Mid Central Operating Engineers Health and Welfare Fund

Summary Plan Description/Plan Document

2015 Edition

Mid Central Operating Engineers Health and Welfare Fund

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This booklet is the Summary Plan Description (SPD/Plan Document) of the Mid Central Operating Engineers Health and Welfare Fund for active and Retired Employees and their Dependents and is in effect as of January 1, 2015. The Trustees reserve the right to amend, modify, or terminate the Plan at any time. This SPD/Plan Document booklet replaces and supersedes the prior SPD/Plan Document. If the Plan is amended or modified, you will receive written notice of such change.

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

Questions regarding the protections that apply and that do not apply to a grandfathered health plan and what might cause a plan to lose grandfathered health plan status can be directed to the Plan Administrator at 812-232-4384. 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.

Table of Contents

Introduction 1

Definitions 2

Eligibility Provisions – Active Plan 12
- Initial Eligibility 12
- Continued Eligibility 12
- Self-Payment Program 13
- Dependent Eligibility 13
- Special Enrollment 14
- When Eligibility Ends 14
- Reinstatement of Eligibility 15
- Changes in Eligibility Rules and Benefits 15
- When Coverage Ends 15
- COBRA Continuation Coverage 16

Eligibility Provisions – Retiree Plan 21
- Retiree Coverage 21
- Initial Eligibility 22
- Credited Service 22
- Dependent Eligibility 22
- Self-Payments for Retiree Coverage 22
- Self-Payment Points Program 23
- Retiree In-and-Out Program 26
- Continued Eligibility 28
- When Eligibility Ends 28
- Reinstatement of Eligibility 28

Family Status Changes 29
- Notify the Welfare Fund 29
- Adding a Dependent 29
- If Your Dependent Loses Eligibility for Coverage 29
- In the Event of Divorce or Court Ordered Legal Separation 29
- Qualified Medical Child Support Order (QMCSO) 29
- If You Are Employed with the International Union 30
- If You Are Unemployed 30
- If You Take Leave under the Family and Medical Leave Act (FMLA) 30
- If You Enter Active Military Service 31
- In the Event You Become Disabled 32
- In the Event of Your Dependent's Death 32
- In the Event of Your Death 33

Schedule of Benefits 34
- Active Plan 34
- Retiree Plan for Non-Medicare Eligible Participants 36
- Retiree Plan for Medicare-Eligible Participants 38

Claim Filing and Appeal Information 39
- Filing Claim Forms 39
- Claim Decisions and Benefit Payment 40
- If a Claim is Denied 41
- Appealing a Denied Claim 42
- Appeal Decisions 42
- Medical Judgments 43
- Timely Handling 43
- No Predetermination of Claims 43
- Authorized Representative 43

Sole Authority on Benefits 44
Benefit Payments 44
Claims and Appeals for Prescription Drug Benefits 45

Medical Benefits For Active Plan Participants and Non-Medicare Eligible Retiree Plan Participants 47
How Medical Benefits Work 47
Covered Medical Benefit Expenses 48
Expenses Not Covered Under Medical Benefits 51

Prescription Drug Coverage For All Plan Participants 55
Brand Name Prescription Drug Annual Deductible 55
Generic and Brand Name Medications 55
Prescriptions that Require Pre-Approval 56
Retail Pharmacy Program 56
Maintenance Drugs through Maintenance Choice Program at Retail or Mail Order Program 57
Covered Prescription Drug Benefit Expenses 57
Expenses Not Covered Under Prescription Drug Benefits 57

Health Reimbursement Arrangement (HRA) 58
Funding of the HRA 58
Eligibility and Coverage 58
Benefits and Reimbursement 58
Termination of Coverage 59
Medical Care Expenses Exclusions 60
Establishment of Account 61
Reimbursement Procedure 61

In the Event of Disability or Death 62
Injury and Illness Weekly Benefit For Active Employees Only 62
Death Benefits For Employees and Retired Employees 62
Dependent Death Benefits For Dependents of Active and Retired Employees 63
Accidental Death and Dismemberment (AD&D) Benefits For Active Employees Only 63
Designating Your Beneficiary 64

General Plan Information 65
Coordination of Benefits 65
Restitution and Subrogation 67
Privacy Policy 70

Plan Information 73

Your ERISA Rights 76

Important Contact Information 78
Other Important Contact Numbers 78

Introduction

The Mid Central Operating Engineers Health and Welfare Fund provides health care coverage to you and your eligible Dependents. The Plan is periodically reviewed to ensure that benefits are being provided to meet your needs while still maintaining a financially stable Fund.

This Summary Plan Description (SPD) describes the benefits available through the Mid Central Operating Engineers Health and Welfare Fund as of January 1, 2015. The Plan provides:

- Medical Benefits, including mental health and substance abuse benefits;
- Prescription Drug Benefits;
- Injury and Illness Weekly Benefits (for active Employees only);
- Death Benefits;
- Accidental Death and Dismemberment Benefits (for active Employees only); and
- Health Reimbursement Arrangement (HRA) benefits.

This SPD is designed to show you how the Mid Central Operating Engineers Health and Welfare Fund fits into the different stages of your life. For ease of reference, *Important Contact Information* is listed on page 78.

You may be eligible for benefits from the Health and Welfare Fund if you work (or worked) for an Employer under a collective bargaining agreement or other agreement requiring payment of contributions on your behalf to the Health and Welfare Fund (including contributions received on your behalf through reciprocity agreements with other welfare funds).

Fund benefits are available to:

- **Active Employees:** You and your Dependents may be eligible for benefits if you are an active Employee or are making Self-Payments for Plan coverage.
- **Disabled Employees:** You and your Dependents may be eligible for benefits if you are a Disabled Employee making Self-Payments for Plan coverage. Disabled coverage is available for Medicare-eligible and non-Medicare eligible Participants.
- **Retired Employees:** You and your Dependents may be eligible for benefits if you are a Retired Employee making Self-Payments for Plan coverage. Retiree coverage is available for Medicare-eligible and non-Medicare eligible Participants.

We hope you find this information helpful. Please take some time to review this booklet. If you are married, share the information in this booklet with your Spouse. If you have any questions about the benefits described in this booklet, contact:

- Welfare Fund at (812) 232-4384;
- Bookkeeping at (877) 299-7099 (toll-free); and
- Claim Department at (877) 299-3699 (toll-free).

Definitions

Throughout this Summary Plan Description/Plan Document, many words are used that have a specific meaning when applied to Plan coverage. When you come across these terms while reading this Summary Plan Description/Plan Document, please refer to the definitions in this section to help you understand some of the limitations or special conditions that may apply to benefits. All definitions have been arranged in alphabetical order and are initially capitalized when used in the Summary Plan Description/Plan Document.

Active Plan

Plan under which an Employee and Dependents are covered for benefits.

Allowable Charge

Covered charges that are:

- Medically Necessary for treatment of an Injury or Illness; and
- Reasonable and customary, as determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned, as provided by the consulting firm of Context.

Association

An association of Employers who are parties to the Trust Agreement that funds this Plan.

Beneficiary

A person designated by an Employee or by the terms of the Plan established pursuant to the Trust Agreement who is or may become entitled to a benefit under this Plan. For Plan purposes, a "person" refers to a human being (i.e., natural person), not a partnership, association, corporation, or other entity.

Chiropractic Services

Treatments and services that detect and correct, by manual or mechanical means, the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column.

Contribution Period

The following periods:

- November through February;
- March through June; and
- July through October.

Copayments

A set dollar amount a person is responsible for paying when certain services and supplies are incurred.

Coinsurance

You and the Fund share the cost for most services. Coinsurance is the percentage of an Allowable Charge that you pay.

Cosmetic

Any surgical procedure performed primarily to:

- Improve physical appearance or change or restore bodily form without materially correcting a bodily malfunction; or
- Prevent or treat a Mental or Nervous Disorder through a change in bodily form.

Credited Hours

Hours of work performed for a Participating Employer for which:

- Contributions are made in accordance with a collective bargaining agreement or other Welfare Fund agreements; or
- The Employee provides check stubs or other documentation approved by the Trustees documenting that contributions were required to be made on their behalf.

Credited Service

Years of service in the Welfare Fund only (see page 22 for a description of how this is computed).

Custodial Care

Services or supplies, regardless of where or by whom they are provided, that:

- A person without medical skills or background could provide or be trained to provide;
- Are provided mainly to help the individual with daily living activities, including, but not limited to:
  - Walking, getting in and/or out of bed, exercising, and moving the individual;
  - Bathing, using the toilet, administering enemas, dressing, and assisting with any other physical or oral hygiene needs;
  - Assistance with eating by utensil, tube, or gastrostomy;
  - Homemaking, such as preparation of meals or special diets, and house cleaning;
  - Acting as a companion or sitter; or
  - Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications;
- Provide a protective environment;
- Are part of a maintenance treatment plan or not part of an active treatment plan intended to or reasonably expected to improve Injury, Illness, or functional ability; or
- Are provided for convenience or because home arrangements are not appropriate or adequate.

Dependent

Any one of the following categories of individuals:

- Employee's Spouse;
- Employee's child who is the natural child, adopted child, child placed with the Employee for adoption, or stepchild. Coverage for a Dependent child will end on his/her 26th birthday. Beginning August 1, 2015, coverage for a Dependent child will continue through the end of the month in which the child has his/her 26th birthday;
- Child for whom the Plan is required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO);
- Employee's unmarried child who is 26 years of age or older and who is permanently and totally disabled due to physical handicap or disability. The child must have become physically or mentally incapable of self-support before reaching age 26. The Employee must provide proof of the child's incapacity at least 120 days before the child would otherwise cease to be eligible for benefits and periodically thereafter, as required by the Trustees;
  - The child must be dependent on the Employee for more than one-half of the child's support during the calendar year, and maintain a principal residence with the Employee for more than one-half of the calendar year. If the child does not maintain a principal residence with the Employee, the child will still be a Dependent child, provided that the:
    - Child's parents are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or living apart at all times during the last six months of the calendar year;
    - Child's parents provide over one-half of the child's support;
    - Child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
    - Child is not the "qualifying child" of any other person during the calendar year as defined in Internal Revenue Code Section 152(c).

For Coordination of Benefit purposes, if a Participant is covered as both a Dependent and an Employee under the Plan, benefits will be paid by the Plan as primary in the Employee's file and as secondary under the file where the Employee is a Dependent.

Developmental Care

Services or supplies, regardless of where or by whom they are provided, that are:

- Provided to a Participant who has not previously reached the level of development expected for his or her age in the following areas of major life activity:
  - Intellectual;
  - Physical;
  - Receptive and expressive language;
  - Learning;
  - Mobility;
  - Self-direction;
  - Capacity for independent living; or
  - Economic self-sufficiency;
- Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Illness); or
- Educational in nature.

Disabled Employee

An Employee who has been determined by Social Security to be disabled.

Durable Medical Equipment

Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness; and
- Is not disposable or non-durable.

Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, electric hospital beds (with safety rails), electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Eligibility Period

The following periods:

- August 1 to November 30;
- December 1 to March 31; or
- April 1 to July 31.

Emergency

A severe condition that:

- Results from symptoms that occur suddenly and unexpectedly; and
- Requires immediate Physician's care to prevent death or serious impairment of health; or
- Poses an imminent serious threat to the Participant or others.

Employee

Any one of the following categories of individuals:

- An employee represented by the Union and working for an Employer, and with respect to whose employment an Employer is required to make contributions into the Trust Fund;

- An employee of the Union who has been proposed for benefits under the Trust Fund by the Union and who has been accepted by the Trustees and for whom the Union agrees, in writing, to contribute to the Trust Fund at the rate fixed for contributions for other Employers;
- An employee of an Employer on whose behalf the Employer is required to make payments or contributions to the Trust Fund at a rate fixed for contributions for other Employers;
- An owner/operator who has been proposed for benefits under the Trust Fund by the Union and who has been accepted by the Board of Trustees in accordance with the rules adopted by the Board of Trustees;
- A new employee currently covered by a new Employer's group health coverage who has been proposed for benefits under the Trust Fund and who has been accepted by the Board of Trustees in accordance with rules adopted by the Board of Trustees;
- Employees of this Trust Fund who are not employed by an Employer but who have been proposed and accepted for benefits by the Trustees (these individuals include Employees of the Trust Fund and Trust Funds affiliated with this Union since the Trustees are considered to be an Employer and will provide benefits for these Employees out of the Trust Fund, on the same basis as for other Employees);
- A person, represented by or under the jurisdiction of the Union, who is employed by a governmental unit or agency, and on whose behalf payment of contributions are made at the times and at the rate of payment equal to that paid by an Employer in accordance with a written agreement, ordinance, or resolution, or a person who had been so employed and who is temporarily making Self-Payments under rules established by the Trustees; and
- Non-bargaining unit Employees of an Employer who have been proposed for benefits under the Trust Fund by such Employer and who have been accepted by the Board of Trustees in accordance with the rules adopted by the Board of Trustees.

Employee Point Total

A total based on an Employee's age and total Credited Service under the Plan at retirement (see example on page 23).

Employer

Any one of the following organizations:

- An employer that is a member of, or is represented in collective bargaining by, the Association and that is bound by a collective bargaining agreement with the Union providing for payments to the Trust Fund with respect to Employees represented by the Union;
- An employer that is not a member of, nor represented in collective bargaining by, the Association, but that has duly executed, or is bound by, a collective bargaining agreement with the Union providing for payments to the Trust Fund with respect to Employees represented by the Union;
- The Union, which, for the purpose of making the required contributions to the Trust Fund, is considered as the Employer of the Employees of the Union for whom the Union contributes to the Trust Fund;
- An employer that does not meet the requirements of the definition of Employer as stated above, but that is required to make payments or contributions to the Trust Fund:
  - By any law or ordinance applicable to the State of Indiana or to any political subdivision or municipal corporation thereof; or
  - Pursuant to any written agreement entered into by the Employer with the State or any political subdivision or municipal corporation thereof; and
- The Board of Trustees of the Trust Fund and Trust Funds affiliated with the Union, which is considered as an Employer of the Employees of the Trust Funds, for whom those Funds contribute to the Trust.

An Employer, as described in this Section, by the making of contributions to the Trust Fund pursuant to collective bargaining or other written agreements, is considered to have accepted and be bound by the Trust Agreement.

Experimental or Investigational

A service or supply that the Board of Trustees determines meets one or more of the following criteria:

- A drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and that has not been so approved for marketing at the time the drug or device is furnished;
- A drug, device, treatment, or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's institutional review board or other body servicing a similar function;
- A drug, device, treatment, or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's institutional review board or other body serving a similar function;
- A drug, device, treatment, or procedure that Reliable Evidence shows is the subject of on-going phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis; or
- A drug, device, treatment, or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis.

For this definition, Reliable Evidence means only:

- Published reports and articles in the 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, treatment, or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment, or procedure.

Relating to Reliable Evidence, Authoritative means that prevailing opinion within the appropriate specialty of the United States medical profession is that the medical and scientific literature is entitled to credit and acceptance, as is, for example, *The New England Journal of Medicine.*

Fund, Trust Fund, or Trust

The entire trust estate of the Mid Central Operating Engineers Health and Welfare Fund, as it may, from time to time be constituted, including, Employer contributions, investments, and the income from any and all investments, , and any and all other assets, property, or policies of insurance.

Health Reimbursement Arrangement (HRA)

An account, funded by Employer Contributions, established to allow you to pay for healthcare expenses that are not paid by the Plan through a tax-free reimbursement. The expenses must be considered medical expenses under IRS Code Section 213.

Home Health Care

Services and supplies that are:

- Ordered in writing by the Participant's Physician; and
- Provided in the Participant's home by a Home Health Care Agency.

