgery, contact BridgeHealth.

To qualify, you must schedule surgery through BridgeHealth Medical

- **Contact BridgeHealth** by phone: 1-888-387-3909; by e-mail: ClientCenter@BridgeHealthMedical.com, or online: www.BridgeHealthMedical.com.
- **Speak with a Care Coordinator**, who can help you locate top-quality providers. They'll also help you understand why quality is so important when it comes to surgery.
- **Discuss your BridgeHealth provider options**.
- **A Care Coordinator** will forward medical records to a BridgeHealth surgeon for review.
- **Relax and let Care Coordinators handle all of the details.**

Don't forget, there may be alternatives to surgery.

Up to 40% of surgeries may be unnecessary. Before making the final decision regarding planned surgery, let BridgeHealth's website provide you with:

- **Interactive tools and resources.** Better understand your diagnosis and treatment options. The more you know about your condition, the better off you'll be when deciding how to treat it.
- **Access to hospital quality ratings.** Not all hospitals are equal. You can feel confident that your procedure will be performed at a top-quality surgical center, greatly reducing the risk of complications.

BridgeHealth™ MEDICAL

Visit www.BridgeHealthMedical.com and register today!

Website access code: PRLT2

www.BridgeHealthMedical.com | 1-888-387-3909

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LOCALS 302 & 612 INTERNATIONAL UNION OF OPERATING ENGINEERS CONSTRUCTION INDUSTRY HEALTH AND SECURITY PLAN

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Pursuant to regulations issued by the federal government, the Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes PHI as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

PROTECTED HEALTH INFORMATION

PHI generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearing house; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization in the following situations:

To Make or Obtain Payment: The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication of reimbursement of your health claims.

To Facilitate Treatment: The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.

To Conduct Health Care Operations: The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants.

Health care operations include: making eligibility determinations; contacting health care providers; providing Participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning-related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees: The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors which assist the Board of Trustees in performing Plan administration functions, such as handling claim appeals. The Trust also may provide Summary Health Information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans.

Summary Health Information is information which summarizes Participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative: When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required By Law: In addition, the Trust will disclose your health information where applicable law requires. This includes:

1. *In Connection With Judicial and Administrative Proceedings.* The Trust may disclose your health information to a health oversight agency for authorized activities (including audits; civil; administrative or criminal investigations; inspections; licensure or disciplinary action); government benefit programs for which health information is relevant; or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

2. *When Legally Required and For Law Enforcement Purposes.* The Trust will disclose your protected health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by state law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, such as identifying a suspect or to provide evidence of criminal conduct.

3. *To Conduct Public Health and Health Oversight Activities.* The Trust may disclose your protected health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law.

   The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

4. *In the Event of a Serious Threat to Health or Safety.* The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

5. *For Specified Government Functions.* In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

6. *For Workers' Compensation.* The Trust may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information without your written authorization.

Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below.

If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. Psychotherapy notes do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct Treatment, Payment and Health Care Operations.

Additionally, your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Trust.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request unless the disclosure at issue is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid by you out-of-pocket and in full.

Right to Inspect and Copy Your Health Information: You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated

with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic format shall not be greater than the Trust's labor costs in responding to the request.

Right to Receive Confidential Communications: You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend the Your Health Information: If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment.

The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

Right to an Accounting: You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you or any one authorized by you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. If the Trust participates in fundraising, you have the right to opt-out of all fundraising communications.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You will be able to obtain a copy of the current version of the Trust's Notice at its website, www.engineerstrust.com. If this Notice is modified you will be mailed a new copy.

Privacy Contact Person/Privacy Official: To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

Privacy Contact Person
Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: (206) 441-7314
Toll Free: (877) 441-1212
Fax No: (206) 441-9110

Privacy Official
C. Gilbert Lynn
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: (206) 441-7314
Toll Free: (877) 441-1212
Fax No: (206) 441-9110

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

EFFECTIVE DATE

This Notice was originally effective **April 14, 2003**, as amended September 3, 2013**.**

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 7, 2013

To: All Eligible Plan Participants
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Re: Summary of Material Modification – Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice and keep it with your benefit booklet or insurance information for future reference.

Annual Maximum Benefit – The Plan's annual maximum benefit increased to $2,000,000 for claims incurred from April 1, 2013 through March 31, 2014.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits.

MHPAEA became effective for this Plan on April 1, 2013. Substance abuse disorder benefits are already paid the same as any other medical benefit and have not been modified. Those benefits continue to be subject to medical necessity, the deductible, the out-of-pocket maximum (PPO only) limitation on Preferred Provider Organization (PPO) claims, and non-PPO inpatient admission co-pay.

Effective with dates of service on or after April 1, 2013, treatment for mental health will also be paid on the same terms and conditions as other similar medical benefits. Those benefits remain subject to the Plan's requirement that treatment be medically necessary. Benefits for covered mental health expenses have been revised as follows:

IMPORTANT: Benefits are based upon the PPO Allowed Amount when services are received from a PPO provider. Benefits are based upon the Usual Customary and Reasonable (UCR) Amount when services are received from a Non-PPO provider.

Mental Health Services	Current Benefit	Benefit Effective April 1, 2013
• Inpatient:	**PPO:** 80% up to out-of-pocket maximum and then paid at 100%. **Non PPO:** 70% after $100 co-pay. **Limitations:** Subject to deductible; preauthorization required;* limited to 70 days per year for participant and 31 days per year for dependent; non-PPO services do not count towards out-of-pocket maximum.	**PPO:** 80% up to out-of-pocket maximum and then paid at 100%. **Non PPO:** 70% after $100 co-pay. **Limitations:** Subject to deductible; preauthorization required;* room and board limited to hospital's average semi-private room rate; non-PPO services do not count towards out-of-pocket maximum.
• Outpatient:	**PPO:** 50% **Non PPO:** 50% **Limitations:** Subject to deductible; maximum benefit is $40 per visit; does not apply to out-of-pocket maximum.	**PPO:** 80% up to out-of-pocket maximum and then paid at 100%. **Non PPO:** 70% **Limitations:** Subject to deductible; non-PPO services do not count towards out-of-pocket maximum.

**All in-patient services must be preauthorized by First Choice. The Trust will not pay benefits for any hospitalization which is not medically necessary. First Choice Behavioral Health (BHCC) phone number: (800) 640-7682.*

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 877-441-1212, option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (877) 441-1212, option 1 or visit www.engineerstrust.com.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124 • Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

June 19, 2012

To: **All Eligible Plan Participants**
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Subject: **Summary of Material Modification – Important Information Regarding Your Health Plan**

Please be sure that you and your family read this notice and keep it with your benefit booklet or insurance information for future reference.

- **Initial Eligibility**

  Effective with July 2012 hours for September 2012 coverage, the minimum contribution required to establish initial eligibility in Washington will increase from $1,390.50 to $1,460.00; the minimum contribution required to establish initial eligibility in Alaska will increase from $1,624.50 to $1,705.00.

- **Continuing Coverage**

  Effective with July 2012 hours for September 2012 coverage, the dollar bank deduction will increase from $927.00 to $973.00 per month in Washington; and from $1,083.00 to $1,137.00 per month in Alaska. At the same time, the maximum you may accumulate in your dollar bank at any one time will increase from $6,489.00 to $6,813.00 in Washington, and from $7,581.00 to $7,960.00 in Alaska.

- **Annual Benefit Maximum**

  Effective April 1, 2012, in accordance with the Patient Protection and Affordable Care Act, the annual benefit maximum for essential benefits increased from $1,000,000 to $1,250,000.

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, and select option 4 per the recorded message.

Sincerely,

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124 • Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

October 6, 2011

To: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

Re: Summary of Material Modifications

Please be sure that you and your family read this notice carefully.
It should be kept with your benefit booklet or insurance records for future reference.

The 2010, Health and Security Fund/Summary Plan Description ("Plan/SPD") was recently amended by the Board of Trustees. The changes made to the Plan/SPD are summarized below, with references to the corresponding Plan/SPD section(s) and page(s).

Preferred Provider Organizations (PPO)

Effective July 1, 2011, the definition of Preferred Provider Organizations (PPO) on page 120 of the 2010 Plan Booklet is amended to include:

- Mat-Su Regional Hospital as a PPO provider.

Step Therapy

Effective July 1, 2011, the provisions regarding Step Therapy on page 63 of the 2010 Plan Booklet are amended as follows:

- ACE Inhibitors is removed from Step Therapy

Benefits of Medicare Part B Expenses

Effective January 1, 2011, the provisions regarding Benefits of Medicare Part B Expenses on pages 106 and 107 of the 2010 Plan Booklet are amended as follows:

- The Plan pays $162 of the deductible required by Medicare.

Acceleration of Initial Eligibility

Effective April 1, 2011, the provisions regarding Acceleration of Initial Eligibility on pages 11 and 12 of the 2010 Plan Booklet are amended as follows:

Initial dollar bank eligibility may be accelerated if you satisfy each of the following requirements:

- Your employer begins contributing to the Fund for the first time under a full compliance collective bargaining agreement on or after March 1, 2004, and signs a written agreement with the Fund to provide accelerated eligibility for all employees who qualify. You may also satisfy this requirement if you are part of a new employee group which was employed by an employer that was not signatory to a full compliance agreement, and the new employee group is acquired on or after April 1, 2011 by an employer signatory to a full compliance agreement covering the new employee group. An employee is considered part of a "new employee group" if the contributing employer: acquires substantial assets (such as a plant or division or substantially all of the assets of a trade or business) of the prior employer; or acquires all of the stock of the prior employer; or otherwise enters into a business transaction wherein the employer acquires the employees of the former employer and the former employer terminates employment of the new employee group. You must be employed by the employer that is signatory to the full compliance agreement and covered by that agreement on the date accelerated eligibility becomes effective. If you become employed by the employer after the effective date of accelerated eligibility, or you are not covered by the collective bargaining agreement, you will not qualify.

- The collective bargaining agreement provides for payment of contributions on your behalf to the Fund on a cents-per-hour basis.

- You were covered under the employer's (or prior employer's) group health insurance plan on the date immediately preceding the effective date of accelerated eligibility.

Accelerated eligibility becomes effective coincident with the termination of the employer's (or prior employer's) group insurance plan. The employer may elect to provide either one month or two months of accelerated eligibility for employees, with all employees receiving the same period of accelerated eligibility. If your employment terminates, accelerated eligibility terminates at the end of the month in which employment terminates. After expiration of accelerated eligibility, eligibility will continue only if you satisfy the dollar bank eligibility rules or apply for self-payment (COBRA) coverage pursuant to the provisions beginning on page 17.

To offset the cost of accelerated eligibility, once you establish dollar bank eligibility, the monthly dollar bank charge, plus an additional amount that is the lesser of the balance in the dollar bank (after deduction of the monthly dollar bank charge) or 25% of the monthly dollar bank charge, will be deducted from your dollar bank for each month of coverage. The additional amount will continue to be assessed until the total of the additional amounts equals the dollar value of the number of months of accelerated eligibility that you were provided.

The dollar bank will be used first to provide a month of current eligibility before assessing the additional amount. If the balance in the dollar bank is not sufficient to provide a month of current eligibility, then an additional amount will not be assessed for that month. However, any dollar bank balance that would otherwise be forfeited, because coverage is lost and not reinstated within a six-month period, will be credited toward the amount due to offset the cost of the accelerated eligibility. If the cost of accelerated eligibility is not recovered before your dollar bank is forfeited, and you later reestablish eligibility, the Plan shall resume crediting your dollar bank for the additional amount remaining due.

NOTICE OF GRANDFATHERED STATUS

This Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office toll free at 877-441-1212, option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact the Administration Office toll free at 877-441-1212, option 1.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124 • Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

March 1, 2011

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Locals 302 and 612 IUOE Construction Industry Health and Security Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS
Please be sure that you and your family read this notice carefully.
It should be kept with your benefit booklet or insurance records for future reference.

This Participant Notice will advise you of certain material modifications that have been made to the Health and Security Fund to comply with the new Patient Protection and Affordable Care Act (the "Affordable Care Act") *effective* April 1, 2011.

COVERAGE FOR DEPENDENT CHILDREN TO AGE 26 - EFFECTIVE APRIL 1, 2011

Attention Parents **- Please make sure to provide a copy of this notice to any children entitled to special enrollment rights. Under the law and applicable regulations, this notice is being transmitted to you for delivery to your children.**

The Affordable Care Act allows certain young adults to be covered by their parents' plan until they reach age 26. The law states that the extension of dependent coverage for children is effective for Plan years beginning on or after September 23, 2010.

Therefore, effective April 1, 2011 the Fund is extending dependent child coverage up to age 26 for natural children, stepchildren, foster children, adopted children and children placed for adoption, regardless of whether the dependent child is married, a full-time student, resides with the employee or retiree, or is financially dependent on the employee or retiree. The current limiting age of 19 (or up to age 24 if a full-time student) will continue to apply to unmarried children who depend on the employee or retiree by virtue of a court order or for whom the employee or retiree has legal custody.

Any dependent children added during this Special Enrollment opportunity will have all the same benefits and coverage that are available to similarly situated individuals.

IMPORTANT NOTE: This Special Enrollment opportunity **does not apply** to dependent children who have health plan coverage available through their own employer, or their spouse's employer, regardless of whether they enroll in that coverage.

SPECIAL ENROLLMENT PROCEDURE – This Special Enrollment opportunity applies to dependent children (son, daughter, stepchild, foster child, adopted child, or child placed with you for adoption) under the age of 26 who:

- previously lost coverage under the Plan because they reached the Plan's limiting age; or
- were previously denied coverage under the Plan because they were over the limiting age; or
- previously lost coverage or were denied coverage because they failed to meet the dependent eligibility requirements (i.e. not a full-time student, were married, did not reside with the employee, did not meet financial support requirements).

Special Enrollment does not apply to children who are dependents by virtue of a court order or because the employee or retiree has legal custody. The limiting age of 19 (or age 24 if a full-time student) will continue to apply to these children. See pages 14-15 in your booklet for the eligibility rules for these dependents.

Eligible employees or retirees must request Special Enrollment for children who qualify within 30 days from the date of this notice for coverage to be effective on April 1, 2011. The Special Enrollment period is the 30-day period from March 1, 2011 through March 31, 2011. A dependent child enrolled during this period will have coverage effective on April 1, 2011. If you do not enroll a dependent child during this 30-day period, claims for that child will not be paid until a completed enrollment form is returned to the Trust Administration Office. Retirees who do not enroll an eligible dependent child during this 30-day period will only be able to enroll the child in the future as allowed under the "Special Enrollment Provisions" section on page 101 of the 2010 Health and Security Fund booklet.

If you have a child who qualifies for Special Enrollment and you wish to enroll him/her in the Plan, you must complete the enclosed enrollment form and return it to the Administration Office postmarked no later than March 31, 2011.

This new Special Enrollment opportunity afforded under the Federal law applies to dependent children and does not create any eligibility for coverage for the husband or wife of the dependent child (the employee/retiree's son-in-law or daughter-in-law) or the children of the dependent child (the employee/retiree's grandchild).

ELIMINATION OF MEDICAL LIFETIME BENEFIT MAXIMUM AND IMPLEMENTATION OF NEW ANNUAL BENEFIT MAXIMUM – EFFECTIVE APRIL 1, 2011

Effective April 1, 2011, the Plan is eliminating the current $1,000,000 lifetime medical benefit maximum. In place of the lifetime maximum, the Plan will be implementing an *annual* medical benefit maximum of $1,000,000 in essential benefits. Individuals whose medical coverage previously ended by reason of reaching the lifetime limit are again eligible to enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment and coverage will be effective April 1, 2011. To enroll the individual must complete an Enrollment Form and return it to the Administration Office with a postmark of no later than March 31, 2011.

OTHER BENEFIT PLAN REVISIONS EFFECTIVE APRIL 1, 2011

The following benefit revisions are also being made effective April 1, 2011. All other Plan limitations and exclusions currently listed in the 2010 Summary Plan Description and subsequent notices will remain unchanged.

- Physical Exams and Screenings for active members, COBRA beneficiaries, retirees and dependents age 14 and older – the maximum benefit of $600 for Alaska and $500 for Washington and other areas is removed. Physical exams will be limited to one per calendar year; necessary x-rays and laboratory tests in connection with an exam are also covered at 100% of the PPO allowed amount or the UCR amount. (see page 51 in your booklet).
- Well Child Care – the limit of $100 per visit is removed. The Plan will cover one routine exam for a new born baby in the hospital; 10 routine exams for dependent children ages 1 month to 18 months; 8 routine exams for dependent children ages 2 years through 13 years. (see page 54 in your booklet)
- Chemical Dependency Treatment – the limits of $5,000 in any 24-consecutive month period and $10,000 per lifetime are eliminated. Preauthorization is required for inpatient treatment. (see page 42 in your booklet)
- Neurodevelopmental therapy – the Plan lifetime limit of $2,000 is removed and benefits are available to dependent children age 6 or younger. (see page 48 in your booklet)
- Pediatric dental care (for dependent children to age 18 only) – the dental benefit maximum per calendar year ($3,000 for treatment in Alaska and $2,500 for treatment in Washington and other areas) is removed for children under age 18. All maximum benefit limits for adults and for other treatment limitations and exclusions, *including* the maximum lifetime dollar limit for Orthodontia, will still apply. (see page 66 in your booklet).
- Diabetic Education – the Plan annual maximum of $300 is removed. (see page 40 in the your booklet).

MANDATORY REPORTING OF SOCIAL SECURITY NUMBERS

Federal law, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), requires that effective January 1, 2009 all individuals (members and dependents) who are covered by a health plan must report all social security numbers to their health plan. The Plan is then required to report all social security numbers to Medicare. You may view this requirement at: www.cms.hhs.gov/MandatoryInsRep.

NOTICE OF GRANDFATHERED STATUS

This Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office toll free at 877-441-1212, option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

The Fund has been certified for participation in the Early Retiree Reinsurance Program ("ERRP"). ERRP is a Federal program that was established under the Affordable Care Act. Under ERRP, the Federal government reimburses a plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, ERRP expires on January 1, 2014.

The Board of Trustees, as the Plan sponsor has chosen to use any reimbursements it receives from ERRP to offset increases in the Plan's self-funded health benefit costs. This may benefit you if future increases to your contributions, co-payments, deductibles or co-insurance are delayed or avoided. This may be advantageous to you for so long as the reimbursements under ERRP are available and the Board of Trustees chooses to use the reimbursements for this purpose.

If you have received this notice, you are responsible for providing a copy of this notice to your family members who participate in this Plan.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

The Fund does not charge a premium for coverage of dependents under the Plan (except in the case of retiree or COBRA coverage). However, this notice is being provided pursuant to the requirements of the Children's Health Insurance Program Reauthorization Act of 2009.

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Washington or Alaska, you can contact your State Medicaid or CHIP office at the number listed below to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in Washington or Alaska, you may be eligible for assistance paying your employer health plan premiums. You should contact the State for further information on eligibility –

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529

To see if any other States have added premium assistance, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact the Administration Office toll free at 877-441-1212, option 1.

Sincerely,

Board of Trustees,
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

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Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Administration Office.

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124 • Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

January 26, 2011

To: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

Re: Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully.
It should be kept with your benefit booklet or insurance records for future reference.

Immunizations at Retail Pharmacies

Significant changes have occurred in the pharmacy landscape as a result of the H1N1 pandemic last year. In an effort to broaden the reach of flu and other disease vaccinations, Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund pharmacy benefit manager, Express Scripts, has developed a retail vaccination program. This program established a retail network which allows our members to obtain vaccinations easily at a large number of retail pharmacies. Pharmacies are now administering a number of vaccine injections on a regular basis and their pharmacists have been trained in the administration of these vaccines. Vaccines administered at your retail pharmacy usually don't require an appointment and have the same effective medications as your physician's office.

Before you visit the pharmacy:

- Make sure the pharmacy you use is part of your Express Scripts participating pharmacy network. If you are not sure, please log on to www.express-scripts.com and after signing in go to Understanding Your Benefits, then click on Find a Pharmacy that Offers Vaccines. You may also call Express Scripts at 1-866-493-9201.
- Call the pharmacy to verify their current vaccination schedule, availability, and any age restrictions.
- Present your combination medical and prescription ID card to the pharmacy. You will be charged your brand copay or the pharmacy's advertised cost, whichever is lower.

The vaccines that are available at retail pharmacies cover the following:

- Influenza
- Tetanus
- Zoster
- Poliomyelitis
- Rabies
- Pneumonia
- Meningococcal
- Rotavirus
- Measles, Mumps, Rubella
- Varicella
- Hepatitis
- HPV
- Travel Vaccines (Japanese Encephalitis, Typhoid, Yellow Fever)
- Diphtheria

Note: Immunizations administered in a doctor's office are subject to the current Physical Exam and Well Child Care provisions and limitations outlined in the 2010 benefit booklet.

If you have other questions regarding benefits or eligibility, please contact the Administration Office at (877) 441-1212.

Board of Trustees
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

The next page is an important message regarding the Trust's Preferred Provider Organizations and the importance of submitting claims to the appropriate locations.

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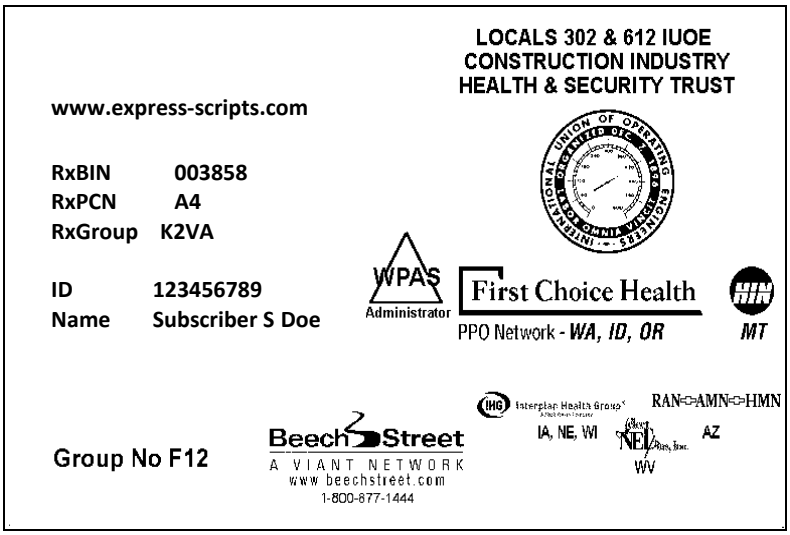
Locals 302 and 612 I.U.O.E. Construction Industry Health and Security Fund

Important Message

The Administration Office would like to take this opportunity to remind you in order to receive the highest level of benefits within the PPO Service Areas, choose PPO providers and/or hospitals and make sure all providers that may be involved in your medical treatment are PPO providers. Be sure to use the most current medical and prescription identification card (sample below). **It is also very important that your providers send claims to the appropriate Preferred Provider Organization.** The next time you visit the doctor or go to the hospital please provide them with your current ID card and make sure they are billing the appropriate location as outlined on the back of the card. Sending claims to the wrong location will cause an unnecessary delay in processing. If you require a new or additional ID card, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Your Location	Preferred Provider	PPO Contact Information
Washington, Oregon, Idaho, and Montana	First Choice Health Network (FCHN)	(800) 231-6935 OR www.fchn.com
Alaska and all other states (not including WA, OR, ID or MT)	Beech Street	(800) 432-1776 OR www.beechstreet.com
Anchorage Borough	Providence Alaska Medical Center	Benefits will be reduced if any other hospital in Anchorage is utilized

Sample ID Card



Preauthorization: Inpatient admissions and selected outpatient services require preauthorization. The plan will not pay for any hospital stays which are not medically necessary. Providence Medical Center is the preferred hospital in Anchorage. Benefits may be reduced when utilizing any other facility in Anchorage.

Contact First Choice: 800.986.9156 Behavior Health (BHCC): 800.640.7682

FOR ELIGIBILITY, BENEFITS & CLAIMS INQUIRIES CALL WPAS:
Members - 877.441.1212 Providers - 800.735.7053

Vision Benefits & filing	Medical and Dental Claims	Electronic Submissions
Info contact VSP	Locals 302/612 Health	Emdeon Group F12
800.877.7195	P.O. Box 34684	ID 91136
www.vsp.com	Seattle, WA 98124-1684	

PRESCRIPTION RETAIL/MAIL ORDER DRUG PROGRAM
EXPRESS SCRIPTS: Member Services: 866.493.9201
Pharmacists Use Only: 800.824.0898

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124 • Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727

Administered by
Welfare & Pension Administration Service, Inc.

July 29, 2010

To: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

Re: Important Information Regarding Your Health Plan

Please be sure that you and your family read this notice carefully.
It should be kept with your benefit booklet or insurance records for future reference.

Revised Summary Plan Description

Enclosed please find the new 2010 Edition of the Summary Plan Description for the Locals 302 and 612 IUOE Construction Industry Health and Security Fund. Please refer to this booklet when health plan questions arise and keep it with your records for future reference.

Surgical Treatment of Obesity

Effective August 1, 2010, the Plan has been improved to provide coverage for surgical treatment of obesity, subject to applicable deductibles, coinsurance and eligibility. Coverage for the surgery must be medically necessary and will be subject to medical review and case management evaluation. Preauthorization will be required through First Choice Health (FCH).

Participants requesting surgical treatment of obesity must satisfy all of the following criteria:

- Patients must be 18 years of age or older
- BMI (Body Mass Index) greater than or equal to 40 **OR** BMI greater than or equal to 35 with at least two of the following co morbidities:

  – Hypertension – Coronary heart disease – Type 2 diabetes
  – Dyslipidemia – Sleep apnea

  Note: Candidates with co morbidities not listed above with BMI of 35 or higher will be reviewed by the FCH Medical Director.

- Evaluation by a licensed psychologist that documents the absence of significant untreated psychopathology that would limit the individual's understanding of the procedure or ability to comply with medical/surgical recommendations.
- Candidates have attempted to lose weight by non-operative means, under a physician-supervised nutrition and exercise program documented in the medical record. The nutrition and exercise program must be in place for at least 3 months and occur within 2 years prior to the date of surgery.

Participants must receive care from a Center of Excellence facility designated by the American Society of Metabolic and Bariatric Surgery. The following facilities in Washington and Alaska are currently designated as Centers of Excellence:

- Overlake Hospital Medical Center – Bellevue, Washington
- Evergreen Hospital – Kirkland, Washington
- Mason General Hospital – Shelton, Washington
- St. Francis Hospital – Federal Way, Washington
- Virginia Mason Medical Center – Seattle, Washington
- Sacred Heart Medical Center – Spokane, Washington
- Southwest Washington Medical Center – Vancouver, Washington
- Providence Alaska Medical Center – Anchorage, Alaska

If you are a participant who is considering surgical treatment of obesity, please contact First Choice Health Network at (800) 986-9156 for more information. If you have other questions regarding benefits or eligibility, please contact the Administration Office at (877) 441-1212.

Board of Trustees
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

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IN ORDER TO AVOID DELAY IN PROCESSING YOUR CLAIM, AN ENROLLMENT FORM MUST BE ON FILE AT THE ADMINISTRATION OFFICE.

The Life and Accidental Death and Dismemberment Benefits described in this booklet are insured by United of Omaha.

All other benefits described in this booklet are funded by the Health and Security Fund.

To All Operating Engineers:

The Board of Trustees is pleased to present you with this new booklet which describes the benefits available to you and your family from your Health and Security Fund. This updated booklet includes all benefit changes made through April 1, 2010.

Please read this booklet carefully so you understand your benefit program. Only the Administration Office represents the Board of Trustees in administering the Plan and providing information relating to the amount of benefits, eligibility and other Plan provisions. No participating employer, employer association, or labor organization, or any individual employed thereby, has any authority in this regard.

Keep this booklet in a convenient place and refer to it whenever you have questions about your benefits. If you have any questions not answered in this booklet, contact the Administration Office at:

Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124

(206) 441-7314
(877) 441-1212

Sincerely,

Board of Trustees

Union Trustees	**Employer Trustees**
Malcolm Auble	Richard Dickson
Ernest Evans	Brett Ferullo
Michael Sean Jeffries	Mike Miller
Daren Konopaski	Doug Peterson
Robert Peterson	Mike Tucci

This booklet describes the Plan for the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund. It provides information about the benefits and how they work and is written as clearly and accurately as possible.

The Trustees will frequently review these benefits and reserve the right to add, modify or eliminate provisions (in whole or part) at any time for any group of employees or participants. The Trustees also reserve the right to terminate the Plan. If any changes occur, you will be notified and you will receive revised information.

In carrying out their respective responsibilities under the Plan, the Board of Trustees has discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits. Any interpretation or determination made under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Web Site

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds have established a web site to provide you with immediate access to your plan information. The site located at **www.engineerstrust.com** includes the following Trust Fund related material:

- Forms – Claim Forms, Legal Documents, and Notices
- Plan Booklets
- Links to Preferred Provider Organizations, Operating Engineer Sites, and other useful sites
- Local Unions and International Contact Information

This site will also provide a link to "My Personal Benefit" information, which may be viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security number. A PIN will be assigned and mailed to you upon your written request. To request a PIN, please complete a PIN REQUEST FORM which can be printed from the website. Please note that a PIN will be assigned. For security purposes you *may not* choose your own PIN. "My Personal Benefits" information includes the following data:

- Personal Information – Name, address, gender, birth date, marital status, etc.
- Hours/Contributions – A statement showing recent employers reporting hours and contributions to the Trust on your behalf.

www.engineerstrust.com

Table of Contents

Summary of Benefits

The following chart provides a brief summary of your benefits. For a complete description of the benefits listed below, refer to the appropriate section of this booklet. For a description of Retiree Benefits, see page 98.

Medical Benefits	
Annual Deductible (7/1 – 6/30)	$300 per person $600 per family
Coinsurance	**PPO Providers Within a PPO Service Area** – Plan pays 80% of the PPO Allowed Amount until out-of-pocket maximum is reached (see below), then the Plan pays 100% of most covered expenses for the rest of the coinsurance period (July 1 through June 30) for most services **Non-PPO Providers Within a PPO Service Area** – Plan pays 70% of the UCR Amount for most services (these expenses do not apply to the out-of-pocket maximum) **PPO and Non-PPO Providers Outside the PPO Service Areas** – Plan pays 80% of the PPO Allowed Amount or the UCR Amount, as applicable, until out-of-pocket maximum is reached (see below), then the Plan pays 100% of most covered expenses for the rest of that coinsurance period (July 1 through June 30)
Out-of-Pocket Maximum	$2,300 per person (including deductible) $4,600 per family (including deductible) Refer to page 35 for expenses that do not apply to the out-of-pocket maximum
Lifetime Maximum	$1,000,000 per person

* * * *

The PPO Service Area for hospitals consists of Washington State and Anchorage Borough. The PPO Service Area for physicians and other providers is Washington State.

Prescription Drug Program		
Retail Pharmacy Card (34 day supply maximum)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic	$10 copay	$10 copay
Preferred brand	$25 copay	$25 copay
Non-preferred brand	$40 copay	$40 copay
Mail Order (90 day supply maximum)		
Generic	$20 copay	
Preferred brand	$40 copay	
Non-preferred brand	$60 copay	

Dental Benefits – Schedule of Allowances* (see page 66)	
Calendar Year Maximum	$2,500 in Western Washington and all other areas outside of Alaska; $3,000 in Alaska
Orthodontic Lifetime Maximum	$2,500 in Western Washington and all other areas outside of Alaska; $3,000 in Alaska
* If you are enrolled in the Willamette Dental plan, the dental benefits described in this booklet do not apply (see page 75)	

Vision Benefits	Schedule (see page 76)

Weekly Disability Benefit (for active employees only)	$300 per week Maximum of 39 weeks
Life Insurance Benefit (for active employees only)	$50,000
Accidental Death And Dismemberment (AD&D) Benefit (for active employees only)	$50,000 Principal Amount

Eligibility Provisions

This Plan is financed by contributions made by employers, as specified in the Labor Agreements with Locals 302, 612, or Stationary Engineers Local 286 or in the Associate Agreements with the Fund.

It is your responsibility to check with your employer, the Administration Office or your Local Union Office to make certain that Health and Welfare contributions are being made for you by your employer.

Your eligibility depends on your employer's contributions:

- If you are a bargaining unit employee and your employer contributes on a cents-per-hour basis, you will be considered an hourly employee and your eligibility is determined under a dollar bank system. (See the following section for eligibility information related to hourly employees.)
- If you are a bargaining unit employee, you work a minimum of 100 hours per month and your employer contributes on a flat-amount-per-month basis, you will be considered an hourly employee and your eligibility is determined under a dollar bank system. (See the following section for eligibility information related to hourly employees.)
- If you are a nonbargaining unit associate employee covered by an associate agreement between your employer and the Fund, or if you are a Stationary Engineer, your eligibility is determined on a month-to-month basis. (See page 13 for eligibility information related to associate employees.)

Retired employees' eligibility and benefits are described beginning on page 98.

Hourly Employees (Dollar Bank Eligibility)

To be eligible for benefits from this Plan, you must have contributions credited on your behalf to your dollar bank and satisfy the eligibility rules as shown below.

Contributions for hours worked under the National Pipeline Agreement which were paid to the Pipe Line Employers Health and Welfare Fund will be credited to your dollar bank if:

- The contributions were transferred to the Plan within 120 days of receipt by the Pipe Line Employers Health and Welfare Fund;
- You were previously covered in this Plan; and
- The transfer is made pursuant to the National Pipeline Agreement.

Initial Eligibility/When Coverage Begins

Each employee is assigned a dollar bank into which employer contributions are credited upon receipt. You are eligible on the first day of the second month following accumulation in your dollar bank of the minimum contribution required to establish initial eligibility as set by the Board of Trustees from time to time. Effective with September 2009 coverage, the minimum amount is $1,390.50 reported and paid to the Fund within a consecutive three month period for Washington employees and $1,624.50 reported and paid to the Fund within a consecutive three month period for Alaska employees.

Here's how it works:

Calendar Months				
1	**2**	**3**	**4**	**5**
If you accumulate $1,390.50 in your dollar bank in 3 consecutive calendar months while working in Washington			LAG	You are eligible the first day of this calendar month

If you earn $1,390.50 in your dollar bank in *one* calendar month, you are eligible on the first day of the second following calendar month. Here's how it works:

Months		
1	**2**	**3**
If you accumulate $1,390.50 in your dollar bank in 1 calendar month while working in Washington	LAG	You are eligible the first day of this calendar month

This lag month is necessary for the processing of reported hours by the Administration Office.

Continuing Coverage

After becoming initially eligible, you must continue to accumulate sufficient contributions in your dollar bank to purchase a month of coverage at the current dollar bank deduction. Effective with September 2009 coverage, the amount of dollar bank deduction is $927 per month in Washington and $1,083 per month in Alaska.

Here is an example for a Washington State employee:

Dollars contributed in the month	$1,010
Subtract coverage dollars	– 927
Excess dollars credited to your dollar bank	$83

In this example, the $83 is added to your dollar bank and applies toward future coverage during months of little or no employment.

The maximum dollars you can accumulate at any one time is set by the Board of Trustees. Currently, the maximum you can accumulate in your dollar bank is $6,489 in Washington and $7,581 in Alaska, after deduction for the current month's coverage.

Acceleration of Initial Eligibility

Initial dollar bank eligibility may be accelerated if your employer begins contributing to the Fund for the first time under a full compliance agreement on or after March 1, 2004, and signs a written agreement with the Fund to provide accelerated eligibility for all employees who qualify. Employees of an employer that currently contributes to the Fund are not eligible for accelerated eligibility. You qualify for accelerated eligibility if you satisfy each of the following requirements:

- Your employer begins contributing to the Fund for the first time under a full compliance agreement and signs a written agreement with the Fund to provide for accelerated eligibility.
- You are employed by the employer and covered by a collective bargaining agreement on the date accelerated eligibility becomes effective. If you are employed by the employer after the effective date of accelerated eligibility, or not covered by the collective bargaining agreement, you will not qualify.
- The collective bargaining agreement provides for payment of contributions on your behalf to the Fund on a cents-per-hour basis.
- You were covered under the employer's group health insurance plan on the date immediately preceding the effective date of accelerated eligibility.

Accelerated eligibility becomes effective coincident with the termination of the employer's group insurance plan. The employer may elect to provide either one month or two months of accelerated eligibility for employees, with all employees receiving the same period of accelerated eligibility. If your employment terminates, accelerated eligibility terminates at the end of the month in which employment terminates. After expiration of accelerated eligibility, eligibility will continue only if you satisfy the dollar bank eligibility rules or apply for self-payment (COBRA) coverage pursuant to the provisions beginning on page 17.

To offset the cost of accelerated eligibility, once you establish dollar bank eligibility, the monthly dollar bank charge, plus an additional amount that is the lesser of the balance in the dollar bank (after deduction of the monthly dollar bank charge) or 25%

of the monthly dollar bank charge, will be deducted from your dollar bank for each month of coverage. The additional amount will continue to be assessed until the total of the additional amounts equals the dollar value of the number of months of accelerated eligibility that you were provided.

The dollar bank will be used first to provide a month of current eligibility before assessing the additional amount. If the balance in the dollar bank is not sufficient to provide a month of current eligibility, then an additional amount will not be assessed for that month. However, any dollar bank balance that would otherwise be forfeited, because coverage is lost and not reinstated within a six-month period, will be credited toward the amount due to offset the cost of the accelerated eligibility. If the cost of accelerated eligibility is not recovered before your dollar bank is forfeited, and you later reestablish eligibility, the Plan shall resume crediting your dollar bank for the additional amount remaining due.

When Coverage Ends for Hourly Employees

Your coverage ends:

- On the first day of any month your dollar bank account has less than a month of eligibility at the current dollar bank deduction rate.
- On the last day of the month after you enter the Armed Services of the United States, except for periods of Reservist Training, unless you elect to run-out your dollar bank coverage. If not, your dollar bank will be frozen until you qualify for reemployment rights. For more information, see “Military Service” on page 25.
- Upon termination of the Plan.
- On the last day of the month in which you fail to make any required self-pay contributions.

Reinstatement of Eligibility

If your coverage ends because your dollar bank has less than the current dollar bank deduction rate, the balance in your dollar bank account, if any, is carried for six months. If during the next six months you work and add dollars to your account, your eligibility

will be reinstated on the first day of the second month after your account has the minimum required for a month of future eligibility.

If your eligibility is not reinstated during the six-month period following the date your coverage ends, the balance in your dollar bank account, if any, is cancelled and you are required to satisfy the initial eligibility rules to again be covered. If you become an associate employee (described next), the balance in your dollar bank is retained and can be used when you no longer are eligible as an associate employee.

If coverage was terminated as the result of uniformed (military) service, your coverage will be reinstated when the balance of your dollar bank is enough to cover the current dollar bank deduction rate or you make the necessary self-payment. See "Reinstatement of Eligibility Following Military Service" on page 28.

Associate Employees

To be eligible for benefits from this Plan, your employer must sign an associate agreement with the Fund and contribute a fixed amount per month on your behalf. You will be eligible on the first day of the second calendar month following the calendar month you worked (e.g., work during March provides coverage for May). Your coverage is month-by-month; for each month a contribution is made on your behalf, you earn a month of coverage.

When Coverage Ends for Associate Employees

Your coverage ends:

- On the last day of the second calendar month following the month for which you last worked and your employer made the required contribution on your behalf.
- On the last day of the month after you enter the Armed Services of the United States, except for periods of Reservist Training, unless you elect to run-out your accrued eligibility. For more information, see "Military Service" on page 25.
- On the last day of the month in which the associate agreement is terminated.

- Upon termination of the Plan.
- On the last day of the month in which you fail to make any required self-pay contributions.

Dependents

Your eligible dependents are covered whenever you are covered, or on the date they become an eligible dependent, if later. Eligible dependents are your:

- Spouse (including your legally separated spouse).
- Your unmarried children who are under age 19 (or under age 24 if attending an accredited college, university or comparable educational institution as a full-course student and are dependent on you for their support). You must continue to provide proof of enrollment. Coverage is not automatic each quarter/semester. To be covered during the summer, your dependent must be qualified as a full-time student the preceding spring quarter/semester and registered for the following fall quarter/semester.

  Your eligible children are your:

  - Natural children.
  - Legally adopted children and children placed with you for adoption.
  - Children who depend on you by virtue of a court order or for whom you have legal custody.
  - Stepchildren or foster children if they depend on you for support and live with you in a regular parent-child relationship.

  Benefits are continued beyond the limiting age for your unmarried child who is chiefly dependent on you for support and is incapable of earning their own living due to a developmental disability, physical handicap or mental retardation which began before age 19 (or age 24 if a student). The child must be covered under this Plan when they reach the limiting age. Coverage will continue for the child as long as the incapacity continues and the child does not marry or become gainfully employed, if you remain eligible. Coverage

is not automatic; you must submit proof of the incapacity to the Administration Office within 31 days after the date the child reaches the limiting age. Periodic updates may be required.

You cannot be eligible for benefits both as an employee and a dependent child.

If you have any changes in family status (e.g., marriage, birth of child, marriage of any of your children, their 19th birthday or their 24th birthday for dependent students, death of any of your dependents or divorce) you must notify the Administration Office. If the change in family status is due to marriage, you must provide a copy of the marriage certificate. If the change in family status is due to divorce, you must provide a copy of the divorce decree, including parenting plan if applicable.

Qualified Medical Child Support Order

Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders (QMCSO) and enrolls dependent children as directed by the order. A QMCSO is any judgment, decree or order (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:

- Provides child support or health benefit coverage to a dependent child, or
- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the employee does not enroll the dependent child, then the non-employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- The name and last known mailing address of the employee,
- The name and mailing address of each dependent child covered by the order or the name and mailing address of the State official issuing the order,
- A description of the type of coverage to be provided by the Plan to each such dependent child,

- The period of coverage to which the order applies, and
- The name of each plan to which the order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Plan under a QMCSO to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian if so required by the QMCSO.

No eligible dependent child covered by a QMCSO will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

If a proposed or final order is received, the Administration Office will notify the employee and each child named in the order. The order will then be reviewed to determine if it meets the definition of a "Qualified Medical Child Support Order." A properly completed National Medical Support Notice issued by a State agency shall be deemed to be a QMCSO. Within a reasonable time, the employee and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party or parties filing the order will be given an opportunity to correct the order. If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire QMCSO and any required self-payments pursuant to an order will be subject to all provisions applicable to dependent coverage under the Plan.

When Dependents' Coverage Ends

Your dependents' coverage ends:

- On the date your coverage ends.

- On the last day of the month for which the dependent no longer meets the definition of an eligible dependent as described in this section.
- On the last day of the month after the dependent enters the Armed Services of the United States, except for periods of Reservist Training.

If your dependents' coverage ends, your dependents may be eligible to continue coverage as described in the next section.

Continuing Your Coverage by Self-Payments (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), "qualified beneficiaries" may extend health benefits (medical, dental, vision) on a self-pay basis under certain circumstances called "qualifying events."

Qualified Beneficiaries

A qualified beneficiary means:

- Any individual who, on the day before a qualifying event, is covered under the Plan, either as an employee, or as a dependent of an employee or retiree.
- A child who is born to, adopted by, or placed for adoption with an employee (as opposed to another family member) during COBRA, provided the child is enrolled by submitting an enrollment form and a copy of the birth certificate or adoption papers to the Administration Office within 30 days of birth, adoption, or placement for adoption, and the appropriate self-payments are made. The child will have the same COBRA rights as a dependent who was covered by the Plan before the qualifying event that resulted in the loss of coverage.

Other dependents who are newly acquired during a period of COBRA may be enrolled in COBRA by submitting an enrollment form along with the appropriate certificates to the Administration Office within 30 days of becoming a dependent. However, such dependents will not be considered qualified beneficiaries.

Only qualified beneficiaries may extend COBRA when there is a second qualifying event.

An individual ceases to be a qualified beneficiary if COBRA is not timely elected, or when the Plan's obligation to provide COBRA otherwise ends.

18-Month Qualifying Events

You and your dependents may elect COBRA for a maximum of 18 months following the date coverage would otherwise end due to one of the following qualifying events:

- Your termination of employment; or
- Your layoff or reduction in hours of employment.

If Social Security determines that a qualified beneficiary is totally disabled either before the 18-month qualifying event or within the first 60 days of COBRA, the disabled individual and all qualified beneficiaries may extend COBRA an additional 11 months beyond the original 18 months, to a maximum of 29 months. In order to qualify for this extension, the qualified beneficiary must notify the Administration Office in writing within 60 days after the date of the Social Security determination, but no later than the date that the initial 18 months of COBRA expires. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Administration Office in writing within 30 days of the determination. For an individual who has extended COBRA beyond the initial 18 months, COBRA will end on the earlier of 29 months from the qualifying event, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

36-Month Qualifying Events

A dependent may elect COBRA for a maximum of 36 months following the date coverage would otherwise end due to one of the following qualifying events:

- Death of the employee;
- Divorce between the employee and spouse; or
- The dependent child ceases to meet the Plan's definition of "dependent."

In the event of the death of an employee, an eligible surviving spouse may continue coverage indefinitely beyond the initial 36 months until remarriage, death, or termination of the Plan, whichever occurs first, provided the required self-payment is made in a timely manner.