The Home Health Care must replace a needed Hospital stay or a needed stay in a Skilled Nursing Facility. In addition, it must be for the care or treatment of an Ill or Injured Participant. Home Health Care services and supplies include:

- Part-time or intermittent home nursing care provided by a Registered Nurse;
- Physical Therapy;
- Medical supplies, drugs, and medications prescribed by a Physician; and
- Lab services, but only to the extent that they would have been covered in a Hospital.

Home Health Care Agency

A public or private agency that:

- Specializes in giving nursing or therapeutic services in the home;
- Is licensed as a home health care agency; and
- Operates within the scope of its license.

Each visit from a Home Health Care Agency of four hours or less is considered a single visit.

Hospice

A facility, or part of one, that:

- Provides inpatient care for terminally ill persons who have been diagnosed by a Physician as having a life expectancy of six months or less;
- Is licensed as a hospice and is operating within the scope of such license;
- Maintains medical records on each patient and provides an ongoing quality assurance program;
- Has full-time supervision by at least one Physician; and
- Provides 24-hour nursing service by Registered Nurses.

Hospital

A licensed institution that:

- Is accredited by the Joint Commission;
- Provides inpatient medical care and treatment for Ill and Injured persons; and
- Provides all of the following:
  - Facilities on its premises for diagnosis of Injury and Illness;
  - Full-time supervision by at least one Physician;
  - 24-hour nursing service by Registered Nurses;
  - Surgery or formal arrangements for available surgical facilities; and
  - Therapeutic care of patients who are convalescing from Injury or Illness.

An institution that is used primarily as a rest home, nursing home, convalescent home, place for the aged, halfway house, board and care facility or that primarily affords educational, transitional, rehabilitative, or Custodial Care is excluded.

Illness

Any bodily sickness or disease, including any congenital abnormality of a newborn child and pregnancy, as diagnosed by a Physician and as compared to the Participant's previous condition.

Injury

Any damage to a body part resulting from trauma from an external source.

International Union

The International Union of Operating Engineers.

Lifetime

In reference to Plan, benefit maximums and limitations, while a Participant is covered under the Mid Central Operating Engineers Health and Welfare Fund. Under no circumstances does Lifetime mean during the Participant's Lifetime.

Medically Necessary or Medical Necessity

A service or supply that is:

- Provided by or under the direction of a Physician or a duly licensed health care practitioner who is authorized to provide or prescribe;
- Determined by the Board of Trustees or its designee to be necessary in terms of generally accepted medical standards on a national basis;
- Determined to provide for the diagnosis for the direct treatment of an Injury or Illness; and
- Determined by the Board of Trustees or its designee to meet all the following requirements:
  - It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury;
  - It is not provided solely for the convenience of the Participant, Physician, Hospital, health care provider, or health care facility; and
  - It is safe and effective for the Illness or Injury for which it is used; and
- The most appropriate supply or level of service that can be provided on a cost effective basis (including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical and other types of care); and

The fact that a Physician or a duly licensed health care practitioner may prescribe, order, recommend, or approve a service or supply does not automatically mean the service or supply is Medically Necessary and covered by the Plan. The determination of whether a service or supply is Medically Necessary will be made by the Board of Trustees or its delegate in the sole and absolute discretion of the Board of Trustees.

Mental or Nervous Disorder

Any Illness that is:

- Defined in the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual; or
- Identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental Health Practitioners

A Physician, psychiatrist, psychologist, certified mental health counselor, or licensed clinical social worker:

- Legally licensed and/or authorized to practice or provide service, care, or treatment of mental health under the laws of the state or jurisdiction where the services are rendered;
- Acting within the scope of his or her license; and
- Who is not the Participant or the parent, Spouse, sibling (by birth or marriage), or child of the Participant.

Morbid Obesity or Morbidly Obese

A condition of obesity where:

- The body mass index is equal to or greater than 35;
- The condition has persisted for a least five years;
- Any of the following severe co-morbidities exist:
  - Coronary heart disease;
  - Type 2 diabetes mellitus;
  - Clinically significant obstructive sleep apnea; or
  - High blood pressure/hypertension (blood pressure is greater than 140 mmHg systolic and/or 90 mmHg diastolic);
- The individual has completed growth (18 years of age or documentation of completion of bone growth); and
- The individual has participated in a Physician-supervised nutrition and exercise program (including dietitian consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This Physician-supervised nutrition and exercise program must meet all of the following criteria:
  - Participation in the nutrition and exercise program is supervised and monitored by a Physician working in cooperation with dietitians and/or nutritionists;
  - The nutrition and exercise program lasts six months or longer; and
  - The nutrition and exercise program occurs within the two years before surgery; and
  - Participation in the Physician-supervised nutrition and exercise program is documented in the medical record by an attending Physician who does not perform the bariatric surgery. Note: A Physician's summary letter is not sufficient documentation.

In the event that this definition of Morbid Obesity is determined by a federal court of competent jurisdiction to be a violation of the Americans with Disabilities Act, this definition is void and will have no effect.

Occupational Therapy

Service, supplies, or treatment for the education, teaching, or training in the use of a bodily function restored, which may include adaptation of tasks or environment.

Participant

Any one of the following individuals:

- An Employee or former Employee of an Employer who is or may become eligible to receive a benefit of any type from the Plan; or
- A Dependent of an Employee or former Employee who is or may become eligible to receive a benefit of any type from the Plan.

Pharmacy

Participating Pharmacy means a walk-in Pharmacy (including a Hospital Pharmacy or mail order Pharmacy, which has entered into an agreement with the service provider to provide prescription drugs.

Retail Participating Pharmacies

Retail Participating Pharmacies allow prescriptions for a supply up to 30 days. The Plan pays for each refill at 100%. after you pay the Copayment as listed in the Schedule of Benefits.

Mail Order Participating Pharmacies

Mail Order Participating Pharmacies allow prescription for a supply of up to 90 days. The Plan pays for each refill at 100%. after you pay the Copayment as listed in the Schedule of Benefits. Mail Order Participating Pharmacies also include the walk-in CVS pharmacies that allow 90 days prescriptions.

Physical Therapy

Therapy that:

- Is prescribed by a Physician when the bodily function has been restricted or diminished as a result of Illness or Injury;
- Has the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the Illness or Injury; and
- Is performed by a Physician or licensed therapist acting within the scope of his or her license.

Physician or Surgeon

A person:

- Licensed to prescribe and administer all drugs and to perform all surgery; or
- Where applicable law requires, licensed to perform services that would be payable under the Plan if performed by a Physician or Surgeon.

Plan

The Mid Central Operating Engineers Health and Welfare Fund and any supplements or amendments, as described in this Summary Plan Description/Plan Document or subsequently provided.

Retired Employee

An Employee, who is eligible for retiree coverage under the Plan by meeting the eligible requirements described on page 22, and who elects retiree coverage.

Retiree Plan

Plan under which a Retired Employee and Dependents are covered for benefits.

Self-Payment or Self-Pay

The opportunity for qualified individuals to maintain eligibility through that individual's payment.

Skilled Nursing Facility

A public or private facility that:

- Is licensed and operated according to law;
- Primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates Illness, Injury or Disability;
- Is accredited by the Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility;
- Maintains on its premises all facilities necessary for medical care and treatment;
- Provides services under the supervision of Physicians;
- Provides nursing services by or under the supervision of a licensed Registered Nurse, with one licensed Registered Nurse on duty at all times;
- Is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- Is not a hotel or motel.

Spouse

The person to whom you are legally married, including same-sex partners.

Trust Agreement

The Agreement and Declaration of Trust establishing the Mid Central Operating Engineers Health and Welfare Fund, as amended from time to time.

Trustees or Board of Trustees

The Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement. Collectively, the Trustees are the Administrator of this Fund, as that term is used in the Employee Retirement Income Security Act, as amended (ERISA).

Union

The International Union of Operating Engineers, Local Unions 103, 318, 649, and 841.

United States

The 50 states of the United States of America and the District of Columbia.

Eligibility Provisions – Active Plan

This section describes eligibility provisions for active Employees; refer to page 22 for information about Retired Employee eligibility.

Initial Eligibility

You are initially eligible for benefits on the first day of the month following completion of four months of continuous employment with an Employer, provided you have at least 400 Credited Hours of employment in that four-month period, with at least one Credited Hour of employment in each of the four months.

If you do not have at least 400 Credited Hours of employment during your initial four months of employment, you are eligible on the first day of April, August, or December following a four month Contribution Period during which you have at least 400 Credited Hours of employment.

Continued Eligibility

Once you are eligible, coverage continues on a period-by-period basis. The Plan looks at four-month periods, known as Contribution Periods and Eligibility Periods. You are eligible for coverage during an Eligibility Period if you have at least:

- 400 Credited Hours for the corresponding Contribution Period (as shown below); or
- 1,200 Credited Hours (known as "bank hours") in the last three Contribution Periods (a one-year period).

Eligibility Period	Contribution Period	Bank Hours
	If you have at least 400 Credited Hours in this period	If you have at least 1,200 in this period
April 1 – July 31	November 1 – February 28 (29)	March 1 – February 28 (29)
August 1 – November 30	March 1 – June 30	July 1 – June 30
December 1 – March 31	July 1 – October 31`	November 1 – October 31

If you meet the Plan's continuing eligibility requirements described in this section, no Self-Payments are required.

Continuing Eligibility Example (No Self-Payment Required): *John has only 300 Credited Hours during the March through June Contribution Period. However, John had more than 1,200 Credited Hours worked in the last three Contribution Periods (July of the previous year through June of the current year). As a result, John is eligible for coverage for the August through November Eligibility Period.*

Self-Payment Program

If you do not have the required 400 Credited Hours in a Contribution Period or 1,200 Credited Hours in the preceding three Contribution Periods, but you have at least 400 Credited Hours in the three proceeding Contribution Periods, you are allowed to continue eligibility by making a Self-Payment. You must make the Self-Payment within a 30-day period following April 1, August 1, or December 1 immediately after eligibility would otherwise end.

You will receive a billing statement from the Health and Welfare Fund showing you the required Self-Payment needed and the Credited Hours reported for that Contribution Period. If not all of your work hours during that period have been reported, please contact the Fund Office.

If you do not have at least 400 Credited Hours in the last three Contribution Periods, you may continue to be eligible by making Self-Payments if you are able to prove, to the satisfaction of the Fund Office, that:

> You must keep the Fund up-dated on your current address. It is still your responsibility to make sure a Self-Payment is not required. You should visit the website at www.midcentral.org or contact the Welfare Fund in March, July, and November to make sure all of your Credited Hours have been reported or if you need to make a Self-Payment.

- You have been actively seeking employment in the industry; or
- Illness or injury prevented you from actively seeking employment in the industry.
    - If you meet these criteria, you may be entitled to remain eligible for benefits by making a full Self-Payment for up to three (3) benefit periods. At the time you first would lose coverage, you must waive COBRA in favor of the Self-Payment Program. After the Self-Payment coverage ends, you may continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) by making the appropriate COBRA payment(s).

> ***Continuing Eligibility Example (Self-Payment Required):*** *John has only 300 Credited Hours from March through June, which means he is 100 Credited Hours short. However, John has 1,150 hours worked from July of the previous year through June of the current year. Since John is only 50 hours short during the last three Contribution Periods, he can make a Self-Payment to continue eligibility. John's billing statement will be based on 50 hours rather than 100 Credited Hours short.*

The Board of Trustees has sole discretion to determine if you qualify for continuation coverage through Self-Payments.

Dependent Eligibility

Generally, your Dependents are eligible for coverage on the date you become eligible, or, if later, on the date you acquire a Dependent. To be eligible for coverage, your Dependents must meet the Plan's definition of Dependent (see page 3).

Once you are eligible for benefits, if you acquire a Dependent through *marriage*, *birth of a child*, *adoption of a child*, or *placement for adoption,* eligibility for that Dependent begins immediately. However, you must notify the Welfare Fund when one of these events occurs, as coverage will not begin until the Welfare Fund is notified and the Dependent is approved. Eligibility will be retroactive to the date the Dependent was acquired.

Enrolling Dependents for Coverage

You (the Employee) are automatically enrolled for coverage when you first become eligible. However, you will need to complete and return an information card to the Welfare Fund. Be sure to complete the entire form, including the Beneficiary Designation and Dependent sections. The information card ensures the Fund has the proper information on file for you, along with the proper documentation. When you become eligible or add a new Dependent for coverage, you must provide the Welfare Fund with proof of Dependent status. A copy of any of the following documents is acceptable as proof of Dependent status:

> You may also be required to submit a certified court order if you were not married to the child's mother/father at the time of birth.

- **Spouse:** A copy of the certified marriage certificate and Social Security card. If your Spouse is employed, you must provide the Welfare Fund with a letter from your Spouse's employer stating that there is no other insurance available or if available and your Spouse is enrolled, the Welfare Fund must receive a copy of both sides of the Spouse's insurance card.
- **Child:** A copy of the certified birth certificate and Social Security card.
- **Step-Child:** A copy of the certified divorce decree/court papers of the natural parents to determine which parent is responsible to provide medical coverage and a copy of the Employee's or Retired Employee's latest tax return showing Dependents, or a copy of the natural parents latest tax papers showing Dependents. If tax papers are not available, please contact the Welfare Fund and you will be provided with an affidavit to be completed by the Employee or Retired Employee. Thereafter, a copy of your tax return will be needed by April 15th of each year.
- **Adopted Child (including children placed for adoption):** A certified court order signed by a judge.

If you have eligible Dependents, you must send the documentation listed above or your Dependents will not be eligible for benefits, until received.

Special Enrollment

All eligible Employees and their eligible Dependents are automatically enrolled in this Plan as soon as they meet the Plan's eligibility requirements (if appropriate documentation to show eligibility is provided as stated below). There is no option to decline coverage.

To enroll your dependent, call the Fund Office for an enrollment form. You must submit the completed enrollment form with the appropriate documentation to the Fund Office within 30 days of the event, for example, your marriage or the birth of a child. If you do not enroll your dependent in 30 days, claims will be denied until you submit the required information. Once the Fund Office receives your completed application, coverage for the dependent will begin on the first day of the month following. See page 13 for additional information about the documents necessary to add a dependent.

When Eligibility Ends

For You

Your eligibility ends on the earliest of the date:

- You no longer meet the Plan's continuing eligibility requirements;
- You no longer belong to a class or classes of persons eligible for coverage under the Plan;
- You become covered under your Employer's plan and the Employer stops contributing to the Fund or if a group of Employees votes to become non-Union;
- Any Self-Payment is due and unpaid;
- You enter the armed forces, subject to USERRA, as described on page 31; or
- The date the Plan ends.

If your coverage ends because your Employer stops contributing to the Fund or because you are part of a group of Employees that vote to become non-Union, you and your Dependents will not be eligible for retiree coverage and will not be eligible for extended eligibility under COBRA Continuation Coverage.

> If your Contribution Hours are not sufficient to continue eligibility, you may continue eligibility by making Self-Payments as described on page 13.

> If your eligibility ends because your Employer stops contributing to the Fund or because a group of Employees vote to become non-Union, you and your Dependents will not be eligible for retiree coverage and will not be eligible to continue coverage by Self-Payments.

For Your Dependents

Your Dependents' eligibility ends on the earliest of the date:

- Your Spouse or child no longer meets the Plan's definition of Dependent;
- Your coverage ends (except as otherwise noted in the event of your death);
- You become covered under your Employer's plan and your Employer stops contributing to the Fund or if a group of Employees votes to become non-Union;
- Any Self-Payment for Dependent coverage is due and unpaid;
- Of a court ordered legal separation; or
- The Plan ends.