Second Qualifying Event

An 18-month period of COBRA may be extended an additional 18 months, for a total of 36 months, for the affected qualified beneficiary (spouse or child), if one of the 36-month period qualifying events occurs during the first 18 months of COBRA. In no event will COBRA extend beyond 36 months from the date coverage was first lost due to the initial qualifying event. This extension applies only if the qualified beneficiary notifies the Administration Office in writing within 60 days of the second qualifying event. The notice must identify the qualifying event that occurred. In the absence of such notice, COBRA will terminate.

Medicare Entitlement

If you have an 18-month qualifying event after becoming entitled to Medicare, your dependents may continue COBRA until the later of:

- 18 months from the date coverage would normally end due to the termination of employment or reduction in hours; or
- 36 months from the date you become entitled to Medicare.

Notice Requirements

The Plan offers COBRA only after it has been notified of a qualifying event. A qualified beneficiary is responsible for notifying the Administration Office of a qualifying event that is a divorce or child losing dependent status. **The qualified beneficiary must provide this notice to the Administration Office in writing within 60 days of the later of the date of the qualifying event; or the date coverage would be terminated as a result of the qualifying event; or the date this booklet or other notice is provided describing of the procedure for electing COBRA.** The notice must identify the individual who has experienced a qualifying event, the employee's name, and the

qualifying event which occurred. If the Administration Office is not notified during the 60-day period, the qualified beneficiary will lose the right to elect COBRA.

If a child is born to, adopted by, or placed for adoption with you during a period of COBRA, you must notify the Administration Office in writing within 30 days of the birth, adoption or placement for adoption, and provide a copy of the child's birth certificate or adoption papers. If the Administration Office is not notified in a timely manner, the child will lose the right to receive COBRA.

In order to qualify for a Social Security disability extension, the qualified beneficiary must notify the Administration Office in writing within 60 days after the latest of the date of the Social Security determination; the date on which the qualifying event occurs; the date coverage would be terminated as a result of the qualifying event; or the date this booklet or other notice is provided describing the procedures for electing COBRA. In any case, the notice of the Social Security determination must be provided before expiration of the initial 18 months of COBRA. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Administration Office in writing within 30 days of the determination.

A qualified beneficiary who first becomes covered under any other group health plan after the date of the election of COBRA, must notify the Administration Office in writing of the other coverage.

The Administration Office will notify qualified beneficiaries of loss of coverage due to termination of employment, reduction in work hours, or the employee's death. However, you are encouraged to inform the Administration Office of any qualifying event to best ensure prompt handling of your COBRA rights.

Election of COBRA

When the Administration Office is notified of a qualifying event, an election form is mailed to the qualified beneficiaries. The election form must be completed and returned to the Administration Office within 60 days of the later of the

termination of coverage, or the date the application was sent. If the election form is not sent to the Administration Office by this date, the qualified beneficiaries will lose the right to elect COBRA.

Each qualified beneficiary has an independent right to elect COBRA. An employee or spouse may elect COBRA on behalf of other qualified beneficiaries in the family. A parent or legal guardian may elect COBRA on behalf of a minor child.

Type of Benefits

The following benefit options are available under COBRA, provided the qualified beneficiary was eligible for such benefits immediately prior to the qualifying event:

- Medical and prescription drug; or
- Medical, prescription drug, dental, and vision.

Life insurance, accidental death and dismemberment benefits, and weekly disability benefits are not available under COBRA.

Cost and Payment

There is a cost for COBRA. Information regarding the cost will be sent with the election forms. The first payment is due 45 days from the date the election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Thereafter, payments must be made monthly to continue COBRA. All payments must be sent to the Administration Office.

COBRA eligibility will not commence, nor will claims be processed for expenses incurred following the date of the qualifying event, until the appropriate COBRA payments have been made. COBRA terminates if a monthly payment is made later than 30 days from the beginning of the month to be covered. If the initial payment, or any subsequent payment is not made in a timely fashion, COBRA terminates.

Termination of COBRA

COBRA ends on the first of the dates indicated below:

- The last day of the month the maximum coverage period for the qualifying event has ended (18, 29, or 36 months).
- The last date for which the self-payment was paid, or when the qualified beneficiary does not make the next payment in full when due. Payments must be made within 30 days of the due date.
- The date the qualified beneficiary first becomes, after the date of election of COBRA, covered under any other group health plan which does not contain any exclusion or limitation that actually applies to any pre-existing condition of the qualified beneficiary.
- The date the qualified beneficiary becomes entitled to Medicare after the date of election of COBRA.
- The last day of the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled as determined by Social Security. This applies only to the 19th through 29th month of disability extended COBRA.
- The date the Fund no longer provides group health coverage.

COBRA is provided subject to eligibility. The Plan reserves the right to terminate COBRA retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Relationship Between COBRA, Medicare and Other Coverage

If you or your dependents are totally disabled as the result of an accidental injury or illness, you may receive benefits related to the disability following the termination of coverage, in lieu of COBRA. However, COBRA may not be elected following the termination of the disability extension.

If you qualify for both COBRA and retiree medical, you and your dependents may elect COBRA in lieu of retiree medical. Following termination of COBRA, you and your dependents may apply for retiree medical. However, if COBRA is declined in

favor of retiree medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

If you have Fund coverage based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Fund will only pay secondary and coordinate with Medicare. If you have Medicare coverage based on end stage renal disease and have Fund coverage (based on COBRA or otherwise), the Fund will pay primary during the 30-month coordination period provided for by statute.

Effect of Not Electing Continuation Coverage

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law as follows:

- Pre-existing condition exclusions under a future group health plan may apply if you have more than a 63-day gap in health coverage, and electing continuation coverage may help you avoid such a gap;
- You can lose the right to purchase guaranteed individual health coverage that does not impose a pre-existing condition exclusion if you do not obtain continuation coverage for the maximum time available to you; and
- You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Fund ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

Notices

Notices and self-payments that are required for COBRA must be sent in writing to the Administration Office at the following address:

Locals 302 and 612 of the IUOE Construction Industry
Health and Security Fund
P.O. Box 34203
Seattle, WA 98124-1203

If you have any questions about continuation coverage, call the Administration Office.

Alternative Continuation Rights

There is no individual or group conversion option available for the medical, dental, or vision benefits provided by the Fund. However, your coverage may continue if you qualify for any of the alternative continuation rights set forth below.

If Coverage Ends While You Are Totally Disabled

If coverage ends while you or your dependents are totally disabled, medical, prescription drug, dental and vision benefits continue for the disabled person as described below. You must submit proof of the total disability in order to qualify for this disability continuation. Total disability is defined on page 123.

Medical and Prescription Drug Benefits

Medical benefits are paid only for covered expenses for the accidental injury or illness that caused the total disability. Benefit payments continue for covered medical expenses for treatment of the condition causing the disability if those expenses are incurred during the calendar year in which eligibility ends and during the next calendar year. Benefits end on the day the disabled person is no longer totally disabled, or becomes covered under any group plan, individual plan with a coordination of benefits provision, or governmental coverage (including Medicare).

Dental and Vision Benefits

Dental and vision coverage for the disabled person is also extended until the earlier of the following date:

- The person is no longer disabled, or
- Three months after the date the disabled person is no longer eligible.

Medical or Family Leave of Absence

A federal law known as the Family and Medical Leave Act (FMLA) may apply to family and medical leaves when you work for an employer with 50 or more employees within a 75-mile radius. All Plan benefits will continue while you are on FMLA leave. You and your dependents may be entitled to coverage for up to 12 work weeks during a 12-month period. If you think you may be eligible for a family or medical leave, contact your employer immediately. Your employer must make arrangements with the Fund to continue your coverage.

If you advise that you are not returning or if you do not return to work after your leave ends, coverage for all Plan benefits will end. You and your dependents will then be able to elect COBRA (see page 17).

Military Service

The following procedures apply for administration of coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) after a participant enters military service.

Periods of Military Service—USERRA Continuation Coverage

If you leave employment with a contributing employer for military service, you have the following options:

- You may elect to run-out your dollar bank. When your dollar bank has less than one month of eligibility, you may elect to extend coverage by making self-payments for USERRA continuation coverage.

- You may elect to freeze your dollar bank until you return from military service. If you freeze your dollar bank, you still have the option of electing to self-pay for USERRA continuation coverage.

Notice of Military Service

You are responsible for notifying the Administration Office that you are entering military service. If you want to freeze your dollar bank, you must notify the Administration Office within 60 days of beginning military service.

If you want to run-out your dollar bank, and then elect USERRA continuation coverage, you must notify the Administration Office of your military service within 60 days of termination of your dollar bank coverage. If you fail to notify the Administration Office within the 60-day time period, you will not be entitled to elect USERRA continuation coverage.

Election of USERRA Continuation Coverage

After timely notification to the Administration Office of military service, you will be sent an election form to affirmatively elect to freeze your dollar bank and/or elect USERRA continuation coverage. Your completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. If you do not return your election forms by the due date, you will not be allowed to freeze your dollar bank or elect USERRA continuation coverage.

Length of USERRA Continuation Coverage

If you provide timely notice and properly elect to freeze your dollar bank, it will be frozen the first of the month following the month in which you begin military service.

If you properly elect to freeze your dollar bank and elect USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which you begin military service, provided the required self-payments are made.

If you decide to run-out your dollar bank before commencing USERRA continuation coverage, USERRA continuation coverage will begin the first of the month following depletion of your dollar bank, provided the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

- 24 months following the month your dollar bank terminates or is frozen because of your entry into military service;
- The last day of the month in which you fail to return to employment or apply for a position of reemployment within the time required by USERRA; or
- The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage

You may elect to self-pay for USERRA continuation coverage for yourself, yourself and your dependents, or only your dependents.

You may elect the following coverage options:

- Medical, prescription drug, dental and vision.
- Medical and prescription drug only.

Once you elect a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated active employees. If the Fund changes its benefits, USERRA continuation coverage will also change.

USERRA continuation coverage is not available for weekly disability, life insurance, or AD&D benefits.

Monthly Self-Payments Required

If your military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Administration Office will notify you of the self-payment amount when it sends you the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made, at which time eligibility will be retroactive to the date your dollar bank coverage ended (or was frozen).

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Administration Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date your dollar bank coverage ended (or was frozen).

Reinstatement of Eligibility Following Military Service

If you properly elected to freeze your dollar bank when you entered military service, the balance in your dollar bank will be carried over until you are discharged from military service. Your dollar bank eligibility will be reinstated the first of the month in which you are discharged. Following reinstatement, dollar bank eligibility will terminate the first day of any month your dollar bank account has less than a month of eligibility at the current dollar bank deduction rate. You are responsible for notifying the Administration Office of your discharge from military service.

If you return to employment with a contributing employer immediately following military service and within the time period required by USERRA, your dollar bank eligibility will be reinstated on the first day of the second month after your dollar bank account has the minimum required for a month of coverage. Pending reinstatement of dollar bank eligibility, you may make self-payments for coverage. If you elected to freeze your dollar bank when you entered military service and you return to employment within the time period required by USERRA, you may make self-payments if you fail to work sufficient hours to reinstate dollar bank eligibility before the previously frozen dollar bank runs out.

To request self-pay continuation coverage after leaving military service, you must notify the Administration Office within 30 days following your return to employment. After timely notification, the Administration Office will provide an election form. Your completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the date it was mailed to you. The initial payment to continue coverage must be included with the completed election form, and cover all months through which the first payment is made. The self-payment rate is the same as the COBRA continuation rate. The coverage provided will be that stated under USERRA continuation coverage.

The self-pay coverage must be continuous, and must commence the later of the first of the month in which you return to employment within the time specified by USERRA or the first of the month following the termination of your previously frozen dollar bank eligibility. The reinstated coverage terminates on the earliest of your receipt of six consecutive months of reinstated coverage, reinstatement of your dollar bank eligibility based upon your hours worked, or the last day of the month for which a timely self-payment is not received or postmarked.

If you are on the out-of-work list at the local union, it is considered a return to employment with a contributing employer for purposes of making self-payments for coverage.

Regardless of whether you want to make self-payments for coverage, you should contact the Administration Office if you return to employment within the time required by USERRA, so that your dollar bank may be credited with any dollars that remained in your account when you left for military service, and eligibility can be reinstated without satisfying the rules for initial eligibility.

Relationship of USERRA Continuation Coverage to COBRA

You may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If you have questions regarding election or

duration of COBRA continuation coverage, contact the Administration Office.

Medically Necessary Leave of Absence from College

Effective April 1, 2010, if your dependent between the ages of 19 through 23 is enrolled in a college, university or other educational institution on a full time basis and must take a medically necessary leave of absence due to the dependent's serious illness or injury, your dependent's coverage shall not terminate because of the leave of absence. Your dependent's coverage shall continue until the leave of absence is no longer medically necessary, the date coverage would otherwise terminate or one year from when the leave of absence began. The Fund may require written confirmation from your dependent's treating physician that your dependent is suffering from a serious illness or injury requiring a medically necessary leave of absence.

Continuation Coverage for Surviving Spouses

Once the continuation of coverage through COBRA is exhausted, eligible surviving spouses may apply for continuation of coverage through self-payment of monthly contributions. The surviving spouse may continue coverage until remarriage, death, or termination of the Plan, whichever occurs first. In order for a surviving spouse to continue coverage beyond the normal COBRA period, the surviving spouse must notify the Administration Office of his or her election and continue making the required self-payment in a timely manner. The surviving spouse must also continue to meet any other eligibility criteria defined by the Plan, as may be amended or modified.

Certificate of Creditable Coverage

If your coverage under this Plan ends and you become eligible for a new health plan, the time you were covered under this Plan may be used to shorten any pre-existing condition waiting period in your new plan.

When your coverage ends, either as an active or retired employee (or dependent), or under COBRA self-pay, you'll receive a certificate of creditable coverage. This certificate contains information your new plan may need (such as coverage periods and types).

Check with your new plan administrator to verify whether the new plan has a pre-existing condition waiting period and how creditable coverage is applied under that plan. If your new plan has a pre-existing condition waiting period, present your certificate to your new plan. The new plan administrator will apply your creditable coverage under this Plan to the pre-existing condition waiting period under your new plan.

Medical Benefits

The Medical Plan provides benefits for the necessary treatment of non-occupational injury or illness for you and your eligible dependents.

Throughout the Medical Plan, "you" refers to any covered person (including eligible dependents), unless otherwise noted. Other important terms are defined in the Definitions section beginning on page 113.

All benefits, unless stated otherwise, are based on the PPO Allowed Amount for PPO Providers or the Usual, Customary and Reasonable Amount (UCR) for Non-PPO Providers.

Preferred Provider Organization (PPO)

When you require health care, you may choose any covered physician, hospital or health care provider. However, benefits may be more favorable if you receive care from a PPO provider or hospital within the PPO Service Area.

If you are covered by Medicare, you do not need to use PPO providers. Medicare already has special negotiated rates with most providers.

PPO Service Areas

Washington. First Choice Health network is the PPO in Washington State. It includes hospitals, physicians and other providers. If you plan to receive medical care in Washington, be sure to call First Choice Health at (800) 231-6935 or visit their website at www.fchn.com for a current list of providers.

Anchorage Borough. The PPO in Alaska is limited to Providence Alaska Medical Center in the Anchorage Borough; at the present time it does not include any other hospitals or any physicians or other providers in Alaska.

To receive the highest level of benefits within the PPO Service Area, choose PPO providers and/or hospitals and make sure all providers that may be involved in your medical treatment are PPO providers. For example, if you are expecting to have surgery,

inform your physician that when providers involved in your surgery (such as an assistant surgeon or anesthesiologist) are PPO providers, you receive higher benefits from your plan. Also, try to make sure that any freestanding lab or x-ray services used by your physician in your medical treatment are covered PPO providers.

Note: Outside of Washington and the Anchorage Borough, The Fund uses the following provider networks:

- **First Choice Health** includes hospitals, physicians and other providers in Idaho, Montana, and Oregon. If you plan to visit or receive medical care in these states, be sure to call First Choice Health at (800) 231-6935 or visit their website at www.fchn.com for a current list of providers.
- **Beach Street/Viant** network includes hospitals, physicians and other providers in Alaska and all other states except Washington, Idaho, Montana and Oregon. If you plan to visit or receive medical care in these states, be sure to call them at (800) 877-1444 or visit their website at www.beechstreet.com for a current list of providers.

Utilizing these providers can reduce your out-of-pocket expense because the network providers have agreed to discount their fees.

Annual Deductible (7/1 – 6/30)

The deductible is the amount of covered expenses which you must pay in one deductible period before any benefits are payable by the Plan. The deductible period is July 1 through June 30 of the next year.

Annual Deductible (July 1 through June 30)	
Each person	$300
Each family	$600

This means you pay the first $300 of covered expenses in the annual deductible period (July 1 through June 30). The deductible is limited to $600 for a family each deductible period. Once the family deductible is reached, no further deductible amounts will be required for any family member in the rest of that annual deductible period. Noncovered charges do not apply to the deductible.

If two or more eligible members of your family are injured in the same accident, only one $300 deductible will be charged against the combined total covered expenses resulting from that accident, regardless of the number of family members injured.

Coinsurance (7/1 – 6/30)

After you satisfy the deductible, you and the Plan share the remaining expenses; the coinsurance period is July 1 through June 30.

Coinsurance amounts are based on:

- PPO Allowed Amounts for services or supplies provided by PPO providers; these amounts are negotiated by the PPO.
- Usual, Customary and Reasonable (UCR) Amounts for services or supplies provided by Non-PPO providers. The Plan determines UCR Amounts as described on page 123.

Coinsurance amounts are shown in the following table.

Type of Provider	Coinsurance Amount
PPO providers within a PPO Service Area	For most covered services, the Plan pays 80% of the PPO Allowed Amount until the annual out-of-pocket maximum is reached; then the Plan pays 100% for the rest of that coinsurance period
Non-PPO providers within a PPO Service Area	For most covered services the Plan pays 70% of the UCR Amount; see Exceptions on the next page*
PPO and Non-PPO providers outside of the PPO Service Areas	For most covered services the Plan pays 80% of the PPO Allowed Amount or the UCR Amount, as applicable, until the annual out-of-pocket maximum is reached; then the Plan pays 100% for the rest of that coinsurance period

* Exceptions:

(1) If you receive covered emergency services from a Non-PPO provider or hospital in a PPO Service Area within 48 hours of an emergency, the Plan will pay 80%/100% of the UCR Amount. After 48 hours, benefits will reduce to 70% of the UCR Amount unless your physician documents that necessary services are not available at a PPO facility.

(2) If you receive covered non-emergency services that are not available from a PPO provider or hospital within the PPO Service Area, the Plan will pay 80%/100% of the UCR Amount; you must submit proof that the services were not available from a PPO provider or hospital.

(3) If you incur charges for covered treatment by a Non-PPO provider within the PPO Service Area that you had no knowledge or choice of selection of a PPO provider, such charges may be reimbursed at 80%/100% of the UCR Amount on a one time exception basis; you must submit proof that you had no choice in provider selection or knowledge of the use of a Non-PPO provider.

Annual Out-of-Pocket Maximum (7/1 – 6/30)

The Annual Out-of-Pocket Maximum is the most you pay toward covered expenses received from PPO providers and eligible providers outside of the PPO Service Areas. This means that once you've reached your Annual Out-of-Pocket Maximum, the Plan pays 100% of the PPO Allowed Amount or UCR Amount for most covered medical expenses for the remainder of the coinsurance period (July 1 through June 30).

Annual Out-of-Pocket Maximum (7/1 – 6/30)	
Each person	$2,300*
Each family	$4,600*

* Including the deductible

The Annual Out-of-Pocket Maximum generally includes the coinsurance amount and the annual deductible. However**, the following do not apply toward the Annual Out-of-Pocket Maximum:**

- 30% coinsurance claims for services received from Non-PPO providers or hospitals within a PPO Service Area.
- Copay ($75) for outpatient treatment of an illness in a hospital emergency room.
- Copay ($10, $25 or $40) on retail pharmacy prescription drugs.
- Copay ($20, $40 or $60) on mail order prescription drugs.
- Copay ($100) for nonemergency admittance to a Non-PPO hospital in the PPO Service Area.
- Outpatient mental illness benefits.
- Skilled nursing facility care benefits.
- Rehabilitative care benefits.
- Benefits for foot orthotics and other supportive devices of the feet.
- Expenses that are in excess of the Plan limits.
- Expenses not covered by the Plan.
- Expenses in excess of UCR Amounts (see page 123).
- Alternative Provider benefits.

Maximum Lifetime Benefit

All covered expenses described in this booklet are subject to a maximum lifetime benefit. The maximum lifetime benefit paid by the Plan for each covered person is $1,000,000.

If benefits have been paid for a covered person, up to $10,000 will be automatically reinstated on January 1 each year until the full lifetime maximum has been reinstated to the covered person.

Coverage Requiring Preauthorization

Understanding whether medical services are considered "medically necessary" by the Plan before receiving those services is very important. The Plan only provides benefits for services that are determined to be medically necessary. To assist in this process, the Plan requires preauthorization of all inpatient hospitalizations, behavioral (chemical dependency/mental health)

and skilled nursing facility admissions, as well as some outpatient services. This program is intended to ensure you are hospitalized, or receive certain outpatient services, only when medically necessary, and for the appropriate length of stay when admitted. The Plan has contracted with First Choice Health (FCH) to provide these services.

Preauthorization will determine medical necessity. In addition, you should contact the Administration Office to confirm eligibility for coverage and that the requested service is a covered benefit.

Note: If you have Medicare or other insurance as your primary insurance, preauthorization through First Choice Health is not required.

For preauthorization, contact First Choice Health (FCH) as follows:

- For hospital admissions, surgical services, skilled nursing facility and other services, contact FCH Medical Management at (800) 986-9156.
- For chemical dependency and mental health services, contact FCH Medical Management at (800) 640-7682.

Inpatient Admissions

The Plan requires you to obtain preauthorization whenever your physician recommends a non-emergency inpatient stay at a hospital, treatment facility or skilled nursing facility. If you do not follow preauthorization procedures, First Choice Health will determine medical necessity when the claim is submitted. If it is determined that the care you received was not medically necessary, benefits will not be provided.

You or your physician should contact First Choice Health at the numbers listed above to arrange your inpatient stay. For an emergency admission, notify First Choice Health on the first normal business day after your admission.

Pursuant to Federal law, no hospital stay in connection with childbirth for either the mother or newborn child, is limited to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, unless there is agreement between

the patient and the attending physician that the length of stay shall be less than the above periods.

Surgical Services

The plan requires you to obtain preauthorization from First Choice Health before any of the following services are performed, whether inpatient or outpatient:

- Breast reduction surgery
- Eyelid surgery, such as blepharoplasty
- Organ transplants
- Reconstructive and/or cosmetic surgery, except after disease
- Removal of breast implants
- Stereotactic radiosurgeries (Gamma knife)
- Surgical interventions for sleep apnea
- Unproven, investigational or experimental services (unless specifically and completely excluded)
- Varicose vein surgery/sclerotherapy.

Other Services

The following services also require preauthorization by First Choice Health, (or the Administration Office as noted below):

- Growth hormones (preauthorization by the Administration Office)
- Home health care
- Home infusion
- Hospice care
- Medical equipment and prosthesis if the purchase price exceeds $2,000 or the monthly rental fee exceeds $500
- Orthognathic surgery (preauthorization by the Administration Office)
- PET scans
- Rehabilitation services – inpatient

- Rehabilitation services – outpatient (preauthorization by the Administration Office).

Individual Case Management

Under special circumstances, First Choice Health nurses act as patient advocates to help meet the needs of patients with catastrophic or chronic medical problems. They work with you, your family and your physician to help you assess, plan and coordinate all of your health care options and find the most appropriate care for your condition. This is a voluntary program available at no cost to you.

Hospital Discharge Planning

Discharge planning helps in situations when you require continued medical care, but not necessarily care that's as intensive as in an acute setting. Case management nurses will work with you, your physician and the hospital staff to develop a plan that allows for safe release from the hospital. Working with your physician and the hospital staff, the case management nurses can also arrange home health care, skilled nursing facilities and hospice care.

Catastrophic/Chronic Illness

The case management program can help patients with long-term, high-cost illnesses and injuries to obtain needed care. A patient who chooses to participate is assigned a case manager to help coordinate care. Many times case managers identify hospital alternatives, such as home health care or skilled nursing facilities.

Alternative Care and Treatment

Hospital confinement is not always the best environment for treating an illness. For a patient who needs significant long-term medical supervision, case management may recommend alternative care and treatment or facilities that are:

- Not normally covered by the Plan
- Covered by this Plan, but payable on a different basis from the care and treatment they replace

- Payable on the same basis as the care and treatment they replace, once approved.

In these situations, the Plan may approve coverage for alternative care and treatment that would otherwise not be covered, when medically necessary treatment can be delivered most cost-effectively.

Contact the Administration Office when you need details about how any case management service applies to you.

Covered Medical Expenses

Most necessary services and supplies required for the treatment of non-occupational illness and accidental injury are considered covered expenses under the Medical Plan. All covered medical expenses are subject to the exclusion sections beginning on pages 55 and 89.

Ambulance or air transport when professional services are used to transport the patient to or from the nearest facility available with appropriate services, when necessary to protect the patient's life or health.

Alternative providers listed below are covered at 50% of the PPO Allowed Amount or UCR Amount for covered expenses to a maximum of $50 per visit and $300 maximum inclusive for all providers per calendar year. Your share of the coinsurance does not apply to the out-of-pocket maximum.

- Registered Naturopaths
- Registered Certified Hypnotherapists
- Acupuncturists
- Registered Dietitians
- Certified Nutritionists

Services of these alternative providers are eligible only if they are covered expenses under the Plan.

Anesthesia and its administration.

Assistant surgeon charges for Medically Necessary surgical assistance by a physician or a physician assistant (PA); the benefit

payable will be based on 20% of the PPO Allowed Amount or the UCR Amount for the corresponding surgery.

Preauthorization is required for inpatient admissions and some surgical services. See "Coverage Requiring Preauthorization" on page 36.

Cancer screenings are not subject to the Medical Plan's deductible and are reimbursed as follows:

- 100% of the PPO Allowed Amount when received from PPO providers within a PPO Service Area.
- 100% of the UCR Amount when received from covered providers outside of the PPO Service Areas.
- 70% of the UCR Amount when received from Non-PPO providers within a PPO Service Area.

The cancer screening benefit includes the following procedures and limitations:

- Breast Cancer
  - For eligible participants under age 40 – mammograms once every two calendar years.
  - For eligible participants age 40 and over – mammograms once each calendar year.
- Colon and Rectal Cancer
  - For eligible participants under age 50 – fecal occult blood test (FOBT) once every two calendar years.
  - For eligible participants age 50 and over – FOBT once each calendar year plus coverage for *one* of the following testing schedules:
    - Flexible sigmoidoscopy – once every five calendar years.
    - Fecal occult blood test plus flexible sigmoidoscopy – once every five calendar years.
    - Double-contrast barium enema – once every five calendar years.
    - Colonoscopy – once every ten calendar years.

- Cervical Cancer
  - For women – one regular Pap test each calendar year, or one liquid-based Pap test once every two calendar years.
- Endometrial (Uterine) Cancer
  - For women age 35 and older and at high risk for hereditary nonpolyposis colon cancer (HNPCC) – screening with endometrial biopsy once each calendar year.
- Prostate Cancer
  - Prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) is provided:
    - For men age 50 and older – once each calendar year.
    - For men at high risk – once each calendar year beginning at age 40.

Any professional office charge made in conjunction with these tests may be covered under the routine physical exam benefits, as outlined beginning on page 51.

Chemical dependency treatment, including expenses of a physician and hospital or an approved treatment facility.

Chemical dependency benefits are covered to a maximum benefit payable of $5,000 during any period of 24 consecutive months and $10,000 during your lifetime.

Preauthorization is required for inpatient chemical dependency treatment. See "Coverage Requiring Preauthorization" on page 36.

Chiropractic visits, limited to a calendar year maximum of 20 visits per person.

Diagnostic x-ray and laboratory examinations. Charges for a routine pap smear, mammogram, fecal occult blood test or prostate specific antigen test will be processed under the cancer screening benefit outlined on page 41. Charges in conjunction with routine physical exams will be processed under the physical exam benefits beginning on page 51. Charges in conjunction with well child care are processed as described on page 54.

Durable medical equipment rental and supplies, including, but not limited to, wheelchair, hospital bed, and crutches, which are:

- Ordered by a physician.
- Of no further use when medical need ends.
- Usable only by the patient.
- Not primarily for the comfort or hygiene of the patient.
- Not for exercise.
- Manufactured solely for medical use.
- Approved as effective and usual and customary treatment of the condition (as determined by the Plan).
- Not for prevention purposes.

Preauthorization is required if the purchase price exceeds $2,000 or the monthly rental fee exceeds $500. See "Coverage Requiring Preauthorization" on page 36.

Rental charges (or purchase when approved by the Fund) that exceed the reasonable purchase price of the equipment are not covered. Batteries and/or equipment maintenance costs are not covered. Deluxe items are not covered.

Expenses for equipment prescribed while eligible under the Plan will be covered if delivered within 30 days of your loss of eligibility.

Emergency room outpatient treatment in a hospital. For an illness you must pay a $75 copay per visit for emergency room services. (The copay will not apply to the out-of-pocket maximum.) A recurrence of an illness is considered a different illness if complete recovery intervenes.

You must notify FCH about emergency inpatient admissions. See "Coverage Requiring Preauthorization" on page 36.

Foot orthotics or other supportive devices of the feet are limited to braces, splints, insoles and supports prescribed by a physician for the treatment of an illness or injury to the foot. Impression casts required for the fitting of these devices are also covered. The device must be worn at all times that shoes are worn

and not just for specific activities. Shoes that accompany these braces are not covered.

The calendar year maximum benefit payable is $350 per person. Your share of the coinsurance for these devices does not apply toward the out-of-pocket maximum.

Hearing care expenses (for active and retired employees only) are limited to a maximum benefit payable of $1,000 per ear during any three-year period. Covered hearing care expenses include:

- Hearing exam, if that exam results in your purchase of a hearing aid device.
- Hearing aid devices prescribed by a legally qualified physician or a certified audiologist, if the examining practitioner certifies in writing (within three consecutive calendar months immediately before the purchase of the device) that you are suffering a hearing loss and the device may serve to lessen that loss.
- Replacement of hearing aid devices, if you meet the above requirements and a three-year period has elapsed since you received your last hearing aid device.

No benefits are paid for batteries or other ancillary equipment not obtained when you purchase a hearing aid device. In addition, repairs, servicing or alteration of a hearing aid device is not covered.

The charges for a hearing aid device prescribed and ordered prior to termination of your eligibility and delivered within 30 days following your date of termination will be covered.

Home health care benefits for patients who are Homebound are paid in the same manner as for any other covered expenses. Home health care is limited to a calendar year maximum of 130 visits per person. Each visit by a member of the home health care team is considered one home health care visit.

Preauthorization is required for home health care. See “Coverage Requiring Preauthorization” on page 36.

Covered home health care expenses include:

- Physical, occupational, inhalation or speech therapy provided by a licensed therapist.
- Skilled nursing care provided on a part-time basis (less than an eight-hour shift) by a registered nurse (RN) or a licensed practical nurse (LPN).
- Home health aide services provided on a part-time basis (less than an eight-hour shift) which:
  - Are performed by a home health aide under the supervision of a registered nurse (RN) or a licensed therapist.
  - Consist mainly of medical care and therapy for the eligible person.
  - May include helping the patient with personal care, taking medications, movement or exercise, and making reports on the patient's condition.
- Medical social services by a licensed social worker with a master's degree in social work.
- Professional ambulance service, which is:
  - Certified by a physician to be necessary because of the patient's medical condition, or
  - Required because of a medical emergency.
- The following equipment and supplies, which are ordered or prescribed by a physician and would be covered as a hospital inpatient expense:
  - Drugs and medicines (including insulin) requiring a physician's written prescription.
  - Medical supplies such as oxygen, catheters, syringes, dressings, antiseptics, irrigation solutions and intravenous fluids.
  - Prosthetic devices, casts, splints, trusses, crutches and braces.
  - Rental (up to the purchase price) of a wheelchair, hospital bed for patient care, or other durable medical equipment.

Hospice care received as a result of a terminal illness. Hospice care benefits are paid in the same manner as any illness, but not to exceed:

- Six months of inpatient and outpatient hospice care services combined in any patient's lifetime.
- UCR charges of the hospice agency.

Preauthorization is required for hospice care. See "Coverage Requiring Preauthorization" on page 36.

Payment of hospice care benefits is not in lieu of hospital or medical benefits under the Plan. However, the Plan will not pay hospice and medical benefits for the same services and supplies.

When hospice care benefits are payable, the Plan also pays for:

- Counseling of the patient and immediate family, up to a maximum benefit payable of $500 for all family members combined.
- Bereavement counseling of the patient's immediate family, up to a maximum benefit payable of $250 for all family members combined.

Counseling and bereavement counseling must be provided by a psychiatrist, a licensed psychologist, or a licensed social worker. Benefits for counseling and bereavement counseling for the patient's immediate family members are payable whether or not the family members are also eligible for benefits described in this booklet.

Immediate family members include the patient's:

- Spouse and children under the limiting age (see page 14 for details on the limiting age).
- Parents, brothers and sisters, in the case of a terminally ill dependent child.

Benefits for bereavement counseling are paid even if eligibility ends before the counseling is received.

No hospice care benefits are paid for:

- Services and supplies which are not part of the home health care plan or the hospice plan.
- Services which consist mainly of housekeeping, companionship or sitting.
- Services which are not directly related to the patient's medical condition, including (but not limited to):
  - Estate planning, drafting of wills or other legal services.
  - Pastoral counseling or funeral arrangements or services.
  - Nutritional guidance or food services such as "meals on wheels."
  - Transportation services (except necessary ambulance services).
- Expense for which benefits are paid under any other provisions of the Plan.

Hospital room, board, services and supplies. Room and board benefits are limited to the hospital's average semi-private room rate. Benefits for confinement in an intensive care or coronary care unit are limited to the hospital's average charges for such unit. Nursery charges for routine care of a newborn and an initial physical exam while the baby is confined are covered.

For a nonemergency admittance to a Non-PPO hospital in the PPO Service Area, you must pay a $100 copay. (The copay will not apply to the out-of-pocket maximum.)

Covered expenses for confinement in a hospital due to treatment for a mental illness are limited to a maximum of 70 days for you and 31 days for your dependent during any one continuous period of disability.

See "Coinsurance" beginning on page 34 for PPO provider and Non-PPO hospital reimbursement percentages and penalties.

Preauthorization is required for inpatient hospital stays. See "Coverage Requiring Preauthorization" on page 36.

Mental illness is covered as follows:

- Physician charges and charges for mental health treatment by providers who are approved or certified in the state in which they practice for outpatient treatment are paid at 50% of the PPO Allowed Amount or UCR Amount of covered expenses, up to a maximum benefit payable of $40 per visit. Your share of the outpatient coinsurance does not apply toward the out-of-pocket maximum.
- Inpatient treatment is paid as any other condition up to a maximum of 70 days for the employee and 31 days for dependents during any one continuous period of disability.

Preauthorization is required for inpatient mental health treatment. See "Coverage Requiring Preauthorization" on page 36.

Multiple surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity to the complete procedure, as determined by the Fund. The allowed amount shall be:

- 100% of the PPO Allowed Amount or UCR Amount for the primary procedure;
- 50% of the PPO Allowed Amount or UCR Amount for the secondary or any additional procedures.

Procedures or services that are designated as a "separate procedure" per guidelines in the Current Procedural Terminology (CPT), will be handled as a separate procedure, not subject to the above rules.

Preauthorization is required for surgical services. See "Coverage Requiring Preauthorization" on page 36.

Neurodevelopmental therapy for a dependent age six or younger is covered as any other condition, up to a lifetime maximum of $2,000.

Neurodevelopmental therapy includes services of those authorized to deliver occupational therapy, speech therapy and physical therapy. To be covered, such services must be:

- Necessary for the maintenance of a dependent child in cases where significant deterioration in the patient's condition would result without the service.
- Necessary to improve function.
- Periodically reviewed by a physician.

Organ transplant expenses are covered provided the transplant is preauthorized by First Choice Health (FCH). See "Coverage Requiring Preauthorization" on page 36.

FCH pre-certification approval for transplants is based on these criteria:

- Your provider submits a written recommendation and supporting documentation.
- Your medical condition requires the requested transplant based on medical necessity.
- The requested procedure is not considered experimental or investigational.
- The procedure is performed at a facility and by a provider approved by FCH.

After FCH pre-certification, the following list of Natural Organs, Natural Organ Parts and Artificial Organ Parts are included:

- Natural Organs:
  - Heart
  - Heart/Lung (combined)
  - Kidney
  - Kidney/Pancreas (combined)
  - Lungs (single/bilateral)
  - Liver
- Natural Organ Parts:
  - Cornea
  - Skin, bone and tendons
  - Bone marrow (including self-donated and unrelated donors) but only as follows:

- With regard to autologous (self-donor) bone marrow transplants, coverage is available for treatment only of the following malignancies/conditions:
  - Non-Hodgkins lymphoma
  - Hodgkins lymphoma
  - Acute lymphocytic or non-lymphocytic leukemias

  Autologous bone marrow transplants for other conditions will not be covered.
- With regard to allogeneic (related or unrelated) bone marrow transplants, coverage is available for treatment only of the following malignancies/conditions:
  - Acute lymphocytic leukemia
  - Acute non-lymphocytic leukemias
  - Chronic myelogenous leukemia
  - Aplastic anemia
  - Hodgkins lymphoma
  - Non-Hodgkins lymphoma
  - Severe combined immunodeficiency (not AIDS)
  - Wiskott-Aldrich syndrome
  - Infantile malignant osteoporosis
  - Homozygous beta-thalassemia

  Allogeneic bone marrow transplants for conditions other than those listed above will not be covered.

- Artificial Organ Parts:
  - Joint replacement (but for functional reason only), skin, heart valves, grafts and patches (vascular), pacemaker, metal plates, and eye lens.

For donor organ procurement costs, up to a maximum of $25,000 per transplant is available, provided the organ recipient is covered for the transplant under this Plan. Donor organ procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and

such other medically necessary procurement costs as determined by the Fund. Donor benefits are charged against the recipient's benefit limits.

Please note: Donor benefits are *not* provided when they are available through other group coverage, when the donor is eligible under this Plan and the recipient is not, or for donor and procurement services and costs incurred outside the United States, unless specifically approved by the Fund.

Benefits are *not* provided for:

- Nonhuman, artificial or mechanical transplants, except as specifically provided under "Artificial Organ Parts" above.
- Experimental or investigational procedures as defined on page 115.
- Services in a non-approved transplant facility.
- Transplant expenses when government funding of any kind is available, or when the recipient is not eligible under this Plan.
- Lodging, food or transportation costs, unless specifically approved by the Fund.
- Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas.
- More than one retransplant (subject to the limits specified above) if the transplant is not successful.

Osteotomy as determined to be medically necessary by the Fund.

Oxygen and its administration.

Physical exam for active members, retirees and dependents age 14 and older, once each calendar year, including necessary x-ray and laboratory tests. No deductible is required and the Plan pays for an exam and any related x-ray and laboratory tests as follows:

- If the exam is received in Washington or other areas, 100% of the PPO Allowed Amount or UCR Amount, up to $500 per calendar year.
- If the exam is received in Alaska, 100% of the PPO Allowed Amount or UCR Amount, up to $600 per calendar year.

Physician services, including expenses for a second surgical opinion. For details related to mental illness treatment, chiropractic visits, and alternative providers, see their respective sections.

Pregnancy-related expenses, including sterilization procedures and abortions, for a female employee or a dependent wife of an employee are covered on the same basis as for any other illness or injury, whether or not the pregnancy begins while the person is covered under the Plan. Covered expenses are those incurred while the person is covered under the Plan. However, if the individual is and continues to be totally disabled when coverage ends, benefits may continue to be payable as described on page 24 of this booklet.

Pursuant to Federal law, no hospital stay in connection with childbirth for either the mother or newborn child, is limited to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, unless there is agreement between the patient and the attending physician that the length of stay shall be less than the above periods.

Prescription drugs are covered under a separate program as described on page 59.

Prosthetic devices to replace natural limbs and eyes that are:

- Prescribed by the patient's physician
- Approved by the Fund as both effective and the usual and customary treatment of the condition
- Manufactured solely for medical use

Examples of noncovered items include:

- Deluxe equipment
- Items not intended to be worn for all activities of daily living such as for exercise, sports or swimming.

Reconstructive breast surgery following or coinciding with a mastectomy that is performed as a result of an illness or injury. In accordance with the Women's Health and Cancer Rights Act of 1998, such benefits include reconstruction of the breast on which a mastectomy was performed, one surgery on the other breast to produce symmetrical appearance following a mastectomy, and

prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. Benefits are not provided for reconstructive breast surgery for complications arising from a cosmetic augmentation or reduction mammoplasty.

Registered nursing care (other than those of a nurse who ordinarily resides in your home or who is a member of your immediate family).

Rehabilitative care, including hospital room, board, services and supplies. Confinement must be recommended by a legally qualified physician for actual rehabilitative treatment following an illness or accidental injury.

Preauthorization is required for rehabilitative services. See "Coverage Requiring Preauthorization" on page 36.

Custodial care is not covered under any circumstances. Your share of the coinsurance for rehabilitative care does not apply toward the out-of-pocket maximum.

Skilled nursing facilities, including hospital room, board, services and supplies. Custodial care is not covered under any circumstances. Coinsurance for skilled nursing facility care does not apply toward the out-of-pocket maximum.

Preauthorization is required for inpatient admissions. See "Coverage Requiring Preauthorization" on page 36.

Temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD), including diagnosis, treatment and/or surgery, if medically necessary as determined by the Plan.

Therapy services on an outpatient basis, including physical, occupational and speech therapy, to the extent that the therapy will significantly restore and improve a lost function(s) following a severe illness, injury or surgery.

This benefit is also available for dependent children when the Plan's Neurodevelopmental benefit has been exhausted provided continued therapy is:

- Necessary for the maintenance of a dependent child in cases where significant deterioration in the patient's condition would result without the service
- Necessary to improve function
- Periodically reviewed by a physician

No benefits will be provided for care that is custodial in nature, or when no significant clinical improvement is expected as a result of the therapy. Coverage is limited to 20 visits per calendar year.

Therapy services must be prescribed by the attending physician and administered by a physician or covered therapist. The patient must continue under the care of the attending physician during the time the therapy is being provided.

Well child care expenses are reimbursed up to $100 per visit for a routine exam for a new born baby in the hospital and for 10 routine exams for dependent children between one month and 18 months of age, and 8 routine exams for dependent children from age 2 through age 13 as follows:

- 100% of the PPO Allowed Amount when received from PPO providers within a PPO Service Area.
- 100% of the UCR Amount when received from covered providers outside of the PPO Service Areas.
- 70% of the UCR Amount when received from Non-PPO providers within a PPO Service Area.

Routine immunizations and laboratory tests are also reimbursed at these amounts. This benefit is not subject to a deductible.

X-ray, radium and radioactive isotope therapy.

Expenses Not Covered

No Medical Plan benefits are payable for:

- Alternative provider treatment except as specifically covered under Alternative Providers.
- Charges incurred by a residential treatment facility.
- Charges that exceed UCR Amounts (see page 123 for details).
- Chelation therapy (except for acute arsenic, gold, mercury or lead poisoning).
- Cochlear implants
- Contact lenses (except for initial placement of contact lenses following cataract surgery and initial lens implant required because of cataract surgery). See vision coverage, beginning on page 76.
- Cosmetic surgery or treatment, unless such surgery is for the repair of a congenital birth defect, repair due to an accidental injury and performed within one year of the injury, or for reconstructive breast surgery.
- Custodial care.
- Dental work, unless such work is for the repair of an accidental dental injury to sound natural teeth, provided such work is done within one year of the injury. Benefits for work which is done after the one year period will be provided if the Plan receives certification from the treating physician that treatment could not have been completed earlier due to the severity of the patient's condition. Dental benefits under this provision will be paid first under the Scheduled Dental Plan and then under the Medical Plan. (See dental benefits beginning on page 66.)
- Eating disorder or obesity treatment, including appetite control, food addictions or other eating disorders, (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, and present significant symptomatic medical problems) or any surgery or reversal of surgery for obesity or for complications resulting from such surgery.

- Eye refractions or the fitting or cost of visual aids, vision therapy, training or orthoptics.
- Fertility treatment including (but not limited to):
  - Fertility tests.
  - Reversal of surgical sterilization.
  - Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.
  - Genetic testing except when there are symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment.
- Habilitative, education or training services, or treatment for dyslexia except for prescription medication and professional charges for management of such medication for attention deficit disorders; behavioral or conduct disorders, learning disabilities and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, except as described under neurodevelopmental therapy benefits for children age six and under, as described on page 48.
- Hospital or anesthesia charges due to dental work, unless such charges are deemed to be medically necessary as determined by the Fund.
- Illness or injury caused by or contributed to or arising out of any employment or occupation for compensation or profit.
- Illness or injury caused by the act or omission of another person (known as a "third party"), and where an opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. The Plan may advance payment of benefits pending recovery from the third party or insurer pursuant to the Right to Reimbursement provisions.
- Implantation, unless the person is totally edentulous (without teeth) and the gum is severely resorbed and cannot support regular dentures or when necessary due to an accidental injury

to sound natural teeth, provided treatment is done within one year of the injury or the Plan receives certification from the treating physician that treatment could not be completed earlier due to the severity of the patient's injuries.