Reinstatement of Eligibility

Once your eligibility ends, you may reinstate eligibility on the earlier of the first day of:

- December, April, or August after you have at least 400 Credited Hours in a preceding Contribution Period; or
- The month following completion of the Plan's initial eligibility requirements for a new Employee.

Changes in Eligibility Rules and Benefits

The Trustees reserve the right, at their discretion, to change, modify, or discontinue all or part of the Plan's eligibility rules or the benefits provided under the Plan, at any time. The Trustees also establish contribution rates and Self-Payment rules and reserve the right to change them at any time.

When Coverage Ends

When coverage under the Plan ends, no conversion privileges are available.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective retroactively to the date when you would have lost coverage under the Plan. However, the following situations are not considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former Spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified. A prospective cancellation is not a rescission of coverage and the Plan is not required to give you 30 days advance written notice.

COBRA Continuation Coverage

If you reject COBRA continuation coverage, but you later decide to elect coverage before the 60-day period expires, you can still elect coverage by notifying the Fund Office in writing before the 60-day period terminates. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form.

You and your Dependents may continue medical and prescription drug benefits if your coverage ends due to a "qualifying event," as described below. For example, your children are eligible to continue coverage under COBRA when they no longer satisfy the Plan's definition of Dependent because of age.

Qualifying Events

You and/or your covered Dependents may be eligible to continue your coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if your coverage under the Plan ends due to a qualifying event.

By making the required monthly payments, you and/or your Dependents may continue the same medical and prescription drug coverage that you had before your coverage ended. Injury and Illness Weekly, Death, and Accidental Death and Dismemberment Benefits are **not** available under COBRA Continuation Coverage.

If you have questions about COBRA Continuation Coverage, contact the Welfare Fund. To maintain your COBRA Continuation Coverage, you must make monthly payments to the Welfare Fund on time.

If you (as the Employee) and/or your Dependent(s) lose coverage, you may continue coverage under COBRA for up to 18, 29, or 36 months, depending on the qualifying event, as shown below:

Qualifying Event	Who is Eligible	Maximum Coverage Period
Your termination or reduction in hours of employment (including retirement), unless due to gross misconduct	You, Spouse, and/or Dependent children	18 months
Your termination or reduction in hours and during your continuation period you or your Dependent is disabled, and entitled to Social Security Disability benefits	You, Spouse, and/or Dependent children	29 months
Your entitlement to Medicare and you voluntarily drop Plan coverage	Spouse and/or Dependent children	36 months
Your death	Spouse and/or Dependent children	36 months
Your divorce or legal separation	Spouse and/or Dependent children	36 months
Your child is no longer a Dependent as defined by the Plan	Dependent child	36 months

See page 20 for information on COBRA Continuation Coverage provisions in the event of a second qualifying event occurring while covered under COBRA Continuation Coverage.

Qualified Beneficiaries

Under the law, only Qualified Beneficiaries are entitled to COBRA Continuation Coverage independent of your enrollment in COBRA. Qualified Beneficiaries include you, your Spouse, and your Dependent child(ren) who were covered by the Plan on the day before the qualifying event.

If you marry, have a newborn child, adopt a child, or have a child placed with you for adoption while covered under COBRA Continuation Coverage, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage. You must enroll your new Dependent within 31 days of the marriage, birth, adoption, or placement for adoption.

In addition, if you are enrolled for COBRA Continuation Coverage and your Spouse or Dependent child loses coverage under another group health plan, you may enroll that Spouse or child for coverage for the balance of the period of COBRA within 31 days after the termination of the other coverage. To be eligible for this special enrollment right, your Spouse or Dependent child must have been eligible for coverage under the terms of the Plan but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage.

It is a good idea to notify the Welfare Fund of any qualifying event. Failure to provide notice within 60 days of a qualifying event may prevent you and/or your Dependents from obtaining or extending COBRA Continuation Coverage.

Adding a Spouse or Dependent child may cause an increase in the amount you pay for COBRA Continuation Coverage. To find out about COBRA rates, contact the Welfare Fund.

One or more of your family members may elect COBRA even if you do not. However, to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the qualifying event. A parent may elect or reject COBRA Continuation Coverage on behalf of Dependent children living with him or her.

Please notify the Welfare Fund immediately if you change your marital status, add new Dependents, or if you, your Spouse, or other Dependents change addresses.

Electing COBRA Continuation Coverage

To elect COBRA Continuation Coverage, you (or your Employer) must notify the Welfare Fund within 60 days from the later of the date the qualifying event occurred, or the date that you would lose coverage under the Fund because of the qualifying event.

In some cases, your Employer will notify the Welfare Fund. In other cases, you or your Dependent must notify the Welfare Fund, as shown below:

Your Employer Should Notify the Welfare Fund of Your:	You (or your Dependent) Must Notify the Welfare Fund of:
■ Termination of employment ■ Reduction in hours ■ Retirement ■ Entitlement to Medicare ■ Death	■ Divorce ■ Legal separation ■ A Beneficiary ceasing to be covered under the Plan as your Dependent child, either because of reaching age limit or death. ■ The occurrence of a second qualifying event after a Qualified Beneficiary has become entitled to COBRA with a maximum duration of 18 (or 29) months. This second qualifying event could include an Employee's death, entitlement to Medicare, divorce or legal separation or a Beneficiary ceasing to be covered under the Plan as your Dependent.

Notice of any of the qualifying events or situation listed above must be provided in writing. You may use the Fund's *COBRA Notice Form for Covered Employees and Other Qualified Beneficiaries* to provide notice to the Fund. You may also send a letter to the Fund including:

- Your name;
- The Qualifying Event or situations listed above under which you are providing notice; and
- The date of the event.

The period to provide notice does not begin until you have been informed of the responsibility to provide notice and the notice procedures through the furnishing of this Summary Plan Description/Plan Document or a general (initial) notice by the Plan.

You, a Qualified Beneficiary, or any representative acting on your behalf may provide notice of a qualifying event. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same qualifying event. For example, if an Employee, Spouse, and child are all covered by the Plan, and the child ceases to be a Dependent under the Plan, a single notice sent by the Spouse would satisfy this requirement.

When you or your Dependents have provided notice to the Welfare Fund of a divorce or legal separation, a Dependent ceasing to be covered under the Plan as a Dependent, or a second qualifying event, but are not entitled to COBRA, the Fund Administrator will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within 14 days of receiving your notice.

To protect your family's rights, you should keep the Welfare Fund informed of any changes in address of family members. You should also keep a copy, for your records, of any notices you send to the Welfare Fund.

If you lose coverage due to a qualifying event:

- Inform the Welfare Fund of the qualifying event and request a COBRA election form.
- Complete and return the election form within 60 days of the date you received it, or 60 days of the date the qualifying event occurred, which-ever is later.
- Make your first payment to the Welfare Fund within 45 days from the date you make your COBRA election.

When the Welfare Fund receives notice of a qualifying event, you will be provided with a COBRA election form, information about COBRA, and the date on which your coverage will end. Under the law, you and/or your covered Dependents have 60 days from the later of the date:

- You would have lost coverage because of the qualifying event; or
- You and/or your covered Dependents received the election form and COBRA information.

If you and/or any of your covered Dependents do not elect COBRA within 60 days of the qualifying event (or, if later, within 60 days after receiving that notice), you and/or your Dependents will not have any group health coverage from this Fund after your coverage ends.

Each Qualified Beneficiary with respect to a particular qualifying event has an independent right to elect COBRA Continuation Coverage. For example, both you and your Spouse may elect COBRA Continuation Coverage, or only one of you. A parent or legal guardian may elect COBRA Continuation Coverage for a minor child.

Paying for COBRA Continuation Coverage

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your Dependents become eligible for this coverage, the Welfare Fund will notify you of the COBRA Self-Payment amount.

Your COBRA Self-Payment may be as much as 102% of the Plan's cost. If you are eligible for the 11-month extension due to a determination of disability by the Social Security Administration, your COBRA premiums may be as high as 150% of the Plan's cost for the additional 11 months. The Board of Trustees adjusts the COBRA Self-Payment effective August 1st of each year.

You must make Self-Payments so that your COBRA Continuation Coverage is continuous. To prevent a lapse in coverage, you must send the first COBRA Self-Payment to the Welfare Fund within 45 days from the date on which you or your Dependent make your COBRA Continuation Coverage election, as determined by postage cancellation. Payments for subsequent months are due on the first day of the month for which COBRA Continuation Coverage is provided. You will have a 30-day grace period to submit payments. If you do not make payment by the end of the grace period, your COBRA Continuation Coverage will end, retroactive to the last day of the previous month, and you will lose all rights to COBRA Continuation Coverage under the Plan.

If you choose COBRA Continuation Coverage within the election period but after your eligibility ended, you must pay the required COBRA Self-Payment retroactively to the date your eligibility ended to cover the elapsed period.

Disability COBRA Continuation Coverage

If you are covered under COBRA for 18 months, and at the time of the qualifying event or within the first 60 days of coverage you (or your covered Dependent) are determined to be disabled, you (or your Dependent) may be eligible to continue COBRA Continuation Coverage for an additional 11 months for a total of 29 months. The disability extension is applicable to all COBRA qualified beneficiaries in your family.

To be eligible, the Social Security Administration must make a formal determination that you (or your Dependent) are disabled and therefore entitled to Social Security Disability benefits. If you are providing notice of a Social Security Administration determination of disability, the notice must be made before the end of the first 18 months of continuation coverage and must be postmarked no later than 60 days after the latest of the date:

- Of the disability determination by the Social Security Administration;
- On which the qualifying event occurs; or
- On which the individual loses (or would lose) coverage under the Plan as a result of the qualifying event.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month that occurs 30 days after the Social Security Administration has determined that you and/or your Dependent(s) are no longer disabled;
- The end of the 29 months of COBRA Continuation Coverage; or
- For the disabled person, the date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Welfare Fund within 30 days of:

- The date that you receive a final Social Security determination that you and/or your Dependent(s) are no longer disabled; or
- The date that the disabled person becomes entitled to Medicare.

Additional Qualifying Events While Covered Under COBRA Continuation Coverage

The maximum period of coverage under COBRA is 36 months, even if you experience another qualifying event while you are already covered under COBRA. If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours, your Spouse and/or Dependent may extend coverage for another 18 months if:

- You get divorced or legally separated;
- You become entitled to Medicare and drop Plan coverage;
- You die; or
- Your child no longer meets the Plan's definition of Dependent.

You, as an Employee, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage because of a disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is *not* treated as a second qualifying event and you may not extend your coverage.

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Welfare Fund to inform your Physician and health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the Physician or provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA Continuation Coverage, or you have elected COBRA Continuation Coverage but have not yet paid for it.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage will end on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- The required COBRA Self-Payment is not made by the due date;
- The person receiving the coverage becomes covered by another group health plan;
- The person receiving the coverage becomes entitled to Medicare; or
- The Plan terminates and no longer provides group health insurance coverage.

If COBRA Continuation Coverage ends before the end of the maximum coverage period, the Welfare Fund will send you a written notice as soon as practicable following the determination that COBRA Continuation Coverage will end. The notice will explain why coverage will end early, the date it will end, and your rights, if any, to alternative individual or group coverage.

Eligibility Provisions - Retiree Plan

At retirement, you may be able to continue coverage for yourself and your Dependents as a Retired Employee by making Self-Payments, as described in this section. When you retire, you may choose to postpone or suspend retiree coverage for yourself and/or your Dependents, for example, if you have other coverage through your Spouse's employer. When you postpone or suspend coverage, you remain eligible for later coverage. This section describes these programs.

It is a good idea to contact the Welfare Fund as you prepare for retirement. The Welfare Fund will assist you through the retirement process and answer any questions you may have about benefits.
It is also a good idea to consult with a retirement or financial advisor.
Contact the Central Pension Fund at (202) 362-1000 for information about your pension benefit.

Retiree Coverage

The Retiree Plan includes:

- Medical Benefits, which includes coverage for:
  - Non-Medicare Eligible Participants (these benefits are the same as those available under the Active Plan); or
  - Medicare Eligible Participants (see following information);
- Prescription Drug Benefits (these benefits are the same as those available under the Active Plan); and
- Death Benefits.

Under the Retiree Plan for Medicare-eligible Participants:

- There is no annual deductible that you need to meet before the Plan begins to pay covered expenses.
- The Plan generally pays medical expenses after Medicare.
- The Plan pays 100% of your Medicare Parts A and B deductibles.
- The Plan generally pays 20% of allowed expenses. However, if Medicare does not pay (because you have used all of your inpatient Hospital days in a year, for example), no benefits are paid by the Plan.
- You should apply for Medicare Parts A and B, because the Plan will pay benefits as if you are enrolled, regardless of whether or not you enroll.

Injury and Illness Weekly Benefits and Accidental Death and Dismemberment Benefits are not available under the Retiree Plan.

Medicare Eligible Retiree Coverage and Medicare Prescription Drug Coverage (Part D)

When you do not enroll for Medicare Prescription Drug Coverage, you continue to receive benefits – both prescription drug and medical benefits – under the Mid Central Operating Engineers Health and Welfare Fund as long as you are otherwise eligible to continue Plan coverage.

If you are a Retired Employee or Dependent of a Retired Employee, are eligible for and enroll in Medicare Prescription Drug Coverage, you will no longer receive prescription drug benefits under the Health and Welfare Fund. You will continue to be eligible to receive medical benefits under the Fund. However, your Self-Payment for coverage under the Fund will not change as a result of not receiving prescription drug benefits from the Fund. Also, note that for most people there is a monthly premium for Medicare Prescription Drug Coverage. If you later drop Medicare Prescription Drug Coverage, Fund prescription drug benefits may be reinstated; however, this is only allowed once in your Lifetime. Enrollment will occur during the same period as Medicare's open enrollment period, which is October 15 through December 7 each year for coverage beginning January 1 of the following year.

If you are a Retired Employee or Dependent of a Retired Employee, enroll for Medicare Prescription Drug Coverage, and elect to stop making all contributions to the Fund, you will no longer be eligible for medical or prescription drug coverage from the Fund. If you later drop Medicare coverage, retiree coverage under the Mid Central Operating Engineers Health and Welfare Fund cannot be reinstated because once retiree coverage ends, it may not be reinstated, unless you had elected to postpone or suspend coverage (see page 26). To obtain coverage in the future, you must meet the Plan's eligibility requirements as an active Employee.

Initial Eligibility

To be eligible for retiree coverage, you must meet these requirements on the day of your initial retirement:

- Be at least 55 years old; or
- Be receiving or approved to receive a pension from a source approved by the Trustees;
- Be covered under the Fund as of the date of retirement;
- Have been covered continuously under the Fund during the last three full Eligibility Periods immediately before retirement; **and**
- Have at least 10 years of Credited Service with:
  - At least three full years of continuous coverage immediately before retirement and 3,000 or more Credited Hours in those three years; or
  - Coverage in at least 12 of the last 15 Eligibility Periods immediately before retirement and 4,000 or more Credited Hours in any three of the last five years immediately before retirement; or
  - Coverage in at least 21 of the last 30 Eligibility Periods immediately before retirement and 7,000 or more Credited Hours in any 7 of the last 10 years immediately before retirement.

Credited Service

Credited Service is based on Eligibility Periods in the Health and Welfare Fund since January 1, 1995. There are three Eligibility Periods per calendar year (beginning April 1, August 1, and December 1). For each Eligibility Period in a calendar year, you may be credited with 0.33 years of Credited Service, through hours worked or remitting a self-pay. This includes any hour bank balances at the time of retirement. If you are covered in all three Eligibility Periods in a calendar year, you will be credited with one year of Credited Service for that year.