- Investigational or experimental services or supplies.
- Massage therapy.
- Marriage or family counseling, except family counseling for the treatment of a minor child's mental illness.
- Maternity benefits, including complications of pregnancy and voluntary termination of pregnancy of dependent children. Complications of pregnancy means all physical effects suffered which have been directly caused by the pregnancy, but which would not be considered from a medical viewpoint the effects of a normal pregnancy, and will include, but are not limited to conditions such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy which terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, and similar medical and surgical conditions.
- Mental illness treatment (except as specifically provided in the "Covered Medical Expenses" section on page 48).
- Organ transplant expenses (except as described in the "Covered Expenses" section beginning on page 49).
- Refractive eye surgeries or similar surgery to correct vision (except for corneal graft or when visual acuity cannot be improved to at least 20/20 in the better eye). See vision benefits beginning on page 76.
- Routine eye examinations, lenses, frames, and fitting fees (see Vision Benefits starting on page 76).
- Routine footcare, including callus, corn paring or excision; toenail trimming; orthopedic shoes; foot orthotics or other supportive devices for the feet (except as specified in the "Covered Medical Expenses" section on page 43).
- Routine immunizations, except as specifically provided under the well-child benefits.

- Services, supplies and durable medical equipment not necessary or reasonable for treatment of illness or injury, not approved or certified by a legally qualified physician.
- Services or supplies that are not medically necessary for the care and treatment of illness or injury (except as provided under the routine physical exam benefit, well child care benefit, diagnosis x-ray and laboratory examination benefit, and alternative care provider benefit).
- Shipping fees or charges.
- Smoking cessation programs or treatment.
- Travel, transportation, whether by professional ambulance or otherwise (except as provided by the "Covered Medical Expenses" section on page 40), lodging, meals, rental car expense or other related charges, fees or expenses.
- Treatment or surgery for sex transformations; or any treatment related to sexual dysfunction, except when necessary due to a clinically documented illness or condition causing the dysfunction.
- Vitamins, minerals, herbs, over the counter food supplements, or prescription food supplements that are not the primary source of caloric intake.
- Charges that are excluded under the General Exclusions on page 89.

Prescription Drug Program

Prescription drug coverage is available in two convenient ways: either through the Retail Pharmacy Card Program or the Mail Order Program. Both programs are administered by Express Scripts, Inc. (ESI). You can contact Express Scripts directly for information about participating pharmacies, mail-order prescriptions and to order refills:

- The toll free Customer Service number is (866) 493-9201. You can call Customer Service 24 hours a day, 7 days a week.
- The Express Scripts website is www.express-scripts.com.

Throughout the Prescription Drug Program, "you" refers to covered employees and dependents.

Retail Pharmacy Card Program

The Retail Pharmacy Card Program provides a 34-day supply of medication per prescription or refill at a pharmacy.

This program offers you the convenience of local participating pharmacies for your short-term and immediate prescription drug needs. You can use a participating pharmacy in the Express Scripts network or you may purchase your drugs at any pharmacy, the choice is yours each time you need a prescription filled.

Under this program, the following copays apply.

Type of Prescription Drug	Participating Pharmacy	Nonparticipating Pharmacy*
Generic	$10 copay	$10 copay
Preferred brand	$25 copay	$25 copay
Non-preferred brand	$40 copay	$40 copay

* These copays also apply if an Express Scripts participating pharmacy is used but your prescription drug card was not presented at the time of purchase.

When you use an Express Scripts network participating pharmacy, you have the advantage of receiving discounted prices and there are no claim forms to file. At participating pharmacies,

the pharmacist will use a computerized system to confirm your eligibility for benefits and determine the discounted cost of your prescription. Simply present your prescription card and make your appropriate copay. Your copay depends on whether the prescription is for a generic or brand-name drug. The copay is waived for diabetic syringes and test strips. Copays are shown in the table above.

If you use a non-participating pharmacy, you will have to pay the full cost of the prescription and file a claim with Express Scripts to be reimbursed for the cost minus the copay amount shown in the table above. Claim forms may be obtained from Express Scripts or the Administration Office. A claim form must be submitted with copies of the prescription receipt (not cash register receipts) and sent to:

Express Scripts Inc.
Attention: Claims Department
P.O. Box 66773
St. Louis, MO 63166-6773

Mail Order Program

The Mail Order Program provides a 90-day supply of medication per prescription or refill.

The mail order program is designed for maintenance medications for ongoing or chronic conditions. Your copay depends on whether the prescription is for a generic or brand-name drug. The copay is waived for diabetic syringes and test strips. The copay amounts are shown in the following table.

Type of Prescription Drug	
Generic	$20 copay
Preferred brand	$40 copay
Non-preferred brand	$60 copay

How to Use the Mail Order Program

To use the mail order program for the first time, complete a patient profile questionnaire. The questionnaire asks for information about your medical history, blood type, allergies and

any other drugs you are taking (prescription and over-the-counter). Express Scripts keeps this information and checks it every time you send a prescription. You may update your profile as you like by including any health condition changes with your prescription. Follow these steps:

- Obtain an envelope (from Express Scripts, the Administration Office or your Local Union). Complete the information requested on the envelope, including your physician's name. Express Scripts automatically fills your prescriptions with a generic alternative whenever possible.
- If you are getting a new prescription filled, have your physician prescribe up to a 90-day supply of the maintenance drug with the appropriate number of refills. If your physician specifies a brand-name drug and writes "Dispense as Written" (DAW) on the prescription, the pharmacist will fill your prescription with the brand-name drug rather than filling it with a generic drug. However, the pharmacist may call your physician to request approval of filling your prescription with a generic drug.
- If you are requesting a refill, you should request your refill at least two weeks before your prescription runs out. With each prescription, Express Scripts sends a postage-paid envelope (for your future use) and a notice showing how many refills you have left. Be sure to contact your physician when you request your last refill from Express Scripts.
- Send your prescription (and questionnaire if it's your first order) or request for a refill and the appropriate copayment in the postage-paid envelope to Express Scripts. You can pay by check, money order, MasterCard or Visa. If you use a credit card, include the card number and expiration date. DO NOT SEND CASH.

Within two weeks or three weeks after ordering a new prescription or two weeks on a refill, your prescription will arrive, at the address you indicated on the envelope, by United Parcel Service (UPS) or U.S. Mail.

Special Reimbursement Procedures

Special procedures through the Administration Office will apply for the following situations:

- Once you meet your medical out-of-pocket maximum (*not* your deductible), your copays per prescription or refill will be reimbursed by the Plan. Please send copies of your prescription drug receipts (not cash register receipts) to the Administration Office showing the amounts paid so you can be reimbursed for those expenses. Refer to page 35 for information about the medical out-of-pocket maximum.
- If you or your dependents are covered under another prescription drug plan, and you submit your prescription claims to the other plan first, this Plan will reimburse you for any copays or coinsurance that you were required to pay under the other plan. For reimbursement, submit proof of the other plan's payment amount and the itemized drug receipt, to the Administration Office.

Covered Prescription Drugs

The Prescription Drug Program covers prescription drugs and medications when prescribed by a physician or other lawful prescriber. This includes:

- Federal legend drugs.
- State restricted drugs.
- Compounded medications of which at least one ingredient is a legend drug.
- Insulin.
- Insulin needles and syringes.
- Over the counter diabetic supplies.
- Oral contraceptives, contraceptive jellies, creams, foams, devices, implants or injections for a female employee or dependent spouse of an employee. Dependent children contraceptives are only covered for treatment of a covered medical condition.

- Retin-A through age 25. After age 25 prior authorization is required.
- Legend prenatal vitamins.
- Growth hormones with prior authorization.
- Immunosuppressants.

Step Therapy

For certain prescription therapies, participants and their physicians will be required to first use lower cost brand or generic equivalents when appropriate, as a first step. If, after using the lower cost brand or generic equivalent, you and your physician still require the higher cost treatment, coverage will be provided under this program. However, the initial prescription must be this step prescription. This program is intended to provide participants with coverage that is most effective, both on a treatment and financial basis. Prescription therapies (conditions) subject to the step therapy program are:

- ACE Inhibitors (high blood pressure)
- Angiotensin II Receptor Antagonists-A2s (high blood pressure)
- Branded NSAIDS (pain/arthritis)
- Cyclooxygenase-2 Inhibitors-COX2s (pain/arthritis)
- Calcium Channel Blockers (hypertension)
- Leukotriene Pathway Inhibitors (asthma/allergies)
- Proton Pump Inhibitors-PPIs (acid reflux/ulcers)
- Selective Serotonin Reuptake Inhibitors-SSRIs (depression)
- HMG-CoA Reductase Inhibitors (cholesterol)
- Topical Immunomodulators (dermatitis, exzema)
- Other Antidepressants (depression)

Certain prescription treatments require preauthorization. Any questions about preauthorization should be directed to Express Scripts at (866) 493-9201.

CuraScript Specialty Pharmacy

Some specialty injectable medications, such as those used to treat Hepatitis C and Multiple Sclerosis, will be filled by CuraScript Specialty Pharmacy (you may receive one fill at a retail pharmacy). This program not only supplies the prescribed medication and related supplies, such as needles and syringes, but also provides clinical support to you to help improve compliance as well as provide convenient delivery. If you are currently being prescribed a medication that will be filled as part of this program, you will receive more information under separate cover.

To begin using CuraScript Pharmacy, you or your physician can call (866) 848-9876.

Expenses Not Covered

- Non-federal legend drugs.
- Non-insulin needles and syringes.
- Fertility agents.
- Anorexiants.
- Smoking deterrents.
- Therapeutic devices or appliances.
- Cosmetic drugs.
- Dietary supplements.
- Over the counter items (except as specifically listed in "Covered Prescription Drugs").
- Drugs whose sole purpose is to promote or stimulate hair growth (Rogaine®) or for cosmetic use.
- Immunization agents and vaccines.
- Biologicals, blood or blood plasma.
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any

State or Governmental Agency, or medication furnished by any other Drug or Medicare Service for which no charge is made to the member.

- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operated on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- Vitamins other than prenatal vitamins.
- More than six doses per month of prescription impotence medication.

Dental Benefits

You have a choice between either the scheduled dental benefits described in this section or coverage under the Willamette Dental of Washington, Inc. pre-paid dental plan (described on page 75) as long as you live in the Willamette Dental service area.

Both the scheduled dental and Willamette Dental generally provide coverage for similar services, but vary in the way they pay benefits and the flexibility of provider choice.

Scheduled Dental Plan

The Scheduled Dental Plan provides benefits for the diagnosis and treatment of the gums, teeth and supporting structures. You do not have to satisfy a deductible before the Plan pays the amount listed in the Covered Expenses section.

Throughout the Scheduled Dental Plan, "you" refers to any covered active participant (including eligible dependents), unless otherwise noted. Retired employees and their dependents are not eligible for these dental benefits.

Maximum Benefit

The maximum benefit for all covered dental expenses (except orthodontics) incurred during any one calendar year is $2,500 for treatment received in Western Washington (and all other areas outside of Alaska) and $3,000 for treatment received in Alaska.

Covered orthodontic expenses (including related oral examinations, surgery and extractions) have a separate maximum benefit. For orthodontic care, the maximum *lifetime* benefit payable is $2,500 for treatment received in Western Washington (and all other areas outside of Alaska) or $3,000 for treatment received in Alaska. Only dependent children under age 19 are eligible for orthodontic benefits unless required before or in conjunction with Medically Necessary orthognathic surgery, which is covered under the medical plan. This benefit does not apply to active and retired employees and their spouses.

Predetermination of Benefits

Predetermination of benefits allows for review of a proposed treatment plan in advance and provides a chance to resolve any questions before the service has been provided to you. As a result, both you and your dentist will know in advance which procedures are covered and the estimated amount of benefits the Plan will pay.

If the total charges are expected to be more than $600, it is recommended that your dentist's proposed course of treatment be reviewed by the Administration Office before dental work begins. Your dentist can submit a treatment plan to the Administration Office. The Administration Office will respond to your dentist with a copy to you, showing the Scheduled Dental Plan's estimated benefits.

A treatment plan is the dentist's report that:

- Itemizes recommended services.
- Shows the charge for each service.
- Is accompanied by supporting x-rays and other diagnostic information when required or requested by the Administration Office.

Covered Expenses

Covered dental expenses are the necessary dental services and supplies, most of which are listed in the following table. Services of a denturist within the scope of his or her license are covered.

Certain dental procedures may be covered even though they are not listed in the following schedule. The Plan determines the benefit for unlisted procedures by taking into account the nature and complexity of the procedure. The amount will be consistent with those listed in the table.

All covered dental expenses, listed or not listed, are subject to the limitations and exclusions sections beginning on page 73 and page 89.

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
	DIAGNOSTIC		
	Examinations		
0120	Periodic oral exam	$49	$59
0140	Limited oral exam	$71	$85
0150	Comprehensive oral exam	$78	$94
	Radiographs (X-Rays)		
0210	Intraoral–complete series (including bitewings)	$116	$139
0220	Single, first film	$23	$28
0230	Each additional film	$18	$22
0270	Bitewing–single film	$21	$25
0272	Bitewings–two films	$37	$44
0274	Bitewings–four films	$50	$60
0330	Panoramic film	$88	$106
	PREVENTIVE		
	Prophylaxis		
1110	Age 13 and over	$92	$110
1120	To age 13	$61	$73
	Fluoride Treatment: To 18		
1203-04	Topical application of fluoride	$36	$43
	Fissure Sealants: 6 to 18		
1351	Topical application of fissure sealant (per tooth)	$43	$52
	Space Maintainers: To 19		
1510	Fixed–unilateral type	$285	$342
1515	Fixed–bilateral type	$311	$373
	MINOR RESTORATIONS		
2140	Amalgam–1 surface	$98	$118
2150	Amalgam–2 surfaces	$130	$156
2160	Amalgam–3 surfaces	$158	$190
2161	Amalgam–4 or more surfaces	$186	$223

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
2951	Pin retention–exclusive of amalgam	$33	$40
2330	Resin–1 surface anterior	$102	$122
2331	Resin–2 surfaces anterior	$128	$154
2332	Resin–3 surfaces anterior	$155	$186
2335	Resin–4 or more surfaces anterior	$173	$208
2391	Resin–1 surface posterior	$116	$139
2392	Resin–2 surfaces posterior	$148	$178
2393	Resin–3 surfaces posterior	$192	$230
2394	Resin–4 or more surfaces posterior	$207	$248
	MAJOR RESTORATIONS		
	Inlays and Onlays		
2510	Inlay, metallic–1 surface	$439	$527
2520	Inlay, metallic–2 surfaces	$404	$485
2530	Inlay, metallic–3 surfaces	$501	$601
2542	Onlay, metallic–2 surfaces	$534	$641
2543	Onlay, metallic–3 surfaces	$558	$670
2544	Onlay, metallic–4 or more surfaces	$599	$719
2642	Onlay, porcelain–2 surfaces	$535	$642
2643	Onlay, porcelain–3 surfaces	$544	$653
2644	Onlay, porcelain–4 or more surfaces	$622	$747
2910	Re-cement inlay	$55	$66
	Crowns		
2720	Resin with high noble	$590	$708
2721	Resin with predominantly base metal	$590	$708
2722	Resin with noble metal	$590	$708
2740	Porcelain/ceramic noble metal	$559	$671
2750	Porcelain fused to high noble metal	$559	$671

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
2751	Porcelain fused to predominantly base metal	$559	$671
2752	Porcelain fused to noble metal	$559	$671
2780	¾ cast high noble metal	$545	$654
2781	¾ cast base metal	$545	$654
2782	¾ cast noble metal	$545	$654
2783	¾ cast porcelain	$545	$654
2790	Full cast high noble metal	$545	$654
2791	Full cast predominantly base metal	$545	$654
2792	Full cast noble metal	$545	$654
2930-31	Stainless steel	$140	$168
2970	Temporary crown	$95	$114
2950	Crown buildup	$145	$174
2920	Re-cement crown	$55	$66
	Endodontics		
3110	Pulp cap–direct	$48	$58
3120	Pulp cap–indirect	$41	$49
3220	Vital pulpotomy	$106	$127
	Root Canal Therapy (includes treatment plan, clinical procedures, follow-up care; excludes final restoration)		
3310	Single-rooted	$484	$581
3320	Bi-rooted	$638	$766
3330	Tri-rooted	$834	$1,001
3410	Apicoectomy (as a separate surgical procedure)	$613	$736
	PERIODONTICS		
	Non-Surgical Services		
4910	Periodontal maintenance	$110	$132
4341	Periodontal scaling and planing (per quadrant)	$150	$180
	Surgical Services		
4210	Gingivectomy (per quad)	$869	$1,043

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
4241	Gingival flap procedure (per quad)	$529	$635
4260	Osseous surgery (per quad)	$1,117	$1,340
4271	Free soft tissue grafts	$797	$956
	PROSTHODONTICS		
	Dentures (includes six months post-delivery care)		
5110-20	Complete upper or lower	$758	$910
5130-40	Immediate upper or lower	$843	$1,012
5211-12	Partial upper or lower, acrylic base (and conventional clasps/rests)	$671	$805
5213-14	Partial upper or lower, predominantly cast base with acrylic saddles (and conventional clasps/rests)	$876	$1,051
	Related Denture Services		
5410-22	Denture adjustment (complete or partial)	$56	$68
5510	Repair denture damage (no teeth)	$83	$100
5520	Replace missing or broken teeth in complete denture–per tooth	$84	$101
5710-21	Rebase denture	$401	$481
5730-41	Reline denture–office	$226	$271
5750-61	Reline denture–lab	$414	$497
	Bridgework		
6210-12	Pontic–cast	$715	$858
6240-42	Pontic–porcelain	$580	$696
6250-52	Pontic–resin	$697	$836
6930	Re-cement bridge	$76	$91

Scheduled Dental Plan			
ADA Code	Procedure	Washington & other areas	Alaska
	ORAL SURGERY		
	Extractions (includes local anesthesia, routine postoperative care)		
7140	Single tooth	$79	$95
7210	Erupted tooth–surgically removed	$189	$227
7220	Impacted tooth–soft tissue	$198	$238
7230	Impacted tooth–partially bony	$266	$319
7240	Impacted tooth–completely bony	$329	$395
7250	Root recovery–per tooth	$195	$234
	Related Oral Surgical Procedures		
7310	Alveoloplasty–per quadrant	$172	$206
7510	Incision, drainage of abscess intraoral	$155	$186
7960	Frenectomy (separate procedure)	$198	$238
9220-21	General anesthesia	$320	$384

If dental coverage ends for you and/or for your dependents for any reason, charges for prosthetic devices (including bridges and crowns) may be covered. To be covered, the devices must have been ordered while you were covered and installed or delivered within 60 days after termination of eligibility.

Orthodontia

Covered orthodontic expenses are paid at 60% of UCR amounts up to a $2,500 lifetime maximum benefit for treatment received in Western Washington (and all other areas outside of Alaska) or $3,000 for treatment received in Alaska. However, for the initial stage of treatment, not more than 25% of the treatment cost is allowable. The remaining benefit provided by the Plan will be pro-rated over the course of the treatment after the initial stage. This orthodontia benefit does not apply to active participants who have elected to receive dental coverage from Willamette Dental.

Covered orthodontic expenses include diagnostic procedures and treatment consisting of surgical therapy, appliance therapy, and function/myofunctional therapy (including related oral examinations, surgery and extractions).

Orthodontic benefits are available for your covered dependent children under age 19 only. Participants age 19 and over are eligible *only* if required before or in connection with medically necessary orthognathic surgery which is covered by the Fund's medical benefits.

Scheduled Dental Plan Limitations

The following limitations apply:

- **Diagnostic:** The maximum benefits for a complete series of x-rays are payable once during any 36 consecutive month period. Benefits for periodic examinations and a maximum of four bitewings are payable once during any six consecutive month period.
- **Preventive:** Benefits for dental prophylaxis and fluoride treatments are provided once during any six consecutive month period. Topical application of sealants (for children ages 6 to 18) are payable once every 36 months for permanent posterior teeth.
- **Periodontics:** Periodontal maintenance is provided once during any four consecutive month period. Periodontal scaling and root planing is provided once during any six consecutive month period.
- **Prosthodontics:** Adjustments to dentures are covered only after they have been installed for at least six months. Denture relining and/or rebasing is covered only after six months have elapsed since installation and is limited to one denture during any 36 consecutive month period.

  Replacement of an existing denture is covered only if the existing denture is unserviceable and cannot be made serviceable. Replacement of prosthodontic appliances is covered only if at least three years have elapsed since the date of the initial installation of that appliance under this Plan.
- **Occlusal/Nightguard:** Covered once per lifetime.

- **Oral Surgery:** Alveoplasty is payable only when performed on the same day as extractions and followed by immediate placement of dentures.
- **Orthodontics:** Treatment is available to dependent children under age 19. Participants age 19 and over are eligible for orthodontic benefits *only* if required before or in connection with Medically Necessary orthognathic surgery which is covered by the Fund's Medical Plan.

  If orthodontic treatment ends for any reason before the treatment is complete, Plan benefits also end. If orthodontic treatment resumes, benefits for any remaining services also resume. However, benefits are only payable for expenses incurred while covered by the Plan.

Expenses Not Covered

No Scheduled Dental Plan benefits are payable for:

- Analgesics (such as nitrous oxide) or euphoric drugs, injections or application of desensitizing medicines, except during oral surgery.
- Appliances or restorations necessary to increase vertical dimension or restore the occlusion.
- Charges that exceed scheduled amounts (see the schedule beginning on page 68).
- Cosmetic services or supplies including personalization or characterization of dentures.
- Diagnosis, treatment or surgery for temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD).
- Duplicate appliances or prosthetic devices.
- Hospital or related anesthesia charges due to dental work.
- Implantation.
- Oral hygiene and dietary instructions.
- Orthodontic treatment, except as specifically provided.
- Plaque control.
- Prosthetic devices (including bridges and crowns) and fittings, if ordered while the individual was covered but installed or delivered to the patient more than 60 days after coverage ends.

- Replacement of a lost, missing or stolen prosthetic device.
- Treatment by other than a dentist (except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the dentist). Covered services provided by a denturist that are within the scope of his or her license are covered.

Willamette Dental Benefits

If you live within Willamette Dental's coverage area, you may choose dental coverage through this program. The Willamette of Washington, Inc. prepaid dental plan offers services through Willamette Dental Group. You will select a Willamette Dental Group dentist for dental services and must receive all services through participating providers to receive benefits.

To find out more about Willamette Dental coverage, including details on the service area, call the Administration Office.

Willamette Dental of Washington, Inc. offers a certificate of coverage that details benefits which you may request from the Administration Office.

Vision Benefits

The Vision Plan, administered by VSP, provides benefits for an eye exam, lenses and frames or contact lenses. You do not have to satisfy a deductible before the Plan pays the amount listed in the following "Covered Expenses" section.

Throughout the Vision Plan, "you" refers to covered employees and dependents.

Covered Expenses

For maximum benefits, it is to your advantage to see a VSP member doctor.

When you go to a VSP member doctor, there are no claim forms for you to file. When you go to a non-VSP provider, you must pay for vision services at the time you receive them and then file a claim with VSP.

To locate a VSP doctor, contact VSP at www.vsp.com or (800) 877-7195.

The Vision Plan covers eye exams, lenses and frames as shown in the tables below:

If you see a VSP Member doctor...	
Copay	$20 per eye exam and/or glasses
Eye Exam (once every 12 months)	Paid in full after the copay
Lenses (one every 24 months) Single vision Lined bifocal Lined trifocal Lenticular Tints, Photochromic	Paid in full after the copay*
Frames (once every 24 months)	Paid in full (up to $120) after the copay**
Contacts – instead of lenses and frames (once every 24 months)	Paid up to $145*** (contacts, evaluation and fitting)

* *Lenses are paid in full, including tinted, dyed and photochromic lenses, as well as polycarbonate lenses for dependent children. VSP may authorize payment for new lenses after 12 months if the new prescription differs from the original by at least a 0.50 diopter sphere or cylinder, there is a change in the axis of 15 degrees or more, there is a 0.50 prism diopter change in at least one eye or the new prescription improves visual acuity by at least one line on the standard eye chart.*

** *A 20% discount is available on any out-of-pocket costs for frames that exceed the frame allowance from a VSP member doctor.*

*** *Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses.*

If you see a non-VSP provider...†		
	in Washington and all other areas	**in Alaska**
Eye Exam (once every 12 months)	Up to $60.50	Up to $72.50
Lenses (once every 24 months)		
Single vision	Up to $49.50	Up to $59.50
Lined bifocal	Up to $81.50	Up to $98.00
Lined trifocal	Up to $125.50	Up to $150.50
Lenticular	Up to $143.00	Up to $171.50
Tints, Photochromic	Up to $22.00	Up to $26.50
Frames (once every 24 months)	Up to $71.50	Up to $86.00
Contacts (instead of lenses and frames)	Up to $121.00	Up to $145.50

† *If you see a non-VSP doctor, you'll pay the provider in full and have 12 months to submit a claim to VSP for partial reimbursement.*

Additional Discounts

In addition to the benefits listed above, VSP member doctors have also agreed to provide the following:

- An average 30% savings on non-covered lens options, like progressives and scratch-resistant and anti-reflective coatings.
- 30% discount off additional glasses and sunglasses, including lens options from the same VSP doctor on the same day as your eye exam. Or get 20% off from any VSP doctor within 12 months of your last eye exam.
- 15% discount off the cost of contact lens exam (fitting and evaluation).
- An average of 15% off the regular price of laser vision correction (or 5% off the promotional price) from contracted

facilities; after surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Low Vision Benefit

A low vision benefit is available for severe visual problems that are not correctable with regular lenses. This benefit requires a prior approval from VSP. Please discuss your options with your provider. Coverage includes:

- Complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions. Including the prescription of corrective eyewear or vision aids where indicated.
- Subsequent low vision aids as visually necessary or appropriate.

	VSP Member Doctor	Non-VSP Provider
Supplementary Testing	Paid in Full	Up to $125
Supplemental Care Aids	75% of Cost	75% of Cost
Benefit Maximum (every 2 years)	$1,000	$1,000

Low vision benefits secured from a non-VSP provider are subject to the same time limits and copay arrangements as described above for a VSP member doctor. You should pay the non-VSP provider's full fee. You will then be reimbursed up to the amount that would have been paid to a VSP member doctor in similar circumstances.

Expenses Not Covered

Limitations

This Plan is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±.50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or materials above Plan benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan benefits.

General Health Care Information

Coordination of Benefits

This Plan is designed to help you meet the cost of medical, dental and vision care expenses. Since it is not intended that you receive greater benefits than the actual expenses incurred, the amount payable under this Plan will take into account any coverage you have under other "plans," as defined below. This means the benefits under this Plan will be coordinated with the benefits of the other "plans."

The Willamette Dental Plan has a separate policy on coordination of benefit rules. Please contact Willamette for details.

When coordinating with other plans, this Plan will pay either its regular benefits in full, or a reduced amount. This reduced amount plus the benefits payable by the other plans will equal 100% of "allowable expenses." "Allowable expenses" mean any necessary, usual, customary and reasonable expense partially or completely covered under any other plan during the calendar year while the person is covered under this Plan.

If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase your later claim payments under the Plan in the same calendar year, to the extent there are allowable expenses that otherwise would not be fully paid by this Plan and the other plans. Therefore, on a later claim you may receive a greater benefit under our Plan than would normally be allowed.

"Plan" means any of the following, even if it does not have its own coordination of benefits provisions:

- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization agreements issued by insurers, health care service contractors and health maintenance organizations.
- Labor-management trustee plans, labor organization plans, or employee benefit organization plans.
- Government programs which provide benefits for their own civilian employees or their dependents (including Medicare).

- Coverage required or provided by any statute, including automobile insurance policies required by statute to provide medical benefits.

The following guidelines have been established to ensure that all plans coordinate benefits in a consistent manner. The primary plan pays benefits first. The secondary plan pays benefits second (after the primary plan has paid). The primary plan is determined using the first of the following rules that apply:

1. Plans Without Coordination of Benefits Provisions. A plan that does not contain coordination of benefits provisions.

2. Plans Covering Non-Dependents. A plan, including this Plan, that covers a person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is primary over plans that cover a person as a dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (i.e. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is secondary and the plan covering the person as a dependent is primary.

3. Plans Covering a Dependent Child. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

    a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

        i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

        ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

    b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;

ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent, first:
- The plan covering the spouse of the custodial parent, second:
- The plan covering the noncustodial parent, third; and then
- The plan covering the spouse of the noncustodial parent last.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

4. Active Employee. The plan that covers a person as an active employee is primary over a plan that covers a person in any other capacity – including any self-pay, retiree, laid-off or non active capacity, regardless of which plan has covered the person longest. The plan covering that same person as a self-pay, retiree, laid-off or non active capacity is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. This rule does not apply if the rule under paragraph 2 above can determine the order of benefits.

5. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under paragraph 2 above can determine the order of benefits.

6. Longer or Shorter Length of Coverage. The plan that covered the person as an active employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

7. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition , this plan will not pay more that it would have paid had it been the primary plan.

If you or your dependents are covered by another group or individual medical, dental or vision plan, claims should be filed under this Plan and the other plan(s) at the same time to avoid delays in claim payments due to coordination of benefits.

Coordination of Benefits with Medicare

If you are an active employee, this Plan is your primary plan and Medicare will be your secondary plan. You may select Medicare as your primary plan for yourself and your Medicare-eligible spouse. However, if you select Medicare as your primary plan, this Plan will not pay any of your medical expenses not paid by Medicare. If you have questions about this election, please contact the Administration Office.

If you are a retired employee, your benefits are provided under the terms of the Retiree Plan. If you and your spouse are eligible for Medicare, Medicare is always your primary plan, and any benefits from the Retiree Plan will only be available after Medicare has processed your claim. See "Retiree Benefits" starting on page 98 for more information on the Retiree Plan.

If your coverage is based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Fund will only pay secondary and coordinate with Medicare.

If you have Medicare coverage based on end stage renal disease and have Plan coverage (based on COBRA or otherwise), the Fund will pay primary during the 30-month coordination period provided by statute.

Right to Information

In determining how to coordinate benefits, the Fund, without consent of or notice to anyone, may release or obtain any information it determines reasonably necessary. A person claiming Plan benefits must furnish, upon written request, information to help the Administration Office implement this provision.

Right to Correlate Payments

A payment made under another health plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made the payment. The amount is treated as though it were a benefit paid under this Plan and the Plan will not pay that amount again.

Right to Reimbursement (Third Party Liability)

The Plan excludes charges incurred for any illness or injury caused by the act or omission of another person (known as a "third party"), and where an opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. If a covered person has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the covered person, may advance benefits pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits in excess of $5,000, the covered person agrees that the Plan is entitled to reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan (including the first $5,000 of such benefits), but not to exceed the amount of the recovery. The Plan is entitled to reimbursement, regardless of whether the covered person is made whole by the recovery, and regardless of the characterization of the recovery, except that the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, if the covered person complies with the terms of the Plan and the agreement to reimburse.
- The Plan can require a covered person to execute and deliver instruments and papers, disclose the circumstances resulting from the injury or illness, and do whatever else is necessary to secure the Plan's right to reimbursement (including an assignment of rights). The Plan may require the covered person and the covered person's representative to sign an agreement to reimburse the Plan from the proceeds of any recovery before the Plan will advance any benefits.
- A covered person must do nothing after payment of benefits to prejudice the Plan's right of reimbursement.
- When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other way, an amount sufficient to satisfy the Plan's reimbursement

amount must be paid by the covered person into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in an escrow or trust account, the covered person will be personally liable for any loss the Fund suffers as a result.

- The Plan may cease advancing benefits if there is a reasonable basis to determine that the covered person will not honor the terms of the Plan or the agreement to reimburse, or the Board of Trustees modifies the Plan provisions related to the advancement of benefits.
- If the Plan is not reimbursed upon recovery on a third party claim, the Plan may bring an action against the covered person to enforce its right to reimbursement and/or the agreement to reimburse, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefit payments of the covered person and the covered person's family members, or by recovery from the source to which benefits were paid.

After recovery on a third party claim, the Plan is relieved from any obligation to pay further benefits for the illness or injury up to the amount of the balance of the recovery.

Disputed Workers' Compensation Claims

The Plan does not provide benefits for expenses incurred in connection with accidental bodily injury or illness arising out of or in the course of employment, or which are compensable under any workers' compensation or occupational disease act or law. If a dispute arises concerning whether an injury or illness is work-related, and the covered person appeals the denial of the claim by a state or federal workers' compensation agency or insurer, the Plan may advance payment of benefits pending resolution of the appeal, provided the covered person submits documentation indicating the basis for denial of the claim and signs and returns an agreement to reimburse the Plan 100% of the amount of such benefits, or the amount recovered if less, upon recovery on the workers' compensation claim. Reimbursement is required regardless of whether recovery is through acceptance of the claim, award, settlement, or disputed claim settlement, or any other method of recovery, and regardless of whether the covered person is made whole by the recovery. The amount to be reimbursed to the Plan shall not be reduced for attorney fees or costs incurred by the covered person. The covered person shall do nothing to prejudice the Plan's right to reimbursement and the Plan may offset future benefit payments, including those of family members, by denying such payments until the benefits provided under this provision have been repaid. Following recovery on the workers compensation claim, no further benefits will be provided related to the injury or illness.

General Exclusions

No Medical, Dental or Vision Plan benefits are payable for:

- Acupuncture treatment except when used as an anesthetic agent for covered surgery or as specified under the alternative provider benefit.
- Any claim under this Plan if you were injured as the result of the commission of an assault, battery, or felony, or if you were an aggressor against another person, or if you were engaged in any acts of violence or physical force that would not be performed by a reasonably prudent person in similar circumstances.
- Charges for services or supplies for which benefits are furnished, paid for or for which benefits are provided or required under any law of a government (this does not include a plan established by a government for its own employees or their dependents).
- Charges for services or supplies (including drugs) which are:
  - Not medically necessary.
  - Not provided in accord with generally accepted professional medical standards, or
  - For experimental or investigational treatment.
- Charges in connection with injury or illness arising out of or in the course of employment, or which are compensable under any workers' compensation or occupational disease act or law, whether or not a claim was filed.
- Charges incurred for any illness or injury caused by the act or omission of another person (known as a third party), and where an opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. The Plan may advance payment of benefits pending recovery from the third party or insurers pursuant to the Right to Reimbursement provisions.

- Charges incurred while you are confined in a hospital operated by the United States of America or an agency thereof (except as otherwise required by law).
- Charges that are made only because the benefit plan exists, or charges that no covered person is legally obligated to pay.
- Charges which are primarily for your convenience or comfort or that of your caretaker, physician or other medical provider.
- Charges on account of donating your human organ or tissue. However, if you are the recipient of a donated human organ, the donor's medical expenses are covered up to the recipient's benefit limit.
- Charges which result, whether you are sane or insane, from
  - intentionally self-inflicted injuries;
  - suicide or attempted suicide;

  unless the injuries or illnesses were the result of a documented illness or injury condition.
- Charges for injuries incurred while being under the influence or overdose of a legal prescription, over-the-counter drug, illegal drug or other chemical substance, voluntarily taken and without the advice of a physician. Being under the influence of a chemical substance will not be considered to affect the person's ability to form intent.
- Charges for services, supplies and associated expenses for procedures intended primarily for treatment of obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and health services of a similar nature. Obesity includes, but is not limited to morbid or gross obesity.
- Conditions caused by or arising out of an act of war, declared or undeclared, armed invasions or aggression, riot or insurrection.
- Education, training or development of skills needed to cope with an injury or illness, except as specifically provided under the rehabilitation, home health or hospice care benefit.

- Education, training, room and board while you are confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Phone calls or missed appointments or filling out forms. Services where a patient is not physically seen by a physician or other covered provider.
- Services or supplies by a provider who normally resides in your home or is related to you by blood or marriage.
- Services or supplies provided or incurred before the effective date of your or your dependents' coverage or delivered after coverage ends except as specifically provided.

Weekly Disability Benefits

If you are an active employee and you become totally disabled and are unable to work as a result of nonoccupational illness or injury, you may be entitled to a benefit of $300 per week for a maximum of 39 weeks for any one period of disability.

Benefits begin on the first day of total disability due to an accident and the eighth day of total disability due to an illness. However, if you are confined as an inpatient in a hospital or have outpatient surgery, benefits begin on the first day for total disability due to either illness or accident.

Total disability or totally disabled, as it applies to this benefit only, means you (the employee) are prevented from performing any and every duty pertaining to your occupation. House confinement during your disability is not required.

Successive periods of disability separated by less than two weeks of continuous, active, full-time work will be considered as one period of disability unless they are due to entirely unrelated causes and begin after you have returned to active full-time work.

Exclusions

No weekly disability benefits will be paid for:

- Any period of disability during which you are not under the care of and certified as totally disabled by a legally qualified physician.
- Any disability which arose out of or in the course of employment.
- Any disability for which you are entitled to benefits under any workers' compensation law or similar law.
- Any disability which began prior to your becoming covered under the Plan or which began during a month in which you did not have active eligiblity.
- Any period of disability during which you are receiving unemployment compensation or compensation (other than for vacation or holiday) from your employer even though no duties are performed.

- Charges incurred for any illness or injury caused by the act or omission of another person (known as a third party), and where an opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. The Plan may advance payment of benefits pending recovery from the third party or insurers pursuant to the Right to Reimbursement provisions.

Taxes

Your Weekly Disability benefit payment is subject to both FICA (Social Security) taxes and FIT (Federal Income Tax). The Plan will automatically withhold the appropriate FICA taxes from your weekly check. You also have the option of having the Plan withhold Federal Income Taxes from your weekly check. (Contact the Administration Office for details). Your employer will send you a W-2 at year end so you will be able to file your Federal Income Taxes.

Life Insurance Benefits

Life insurance benefits are available to eligible active employees only; retirees and dependents are not eligible for this benefit.

Life insurance benefits are underwritten by United of Omaha. A life insurance benefit of $50,000 is paid as soon as the Administration Office receives proof of your death. Payment will be made in the event of your death at any time or place or from any cause.

You may elect to have your life insurance paid either in one sum or in monthly installments. If you elect to have your life insurance paid in one sum, the beneficiary may change that election (after your death but before payment is made) and elect to have the insurance paid in monthly installments.

Designation of Beneficiary

Payment will be made to your designated beneficiary or beneficiaries. You may designate a beneficiary or change your designation of beneficiary by written request, which is filed with the Administration Office.

A beneficiary designation of a spouse will be automatically revoked at the time a marriage is dissolved or invalidated. You should complete a new beneficiary designation following a dissolution or invalidation of marriage, even if you intend to redesignate your former spouse.

If you do not name a beneficiary, your benefits will be paid to your spouse, children, parents, brothers and sisters, in that order. If none of the beneficiaries are living, the benefits will be paid to your estate.

Total and Permanent Disability

If you become totally and permanently disabled before age 60, and if the disability continues after life insurance premiums are no longer payable, your life insurance will remain in force (without payment of premium) during the disability for up to twelve months. United of Omaha must receive written proof (within twelve months after premiums discontinue) that you have been disabled for at least nine months. Your premium is waived for successive further periods of one year while disabled, if proof of continuing disability is submitted in writing to United of Omaha within three months preceding each year.

It is your responsibility to initially apply for this waiver of premium, and to submit continued proof of disability to United of Omaha.

You are considered to be "totally and permanently disabled" only if illness or injury prevents you from engaging in your own or any other gainful occupation and continues to prevent you from engaging in any reasonable occupation for which you are, or may reasonably become, fitted by education, training, or experience.

Converting Coverage

If your life insurance coverage ends because you are no longer eligible you may convert your group life insurance (without providing evidence of good health) to any United of Omaha individual policy (except term insurance).

You must apply to United of Omaha and pay the applicable premium within 31 days after the date you are no longer eligible.

Your group life insurance is payable if you die within the 31-day conversion period whether or not you have made application for an individual policy.

If you convert coverage, the provisions and benefits will not necessarily be the same as under your current plan. Plan information and premium rates can be obtained from United of Omaha when coverage described in this booklet ends. Conversion applications are available from the Administration Office.

Accidental Death and Dismemberment (AD&D) Benefits

This benefit is available to eligible active employees only; retirees and dependents are not eligible for this benefit.

Accidental death and dismemberment benefits are underwritten by United of Omaha.

If you suffer death or dismemberment as a result of accidental bodily injuries (including bodily injuries arising out of or in the course of employment), you will be paid a benefit, as described in the table below, if the loss occurs within 365 days after the date of the accident.

In the event of loss of:	Your AD&D benefit is:
Life	$50,000
Both hands or both feet	$50,000
Both eyes	$50,000
One hand and one foot	$50,000
One foot and one eye	$50,000
One hand and one eye	$50,000
One hand or one foot	$25,000
One eye	$25,000

Loss of a hand or a foot means dismemberment by severance through or above the wrist or ankle joint. Loss of an eye means the entire and irrecoverable loss of sight of the eye.

Not more than $50,000 will be paid for all losses sustained by you through one accident. Payment is made for permanent losses only.

Designation of Beneficiary

Payment will be made to you, if living, otherwise to your designated beneficiary. You may designate a beneficiary or change your designation of beneficiary by written request, which is filed with the Administration Office.

A beneficiary designation of a spouse will be automatically revoked at the time a marriage is dissolved or invalidated. You should complete a new beneficiary designation following a dissolution or invalidation of marriage, even if you intend to redesignate your former spouse.

If you do not name a beneficiary and you die, your benefits will be paid in the same manner as your life insurance benefit.

Exclusions

AD&D insurance does not cover losses caused or contributed to by:

- Bodily or mental infirmity.
- Disease, ptomaines or bacterial infections (except a pus forming infection resulting directly from an injury not excluded under this benefit).
- Intentionally self-inflicted injury.
- Medical or surgical treatment, except a loss resulting directly from a surgical procedure required for treatment of an injury not excluded under this benefit (treatment must be performed within 365 days after the date of injury).
- Suicide or a suicide attempt (whether sane or insane).
- War or any act of war, declared or undeclared, or international armed conflict.

Retiree Benefits

Eligibility Provisions

If you are a retired employee who meets the eligibility requirements described below, you are eligible for benefits on the first day of the month following or coinciding with the date you retired (or, if later, the first day of the month following or coinciding with the termination of your eligibility as an active employee under the Plan).

Retirees Age 60 and Older

If you are a retired employee age 60 or older, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving a Normal, Early, or Late Retirement Benefit from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan or you worked for 10 consecutive years under a Local 302 or 612 of the I.U.O.E. collective bargaining agreement.

  If you qualify for coverage by receiving a Retirement Benefit, you must have at least 10 years of credited service or 15,000 hours in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan.

  If you qualify for coverage by receiving a pro-rata pension, you must have at least 10 years of credited service in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan. Related plan credits cannot be used.

- You had contributions made on your behalf to the Plan during at least 12 months of the 48 months immediately before age 60 (or your actual retirement date, if it is after age 60).

- You enroll in the Plan and make the required retiree self-payments.

Retirees Under Age 60

If you are a retired employee between ages 52 and 60, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving an Early Retirement Benefit from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan or you worked for 10 consecutive years under a Local 302 or 612 of the I.U.O.E. collective bargaining agreement.

  If you qualify for coverage by receiving a Retirement Benefit, you must have at least 10 years of credited service or 15,000 hours in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan.

  If you qualify for coverage by receiving a pro-rata pension, you must have at least 10 years of credited service in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan. Related plan credits cannot be used.

- You had contributions made on your behalf to the Plan during at least 12 months of the 48 months immediately before your retirement.

- You enroll in the Plan and make the required retiree self-payments.

Disabled Retirees

If you are a disabled retired employee age 40 or older, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving a Disability Retirement Benefit from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan or you worked for 10 conseccutive years under a Local 302 or 612 of the I.U.O.E. collective bargaining agreement.

  If you qualify for coverage by receiving a Retirement Benefit, you must have at least 10 years of credited service or 15,000 hours in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan.

If you qualify for coverage by receiving a pro-rata pension, you must have at least 10 years of credited service in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan. Related plan credits cannot be used.

- You had contributions made on your behalf to the Plan during at least 12 months of the 48 months immediately before your date of disability.
- You enroll in the Plan and make the required retiree self-payments.

Former Associate Employees

If you are a retired employee who participated as an associate employee and you do not satisfy the rules for retiree eligibility because you are not receiving a pension from the Locals 302 and 612 I.U.O.E. Employers Construction Industry Retirement Plan, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving benefits from a Taft-Hartley pension plan.
- You participated in the Plan as an associate employee for at least 60 months immediately preceding your retirement.
- You enroll in the Plan and make the required retiree self-payments.

This Program is Not Guaranteed.

The Board of Trustees is providing this program of retiree health and benefits to the extent that monies are currently available to pay for the cost of such programs. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for this program and to determine the expenditure of such monies for the program. The program is not guaranteed to continue indefinitely. The program may be terminated or modified at any time by the Board of Trustees.

How and When to Enroll

You must enroll at the time you retire to receive retiree benefits; coverage is not automatic. You may also enroll your dependents

at the time of your retirement. Enrollment forms are available at the Local Union Office and the Administration Office.

Retiree benefits become effective on the first day of the calendar month after the completed request for enrollment is received by the Administration Office or when you become eligible, if later.