Before January 1, 1995, Credited Service is based on your years of service in the Central Pension Fund. Years of service were computed on a calendar year basis and you are eligible to receive one year of Credited Service if you had 1,000 Credited Hours in a calendar year. Please do not use your service years showing on your Central Pension Fund statement or your Central Pension Fund Participant Basic Data Report as your Credited Service for this Plan. You must call the Welfare Fund for your current Credited Service.

> Those who retire and qualify as described above and then return to work in covered employment must work the required hours for continued eligibility in a contribution period; otherwise, their full retiree Self-Payment must be satisfied. Retirees do not have bank hours.

Dependent Eligibility

Generally, your Dependents become eligible for retiree coverage on the date you become eligible, or, if you opt to postpone coverage, on the date your coverage begins. To be eligible for coverage, your Dependents must meet the Plan's definition of Dependent (see page 3). Retirees must enroll Dependents within 30 days of acquiring them as Dependents, and provide the documentation listed in the Section entitled *Enrolling Dependents for Coverage* beginning on page 13.

Self-Payments for Retiree Coverage

When you retire, if you are eligible and elect retiree coverage (instead of COBRA Continuation Coverage), you are required to make Self-Payments for this coverage.

For retirees (including Disabled Employees, surviving Spouses, and Dependents) that were eligible for retiree coverage before December 1, 2007, you must make a Self-Payment for each Eligibility Period by the first day of the Eligibility Period (August 1, December 1, or April 1). The amount of the Self-Payment is established by the Trustees based on the cost of providing coverage. The Trustees reserve the right to change the amount of the Self-Payment at any time.

If the required Self-Payment is not made within 30 days of August 1, December 1, or April 1, retiree coverage will end for you and your Dependents. Once retiree coverage ends, it cannot be reinstated.

For retirees (including Disabled Employees, surviving Spouses, and Dependents) that are first eligible for retiree coverage on and after December 1, 2007, the Fund includes a Self-Payment Points Program, as described in the following section. This program does **not** apply for Participants covered under the Retiree Plan before December 1, 2007.

The Fund Office will permit a **one-time** late Retiree Self-Payment within the current Eligibility Period upon written request. The payment must be received within 10 days of the written request and not later than the next Eligibility period.

Self-Payment Points Program

To determine the Self-Payment rate, the Self-Payment Points Program looks at:

- Employee Point Total; and
- Individual Class.

Employee Point Total

The Employee Point Total is based on the Employee's age and total Credited Service under the Plan at retirement, as defined by the Fund. For example, if you are 65 and have 35 years of Credited Service when you retire, your point total is 100 (65 + 35).

> If your point total is 80 or more, the Fund pays a portion of the total cost of retiree coverage.

This portion of calculating the Self-Payment rate is based only on the Employee's age and Credited Service. However, please note that:

- Your Employee Point Total at retirement will not change; you will have the same Employee Point Total throughout your eligibility for retiree coverage. This also applies if you retire and return to work; your Employee Point Total will not change based on your subsequent age when you retire or any additional Credited Service you earn. For example, if your Employee Point Total is 82 when you initially retire and you subsequently return to work and earn two additional years of Credited Service, your Employee Point Total will still be 82 when you re-retire.
- Your Employee Point Total will also be your Spouse's point total. However if both you and your Spouse are Employees, whoever has the higher Employee Point Total once you are both retired will be used for both of you.
- The more years of Credited Service you have and/or the older you are when you retire, the higher the Employee Point Total.
- When calculating the Employee Point Total, the Plan looks at your actual age (years and months) and Credited Service (years and Plan periods only; no credit is given for partial periods; only full four-month periods will count towards the Employee Point Total). For example, if you are age 62 and 8 months and have 17 years and 1 period (which is 4 months) of Credited Service, your point total at retirement would be 80.
- The Plan looks at all of your Credited Service, regardless of whether or not it has been continuous. To determine Credited Service for the Employee Point Total, the Plan looks at Credited Service under the:
  - Mid Central Operating Engineers Health and Welfare Fund since January 1, 1995; and
  - Central Pension Fund before January 1, 1995.
- The higher the Employee Point Total, the higher the percentage of the total cost of retiree coverage the Fund will pay. The percentage the Fund will pay ranges from 75% (for Employee Point Totals of 95 or more) to 0% (for Employee Point Totals of less than 80).

Individual Class

There are two individual Classes of Self-Payment rates based on age:

- Class 1 – Individuals that are not eligible for Medicare;
- Class 2 – Individuals that are Medicare-eligible; and

Except under circumstances involving disability, you are eligible for Medicare age 65.

While the Employee Point Total is based on the Employee's age and Credited Service and is the same for the Employee and the Spouse, an individual's Class is determined separately for Employees and Spouses (or Dependents). Your individual Class and your Dependent's individual Class will be determined separately, based on your actual ages. Therefore, it is possible that you and your Dependent will be in different individual Classes.

Individual Classes are based on Medicare eligibility because once a Retired Employee or a Retired Employee's Spouse is eligible for Medicare- the cost of providing coverage is less because Medicare pays first.

In addition, while the Employee Point Total at retirement does not change, an individual's Class may change over time. For example, if you retire at age 64 and your Spouse is age 61, you and your Spouse will be in Class 1. One year later, when you reach age 65 and your Spouse is age 62, you will be in Class 2 and your Spouse will be in Class 1.

Self-Payment Rates

Self-Payment rates per four-month period are separate for the Employee and the Employee's Dependent (Spouse, surviving Spouse, or Dependent children). Self-Payment rates are based on the Employee Point Total and Individual Class, as follows:

- If you are an Employee, your Self-Payment rate is based on your Employee Point Total and your Class.
- If you are the Spouse of an Employee (or if there is no Spouse and you are the Dependent child of an Employee), your Self-Payment rate is based on the Retiree's Employee Point Total and your Class (based on your age).

The Board of Trustees reserves the right to modify the monthly Self-Payment rates at any time without prior notice.

NOTE: If you are married and you and your Spouse are covered under the Plan, each of you will have a separate per person rate as described in this section; there is not a separate Self-Payment for your Dependent children. However, if you do not have a Spouse but have eligible Dependent children covered under the Plan, your Self-Payment will be based on yourself and one Dependent child, regardless of the number of children covered. The Self-Payment rate for the Dependent in this instance will be based on the Employee Point Total and Class 1.

The following table shows the Self-Payment rates per month, per individual, as of April 1, 2015 for retirement classes on or after December 1, 2007:

Employee Point Total		Class 1	Class 2
Point Group	*If your Employee Point Total (age + Credited Service) at retirement is:*	*If not eligible for Medicare, the monthly Self-Payment rate is:*	*If Medicare-eligible, the monthly Self-Payment rate is:*
A	95 or more points	$260	$153
B	90 up to 94 points	$435	$153
C	85 up to 89 points	$510	$230
D	80 up to 84 points	$560	$243
E*	Less than 80 points	$610	$282

Rates shown in the above chart, which are effective April 1, 2015, are per person *monthly* rates; however, Self-Payments are based on benefit periods that are four months each. These rates are reviewed regularly by the Board of Trustees and are subject to change based on the cost of providing coverage. Please visit www.midcentral.org for updated Self-Payment Rates.

As you can see, the more Credited Service you have and/or the later you retire, the lower the Self-Payment rate. In addition, your Self-Payment rate and your Dependent's Self-Payment rate is automatically lowered as you and your Dependent get older and move from one Class to another. There is no adjustment to Self-Payment for the benefit period in which your age changes. Your Self-Payment rate will be adjusted at the beginning of the next Eligibility Period, following your birth date.

In the Event of Disability

If you are eligible for retiree coverage as a Disabled Employee, the Plan looks at your age and Credited Service when eligible for Social Security disability benefits to determine your Employee Point Total.

In the Event of Your Death

The Plan provides retiree coverage for surviving Spouses and/or Dependents in the event of the death of a Retired Employee. In the event of your death, if your surviving Dependents are eligible to continue coverage, your surviving Spouse's Self-Payment amount will be based on your Employee Point Total and your Spouse's age.

Examples

Here are some examples to help clarify how the Self-Payment Points Program works for different individuals.

Husband and Wife Employees: *John and Sherry are both operating engineers covered under the Plan. Sherry is age 54 and has 20 years of Credited Service. John is 60 years old with 30 years of Credited Service when he decides to retire (his Employee Point Total at retirement is 90). John will continue coverage under the Active Plan as Sherry's Dependent. When Sherry retires five years later at age 59, her Employee Point Total is 84 (59 years old + 25 years of Credited Service). The Plan will look at both John's and Sherry's Employee Point Total. Since John's is higher, his Employee Point Total will automatically be used for both John and Sherry. However, John will be in Class 2 and Sherry will be in Class 1 based on their individual ages.*

Death of Active Employee: *Jim is 55 years old, with 27 years of Credited Service when he dies. His wife, Marcia meets the Plan's eligibility requirements for retiree coverage at the time of his death (even though he had not yet retired). When calculating Marcia's Self-Payment, the Plan looks at Jim's Employee Point Total at the time of his death, which is 82 (55 years old + 27 years of Credited Service). Marcia is 55years old, so she is in Class 1 (because she is younger than age 65), which means her Self-Payment amount will be $2,240 per period.*

Death of Retired Employee: *David and his wife Fran are covered under the Plan's retiree coverage. David's Employee Point Total when he retired was 96. David subsequently dies when his wife Fran is 63 years old. Since Fran meets the Plan's eligibility requirements to continue retiree coverage, her initial Self-Payment amount will be based on David's Employee Point Total of 96 and her Class1 status.*

__Postponing Retiree Coverage:__ John decides to retire at age 63 with 33 years of Credited Service; his Employee Point Total is 96 (63 years old + 33 years of Credited Service). If John elects retiree coverage immediately, for himself only, his Self-Payment rate would be $1,040, since he would be in Class 1. However, John decides to postpone electing retiree coverage, for himself and his wife, since his wife, Nancy, is still working and he is covered under her employer's plan. Five years later when Nancy retires and they will no longer have other coverage, John and Nancy apply for retiree coverage under the Fund, in accordance with the Plan's guidelines. Even though John is now 68 years old, his Employee Point Total is still 96 since his total is determined at the time of his retirement and does not change throughout his retirement. However, John would now be eligible for Class 2 Self-Payment rates and Nancy, who is 65 years old, will be eligible for Class 2 rates based on John's Employee Point Total of 96.

Please note that the actual Self-Payment rates, in each point group and Class category, are subject to change by the Board of Trustees.

Retiree In-and-Out Program

Often the Fund's retiree coverage is the only coverage you and your Dependents have when you are no longer working. However, realizing that sometimes you and/or your Dependents may not need this coverage at all times, for example if you have other coverage, you may postpone or suspend retiree coverage for you and/or your Dependents. For example, if you and/or your Dependents have other medical coverage available through another group plan, such as through your Spouse's employer, you may elect to postpone retiree coverage at retirement, or if you are already covered, you may elect to suspend your retiree coverage, until other coverage ends.

Under the provisions of the Retiree In-and-Out Program, you **and** your Dependent(s) may postpone or suspend retiree coverage, maintaining your eligibility to participate in this Plan later, when you and your Dependents are no longer eligible for other coverage.

Please note that the Retiree In-and-Out Program applies to all eligible Retired Employees and their Dependents. Once you are considered retired under the Health and Welfare Fund, your Retired Employee status will not change. In addition, this Program does not affect:

- An individual's ability to continue active coverage upon initial retirement using Credited Hours. For example, you (or your surviving Dependents in the event of your death), may continue active coverage by using Credited Hours (including Self-Paying the difference between actual Credited Hours and the number of Credited Hours needed to continue active coverage). If you elect to postpone coverage, you will not lose your Credited Hours. Your Credited Hours will be frozen and may be used toward Self-Paying for coverage when you begin or resume coverage.
- Any death benefits you and/or your Dependents are eligible for in the event of your death or the death of a Dependent. For example, in the event of your death while your retiree coverage is postponed or suspended, your surviving Dependents are still eligible to receive the same death benefits they would have received had you not postponed or suspended your retiree coverage. However, please note that you must have completed any necessary forms electing to postpone or suspend retiree coverage to be eligible for death benefits.

Opting Out When Initially Eligible for Retiree Coverage

If you are an active Employee, when you are initially eligible and apply for retiree coverage, you will have the opportunity to postpone retiree coverage for:

- Yourself and your Dependents; or
- Your Dependents only.

You and your Dependents are only given an opportunity to postpone or suspend retiree coverage and remain eligible for later coverage once; this may be when you initially retire or later. For example, if you choose to begin retiree coverage at the time of your retirement, you will be given one opportunity to postpone or suspend coverage and begin or resume it later.

Please note that if you elect to postpone or suspend retiree coverage for yourself, this will also postpone or suspend retiree coverage for your Dependents as well. The application for retiree coverage will include a section about postponing or suspending coverage. If you elect to postpone or suspend retiree coverage (for yourself and/or your Dependents), you must return the application to the Welfare Fund by the deadline provided.

Opting Out After Retiree Coverage Begins

Once your retiree coverage begins, you will have one opportunity, at any time (provided you did not postpone retiree coverage when you were initially eligible), to suspend retiree coverage for:

- Yourself and your Dependents; or
- Your Dependents only.

> If you elect to suspend coverage for yourself, this will also suspend retiree coverage for your Dependents as well.

This is a one-time only option; however, you may choose to suspend coverage at any time.
To suspend retiree coverage, request a Retiree In-and-Out Program Application form from the Welfare Fund. You must complete, sign, and return this form to the Welfare Fund at least 30 days prior to the date you wish your suspension of retiree coverage to be effective. If you elect to suspend retiree coverage, upon approval of your Retiree In-and-Out Program Application by the Welfare Fund, your retiree coverage will be suspended as of the first day of the month following both the timely receipt of your completed Application and approval by the Welfare Fund. The Plan does not allow a partial refund of the Self-Payment.

Opting In

To begin or resume retiree coverage for yourself and/or your Dependent, you must:

- File a written application for retiree coverage with the Welfare Fund within **60 days** following the date other coverage ends (for example, if you elected to postpone or suspend retiree coverage because you had other coverage and that other coverage ends, you must apply for retiree coverage within 60 days of when that other coverage ends or you will no longer be eligible for retiree coverage);
- Provide proof of other coverage that you and/or your Dependents have had for at least 12 months immediately before electing to begin or resume retiree coverage (or if other coverage has not been in place for at least 12 months, provide proof of continuous coverage by another plan since the date retiree coverage under this Plan was postponed or suspended). You can ask the prior plan's administrator for a certificate of credible coverage ; and
- Make the required Self-Payments for retiree coverage.

> To begin or resume retiree coverage for a Dependent, the Dependent must meet the Plan's definition of Dependent, on page 3.

The above also applies to your Spouse. For example, if you elected to postpone retiree coverage for your Spouse only, you may elect to begin or resume your Spouse's retiree coverage when his or her other coverage ends, as described above.

Retiree coverage will begin as soon as administratively possible after electing to resume retiree coverage; you do not need to wait until the beginning of an Eligibility Period.

Opting In – In the Event of the Retiree's Death

In the event of your death while you are a Retired Employee during the period that coverage is postponed or suspended for you and/or your Dependents, your eligible Dependents can begin or resume retiree coverage immediately or when their other coverage ends. Retiree coverage is available to your eligible surviving Dependents according to the same Plan rules that apply to surviving Dependents of Retired Employees who had not postponed or suspended coverage, as well as the other provisions outlined in the previous section.

To begin or resume retiree coverage, your eligible surviving Dependents must apply for retiree coverage within **60 days** following the date other coverage ends, as described in the previous section. If your surviving eligible Dependents do not apply for coverage by this deadline, they will have no future rights to retiree coverage under the Plan.