Participants Not Medicare Eligible

If you do not enroll at the time of retirement, you may not enroll yourself or your dependents until you are eligible for Medicare, unless you satisfy the special enrollment provisions described below.

Medicare Eligible Participants

If you did not enroll at the time of retirement, you may enroll yourself and your dependents within 31 days of becoming eligible for Medicare. You must notify the Administration Office in writing, submit a photocopy of your Medicare card and enroll in the Medicare Supplemental Plan.

If you do not enroll yourself and your dependents at the time of retirement or Medicare eligibility, you and your dependents may not enroll at a later date, except under special enrollment provisions described below.

Special Enrollment Provisions

If you decide not to enroll yourself or a dependent at retirement or when you become eligible for Medicare, you may only enroll yourself or a dependent at a later date if one of the following special enrollment provisions is satisfied:

(1) Special Enrollment Upon Termination of Other Group Coverage. If you decline to enroll yourself or your dependent in the retiree plan at the time of retirement or Medicare eligibility because of other group health coverage, you may enroll yourself or your dependent upon termination of the other coverage. However, to qualify for enrollment, the other coverage must have terminated due to:

- loss of eligibility, including loss due to legal separation, divorce, death, termination of employment or reduction in work hours;

- termination of employer contributions; or
- if the other coverage was COBRA coverage, the maximum coverage period was exhausted.

You must enroll yourself and your dependent in the retiree plan within 31 days of the termination of the other group health coverage to qualify for special enrollment. Eligibility is effective the first day of the first calendar month following the month in which the other group coverage terminated.

(2) Special Enrollment Upon Acquiring a New Dependent. If a retiree is already enrolled in retiree medical, then acquires a new dependent, he or she will still be allowed to enroll that dependent within 30 days from the date acquired.

COBRA Continuation Option

Instead of the retiree coverage described in this section, you may temporarily elect to continue coverage under the active plan by making the required COBRA self-payments. (See page 17 for more information on self-pay coverage.) After you have used up your self-pay coverage, you may then elect retiree coverage if you met the retiree eligibility requirements at the time of your retirement.

Cost

Monthly self-payments are required from all retirees. You may make your payments one of the following ways:

- Deductions from the retirement payments received from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan for those who elect such deductions.
- Monthly payments to the Administration Office for those who do not elect deductions from their pension checks.
- Automatic deductions from your checking account.

Monthly self-payments are a percentage of the actual cost, as determined by the number of hours worked by the retiree prior to retirement while an active participant in this Plan, the retiree's age and the plan selected. The Board of Trustees may change the amount of self-payments from time to time. Contact the

Administration Office for details about monthly self-payment amounts.

When Coverage Ends

Your retiree coverage ends when:

- You die.
- The Plan terminates.
- You fail to make any required contribution.

Your dependents' coverage ends when:

- Your coverage ends (unless your surviving spouse elects to continue coverage by self-pay as described in the next section).
- You become divorced.
- A dependent child no longer meets the definition of an eligible dependent.
- You terminate your dependents' coverage. You may terminate your dependents' coverage by contacting the Administration Office.

If your dependents' coverage ends, your dependents may be eligible to continue coverage as described in the next section.

Self-Pay Coverage for Dependents

If you are covered by this Plan and you die or become divorced, your spouse who would otherwise lose coverage may continue coverage under the COBRA continuation coverage provisions (see page 17). Thereafter, surviving spouses may continue self-payment until they remarry, die, or until the Plan terminates, whichever occurs first.

When the dependent child of a retired employee no longer meets the definition of an eligible dependent, he or she may continue coverage under the COBRA continuation coverage provisions (see page 17).

In order to continue coverage under the COBRA continuation provisions, you must provide timely notice. See page 19 for details.

Benefits – Not Medicare Eligible

As an eligible retiree or dependent who is not yet eligible for Medicare, you have the following coverage under this Plan.

Medical – The same benefits as an active employee, as described beginning on page 32. However, you have a choice between two plans:

- Plan A (regular). Under Plan A, you are covered by the same medical benefits as active participants. The deductible (as described on page 33) and the out-of-pocket maximum (as described on page 35) apply to all covered medical benefits.
- Plan B (low option). Under Plan B, you have the same covered expenses with the same limitations and exclusions as Plan A. However, your deductible is $800 per person and $1,600 per family; the out-of-pocket maximum is $2,800 per person and $5,600 per family.

Prescription Drugs – The same benefits as an active employee, as described beginning on page 59.

Vision Care – The same benefits as an active employee, as described beginning on page 76.

Optional Dental Plan – As described on page 108.

Benefits – Medicare Eligible

As an eligible retiree or dependent who is eligible for Medicare, you have the following coverage under this Plan.

Medicare Supplemental Plan – This plan pays a portion of those expenses not presently covered by Medicare; see page 105 for more details.

Prescription Drug Benefits – The Plan covers prescription drugs as described beginning on page 59.

The Plan also pays 100% of the cost of medications administered or dispensed by a covered provider that would otherwise be covered under any other provisions of the medical or prescription drug benefits of the Plan if they are not reimbursable under Medicare Parts A and B. To qualify for this benefit, you or your Medicare-eligible dependent must be enrolled in the Prescription Drug Program offered by the Fund instead of enrolling in Medicare Part D coverage.

Participants who elect coverage under a Medicare Part D Prescription Drug Plan are not eligible for the prescription drug benefits provided by the Fund.

Vision Care – The same benefits as an active employee, as described beginning on page 76.

Optional Dental Plan – As described on page 108.

Medicare Supplemental Plan

When benefits are determined under the Medicare Supplemental Plan, it is assumed you enrolled in Medicare and that benefits are payable from Part A (the hospital insurance portion) and Part B (the medical insurance portion). Even if you don't enroll in Medicare, benefits are paid as if you did. As a result, it is important that you enroll in Medicare on a timely basis.

Only the usual, customary and reasonable charges for treatment of illness and non-occupational accidental injuries will be covered. The Medical Plan limitations also apply to the Medicare Supplemental Plan.

All expenses covered by this Medicare Supplemental Plan are subject to the maximum lifetime benefit of $1,000,000 per person,

including any benefits paid under the Medical Plan while you were an active employee.

The Medicare Supplemental Plan provides benefits as follows:

Hospital Benefits

The hospital benefits listed below may refer to a "benefit period." A benefit period begins the first day you enter a hospital or skilled nursing facility and ends as soon as you have not been a bed patient in any hospital or skilled nursing facility for 60 consecutive days.

- The Plan pays the current initial deductible required by Medicare for each inpatient admission per benefit period.
- The Plan pays the current per day deductible required by Medicare for the 61st through the 90th day in each benefit period.
- After the 90th day of confinement, Medicare provides you with an additional lifetime reserve of 60 hospital days. The Plan pays the current per day deductible Medicare requires you to pay when you use these extra days.
- After you have used all your Medicare benefits, the Plan will pay the current per day benefit if you remain in the hospital.

Any excess of a hospital's room and board charge over the semi-private room rate will not be considered a covered medical expense if private accommodations are used.

Skilled Nursing Facility Benefits

When you are in a Medicare-approved skilled nursing facility, the Plan pays the current coinsurance required by Medicare for the 21st through the 100th day of your stay. No further benefits will be provided.

A "skilled nursing facility" is one defined as such under Medicare, and which participates under Medicare.

Benefits for Medicare Part B Expenses

Medicare Part B expenses include physician services, hospital outpatient services, diagnostic x-ray and laboratory tests,

radiation therapy, durable medical equipment, ambulance services and any other expenses recognized by Part B of Medicare.

- The Plan pays $155 of the deductible required by Medicare.
- The Plan pays 20% of usual, customary and reasonable charges for the medical and other health services covered under Part B of Medicare.
- The Plan pays 50% of the PPO Allowed Amount or UCR Amount for covered expenses for the following alternative providers:
  - Registered Naturopaths
  - Registered Certified Hypnotherapists
  - Acupuncturists
  - Registered Dietitians
  - Certified Nutritionists

  up to a maximum of $50 per visit and $300 maximum, inclusive of all providers, per calendar year. Services of these alternative providers are eligible only if they are covered expenses under the Plan.

Additional Covered Medical Expenses

You must pay the deductible before Plan benefits for additional covered expenses are payable. The deductible period runs 7/1 – 6/30 and is $100 for each person eligible for Medicare. When you and your dependents who are eligible for Medicare have incurred a combined deductible expense of $200, no further deductible is required for any family member during the deductible period.

During the initial year under the Medicare Supplemental Plan, any deductible recognized under the Medical Plan will be applied toward this deductible.

After you have satisfied the deductible, the Plan pays 80% of UCR (defined on page 123) for:

- A registered graduate nurse (RN) excluding charges of a nurse who ordinarily resides in the employee's home or who is a member of your or your spouse's family.

- Blood, or units of packed red blood cells, that a patient receives.
- Hearing care expenses for retirees only, as described on page 44.

Optional Dental Plan

The Plan offers two optional dental plans. These programs are voluntary and the entire premium is paid by the retiree. For details of these plans, please contact the Administration Office at (206) 441-7314 or (877) 441-1212. These plans are available to retirees who participate in the retiree medical plan. Open Enrollment is held once a year and retired participants may join or terminate dental coverage during this period. Dental coverage may not be terminated other than at Open Enrollment.

What is Medicare?

Medicare includes:

- Part A (hospital insurance) which helps cover inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Generally, there is no cost for Medicare Part A.
- Part B (medical insurance) which helps cover doctors services and outpatient hospital care. It may also cover some services that Medicare Part A does not cover. You must generally pay a monthly premium for Medicare Part B. You must also pay a deductible before Medicare starts to pay.
- Part D (prescription drug coverage) which helps cover prescription drugs at participating pharmacies. You must generally pay a monthly premium and an annual deductible. You also pay a part of the cost of your prescriptions. Costs will vary depending on which plan you choose.

Who's Eligible

You are eligible to enroll in Medicare if:

- You are age 65 or older;
- You are under age 65 and receiving disability benefits from Social Security or the Railroad Retirement Board. (There may be a waiting period before you can commence Medicare); or
- You have end-stage renal disease (ESRD). If while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of ESRD, this Plan generally pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Then starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Medicare Enrollment

If you are receiving benefits from Social Security or the Railroad Retirement Board, you should be automatically enrolled in

Medicare the first day of the month you turn age 65. If you are under age 65 and disabled, you should be automatically enrolled after you have received disability benefits from Social Security or the Railroad Retirement Board for 24 months (although a shorter waiting period may apply in some instances). If you do not want Medicare Part B, you must follow the instructions that come with your Medicare card. **However, if you are a retiree or dependent of a retiree and you are eligible for Medicare Part B, Plan benefits are provided as if you are enrolled in Medicare Part B, regardless of whether you actually enroll.**

If you are turning age 65 and you are not receiving Social Security or Railroad Retirement benefits, you must apply for Medicare. **Even if your Social Security age is older than age 65, you are still eligible to enroll in Medicare at age 65.**

There is an initial enrollment period for Medicare Part B, which begins three months before the month you turn age 65, and ends three months after the month you turn age 65. However, your starting date for Medicare Part B will be delayed if you do not sign up before the month you turn age 65.

If you do not sign up for Medicare Part B during the initial enrollment period, you may sign up during the general enrollment period which runs from January 1 through March 31 of each year. Medicare Part B will start on July 1 of the year you sign up. The cost of Medicare Part B generally increases for each 12-month period that you could have taken Medicare Part B, but did not.

There is a special enrollment period if you waited to enroll in Medicare Part B because you or your spouse was working and had other group health plan coverage based upon your employment. The special enrollment period is anytime you are still covered in the group health plan, or during the eight months following the earlier of the month that the group health plan ends or employment ends.

Retirees and their spouses are expected to enroll in both Medicare Part A and Part B when first eligible. Even if you retire and elect COBRA coverage in lieu of Retiree Benefits, you must enroll in Medicare Part A and Part B. If you are eligible to enroll in Medicare Part A and Part B, benefits are provided by the Plan as if you are enrolled, regardless of whether you actually did enroll.

Medicare Part D Prescription Drug Plans for Retirees with Medicare

If you and/or your dependents are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D prescription drug benefits. It has been determined that the prescription drug coverage offered by the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund is "creditable." This means that the Plan's prescription drug coverage provided to Medicare eligible retirees is of equal or greater financial value as the Medicare Part D prescription drug coverage.

Because your existing coverage is "creditable coverage." You **do NOT need to enroll** in a Medicare prescription drug plan in order to avoid a late penalty under Medicare.

If you go 63 continuous days or longer without prescription drug coverage that is "creditable coverage," your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

You may enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. In addition, participants leaving employer/union sponsored coverage may also be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

If you enroll in a Medicare prescription drug plan, it is important to note that you and your dependents will lose your current prescription drug coverage under the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund and you will not be reimbursed for your Part D premiums.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please contact the Administration Office before you enroll in any Medicare Part D prescription drug plan.

Definitions

For the purpose of this Plan, the following definitions will apply:

Approved Treatment Facility

An approved treatment facility means an institution providing treatment for chronic chemical dependency abuse and operating under the direction and control of the Washington State Department of Social and Health Services or the equivalent department of another state. If the facility does not operate under the direction and control of the Department, then it must provide effective treatment for chemical dependency through a contact with the Department, be included in the Department's current list of approved public and private treatment facilities, and meet all applicable government standards.

Board of Trustees

Board of Trustees means the persons and their successors established by the Trust Agreement.

Continuous Period of Disability

Successive periods of hospital confinement and successive surgical procedures will be considered as occurring during one continuous period of disability, unless you or your dependent have completely recovered from the injury or illness causing the earlier confinement or surgical procedure, or

- In your case, unless you have returned to active work for at least one full day before the later confinement or procedure, or
- In the case of your dependent, unless the later confinement or procedure is due to an injury or illness entirely unrelated to the causes of the earlier confinement or procedure.

Cosmetic Surgery

Cosmetic surgery is surgery that is performed primarily to alter:

- Texture or configuration of the skin, or
- Configuration or relationship with contiguous structures of any feature of the human body when performed primarily for

psychological purposes and not to correct or materially improve a bodily function.

Covered Provider, Hospital or Facility

A covered provider, hospital or facility means the following, as defined in this section:

- Approved treatment facility (see page 113).
- Dentist (see below).
- Home health care agency (see page 117).
- Hospice care agency (see page 117).
- Hospital (see page 118)
- Occupational therapist (see page 119).
- Physical therapist (see page 119).
- Physician (see page 120).
- Rehabilitative hospital (see page 120).
- Residential treatment facility (see page 121).
- Skilled nursing facility (see page 122).

Custodial Care

Custodial care is services and supplies provided to a person in or out of an institution, primarily to assist the person in daily living activities, whether or not the person is disabled, and independent of whom recommends or provides it.

Dental Injury

A dental injury is an injury to sound natural teeth cause by an external force such as a blow or fall. It does not include tooth breakage while chewing.

Dentist

A legally qualified dentist or a physician authorized by license to perform the particular dental procedure rendered. The term Dentist shall also include a denturist who is performing services within the scope of the license.

Emergency Care

Emergency care means a sudden unexpected onset of an illness or accidental injury that is severe enough, from the view of a reasonably prudent person, to require immediate medical treatment to safeguard the patient's life or prevent serious impairment of bodily functions.

Employer

Employer means an employer that satisfies the requirement of the Trust Agreement and of the Board of Trustees and is obligated to make contributions to the Fund for the purpose of providing welfare benefits to employees.

Experimental or Investigational

Experimental or Investigational means a service or supply if any of the following apply:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished.
- The drug, device, or medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status.
- Federal law classifies the drug, device or medical treatment under an investigational program.
- Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below).
- Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety,

efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below).

For this section, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Exceptions: A service or supply will not be considered experimental or investigational if it is not part of an approved clinical trial. An approved clinical trial is one that meets the criteria in either Category 1 or 2 below:

- Category 1
  - The trial is a Phase III or Phase IV trial approved by the National institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center
  - The trial has been reviewed and approved by a qualified institutional review board
  - The facility and personnel have sufficient experience or training to provide the treatment or use the supplies
- Category 2
  - The trial is to treat a condition too rare to qualify for approval under Category 1
  - The trial has been reviewed and approved by a qualified institutional review board
  - The facility and personnel have sufficient experience or training to provide the treatment or use the supplies
  - The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy
  - There is no therapy that is clearly superior to the trial treatment

The plan's administrative agent investigates each claim for benefits that might include experimental or investigational treatment.

The administrator consults with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above.

Fund

Fund is defined by the Trust Agreement, and includes all money and property held by the Trustees, including contract rights and records of the Trustees.

Homebound

Homebound means that leaving home involves a considerable and taxing effort and the patient is unable to use public transportation without the assistance of another.

Home Health Care Agency

Home health care agency means a public or private agency or organization that administers and provides home health care and is either:

- A Medicare-certified home health care agency, or
- Certified as a home health care agency by the Washington State Department of Social and Health Services (or equivalent department of another state).

Home Health Care or Hospice Care Treatment Plan

A home health or hospice treatment plan is a program for continued care and treatment established in writing by the patient's attending physician.

Hospice Care Agency

Hospice care agency means a public or private agency or organization that administers and provides hospice care and is either:

- A Medicare-certified hospice agency, or

- Certified by the Washington State Department of Social and Health Services (or equivalent department of another state) as a hospice care agency.

Hospital

A hospital is an institution which meets each of the following requirements:

- It is primarily engaged in providing facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians.
- It continually provides 24-hour registered graduate nursing (RN) services.
- It is not, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

Illness

Illness means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a mental health disorder for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered mental health treatment. Illness does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational injury law or similar legislation.

Injury

Injury means physical harm sustained as the direct result of a non-occupational accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Medically Necessary

A medically necessary procedure is a service or supply that meets all of the following criteria:

- Is essential and appropriate for the diagnosis and/or treatment of illness or injury.
- Is professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating illness or injury.
- Is not primarily for the convenience of the patient or provider.
- When applied to an inpatient, cannot safely be provided to an outpatient.

Medically necessary procedures, services or supplies may be necessary in part only. The fact that a procedure, service, or supply may be furnished, prescribed, recommended, or approved by a physician does not make it medically necessary.

Month

The period of time beginning on the first day of any calendar month and ending on the last day of the same calendar month.

Necessary Service or Supply

A service or supply is considered necessary only if it is broadly accepted professionally as essential to the treatment of the illness or injury.

Occupational Therapist

An occupational therapist is a person who is duly licensed in the state where the services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified by the American Occupational Therapy Association.

Physical Therapist

A physical therapist is a person who is duly licensed in the state where the services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered physical therapist by the American Physical Therapy Association.

Also included is a physical therapy assistant who is practicing within the scope of their license.

Physician

A practitioner of the healing arts who practices within the scope of his or her license. For purposes of this Plan, a physician may be a medical doctor (MD) or an osteopathic physician (DO).

If the practitioner performs services covered under the Plan and within the scope of his or her license, a physician may also be a licensed: dentist (DDS), podiatrist (DPM), psychologist (PhD), optometrist, chiropractor, certified midwife, registered nurse, licensed practical nurse, or Religious Non-Medical Health Care Practitioner, registered naturopath, registered certified hypnotherapist, acupuncturist, registered dietician, certified nutritionist or a licensed mental health provider. Before you receive treatment from any practitioner other than an MD or DO, check with the Administration Office to find out if the expenses will be recognized as covered expenses.

Preferred Provider Organizations (PPO)

- Washington, Oregon, Idaho and Montana - First Choice Health is the PPO in these states
- Anchorage Borough - is limited to a preferred hospital, which is the Providence Alaska Medical Center.
- Alaska and all other states except Washington, Oregon, Idaho and Montana – Beech Street/Viant is the PPO.

PPO Allowed Amount

The fee negotiated by the PPO, if a service or a supply is provided by a PPO provider.

PPO Service Area

The PPO Service Area for hospitals consists of Washington State and the Anchorage Borough. The PPO Service Area for physicians and other providers consists of Washington State.

Rehabilitative Hospital

A rehabilitative hospital is an institution that:

- Is licensed.
- Provides facilities for the diagnosis and inpatient rehabilitative treatment of illness or injury with the objective of restoring physical function to the fullest extent possible. (Examples of conditions treated in a rehabilitative hospital are: amputations, spinal cord injuries, head injuries, paraplegia and quadriplegia, CVA, severe arthritis and paralysis.)
- Has facilities or a contractual agreement with another hospital in the area for emergency treatment, surgery, and any other diagnostic or therapeutic services that might be required during a confinement.
- Provides all normal infirmary level medical services required for the treatment of any illness or injury occurring during confinement.
- Has a staff of physicians specializing in physical medicine and rehabilitation directly involved in the treatment program, one of whom is present at all times during the treatment day.
- Is accredited as a medical inpatient rehabilitation hospital by the Joint Commission On Accreditation of The American Hospital Association and/or the Commission on Accreditation of Rehabilitation Facilities.
- Is not a place for rest, the aged, drug addicts or alcoholics, a chronic disease facility, a nursing home or sheltered workshop.
- Does not provide as its primary purpose custodial care, treatment of mental disorders, special education, vocational counseling, job training, or social adjustment services.

Residential Treatment Facility

A treatment facility that provides full-day and part-day programs to treat alcohol and drug dependence or mental conditions but that is not licensed to provide inpatient care. The center must be licensed or otherwise approved to provide this care by the state in which it is located.

Routine Physical Exam

A routine physical exam is a medical exam performed by a physician when there are no signs of illness or injury.

Skilled Nursing Facility

A skilled nursing facility is an institution (or distinct part thereof) which meets each of the following tests:

- It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons recovering from injury or illness, professional nursing services provided by a registered graduate nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered graduate nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its services are provided for compensation from its patients and under the full-time supervision of a physician or registered graduate nurse.
- It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse.
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

Sound Natural Teeth

Teeth which are:

- Wholly or properly restored.
- Without impairment or periodontal disease.
- Not in need of the treatment provided for reasons other than dental injury.

Speech Pathologist

A speech pathologist is a person who is duly licensed in the state where the services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the pathologist must be certified as a registered

speech pathologist by the American Speech and Hearing Association.

Totally Disabled or Total Disability

Totally disabled or total disability for the purposes of health benefits means, unless otherwise indicated:

- The individual is prevented because of injury or illness from engaging in his or her customary occupation and is performing no work of any kind for pay or profit; or
- The covered dependent is prevented because of injury or illness from engaging in substantially all of the normal activities of a person of like age and sex in good health.

This definition applies to the extension of benefits provided for a totally disabled person, as described on page 24 and 95.

Trust Agreement

Trust Agreement means the Trust Agreement establishing the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund and any modification, amendment, extension or renewal thereof.