Continued Eligibility

Once you are eligible for retiree coverage, your coverage will continue as long as the required Self-Payments are made by the due date.

When Eligibility Ends

For You

Your eligibility ends on the earliest of the date:

- Any Self-Payment is due and unpaid;
- You enter the armed forces, subject to USERRA, as described on page 31; or
- The Plan ends.

For Your Dependents

Your Dependent's eligibility ends on the earliest of the date:

- Your Spouse or child no longer meets the Plan's definition of Dependent;
- Your coverage ends (except as otherwise noted in the event of your death);
- Any Self-Payment for Dependent coverage is due and unpaid;
- Of a court ordered legal separation; or
- The Plan ends.

Reinstatement of Eligibility

Once your eligibility ends under the Retiree Plan, you cannot reinstate coverage under the Retiree Plan. To obtain coverage in the future, you must meet the Plan's eligibility requirements as an active Employee.

Family Status Changes

At some point in your life, you will probably experience a change in family status that affects your Welfare Plan benefits. It is important that you understand what you or your Dependents need to do when you experience a change in family status.

Notify the Welfare Fund

You must notify the Welfare Fund:

- Of new Dependents; or
- When a Dependent is no longer eligible for coverage (you may want to continue his or her coverage through COBRA, see page 16).

If you do not notify the Welfare Fund, coverage may be delayed or denied.

When you experience a change in family status, you should contact the Welfare Fund within 30 days of the event to provide any required information. It is important that you provide any requested information to the Welfare Fund because it helps ensure that the Welfare Fund has your correct address and family information on file. It also enables the Welfare Fund to keep updated marital status, Dependent information, and information about whether you or your Dependents have other benefits coverage. This information helps in processing your claims quickly and accurately.

> Notify the Welfare Fund of any change in your family status.

> You must also contact the Welfare Fund to update your:
> - Beneficiary information, if you experience a change in family status; or
> - Address, if you move.

Adding a Dependent

Depending on your situation, there may be paperwork that you will need to submit to the Welfare Fund. Adding a Dependent could result from any of the following:

- Having a baby;
- Adopting a child or having a child placed with you for adoption; or
- Getting married.

See page 13 for procedures and items you need to provide to enroll a Dependent for coverage.

If Your Dependent Loses Eligibility for Coverage

If your Dependent loses eligibility for coverage because of a loss of Dependent status under the Plan, and wants to continue coverage under COBRA, you must contact the Welfare Fund within 60 days from the date your Dependent loses eligibility. See page 16 for more information about COBRA Coverage.

In the Event of Divorce or Court Ordered Legal Separation

If your ex-Spouse was covered under the Plan and he/she wants to continue coverage under COBRA, you or your ex-Spouse must contact the Welfare Fund within 60 days of the date of the divorce or court ordered legal separation to request COBRA information from the Welfare Fund. See page 16 for more information about COBRA Coverage.

Qualified Medical Child Support Order (QMCSO)

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for a Dependent child(ren) as determined by a court order in the event of a divorce or other family law action. Orders must be submitted to the Welfare Fund to determine if the order is a QMCSO, as required under federal law. The Welfare Fund will provide you with a copy of the Plan's QMCSO procedures, free of charge, upon request.

If You Are Employed with the International Union

In the event you are employed full-time with the International Union of Operating Engineers, you will receive Credited Hours as if you remained continuously covered under the Plan, provided:

- You were eligible for coverage through the Fund the month before your full-time employment with the International Union or the month in which you begin employment with the International Union; and
- That within 30 days following termination of full-time employment with the International Union, you begin employment under a contract requiring contributions to the Fund or you apply for retiree coverage.

If You Are Unemployed

If you are actively seeking work in the industry, but have not been employed by an Employer in the last two Contribution Periods, you may continue to remain eligible for all benefits by making the appropriate Self-Payment, see page 13.

If you do not have at least 400 Credited Hours in the last three Contribution Periods, you may continue to be eligible by making Self-Payments, if you are able to prove, to the satisfaction of the Welfare Fund Office, that you have been actively seeking employment in the industry or that illness or injury prevented you from actively seeking employment in the industry. If you do so, you may be entitled to remain eligible for benefits by making a full Self-Payment for up to three (3) benefit periods. You may thereafter continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) by making the appropriate COBRA payment(s).

If You Take Leave under the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks (or 26 weeks, if applicable) of unpaid leave during any 12-month period due to the:

- The birth of a child and to care for the newborn child within one year of birth;
- The placement with you of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- Care of a seriously ill Spouse, parent, or child;
- Your serious Illness that makes you unable to perform the essential functions of your job; or
- A qualifying urgent need for leave because your Spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- Your Spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of duty while in military service; and
- An outpatient or on the temporary disability retired list of the armed services.

Your eligibility for FMLA leave and benefits will be determined by your contributing Employer. You are eligible for a leave under FMLA if you:

- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within a 75-mile radius.

The Welfare Fund will maintain your prior eligible status until the end of the leave, provided your contributing Employer properly grants the leave under the federal law and the Employer makes the required notification and payment to the Welfare Fund.

If you and your Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Trustees will have no direct role in resolving the dispute. Coverage under this Plan will continue during FMLA leave on the same basis as other similarly situated Employees.

Call your Employer to determine if you are eligible for FMLA leave. During your leave, you will maintain all the coverage offered through the Fund, provided you Self-Pay the required contribution, if required.

If You Enter Active Military Service

If you are eligible for coverage under the Welfare Plan when you enter Active Military Service, your eligibility will be reinstated when you return to work for a Contributing Employer as described in this section.

If you are on active duty for 31 days or less, you will continue to receive health care coverage for up to 31 days, according to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on duty for more than 31 days, your coverage under this Plan will normally end. However, USERRA permits you to continue medical and prescription drug coverage for you and your Dependents at your own expense for up to 24 months. Your Dependent(s) may be eligible for military health care coverage under TRICARE.

Coverage under this Fund will not be offered for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

If you enter military service, you should:

- Notify your Employer and the Welfare Fund that you want to elect continuation coverage for yourself and/or your family under the provisions of USERRA; and
- Make any required Self-Payments to the Welfare Fund to continue your coverage.

Upon an honorable discharge, the eligibility that you had remaining before entering military service will be reinstated on the day you return to work with a Contributing Employer for at least four months, if you report back to work or return to employment:

- Within 90 days from the date of discharge if your service lasted more than 180 days;
- Within 14 days from the date of discharge if your service lasted 31 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if your service lasted less than 31 days.

If you are hospitalized or convalescing from an Injury or Illness caused by active duty, these time limits can be extended for up to two years.

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave affects your benefits, please contact the Welfare Fund.

Reemployment

Following your discharge from service, you may be eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in an existing health care coverage provided by your Employer.

Your USERRA coverage may be terminated if:

- You do not pay any required Self-Payment;
- You exhaust the 24-month coverage period;
- The Plan ceases to provide group health coverage;
- You lose your rights under USERRA (for instance, for a dishonorable discharge); or
- You fail to return to work or apply for reemployment within the time required under USERRA.

In the Event You Become Disabled

If you are an Employee covered under the Active Plan, become disabled, and begin receiving Social Security Disability benefits, you and your Dependents are eligible to continue coverage under the Active Plan Self-Payment Program (see page 13) until you become eligible for Medicare. The Active Plan Self-Payment amount for each four-month Eligibility Period is the current hourly contribution rate (based on your Local Union's hourly contribution rate) times 400. If you die while covered under the Active Plan, your surviving Spouse and/or Dependents can continue coverage as outlined on page 33.

You are eligible for benefits as a Disabled Employee if you:

- Receive Social Security Disability;
- Are covered on the date of your disability, as established by the Social Security Administration; and
- Were covered continuously for three full years immediately before your date disability, provided you had at least 3,000 Credited Hours during those years.

If you qualify as described above and then return to work in Covered Employment, you must work the required Credited Hours for continued eligibility in a Contribution Period; otherwise, your full Self-Payment must be satisfied. Disabled Employees do not have bank hours.

Once you become eligible for coverage under Medicare, you are considered a Retired Employee and your Self-Payment amount will change to the rates for a Retired Employee eligible for Medicare, as described on page 25.

In the Event of Your Dependent's Death

Contact the Welfare Fund to notify them of your Dependent's death. The Welfare Fund will provide you with information on how to apply for the Dependent Death Benefit.

In the Event of Your Death

In the event of your death, your surviving Dependents should contact the Welfare Fund for information on how to apply for the Death Benefit and how to continue coverage under the Plan.

If you die while eligible for benefits (as either an active Employee or Retired Employee), your surviving Spouse and Dependent children's coverage will continue until the last day of the Eligibility Period for which you would have been eligible. Once all Credited Hours that you had are used to maintain eligibility, your surviving Spouse and/or Dependents may make Self-Payments for coverage under the:

- Active Plan if at the time of your death you were covered under the Active Plan and your Spouse (or Dependents in the event you do not have a Spouse) is under age 55 and not eligible for Medicare; or
- Retiree Plan, if at the time of your death you were a Retired Employee.

You must contact the Fund Office for a claim form. A death certificate and other documentation as required by the Fund must be submitted with the claim form before the benefit will be paid.

Dependent children are eligible for coverage until the earliest of the date:

- The child no longer meets the definition of a Dependent under the Plan;
- The Plan is terminated; or
- The required Self-Payment is not received by the due date.

Continuing Dependent coverage through Self-Payment is different from COBRA Continuation Coverage. Contact the Welfare Fund if you have questions about continuing your coverage as a surviving Spouse.

Active Plan

The Active Plan Self-Payment rate is based on 400 Credited Hours during the corresponding Contribution Period at the contribution rate of your home Local Union. If the contribution rate of your home Local changes at any time, the Self-Payment rate will change accordingly. Your surviving Spouse can continue coverage under the Active Plan Self-Payment program until the earliest of the date:

- He or she remarries;
- He or she becomes covered under another group health plan;
- He or she becomes disabled and eligible for Medicare;
- He or she reaches age 55;
- The Plan ends; or
- He or she does not make the required Self-Payment by the due date.

Your designated Beneficiary must contact the Fund Office for a claim form. A death certificate and other documentation as required by the Fund must be submitted with the claim form before the benefit will be paid.

Retiree Plan

If your surviving Spouse is eligible for coverage under the Retiree Plan, as explained on page 22, he or she can continue coverage until the earliest of the date:

- He or she remarries;
- He or she becomes covered under another group health plan (See page 26 for information on opting out of coverage.);
- Of his or her death;
- The Plan ends; or
- He or she does not make the required Self-Payment by the due date.

When your surviving Spouse turns age 55 or becomes disabled and eligible for Medicare, he or she can continue coverage under the Retiree Plan as outlined on page 24.

Schedule of Benefits

The following chart highlights key features of the Plan. These benefits are described in detail throughout this booklet.

Active Plan

Medical Benefits	
Annual Maximum	No maximum
Calendar Year Deductible	$500 per person; $1,500 family maximum
Coinsurance (unless noted otherwise) PPO Non-PPO	After deductible (when applicable), Plan pays: 80% 70%
Calendar Year Out-of-Pocket Maximum	$1,500 per person; $4,500 family maximum
The out-of-pocket-maximum does not include amounts paid toward meeting the deductible. In addition, amounts paid for Physical Therapy, and Chiropractic Services (which includes X-rays and lab testing) do not apply toward meeting your out-of-pocket maximum. In addition, these expenses are not paid at 100% once you reach your out-of-pocket maximum.	
Routine Immunizations	Plan pays 100%, no deductible. The Plan follows the guidelines recommended by the American Academy of Pediatrics and/or Centers for Disease Control (CDC).
Mental Health Treatment Inpatient Outpatient	After the deductible, Plan pays: 80% 80%
Substance Abuse Treatment Inpatient Outpatient	After the deductible, Plan pays: 80% 80%
Calendar Year Maximums Chiropractic Services Outpatient Physical/Occupational Therapy Family Planning Diabetic Therapeutic Supplies and Services Mastectomy Bra Post-Mastectomy Camisole	After deductible, Plan pays up to: $1,250 per person 40 visits per person $300 per Employee and/or Dependents No maximum Four per year following surgery up to $300 per person One following surgery up to $50 per surgery
Lifetime Maximums Cochlear Implants Wheelchairs Artificial Limbs or Eyes TMJ	After deductible, Plan pays up to: No maximum One wheelchair per person One set of artificial limbs and one set of artificial eyes per person No maximum
Glasses or Contacts (after cataract surgery)	After deductible, the Plan pays $200 per person

Active Plan *(continued)*

Prescription Drug Benefits		
Brand Name Annual Deductible (Retail and Maintenance Drug/Mail Order Programs) Separate from Medical deductible	$100 per person; up to $300 family maximum	
Retail Program Generic Medication Brand Name Medication Single-Source Multi-Source Fill limit for maintenance (long-term) medications through the retail program	For up to a 30-day supply, you pay: $10 per prescription After deductible: $20 per prescription $20 per prescription plus the difference in cost between the generic and multi-source brand name medication; with a minimum Copayment of $40 Coverage is provided for up to 3 fills only	
Maintenance Drugs through Maintenance Choice Program at Retail or through Mail Order Programs Mail Order Program Generic Medication Brand Name Medication Single-Source Multi-Source Fill limit for maintenance (long-term) medications through the retail program	For up to a 90-day supply, you pay: $20 per prescription After deductible, $50 per prescription $50 plus the difference in cost between the generic and multi-source brand name medication; with a minimum Copayment of $100 No limit if filled through Maintenance Choice or Mail Order Programs	
Prescriptions filled at non-participating pharmacies, Take-home prescriptions and self-administered drugs provided by the Hospital, Non-sedating prescription allergy medications, Proton pump inhibitors (stomach medication) Compound prescriptions not processed under your Caremark Card	50%, after deductible	
Injury and Illness Weekly Benefit	**Employee Only**	
Weekly Benefit	$300	
Benefit Payable	26 weeks per occurrence	
When Benefits Begin for Total Disability Caused By: Non-Occupational Injury Non-Occupational Illness	 First day Eighth day	
Death Benefit		
Employee	$5,000	At the end of the calendar year each individual and/or designated Beneficiary will receive a tax document (1099R) from the Plan Office indicating the amount of Death Benefit and/or Accidental Death and Dismemberment Benefit received.
Spouse	$2,500	
Dependent child less than 19 years of age	$1,250	
Accidental Death and Dismemberment Benefit	**Employee Only**	
For loss of life, two limbs, sight in both eyes, or one limb and sight of one eye	$5,000	
For loss of one hand, one foot, or sight in one eye	$2,500	
For loss of thumb or index finger of one hand	$1,250	

Retiree Plan for Non-Medicare Eligible Participants

Medical Benefits	
Annual Maximum	No maximum
Calendar Year Deductible	$500 per person; $1,500 family maximum
Coinsurance (unless noted otherwise) PPO Non-PPO	After deductible (when applicable), Plan pays: 80% 70%
Calendar Year Out-of-Pocket Maximum	$1,500 per person; $4,500 family maximum
The out-of-pocket-maximum does not include amounts paid toward meeting the deductible. In addition, amounts paid for Physical Therapy, and Chiropractic Services (which includes X-rays and lab testing) do not apply toward meeting your out-of-pocket maximum. In addition, these expenses are not paid at 100% once you reach your out-of-pocket maximum.	
Routine Immunizations	Plan pays 100%, no deductible The Plan follows the guidelines recommended by the American Academy of Pediatrics and/or Centers for Disease Control (CDC).
Mental Health Treatment Inpatient Outpatient	After the deductible, Plan pays: 80% 80%
Substance Abuse Treatment Inpatient Outpatient	After the deductible, Plan pays: 80% 80%
Calendar Year Maximums Chiropractic Services Outpatient Physical/Occupational Therapy Family Planning Diabetic Therapeutic Supplies and Services Mastectomy Bra Post-Mastectomy Camisole	After the deductible, Play pays: $1,250 per person 40 visits per person $300 per Employee and/or Dependents No maximum Four per year following surgery up to $300 per person One following surgery up to $50 per surgery
Lifetime Maximums Cochlear Implants Wheelchairs Artificial Limbs or Eyes TMJ	After the deductible, Plan pays: No maximum One wheelchair per person One set of artificial limbs and one set of artificial eyes per person No maximum
Glasses or Contacts (after cataract surgery)	After the deductible, the Plan pays $200 per person

Retiree Plan for Non-Medicare Participants *(continued)*

Prescription Drug Benefits	
Brand Name Annual Deductible (Retail and Mail Order Programs) Separate from Medical deductible.	$100 per person; up to $300 family maximum
Retail Program Generic Medication Brand Name Medication Single-Source Multi-Source Fill limit for maintenance (long-term) medications through the retail program	For up to a 30-day supply, you pay: $10 per prescription After deductible: $20 per prescription $20 per prescription plus the difference in cost between the generic and multi-source brand name medication; with a minimum Copayment of $40 Coverage is provided for up to 3 fills only.
Maintenance Drugs through Maintenance Choice program at Retail and through Mail Order Program Generic Medication Brand Name Medication Single-Source Multi-Source Fill limit for maintenance (long-term) medications	For up to a 90-day supply, you pay: $20 per prescription After deductible, $50 per prescription $50 plus the difference in cost between the generic and multi-source brand name medication; with a minimum Copayment of $100 No limit if filled through the Maintenance Choice or Mail Order Programs
Prescriptions filled at non-participating pharmacies, take-home prescriptions and self-administered drugs provided by the Hospital, non-sedating prescription allergy medications, and proton pump inhibitors (stomach medication) are covered at 50%. Compound prescriptions not processed under your Caremark Card will be covered at 50%.	
Death Benefit	
Retired Employee	$5,000
Spouse	$2,500
Dependent child less than 19 years of age	$1,250
At the end of the calendar year each individual and or designated Beneficiary will receive a tax document (1099R) from the Plan office indicating the amount of Death Benefit received.	