Usual, Customary and Reasonable (UCR) Amounts

In determining the UCR Amounts made by a provider, the Plan takes into consideration all of the following:

- The usual fee which the provider of service most frequently charges to the majority of his patients for a similar service or medical procedure.
- The fees which fall within the customary range of fees charged in a locality by most providers of a similar training and experience for the performance of a similar service or medical procedure.
- Unusual circumstances or medical complications requiring additional time, skill and experience in connection with a particular service or medical procedure.

The Plan makes the final determination as to whether or not the fee is “usual, customary and reasonable.”

Filing a Claim

Willamette Dental has a separate claims process. Please contact Willamette for details.

Only claims incurred during periods of eligiblity will be processed. Your claim and all related bills must be submitted to the Administration Office within 90 days following the date expenses are incurred. (Claims received more than one year after the expenses have been incurred will be denied.)

Payment can be handled as follows:

- You may assign payment of benefits by signing the authorization on the claim form or by filling out one of the provider's own assignment forms. If you do assign your benefits, the payment is sent directly to the provider of service.
- You may pay the bill directly, in which case the benefit check will be made payable to you.
- All benefit checks other than those assigned will be mailed by the Administration Office to you.
- All benefit payments for expenses incurred at a PPO hospital or provider will always be mailed directly to the hospital or provider, as required under the PPO contract arrangement.

Be sure to save all bills for any items of covered expense and, in each case a record of the date the expense was incurred (not the date of the bill).

To receive prompt payment, file a claim as described below:

- Obtain a claim form from your local Union Office, Administration Office, VSP (for vision) or Express Scripts (for prescription drugs).
- Complete the Employee Statement section of the form, and sign your name on the line specified.
  - For doctor's services, attach an itemized copy of your doctor's bill or have your doctor complete his or her portion of the claim form.
  - For hospital services, attach an itemized copy of the hospital bill which lists all services and supplies received.

- For prescription drugs, be sure to attach itemized pharmacy receipts showing the date of purchase, name of the individual for whom the drugs were prescribed, the prescription number, name of drug prescribed and charge for each drug as well as the name of the doctor prescribing the drug.
- For mail order prescription drugs, see page 60.

- Keep separate records of medical expenses incurred for yourself and each of your dependents, since the deductible amounts, the maximums and other provisions apply separately to each individual.
- Forward the completed claim form along with itemized bills to the following addresses:

Medical and Dental Benefits
Operating Engineers Locals 302 and 612
P.O. Box 34684
Seattle, WA 98124-1684
(206) 441-7314 or (877) 441-1212

Non-Participating Pharmacy Prescription Drug Benefits
Express Scripts Inc.
Attention: Claims Department
P.O. Box 66773
St. Louis, MO 63116-6773

Non-VSP Member Vision Benefits
VSP
Out of Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105
(800) 877-7195

Weekly Disability, Life insurance and AD&D claim forms are available from your local Union Office or the Administration Office. Completed forms should be returned to the Administration Office.

If you are disabled and your insurance ends while you are disabled, you must contact the Administration Office to receive a

premium waiver claim form for life insurance. This form must be submitted within one year. See page 95 for more information on life insurance benefits related to disability.

Questions

If you have any questions regarding your claim, call the Administration Office at (206) 441-7314 or (877) 441-1212. Be sure to provide them with your identification number as listed on your ID card.

Processing of Claims

Claims that are properly filed will be processed in accordance with the following guidelines.

Health Claims

Claims for medical, dental, vision or prescription drug benefits will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension of time for making the determination is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Weekly Disability Claims

Claimants will be notified of a determination on a claim for weekly disability benefits within 45 days after receipt of the claim by the Plan. This period may be extended for up to 30 days (to a total of 75 days) if the Plan determines that an extension of time for making the determination is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the Plan determines that an additional extension of time for making the benefit determination is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be

extended by the Plan for an additional 30 days (to a total of 105) days.

If an extension is necessary due to the claimant's failure to submit information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Life Insurance and Accidental Death and Dismemberment Claims

A determination on a claim for life insurance or accidental death and dismemberment will be made within a reasonable period of time. If the Plan needs additional information to make a decision, the claimant will be notified as to what information must be submitted.

Notification of Benefit Denial

If a claim is denied or partly denied, you will be notified in writing and given an opportunity for review. The written denial will give:

- The specific reasons for the denial.
- Specific reference to pertinent Plan provisions on which the denial is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and explanation of why such material or information is necessary.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.

- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request.
- An explanation of the Plan's claim review procedure, including a statement of the claimant's right to bring a civil action under ERISA § 502(a).

Appeal to the Board of Trustees

Notice of Appeal

Any employee, retired employee or beneficiary (hereafter claimant) who applies for benefits under this Plan and is ruled ineligible by the Trustees (or by the Administration Office acting for the Trustees) or who believes he did not receive the full amount of benefits to which he is entitled or who is otherwise adversely affected by any action of the Trustees or the Administration Office, shall have the right to appeal the matter to the Board of Trustees, provided that he files a written notice of appeal within 180 days after receipt of the adverse decision, and provided further that the Trustees or their representatives shall not consider applications for appeal which are submitted without an authorization to release health care information relevant to the denied claim.

The appeal shall be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees which has been allocated the authority for making a final decision in connection with the appeal.

Scheduling of Appeal

The Trustees shall review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within thirty (30) days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustee's receipt of the notice of appeal, unless there are special circumstances requiring a further

extension of time, in which case a benefit determination shall be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustee's receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for a hearing on the appeal, then prior to the commencement of the extension, the Plan shall notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

Appeal Procedures

The claimant is generally entitled to present his position and any evidence in support thereof, at an appeal hearing. The claimant may be represented by an attorney or by any other representative of his choosing at his own expense.

The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to his or her claim for benefits.

The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is

the subject of the appeal, nor the subordinate of any such individual.

Decision After Appeal Hearing

The Trustees will issue a written decision on review of a claim as soon as possible, but not later than 5 days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits.
- A statement of the claimant's right to bring a civil action under ERISA § 502(a).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.

Review of Trustees' Decision

The Plan does not provide for any voluntary alternative dispute resolution procedures. If a claimant remains dissatisfied with the Plan's determination after exhausting the claim appeal procedures, the claimant may bring a civil action under ERISA § 502(a). The question on review of the Trustees' determination will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence.

Sole and Exclusive Procedures

The Plan's appeal procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. The appeal procedures must be exhausted prior to filing a legal action.

HIPAA Privacy Disclosures and Certification

Protected Health Information

"Protected Health Information" (PHI) has the same meaning as in 45 CFR § 164.501. This section will be administered by the Trustees in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR Part 164.

Request, Use and Disclosure of PHI by Trustees

The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following administrative functions:

- To make or obtain payment for care received by covered persons.
- To facilitate treatment which involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to covered persons.
- In connection with judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other plan administrative functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.

- For authorized activities by health oversight agencies, including audits, civil, administrative or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to a covered person's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
- For specified government functions under 45 CFR Part 164.
- To the extent necessary to comply with laws related to workers compensation or similar programs.

Trustee Certification

The Plan will disclose PHI to a Trustee based upon the following certification, which was agreed to by the Trustees, as Plan sponsor:

Prohibition on Unauthorized Use or Disclosure of PHI The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this Article or required by law.

Subcontractors and Agents The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.

Permitted Purposes The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.

Reporting The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by this Article of which they become aware.

Access to PHI by Individuals The Trustees will make PHI available to the Plan to permit individuals to inspect and copy their PHI contained in a designated record set pursuant to 45 CFR § 164.524.

Amendment of PHI

The Trustees will make an individual's PHI available to permit the individual to amend or correct PHI contained in a designated record set that is inaccurate or incomplete and the Trustees will incorporate the amendments pursuant to 45 CFR § 164.526.

Accounting of PHI The Trustees will make an individual's PHI available to permit the Plan to provide an accounting of disclosures pursuant to 45 CFR § 164.528.

Disclosure to Government Agencies The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services (DHHS) or its designee for the purpose of determining the Plan's compliance with HIPAA.

Return or Destruction of Health Information When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests

The Trustees will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Adequate Separation

The Trustees represent that adequate separation exists between the Plan and the Trustees so that PHI will be used only for Plan administration. Each Trustee will certify as to the employees, or other persons under his control, that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

Notice of Privacy Practices

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

Pursuant to regulations issued by the federal government, the Fund is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As required by law, the Fund has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

Protected Health Information

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the

care you receive. For example, the Fund may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Fund may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating physician to another treating physician for the purpose of obtaining x-rays.

To Conduct Health Care Operations. The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations include such activities as: contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Fund (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings. If required or permitted by law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Fund will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes. The Fund will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted

or required by law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

To Your Personal Representative. The Fund may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Fund may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Fund may disclose your health information to its Business Associates, which are entities or individuals not employed by the Fund, but which perform functions for the Fund involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Fund's Business

Associates are required to safeguard the confidentiality of your health information.

For Workers' Compensation. The Fund may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

For Disclosure to the Plan Trustees. The Fund may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the plan. The Fund may also disclose information to the Trustees regarding whether you are participating or enrolled in the plan.

Authorization to Use or Disclose Health Information

Other than as stated above, the Fund will not disclose your health information other than with your written authorization. Authorization forms are available from the Privacy Contact Person, listed below. If you have authorized the Fund to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Fund maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request unless the disclosure is to another health plan for the purposes of carrying out payment or health care operations and your health care provider has been paid out-of-pocket in full. If you wish to request restrictions, please make the request in writing to the Fund's Privacy Contact Person listed below.

Right to Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Fund's Privacy Contact Person, listed below. The Fund will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information in paper or electronic format, if available. You also have the right to have the Fund transmit a copy of your health information to an entity or person of your choice. These rights, however, do not extend to psychotherapy notes or information compiled in anticipation of civil, criminal or administrative proceedings. The Fund may deny your request in certain situations subject to your right to request review of the denial. A request to inspect, copy or transmit records containing your health information must be made in writing to the Privacy Contact Person, listed below. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Contact Person, listed below. The Fund may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting be amended is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

If the Fund denies a request for amendment, you may write a statement of disagreement. The Fund may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Fund's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Fund. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003 when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person, listed below. You will also be able to obtain a copy of the current version of the Fund's Notice at its web site, www.wpas-inc.com.

Privacy Contact Person. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Fund has also designated a Privacy Official, listed below.

Privacy Contact Person

Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: (206) 441-7314
Toll Free: (877) 441-1212
Fax No: (206) 441-9110

Privacy Official

C. Gilbert Lynn
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: (206) 441-7574
Toll Free: (800) 331-6158
Fax No: (206) 441-9110

Duties of the Fund

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within

60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Privacy Contact Person identified above. The Fund encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

General Provisions

Right to Amend

In order that the Fund may carry out its obligation to maintain within the limits of its resources, a program dedicated to providing the maximum possible benefits for all employees, the Board of Trustees reserves the right, in its sole discretion, and at any time and from time to time, but upon a nondiscriminatory basis, to modify, add, reduce, or eliminate, in whole or in part, any or all provisions of the Plan including, but not limited to, any benefit, benefit structure, condition for or method of payment, and rate of contribution whether applicable to all or a category of individuals.

Right to Terminate

The Board of Trustees reserves the right, and at any time, to terminate the Plan, even though such termination may affect the claims which have already accrued. Termination of the Plan is subject to the applicable laws.

Construction of Plan

The Trustees have the exclusive right to construe the provisions of the Plan and to determine any and all questions arising thereunder or in connection with the administration thereof, including the right to remedy possible ambiguities, inconsistencies, or omissions, and any such construction or determination by the Trustees made in good faith shall be conclusive on all persons affected thereby.

Scope of Rights and Benefits

No employee, retiree or dependent shall have any rights or claims to benefits under the Plan, except in accordance with the provisions of the Plan. Neither the Employers, any signatory association, the Union, nor any Trustee shall be liable for the failure or omission for any reason of the Fund to pay any benefits under the Plan.

Right to Receive and Release Necessary Information

As a condition to receiving benefits under this Plan, the covered person agrees to:

- Provide, on request, information necessary to review and process a claim for benefits under the Plan.
- Authorize any physician, hospital, or other provider of services or party having knowledge to disclose to the Plan any medical information it requests.
- Authorize the Plan to examine any medical records of the patient at the offices of any physician, hospital or other provider of services for the purpose of verifying services or supplies.
- Waive any claim of privilege or confidentiality that might be asserted in any action by or against the Plan or the party furnishing such information.

Right of Recovery

Payment of a claim due to error or incomplete or inaccurate information does not constitute a waiver by the Plan of any provisions, limitations or exclusions of this Plan, or a waiver of the Plan's right to recover such payment when the error is discovered or when complete or accurate information is received. The Plan may request refunds from providers or may offset any future benefit payments, including those of family members, by denying such payments until the amount of benefits provided in error has been repaid.

Protection of Trust Fund, Contributions and Benefits

No part of the Fund (including the contributions) or the benefits payable under the Plan shall be subject in any manner by an employee, dependent or other beneficiary to anticipation, alienation, sale, transfer, assignment, encumbrance, or charge, and any such attempt shall be null and void, provided that the Trustees may recognize assignment of benefits from an employee,

dependent or other beneficiary to a doctor, hospital, or other person or institution that has treated or cared for, or provided services or goods to the employee, dependent, or other beneficiary, and provided further that the Trustees shall recognize the assignment of benefits, or an alternate payee's right to receive benefits, under a Qualified Medical Child Support Order, and the assignment of rights under a state plan for medical assistance approved under Title XIX of the Social Security Act. No part of the Fund (including contributions, or the benefits payable under the Plan) shall be liable for the debts of an employee, dependent or beneficiary, nor be subject in any manner to garnishment, attachment, lien, charge or any other legal process brought by any person against an employee, dependent or other beneficiary and any attempt shall be null and void.

Correlation with State Plans

Payment of benefits by the Plan will be made in accordance with any assignment of rights made by or on behalf of the employee or dependent as required by a State plan. If payment has been made under a State plan, and the Plan has legal liability to make payment, benefits by the Plan shall be paid in accordance with any applicable State law which provides that the State has acquired the rights of the employee or dependent to such payment.

In determining eligibility or providing benefits, the Plan shall not take into account that an employee or dependent is eligible for or provided medical assistance under a State plan.

For purposes of this Section, State plan means a plan for medial assistance approved under Title XIX of the Social Security Act. This Section shall be administered pursuant to ERISA § 609(b).

Special Disclosure Information

Name of Plan

This Plan is known as Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Plan. The trust fund through which the Plan is funded is the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund.

Board of Trustees - Plan Administrator

The Name and Address of the Joint Board of Trustees is:

Board of Trustees Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund
c/o Welfare & Pension Administration Service, Inc.
2815 Second Avenue, Suite 300
P.O. Box 34203
Seattle, WA 98124
Phone: (206) 441-7314 (877) 441-1212

Identification Number and Plan Number

The employer identification number assigned to the Plan Sponsor by the Internal Revenue Service is EIN 91-6028570. Plan Number 501.

Type of Plan

This Plan can be described as a welfare plan providing the following benefits: medical, prescription drug, mail order prescription drug, dental, vision, weekly disability, life and accidental death and dismemberment.

Type of Administration

This Plan is administered by a joint labor-management Board of Trustees with the assistance of a contract administrative organization.

Agent for Service of Legal Process

The Administrative Manager at the Administrator's Office is designated as agent for purposes of accepting service of legal process on behalf of the Plan. Each member of the Joint Board of Trustees is also authorized to accept service of legal process on behalf of the Plan.

The names, titles, and addresses of the individuals currently serving on the Joint Board of Trustees are:

Employer Trustees

Richard Dickson
William Dickson Co.
3315 S Pine Street
Tacoma, WA 98409-5718
Phone: (253) 472-4489

Brett Ferullo
Northwest Construction, Inc.
1408 140th Place NE, Suite 101
Bellevue, WA 98007-3962
Phone: (425) 453-8380

Mike Miller
Granite Construction Company
11301 Lang Street
Anchorage, AK 99515-3006
Phone: (907) 344-2593

Doug Peterson
AGC of Washington
1200 Westlake Avenue N, Suite 301
Seattle, WA 98109-3528
Phone: (206) 284-0061

Mike Tucci
Tucci and Sons, Inc.
4224 Waller Road East
Tacoma, WA 98443-1623
Phone: (253) 922-6676

Union Trustees

Malcolm Auble
Operating Engineers Local 302
18701 120th Avenue NE
Bothell, WA 98011-9514
Phone: (425) 806-0302

Ernest Evans
Operating Engineers Local 612
1555 Fawcett Avenue S
Tacoma, WA 98402-1803
Phone: (253) 572-9612

Michael Sean Jeffries
Operating Engineers Local 302
403 S. Water Street
Ellensburg, WA 98926-3620
Phone: (509) 933-3020

Daren Konopaski
Operating Engineers Local 302
18701 120th Avenue NE
Bothell, WA 98011-9514
Phone: (425) 806-0302

Robert Peterson
Operating Engineers Local 302
9309 Glacier Hwy Bldg A, Suite 102 B
Juneau, AK 99801-9300
Phone: (907) 586-3850

Source of Contributions

The Plan is funded through employer contributions, the amount of which is determined through collective bargaining between participating employers and labor organizations, and which is specified in the underlying collective bargaining agreements. Self-payments are also permitted, as outlined in the booklet, for retiree coverage and to continue employee and dependent coverage.

Description of Collective Bargaining Agreements

The Plan is maintained pursuant to many separate collective bargaining agreements between participating employers and participating labor organizations. A copy of such agreements may be obtained by participants and beneficiaries at the Administration Office, and at Local Union Offices, upon 10 days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. You may wish to inquire as to the amount of the charges before requesting copies.

Entities Used for Accumulation of Assets and Payment of Benefits

The employer contributions and employee and retiree self-payments are received and held by the Board of Trustees in trust pending payment of insurance premiums and/or claims and administrative expenses. Life and Accidental Death and Dismemberment benefits are insured by United of Omaha. Medical, Prescription Drug, Dental, Vision and Weekly Disability benefits are funded by the Plan.

The following are the names and addresses of issuers under contract with the Plan:

United of Omaha
1601 Fifth Avenue, Suite 2201
Seattle, WA 98101

Provides fully insured life insurance and accidental death and dismemberment benefits and administers those benefits.

Group Health Cooperative
P.O. Box 34750
Seattle, WA 98124

Provides services to retirees currently enrolled in the HMO alternative.

Washington Dental Service
P.O. Box 75983
Seattle, WA 98175-0983

Provides optional dental services to retirees.

Willamette Dental of Washington, Inc.
6950 N.W. Campus Way
Hillsboro, OR 97124

Provides dental services to participants electing this alternative.

First Choice Health Network
600 University Street, Suite 1400
Seattle, WA 98101-3124

Administers the PPO network and provides utilization review and case management services.

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121

Provides pharmacy network management and mail order services.

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Provides vision network and vision claims administration.

Providence Alaska Medical Center
3200 Providence Drive
Anchorage, AK 99508

Provides PPO hospital services in the Anchorage Borough.

Beech Street/Viant
25500 Commercentre Drive
Lake Forest, CA 92620

Administers the PPO network in Alaska and all other states except Washington, Oregon, Idaho and Montana.

Eligibility and Benefits

You become eligible for benefits of this Plan in accordance with the eligibility rules described beginning on page 8. Retiree eligibility rules are described beginning on page 98.

Termination of Eligibility

For medical, prescription drug, mail order prescription drug, dental, vision, weekly disability and life, coverage will terminate on the earliest of the following days:

- On the last day of the month following the month in which you fail to meet the eligibility requirements set by the Plan.
- On the last day of the month after you enter the Armed Services of the United States, except for periods of Reservist Training unless you elect to run-out your eligibility.
- In case of dependents, on the last day of the month that the dependent ceases to be a dependent within the definition given.
- Upon termination of the Plan.
- On the last day of the month in which you fail to make any required self-contributions.

Circumstances Which May Result in Ineligibility or Denial of Benefits

The circumstances which may result in disqualification, ineligibility, denial, or loss of benefits appear throughout this booklet.

The Future of the Plan and Trust Fund

The Board of Trustees has the authority to terminate the Trust Fund. The Trust Fund will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust Fund.

In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

End of the Plan Year

The Plan year end is March 31.

Your ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to you as a participant of this Plan. ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 Group Health Plan Coverage

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

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

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees. If you are dissatisfied with the determination of the Trustees, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, contact the Department of Labor at one of the following addresses:

Employee Benefits Security Administration
U.S. Department of Labor
Seattle District Office
1111 Third Avenue, Suite 860
Seattle, WA 98101-3212
Phone: 206-553-4244

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Amendment and Termination

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all participants, the Board of Trustees expressly reserves the right, in their sole discretion at any time and from time to time, but upon a nondiscriminatory basis, to:

- Terminate or amend the Plan;
- Alter or postpone the method of payment of any benefit;
- Construe the provisions of the Plan and determine any and all questions pertaining to administration, eligibility, and benefit entitlement, including the right to remedy possible ambiguities and inconsistencies or omissions. Any construction or determination by the Trustees made in good faith shall be conclusive on all persons affected thereby;
- Reduce or eliminate any plan subsidy; and
- Amend or rescind any other provision of this Plan.

The Fund may be terminated by the employers and union by an instrument in writing executed by mutual consent at any time, subject, however, to all of the requirements and procedures for plan termination under ERISA and all regulations issued thereunder. Upon voluntary termination of the Fund, all assets remaining in the Fund after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets have been depleted.

Benefits Not Guaranteed

None of the benefits provided by this Plan are insured by any contract of insurance, except the life insurance and accidental death and dismemberment benefits, and certain dental benefits. There is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amount in the Fund collected and available for such purpose. No employee or dependent shall have any accrued or vested rights to benefits under this Plan.

Information Available to You

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the administrative office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Plan Administrator will state the charge for specific documents on request so that you can find out the cost before ordering.

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Administered by:

WELFARE & PENSION ADMINISTRATION SERVICE, INC.

2815 Second Avenue, Suite 300

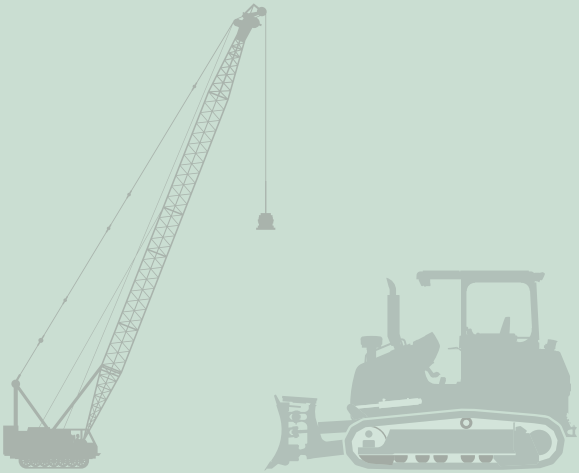
P.O. Box 34203

Seattle, Washington 98124-1203

(206) 441-7314

(877) 441-1212

www.engineerstrust.com



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