Retiree Plan for Medicare-Eligible Participants

Medical Benefits	
Fund Annual Deductible	None
Medicare Parts A and B Deductibles	Plan pays 100%
Medicare Part A Hospital Stays: 1 - 60th Day 61st - 100th Day Skilled Nursing Facility 21st to 100th Day Home Health Care Blood	 Plan pays 100% of Medicare Part A Deductible Plan pays 100% of per diem (if Medicare does not pay because all of inpatient Hospital days have been used, no benefits are paid by the Plan) Plan pays 100% of per diem Plan pays 20% of Medicare allowable Plan pays 20% of Medicare allowable (Participant pays for first three pints of blood, unless someone else donates blood to replace).
Medicare Part B Medical, Home Health, Outpatient Hospital, and Other Services Outpatient Mental Health Mammogram Screening, Bone Mass Measurements, Pap Test and Pelvic Exams Colorectal Cancer Screening Prostate Cancer Screening Vaccinations	Plan pays 100% of Medicare Part B Deductible Plan pays 20% of Medicare allowable Plan pays 50% of Medicare allowable Plan pays 20% of Medicare allowable Plan pays 20% of Medicare allowable Plan pays 20% of Medicare allowable Plan pays 20% of Medicare allowable Plan pays 20% of Medicare allowable for Hepatitis B shots Medicare pays 100% of flu and pneumococcal immunizations if the provider accepts Medicare assignment. Plan pays 20% of Medicare allowable for the injection for flu and pneumococcal immunizations
Prescription Drug Benefits	
Brand Name Annual Deductible (Retail and Maintenance Drug/ Mail Order Programs) Separate from Medical deductible	$100 per person; up to $300 family maximum
Retail Program Generic Medication Brand Name Medication Single-Source Multi-Source Fill limit for maintenance (long-term) medications through the retail program	For up to a 30-day supply, you pay: $10 per prescription After deductible: $20 per prescription $20 per prescription plus the difference in cost between the generic and multi-source brand name medication; with a minimum Copayment of $40 Coverage is provided for up to 3 fills only
Maintenance Drugs through Maintenance Choice Program at Retail or through Mail Order Programs Mail Order Program Generic Medication Brand Name Medication Single-Source Multi-Source Fill limit for maintenance (long-term) medications	For up to a 90-day supply, you pay: $20 per prescription After deductible, $50 per prescription $50 plus the difference in cost between the generic and multi-source brand name medication; with a minimum Copayment of $100 No limit if filled through the Maintenance Choice or Mail Order Programs
Prescriptions filled at non-participating pharmacies, take-home prescriptions and self-administered drugs provided by the Hospital, non-sedating prescription allergy medications, and proton pump inhibitors (stomach medication) are covered at 50%. Compound prescriptions not processed under your Caremark Card will be covered at 50%	

Death Benefit	
Retired Employee	$5,000
Spouse	$2,500
Dependent child less than 19 years of age	$1,250
At the end of the calendar year each individual and or designated Beneficiary will receive a tax document (1099R) from the Plan office indicating the amount of Death Benefit received.	

Claim Filing and Appeal Information

Filing Claim Forms

Most health care providers will submit your claims for you. Be sure to show your ID card to your Physician so they will know where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so.

All claims should be submitted within 90 days after you receive the services or supplies, but no later than the maximum time limits listed below. To assist the Welfare Fund in processing claims as quickly as possible, please follow the steps listed below.

Step 1: Complete your portion of the form by filling in all information requested.

- Be sure to include the last four digits of your Social Security number or your Unique Identification Number as provided to you by the Fund and sign your form. If the claim is for a Dependent, provide the name of the Dependent and include the name of any other group health plans, if applicable.
- If you or your Dependent has coverage under two or more health plans, be sure to include the other health plan's name, address, group/policy number, telephone number on the claim form, and a copy of the front and back of your other Plan's identification card.
- If the claim is the result of an accident, be sure to complete the accident portion of the benefit claim form.
- If applying for the Injury and Illness Weekly Benefit, be sure to attach a disability statement completed by your Physician.
- If the condition occurred in the course of employment, provide the name of the Employer and their workers' compensation carrier.
- Sign and date the claim form.

Step 2: Forward the completed form, within 45 days if possible, and all related bills to:

Mid Central Operating Engineers Health and Welfare Fund
1100 Poplar Street
P.O. Box 9605
Terre Haute, IN 47808

For more claims related information, such as how benefits are coordinated and what happens when a third party is involved, see *General Plan Information,* beginning on page 65.

Most providers will file claims for you. If your provider does not, follow the steps listed in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees.

If you or a Dependent has coverage under more than one health care plan, benefits are coordinated (see page 66).

Receipt of completed claim forms, invoices from providers, or receipts for payment of covered services or supplies are considered as notice of claim. Please submit these items within 90 days of the occurrence of an Injury or Illness or as soon as is reasonably possible thereafter. Benefits will not be paid for any claims submitted later than:

- 90 days for disability claims;
- 18 months after the expense was incurred for health care claims submitted by Medicare-eligible Retirees; or
- 12 months for all other claims.

If additional information is requested to complete the claim, you must provide that information within 24 months of the service date or your claim will be denied.

During disability, you will periodically be asked to complete a supplementary statement to help determine continued eligibility for this benefit. You and your Physician must complete this form.

Claim Types

- **Health Care Claims:** Health care claims include medical claims for services you have already received. Claims related to prescription drug benefits are administered as provided in the subsection entitled *Claims and Appeals for Prescription Drug Benefits* on page 45.
- **Disability Claims:** Disability claims are claims for Injury and Illness Weekly Benefits or Accidental Death and Dismemberment (when due to dismemberment) Benefits. Be sure to notify your Employer and the Welfare Fund if you are Ill or Injured and are unable to work. The Welfare Fund will send you a disability form upon request. Have your Physician complete the form. Then send the completed form to the Welfare Fund as soon as possible. Benefits are not payable until you apply for and submit the required information.
- **Death Claims:** Death claims are claims for Death and Accidental Death and Dismemberment (when due to an accident) Benefits. In the event of your death, your Beneficiary should call the Welfare Fund for help in filing a claim.

Claim Decisions and Benefit Payment

When a claim for benefits is submitted to the Welfare Fund, the Welfare Fund will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. In some situations, the Fund has the right to request a physical exam by a Physician of its choice or an autopsy in the event of death.

- **Health Care Claims:** Generally, you will be notified of the decision on your health care claim within 30 days from the Plan's receipt of the claim. This period may be extended by the Plan once for up to 15 days if the extension is necessary due to matters beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

  If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided based on the information that the Plan has and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a health care claim and notify you of the determination.

- **Disability Claims:** Generally, you will receive written notice of a decision on your initial claim within 45 days of the Fund's receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days if the Plan Administrator notifies you, before the end of the first 30-day extension period, of the circumstances requiring the extension and the date the Plan expects to make a decision. When there is an additional extension, the Plan will send a notice that explains the:
  - Standards for eligibility of the benefit;
  - The unresolved issues preventing a decision on the claim; and
  - Any additional information that is needed to process and make a determination on your claim.

  If additional information is needed to process your claim, you will be notified of the need for the additional information and you then have up to 45 days from when you receive the notice to provide the requested information. Once the information is received, the Plan will make a determination within 15 days. If you do not provide the information within the 45-day period, then your claim may be denied.
- **Death Claims:** Generally, written notice of a decision on the claim will be received within 90 days after the Plan receives the claim. If circumstances require an extension for processing, the claimant will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Welfare Fund. If a disagreement is not resolved, there is a formal appeal procedure you can follow to have your claim reconsidered.

If a Claim is Denied

If your claim is denied (in whole or in part), the Plan will:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes.

Information Requirements

When the Plan notifies you of its initial denial on your claim, it will provide:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and
- A copy of the Plan's claim review procedures and periods to appeal your claim, plus a statement of your right to bring a lawsuit under ERISA Section 502(a) following the denial of your claim.

In addition, for ***health care*** and ***disability*** claims, you will receive a copy, or a statement that a copy is available to you at no cost upon request, of:

- Any internal rule, guideline, protocol, or similar criteria if such internal rule, guideline, protocol, or similar criteria that was relied on in deciding your claim; or
- Any scientific or clinical judgment if your claim is denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit.

Appealing a Denied Claim

If your claim is denied (in whole or in part) or you disagree with the Trustees' determination in regards to your eligibility for benefits or the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Fund Administrator at the Welfare Fund as soon as possible. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days after you receive the notice of denial for ***health care*** or ***disability*** claims; or
- 60 days after you receive the notice of denial for ***death*** claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents; and
- Request to review all relevant information (free of charge).

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Welfare Fund authorizing this representative.

You have the right to request a free copy or an explanation of any of the following if your claim for ***health care*** or ***disability*** benefits is denied based on:

- Any internal rule, guideline, protocol, or other similar criteria, regardless of whether or not it was relied on in deciding your claim; or
- A Medical Necessity, Experimental treatment, or similar exclusion or limit.

Appeal Decisions

The Board of Trustees is the Plan Administrator and the fiduciary responsible for all benefit determinations on appeal. The Board of Trustees may delegate all fiduciary responsibility for claims determinations to an Appeal Committee. The Appeal Committee will meet at regularly scheduled times and decisions will be made within the periods described in this section.

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made and the Trustees will not take into consideration the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The timeframe for appeals determinations for the various types of claims are as follows:

- **Health Care Claims:** A determination will be made within 60 days from receipt of the appeal.
- **Disability Claims:** Generally, a determination will be made within 45 days from receipt of the appeal. If additional time is required to make a determination (for reasons beyond the control of the Plan), you will be notified within this time. The notification will include the circumstances requiring the extension and the date the Plan expects to make a decision. A decision will be made within 45 days of the time the Plan notifies you of the extension.
- **Death Claims:** Generally, a determination will be made within 60 days from receipt of the appeal. If additional time is required to make a determination (for reasons beyond the control of the Plan), notification will be provided, which will include the circumstances requiring the extension and the date the Plan expects to make a decision. A decision will be made within 60 days of the time the Plan provides notification of the extension.

Information Requirements

When the Plan notifies you of its determination on your appeal, it will provide:

- The specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records, and relevant information;
- A statement of your right to bring a civil lawsuit under ERISA Section 502(a) following the denial of your claim appeal.

In addition, for ***health care*** and ***disability*** claim appeals, you will receive a copy, or a statement that a copy is available to you at no cost upon request, of:

- Any internal rule, guideline, protocol, or similar criteria if such internal rule, guideline, protocol, or similar criteria, whether or not it was relied on in deciding your appeal; or
- Any scientific or clinical judgment relied on in deciding your appeal, if your appeal is denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit.

Medical Judgments

If your claim is denied based on a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity, upon request, of any medical experts consulted in making a determination of your appeal.

Timely Handling

You must submit all claims to the Welfare Fund within one year from the date of service. Medicare eligible Retiree's must submit all claims to the Welfare Fund within 18 months from the date of service. The Plan will not consider benefits for any claim not submitted within these time periods.

No Predetermination of Claims

Notwithstanding anything to the contrary, in no event will the approval or denial of a claim be made before the expense is incurred and submitted for payment, with sufficient documentation and written in English, to the Board of Trustees.

Authorized Representative

An authorized representative is the person with authority to act on your behalf to file a claim in accordance with the Plan's claims procedures. The following individuals may be recognized as your authorized representative: health care provider; legal Spouse; Dependent child age 18 or older; parents or adult siblings; grandparent; court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or other adult.

The Plan requires that you make a written statement that you are designating one of the above individuals or entities as your authorized representative along with the representative's name, address and phone number. If you are unable to provide a written statement, the Plan will require written proof (e.g. power of attorney for health care purposes, court order of guardian/conservator) that the proposed authorized representative has been authorized to act on your behalf.

Once you name an authorized representative, the Plan will route all future claims and appeals-related correspondence to your authorized representative and not to you. The Plan will honor the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. You may revoke a designated authorized representative by submitting a signed statement.

Sole Authority on Benefits

Under the documents creating the Plan, the Trustees have sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision making authority has been delegated by the Trustees, in their sole discretion, decide the Participant or Beneficiary is entitled to benefits under the Plan's terms. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a Plan benefit. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner.

You must follow and exhaust the Plan's claims and appeals procedures completely before you bring an action in court under the Employee Retirement Income Security Act (ERISA) to obtain benefits. You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the review procedures described in this section. No legal action for an appeal decision (including actions or proceedings before administrative agencies) may begin later than two years from the date the claim was required to be filed.

You may have, at your own expense, legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

Benefit Payments

Benefit payments under the Fund may become payable to a person who is judged to be incompetent or to a person who, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer such payments properly. In that event, the Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which paid if they are paid:

- Directly to such person;
- To the legally appointed guardian or conservator of such person;
- To any Spouse, child, parent, brother, or sister of such person for the welfare, support, and maintenance of that person; or
- By the Trustees directly for the support, maintenance, and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

Right of Recovery

Whenever payments have been made by the Trustees with respect to charges in a total amount at any time in excess of the maximum amount of payment required under the provisions of the Plan, the Trustees shall have the right to recover such payments, or to offset against future obligations, to the extent of such excess, from among one or more of the following, as the Trustees shall determine and as applicable:

- Any persons or entities to or for or respect to whom such payments are made;
- Future obligations of the Plan to the affected Employees or Dependents;
- Any insurance companies;
- Any service providers; and
- Any other organization.

In the event that the Trustees take legal action to recover any excess payments, jurisdiction will be in Vigo County, Indiana. The Employee, Dependent or organization against whom the action for recovery of excess payments is brought will, in addition to the excess payments, be responsible to pay for attorneys' fees and court costs incurred by the Trustees in bringing the action.

Claims and Appeals for Prescription Drug Benefits

When you present a prescription to the CVS Caremark Pharmacy or mail order Pharmacy, or a non-participating Pharmacy, you are not considered to have made a claim for prescription drug benefits. However, if the Pharmacy denies your prescription, you may submit a claim to the Caremark Customer Care Department, using the following procedures:

Right to file a claim. If a network retail or mail order Pharmacy, or non-network Pharmacy denies your prescription, you have the right to file a claim for benefits through the Caremark Customer Care Department. In addition, if you obtain a prescription through a non-participating Pharmacy, you may file a claim for reimbursement. You or your representative must submit your claim in writing by fax or mail to the Caremark Appeals Department within one year of the date the Pharmacy refuses to fill your prescription, or the date you fill your prescription through a non-participating Pharmacy and seek reimbursement for payment for your prescription. You may contact the Caremark Customer Care Department for instructions on where and how you should file this initial claim. You should send any supporting documentation along with your claim. In the case of an Urgent Care claim, you or your Physician may make the request by telephone.

Upon receipt of your claim, the Appeals Analyst at Caremark will consider relevant and supporting documentation that is submitted by you or on your behalf. Supporting documentation may include a letter by your Physician in support of your claim, a copy of the denial letter or other documentation issued by the Pharmacy and/or Caremark, a copy of your payment receipt, or your medical records. The Appeals Analyst reviews and determines claims that relate to clinical benefits, such as eligibility determinations, Copayment issues, and explicit exclusions under the Plan. Claims involving clinical knowledge, such as prior authorization denials, are reviewed by the Appeals Pharmacist.

Your claim will be processed within the following periods from the date your claim is received:

- Within 15 days for Pre-Service claims;
- Within 30 days for Post-Service claims; and
- Within 72 hours for Urgent Care claims.

If your claim cannot be processed due to insufficient information, Caremark will notify you about what specific information is needed before the expiration of the claim decision period above (and within 24 hours for Urgent Care claims). You will then have 45 days (5 days for Urgent Care claims) to supply the additional information. If you do not provide the information during this period, your claim will be decided on the information available to Caremark, and may be denied. During the period in which you are permitted to provide this additional information, the normal period for making a decision is suspended until the earlier of the expiration of this additional period, or the date Caremark receives your information. Caremark then has 15 days (48 hours for Urgent Care claims) to make a decision on your claim and notify you of the decision.

If your claim is allowed, the notice will include the basic steps or process that either CVS Caremark or you need to follow. If your claim is denied, you will receive a notice that:

- Gives the specific reasons for the denial;
- Refers to the specific Plan provisions on which the denial is based;
- Describes any additional information needed to perfect your claim and gives an explanation of why such information is necessary;
- Provides an explanation of the Plan's appeal procedure, along with time limits;
- Contains a statement that you have a right to bring a civil action under ERISA Section 502(a) following an appeal; and
- If the denial is based on an internal rule, guideline, protocol, or similar criterion, provides a statement that such rule, guideline, protocol or criteria will be provided to you free of charge, upon request; and
- If the denial is based on a medical judgment (medical necessity, Experimental or Investigational), provides a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free of charge upon request.

Appeal of the denial of your initial claim. Caremark will decide appeals of denials of your initial claim (including those regarding Prior Authorization requests that are upheld during your initial claim).

Submitting an Appeal. All appeals must be submitted to the Claims Administrator in writing. In the case of an appeal of an Adverse Benefit Determination rendered on an Urgent Care Claim, the attending physician may also call the Claims Administrator to submit an appeal.

Your appeal should include the following:

- Name of the person the appeal is for
- CVS Caremark Identification Number
- Date of Birth
- Written statement of the issue(s)
- Drug name(s) being appealed
- Documents, records or other information relating to the Claim

Your written appeal and supporting documentation may be mailed or faxed to the Claims Administrator:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

Please note that only for appeals of denials of Prior Authorization requests that are upheld in the first level of appeal, the appeals are conducted by an external independent review organization (IRO) that contracts with Caremark for such reviews. The IRO conducts independent specialist Physician reviews of denials of authorization of benefits when you are entitled to such a review. Once you have requested an appeal, the reviewer may contact you for additional information that is necessary or potentially useful in the review. The IRO will prepare an independent rationale in support of the final decision, which Caremark will forward to you.

For all appeals, you or your representative must submit your appeal in writing by fax or mail to the Caremark Appeals Department within 180 days of the date of decision on your initial claim. The letter you receive denying your claim will instruct you where and how you should file your appeal. In the case of an Urgent Care appeal, you or your physician may make the request for appeal by telephone.

The Appeals Analyst at Caremark will consider relevant and supporting documentation that is submitted by you or on your behalf. Supporting documentation may include a letter by your Physician in support of your appeal, a copy of the denial letter or other documentation issued by the Pharmacy and/or Caremark, a copy of your payment receipt, or your medical records. The Appeals Analyst reviews and determines appeals that relate to clinical benefits, such as eligibility determinations, Copayment issues, and explicit exclusions under the Plan. Appeals involving clinical knowledge are reviewed by the Appeals Pharmacist.

Your appeal to Caremark will be processed within the following periods from the date you request the review:

- Within 15 days for Pre-Service claims;
- Within 30 days for Post-Service claims; and
- Within 72 hours for Urgent Care claims.

You will receive a written notice of the decision. If your claim is denied, the notice will include the specific reasons for the denial, references to the section of the Plan on which the denial was based, and information regarding how you may bring an action under Section 502 of ERISA. If your claim is allowed, the notice will include the basic steps or process that either CVS Caremark or you need to follow.

Medical Benefits

For Active Plan Participants and Non-Medicare Eligible Retiree Plan Participants

How Medical Benefits Work

Each year between January 1 and December 31, the Plan's benefits are provided as follows:

- **Annual Deductible:** The annual deductible is the amount of covered medical expenses that you and your family pay before the Plan begins to pay covered Medical Benefit expenses. You are responsible for meeting the individual or family deductible. No one family member can apply more than the individual deductible amount toward meeting the family maximum. However, payments toward the individual deductible are limited to the family maximum; so once payments toward the individual deductible for all family members reach the family maximum, individual deductibles for all family members will automatically be satisfied for that year.

  Here's an example:

  Tom is married to Sue and they have two children, Sally and Rob, the individual deductible for them is $500, while the family deductible is $1,500. Here's how they reached their family deductible for the year:

Patient	Claim Amount	Amount Applied toward Individual Deductible	Amount Applied toward Family Deductible	Total Family Deductible
Sue	$6,500	First $500	$500	$500
Rob	$5,800	First $500	$500	$1,000
Sue	$575	$0*	$0	$1,000
Sally	$250	$250	$250	$1,250
Tom	$790	$250**	$250	$1,500

*Once Sue met her individual deductible, any additional covered expenses for Sue will not count toward the family deductible.

**Once the family deductible is met ($1,500), all family members have met the deductible and any additional covered expenses will be covered from the first dollar at the appropriate Coinsurance rate.

- **Deductible Carryover:** If you incur expenses toward your deductible in October, November, or December of one year, those expenses will also be applied toward your deductible for the following year.
- **Coinsurance:** Once you or your family meet the annual deductible, the Plan pays a percentage of covered expenses and you pay the rest. The amount the Plan pays varies depending on whether you use PPO or non-PPO providers, as shown on the *Schedule of Benefits*.
- **Out-of-Pocket Maximum:** The Plan limits the amount you pay out-of-pocket in a calendar year toward covered medical expenses. Once the Coinsurance amounts you pay for covered expenses, including the amounts you paid toward your annual deductible, reach the individual or family out-of-pocket maximum, the Plan pays 100% of most covered expenses for that individual or family, as applicable, for the remainder of the year. Note that amounts paid for Physical Therapy and Chiropractic Services (which includes X-rays and lab testing) do not apply toward meeting your out-of-pocket maximum. In addition, these expenses are not paid at 100% once you reach your out-of-pocket maximum. Your out-of-pocket maximum starts at $0 every January.

When you need to see a Physician…

- Call and make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you are taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment.
- File a claim with the Welfare Fund if your provider does not file claims for you. It is a good idea to make a copy of the claim form and any supporting materials for your records before submitting the claim.

- **Lifetime Maximum:** The Plan pays some specific medical covered expenses up to the Lifetime Maximum listed on the *Schedule of Benefit* for each person.

The annual deductible and out-of-pocket maximum do not apply to every covered service, as shown in the *Schedule of Benefits*. Some expenses may be covered differently or are subject to benefit maximums.

- **Unclaimed Checks.** In addition, any benefit payments that are unclaimed (e.g., uncashed benefit checks) will be honored for 24 months after issuance and then will become property of the Fund if still uncashed at that time.

> **PPO**
>
> A Preferred Provider Organization (PPO) is a network of Hospitals, Physicians, and other providers that have agreed to charge negotiated rates. Since PPO providers have agreed to these negotiated rates, you help control health care costs for you and the Plan when you use PPO providers.

Preferred Provider Option (PPO)

The Plan provides benefits through a Preferred Provider Organization (PPO). When you use a PPO provider, you save money for yourself and the Plan because PPO providers have agreed to charge negotiated rates. In addition, you pay less when you use a PPO provider because the Plan pays a higher percentage of covered expenses provided by PPO providers. However, it is your decision whether to use a PPO or Non-PPO provider. You always have the final say about the providers you and your family use.

Example of How Using PPO Providers Saves Money

Let's compare what Joe pays when using a PPO provider versus a non-PPO provider, based on total non-network charges of $5,000 (this assumes Joe has met his annual deductible):*

	*PPO Provider**	*Non-PPO Provider**
Covered Expenses	*$4,000*	*$5,000*
Percent Plan Pays	*x 80%*	*x 70%*
Amount Plan Pays	*$3,200*	*$3,500*
Covered Expenses	*$4,000*	*$5,000*
Percent Joe Paysx 20%	*x 30%*	
Amount Joe Pays	*$800*	*$1,500*

*Joe saves **$700** by using a PPO provider; and the Plan pays less as well.*

**This example, which is for illustrative purposes only, assumes a PPO savings of 20%.*

For a list of PPO providers, or to find out if your provider is in the PPO network, contact the PPO (see the *Important Contact Information* page 78).

Covered Medical Benefit Expenses

The Plan pays covered expenses based on the Usual and Customary amount for the Medically Necessary expenses ordered by a Physician described in this section.

> Non-PPO providers' services are always computed on the Usual and Customary amount, so the covered expense (actual charge) could be reduced before payment is calculated and the eligible individual would be liable for this reduction.

1. Hospital services and supplies, including:
   a. Hospital semi-private room and board charges;
   b. Hospital miscellaneous charges; and
   c. Hospital outpatient charges.
2. Surgery and related services and supplies, including:
   a. Physician's surgical charges, including assistant Surgeon; and
   b. Professional anesthetist charges.
3. Nursing and therapeutic services, including:
   a. Charges by a Registered Nurse for treatment of an Illness or Injury, except for services rendered by a person who ordinarily resides in the Employee's or Dependent's household or is a family member;
   b. Physical and Occupational Therapy, up to the limits shown in the *Schedule of Benefits*; and

c. Home Health Care, including part-time or intermittent home nursing care provided by a Registered Nurse.

4. Medical supplies, drugs, and medications prescribed by a Physician, and lab services, but only to the extent that they would have been covered in a Hospital.

5. Hospice care.

6. Medically Necessary Emergency transportation, including charges for local Emergency professional ambulance service and, if the Injury or Illness requires special and unique Hospital treatment, transportation within the United States or Canada to the nearest Hospital equipped to furnish the treatment not available in a local Hospital, by professional ambulance, railroad, or air ambulance.

7. Medically Necessary drugs, prosthetic devices, dressings, and laboratory services, including:

    a. Diagnostic X-ray and laboratory service;

    b. Oxygen and rental of equipment for its administration;

    c. Blood or blood plasma and its administration;

    d. Radium, radioactive isotopes, and X-ray therapy;

    e. Casts, splints, braces, trusses, and crutches; and

    f. Artificial limbs and eyes to replace natural limbs and eyes lost, up to the individual Lifetime maximum (which includes repairs and maintenance) listed on the *Schedule of Benefits*.

8. Durable Medical Equipment, which includes, but is not limited to Medically Necessary equipment to treat an Injury or Illness such as:

    a. Apnea monitors;

    b. Blood sugar monitors;

    c. Nebulizers, oximeters, oxygen and supplies, and ventilators;

    d. Rental or purchase (once in a Participant's Lifetime) of hospital-type bed or similar Durable Medical Equipment;

    e. Purchase of a motorized or non-motorized wheelchair (once in a Participant's Lifetime) up to the per person Lifetime maximum listed on the *Schedule of Benefits*; and

    f. Orthotics limited to one pair per Lifetime.

9. Gynecological services, including:

    a. Family planning, which includes birth control drugs, contraceptive devices, other contraceptive management, and related expenses, up to the per person maximum listed on the *Schedule of Benefits*. (Patient must pay for birth control drugs and any prescription contraceptive devices at the time of purchase and remit receipt to the Welfare Fund for processing.); and

    b. Reconstructive surgery following mastectomy, as required by the Women's Health and Cancer Rights Act of 1998, which includes:

        i. All stages of reconstruction of the breast on which the mastectomy has been performed;

        ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

        iii. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema (swelling associated with removal of lymph nodes).

    c. Four mastectomy bras per year and one post-mastectomy camisole following mastectomy surgery up to the limits shown in the *Schedule of Benefits*.

    These benefits are subject to the same deductibles and Coinsurance applicable to other Plan medical and surgical covered expenses.

10. Maternity (condition of motherhood) services and supplies for Employees and Dependent Spouses, which are covered the same as any other medical covered expense. All expenses incurred are considered the mother's medical expenses. In addition to other covered medical expenses, covered maternity expenses include:
    a. Inpatient nursery charges;
    b. Inpatient newborn Physician charges;
    c. Delivery by a licensed Midwife in a hospital;
    d. Amniocentesis; and
    e. Ultrasound tests.
11. Mental health and substance abuse treatment, as follows:
    a. Mental or Nervous Disorder treatment as shown in the *Schedule of Benefits* if provided by a Mental Health Practitioner, and
    b. Voluntary alcoholism/drug abuse treatment as shown in the *Schedule of Benefits*.
12. Chiropractic Services and treatment as shown in the *Schedule of Benefits* when performed by a Physician or licensed chiropractor.
13. Cochlear implants, which include expenses for the cochlear implants, devices, surgical implantation of the device, Physician services associated with implantation, repairs or replacements of the device component, and post-operative rehabilitation or therapy, as Medically Necessary provided that a patient meets all of the following criteria:
    a. Diagnosis of bilateral moderate-to-profound sensor neural hearing impairment with "limited benefit" from appropriate hearing (or vibrotactile) aids;
    b. Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
    c. Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;
    d. No contraindications to surgery; and
    e. The cochlear implant device is used in accordance with the Food and Drug Administration (FDA) approved labeling.

    "Limited benefit" from amplification, as described above, means a patient who is defined by hearing test scores of less than or equal to 40% correct in the best-aided listening condition on tape-recorded tests of open-set sentence cognition.
14. Dental services limited to:
    a. Dental services rendered by a Physician or dentist for the treatment of an Injury, from an outside source, to the jaw or to sound and natural teeth including the initial replacement of these and any necessary dental X-rays resulting from an accident, provided the treatment is rendered within six months from the date of the accident and the person is eligible for benefits at the time of service;
    b. Temporomandibular Joint (TMJ) treatment, provided that such treatment is not solely for a Cosmetic reason. Services that are considered dental in nature are excluded, and
    c. Dental treatment or dental surgery that is part of a cancer treatment plan recommended by your treating Physician.
15. Routine physical examinations and well-child exams, including but not limited to:
    a. Routine lab work;
    b. Mammogram;
    c. Colorectal screening;

The Plan does not restrict benefits for any covered Hospital length of stay in connection with childbirth for the mother and/or newborn Child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. The Plan does not require a health care provider to obtain pre-certification for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours, or 96 hours, as applicable.

Contraindications means a condition or factor that increases the risks involved in using a particular drug, carrying out a medical procedure, or engaging in a particular activity.

   d. PSA screening;
   e. Pap tests;
   f. Urinalysis; and
   g. Routine adult and childhood immunizations as shown in the *Schedule of Benefits*. The Plan follows the guidelines recommended by the American Academy of Pediatrics and/or Centers for Disease Control (CDC).

16. Morbid Obesity treatment, which includes charges for one course of treatment per Lifetime for the surgical treatment of Morbid Obesity when provided by a PPO provider and subject to the Plan's Morbid Obesity criteria (see page 9), including, but not limited to:
   a. Gastric restrictive procedures;
   b. Gastric or intestinal bypass;
   c. Follow-up surgery to correct a previous gastric surgical procedure and/or any complications due to surgery; and
   d. Post-surgical counseling; provided that the patient:
      i. Is at least age 18 but not older than age 60;
      ii. Has previously tried and failed other weight loss options of at least six months' duration during the five-year period before surgery; and
      iii. Is Morbidly Obese (as defined on page 9).
17. Diabetic therapeutic supplies and services such as therapeutic shoes, inserts, shoe modifications (instead of inserts), diabetes self-management training or medical nutrition therapy services, along with routine care of feet, including callus or corn paring, trimming of toenails or other routine services associated with diabetes (as shown on the *Schedule of Benefits*).

    These benefits are subject to the same deductibles and Coinsurance applicable to other Plan medical and surgical covered expenses.

    Therapeutic shoes/shoe modifications or inserts must be prescribed by a podiatrist or qualified doctor. A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes.
18. Diabetic services, devices, and supplies including, but not limited to, hypodermic needles, syringes, blood sugar testing monitors, blood sugar test strips, lancets, and insulin pumps.
19. Drug screening for Crane Operator's Certificate or CDL Certification with proof of certification.

Expenses Not Covered Under Medical Benefits

Medical Benefits do not provide coverage for certain expenses incurred for the treatment of an Illness or Injury. The expenses described below are not covered by the Plan for Medical Benefits and/or Injury and Illness Weekly Benefits.

1. The Plan pays benefits only for those expenses expressly described as covered; any omission will be presumed to be an exclusion
2. Preventative immunizations and injections, except as provided under the guidelines recommended by the American Academy of Pediatrics and/or Centers for Disease Control (CDC).
3. Pre-employment physicals, (except drug screening for Crane Operator's Certification or CDL Certification) pre-martial blood tests, and similar tests.
4. Any Injury or Illness that arises out of, or in the course of, any occupation or employment, or any claim covered by workers' compensation or occupational disease law. This exclusion does not apply to Accidental Death and Dismemberment Benefits.
5. Any expense or charge for services or supplies that are provided or paid for by the federal government or its agencies, except for:
   a. The Veterans Administration, when services are provided to a veteran for a disability that is not service connected; and

   b. A group health plan established by a government for its own civilian employees and their Dependents.

6. Any loss caused by war or any act of war.
7. Any loss incurred while engaged in military, naval, or air service.
8. Any loss, expense, or charge for care, treatment, services, supplies, or drugs, due to pregnancy for a Dependent child.
9. Any loss, expense, or charge for sex transformation or any treatment, service, supply, or drug related to treatment of sexual dysfunctions.
10. Any loss, expense, or charge for care, treatment, services, supplies, drugs, or research studies that are Experimental.
11. Any loss, expense, or charge for care, treatment, services, supplies, or drugs not considered legal in the United States.
12. Any loss, expense, or charge for care, treatment, services, supplies, or drugs that are not uniformly and professionally endorsed by the general medical community as standard medical care.
13. Any loss, expense, or charge for care, treatment, services, supplies, or drugs due to exogenous obesity, weight reduction, and control.
14. Eye refraction (unless following Injury to the eye), routine eye examinations, fitting or cost of eyeglasses, vision therapy (including, but not limited to, amblyopia, binocular dysfunction, myopia, estropia, and exotropia). However, the first pair of glasses (including frames) or contact lenses after cataract surgery will be covered up to maximum listed on the *Schedule of Benefits*.
15. Radial keratotomy or any other surgery to correct vision, except for surgical removal of cataracts and surgical correction of exotropia or estropia.
16. Hearing tests or hearing aids.
17. Cosmetic, plastic, or reconstructive surgery, except:
    a. To repair or alleviate damage resulting from or caused by Injury, congenital defect, or disfigurement related to disease; and
    b. Reconstructive surgery following a mastectomy, to the extent that required under the Women's Health and Cancer Rights Act.
18. Smoking cessation programs and/or tobacco use disorders.
19. Preventative injections (i.e., Vitamin B-12 injections), biological, or immunization agents or inoculations, except as provided under routine childhood immunizations for Dependent children and adult immunizations and special programs approved by the Board of Trustees.
20. Non-Emergency ambulance or transportation services, except as provided otherwise.
21. Chelation therapy, except in the cases of lead poisoning.
22. Injury or Illness arising from or occurring during the claimant's attempt to commit or in the claimant's commission of:
    a. A misdemeanor, other than a minor misdemeanor (such as a Class B or Class C misdemeanor in Illinois, or a Class B or Class C misdemeanor in Indiana), that results in a conviction, including a conviction for driving while legally impaired; or
    b. A felony that results in a conviction, including a conviction for driving while legally impaired.

    However, Injuries or Illnesses that are due to an underlying physical or mental health condition, as defined by applicable federal law, or that occur during acts of domestic violence will not be excluded from coverage under the Plan, regardless of a related conviction.
23. Any Illness or Injury that arises out of or occurs as a result of a third party whose insurance may be responsible for paying the expenses.
24. Non-prescription drugs, supplies, services, or over the counter items, even if prescribed by a Physician.
25. Orthopedic or customized shoes, except when joined to a full leg brace or other supportive devices for the feet, including, but not limited to, arch supports and heel lifts, except for the purchase of one pair of custom orthotics, per Lifetime.

26. Routine care of feet, including callus or corn paring, trimming of toenails, or other routine services.
27. Medical services and supplies, including prescription drugs and day care, furnished in or by a nursing home, sanitarium, rest home, convalescent home, Skilled Nursing Facility or similar establishment, or in a facility that provides educational or behavior modification services in a residential setting for individuals with behavioral or social adjustment problems, mental retardation, or autism.
28. Diagnosis or treatment of fertility or infertility or promotion of fertility including, but not limited to:
    a. Fertility tests and procedures;
    b. Reversal of voluntary, surgically induced infertility; and
    c. Attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, and embryo transfer.
29. Repairs or maintenance on purchased Durable Medical Equipment, including, but not limited to, batteries, tires, protective supplies, construction services, blood pressure cuffs, free standing traction devices, feeding pumps, breast pumps, trapeze bar, purchase or rental of supplies, appliances or equipment for personal hygiene, beautification, comfort or convenience, including, but not limited to, cosmetics, air purifiers or air conditioners, humidifiers or dehumidifiers, health club fees, vaporizers, heaters, speech teaching aides, Braille training texts, exercise equipment, whirlpools, tanning beds, water beds, paraffin baths, shower chairs, bed lifts, commodes, wigs, electric scooters, telephones, televisions, or other items not essential for treatment of an Illness or Injury.
30. Speech therapy, except in the case of Illness or Injury where normal speech was lost.
31. Therapeutic devices, including, but not limited to, hypodermic needles, syringes, support garments, support hose/stockings, flexible cervical collars, air mattresses or other bedding products, and non-medical substances purchased for self-use.
32. Services provided primarily for training or educational purposes, including, but not limited to, gait training, therapeutic activities, massage therapy, aquatic therapy, whirlpool therapy, orthotic training, iontophoreisis, and kinetic therapy.
33. Custodial or Developmental Care, regardless of the facility where provided or services provided.
34. Telephone calls to or from a Physician, Hospital, or other medical provider.
35. Charges for completing claim forms, disability forms, or completion of any form.
36. Breast augmentation, breast reduction, or removal of breast implants that are not associated with cancer of the breast or another Medically Necessary service.
37. Mental or Nervous Disorders that are classified as sexual deviations or disorders.
38. Elective abortions, except in the case of rape, incest, or to save the life of the mother; however, complications of abortion are covered by the Plan.
39. Services or supplies that are not prescribed by a Physician or other medical professional or that are not Medically Necessary.
40. Charges in excess of Usual and Customary provided by a non-PPO provider.
41. Acupuncture (except for use in lieu of anesthesia when rendered by a Physician practicing within the scope of his or her license) and hypnosis.
42. Expenses incurred primarily for a Participant's convenience, comfort, or that of the Participant's family, caretaker, Physician, or other medical provider.
43. Dental treatment, which includes, except when it is part of a cancer treatment plan as covered under item 14 in the Section entitled *Covered Medical Benefit Expenses*:
    a. Treatment of infections or diseases related to the teeth;
    b. Myofunctional therapy, which is muscle training therapy or training to correct or control harmful habits;
    c. Charges to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;

    d. Routine charges to repair, replace, or restore fillings, crowns, dentures, or bridgework, in the mouth;
    e. Scaling, planning, or scraping, root canal therapy or dental cleaning and routine tooth removal.

44. Any treatments, services, and supplies provided outside the United States, except for Emergencies.
45. Family/marriage counseling, including any therapy for marriage related issues such as, parent counseling, psychological testing, stress management, hypnotism, and domestic abuse.
46. Non-medical services in connection with learning disabilities, mental retardation, developmental delay, autistic disease of childhood, dyslexia, or special education.
47. Any expense for donor charges associated with organ transplants, including, but not limited to, supplies, testing, or harvesting.
48. Biofeedback, non-medical self-care, or self-help training, such as recreational, educational, or milieu therapy.
49. Any treatment, service, or supplies in connection with varicose veins, unless Medically Necessary, such as skin change (varicose eczema or lipodermatosclerosis), actual ulceration consequent on varicose veins, two or more episodes of thrombophlebitis, or bleeding from varicose veins in a pressurized superficial venous system).
50. Maternity or delivery expenses of Dependent children, except for complications of pregnancy.
51. Gene Expression Services, unless Medically Necessary.

Prescription Drug Coverage

For All Plan Participants

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan offers coverage for your short-term prescription needs as well as your long-term prescription needs. The Fund has contracted with a prescription drug manager (see *Important Contact Information* on page 78) to provide you with access to a network of participating retail pharmacies and a mail order program. You save money for yourself and the Plan when you have your prescriptions filed at a participating Pharmacy or through the mail order program.

Please note that the prescription drug manager with which the Fund has contracted retains the right to make periodic drug "adjustments" to its drug formulary (its list of preferred and covered drugs) under the terms of its contract with the Fund. Therefore, the manner of coverage of particular drugs may change during the course of your coverage.

You can use a participating retail Pharmacy to fill your prescription for a 30-day supply. If you are taking a prescription on a long-term basis, you should have your prescription filled through the mail order program. When you use the mail order program, you can have prescriptions filled for up to a 90-day supply.

When you have a prescription filled at a participating Pharmacy:

- Present your ID card.
- Pay your Coinsurance percentage, as shown on the *Schedule of Benefits*.

When you have a prescription filled at a non-participating Pharmacy or do not present your ID card at a participating Pharmacy:

- Pay the full cost of the prescription.
- Submit your receipts and a completed claim form to CVS Caremark.

Note that claims for non-participating Pharmacy prescriptions are reimbursed at 50% of the Usual and Customary charge.

Brand Name Prescription Drug Annual Deductible

Prescription drug benefits are subject to a separate annual deductible for brand name medications. This means that amounts you pay for covered brand name prescription drug expenses count toward meeting this prescription drug annual deductible; however, these amounts do not count toward meeting your medical annual deductible or out-of-pocket maximum.

You are responsible for meeting the brand name prescription drug annual deductible before the Plan begins to pay prescription drug benefits for any brand name medication at a retail Pharmacy or through the mail order program.

Amounts you pay for covered brand name prescription drug expenses apply to the brand name prescription drug annual deductible, not the medical annual deductible.

Generic and Brand Name Medications

Many prescription medications have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness, but generics generally cost less.

The Plan divides prescription drugs into three categories:

- **Generic medications** are chemically and therapeutically equivalent to the corresponding brand name drug, but are available at a lower price.
- **Single-source brand name medications** are available from only one manufacturer and are patent protected. No generic equivalent is available.
- **Multi-source brand name medications** are available from more than one manufacturer and have at least one generic equivalent alternative available.

While the Plan covers generic and brand name medications, you pay more when you receive a brand name medication. When available, generic medications can save you money and should be substituted for brand medications. Therefore, when you or your Dependent needs a prescription, you may want to ask your Physician whether a generic can be substituted for a brand name medication.

The *Schedule of Benefits* shows the Copayment for each type of medication. Please note that when you have your medication filled with a multi-source brand name medication, you are responsible for the brand name Copayment, **plus** the difference in cost between the generic and multi-source brand name medication.

Prescriptions that Require Pre-Approval

Certain dosages, quantities, and medications require pre-approval by the Fund's Pharmacy benefit manager. If your prescription exceeds the federal or clinically recommended dosage or quantity limits or is prescribed for a certain condition, your prescription may be denied. In this case, your Physician must contact the Pharmacy benefit manager to provide clinical information needed for the pre-approval process.

The Pharmacy benefit manager will apply standards based on Food and Drug Administration (FDA) approved labeling and clinical guidelines. The Pharmacy benefit manager will seek to ensure that you receive the most appropriate prescription for your condition by reviewing:

- Possible interactions with other current prescriptions;
- Cost-effectiveness;
- Whether the prescription is age appropriate; and
- Whether the dosage and quantity are appropriate.

In certain situations, it may be more clinically appropriate to take a stronger dose once a day than to take a lower dose twice a day. If this opportunity exists, the Pharmacy benefit manager may ask your Physician to approve the changes to the dosage and strength before authorizing payment with your pharmacist.

Retail Pharmacy Program

You will receive a prescription drug ID card when you are eligible for coverage. When you have a prescription filled at a participating Pharmacy and present your ID card, you pay your Copayment when you pick it up and the Plan pays the rest. The amount you pay varies depending on the type of medication, as shown on the *Schedule of Benefits*.

If you fill a prescription at a non-participating Pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled. You will then need to submit a reimbursement form, along with a receipt, to the Welfare Fund. Claims for prescriptions filled at a non-participating Pharmacy are paid at 50% of the Usual and Customary charge.

Fill limit for maintenance (long-term) medications obtained at retail pharmacies. The Fund will allow three (3) fills for maintenance (long-term) medications that you obtain from any network Pharmacy. After the three fills, the Fund will cover maintenance (long-term) medications only if you have 90-day supplies of the medication filled through the mail order service, or at a CVS Pharmacy. If you continue to fill your 30-day supplies of maintenance medications at retail after three fills, the Fund will not pay for the medication.

Maintenance medications are prescription drugs that are used on an on-going basis. These prescriptions can be used to treat chronic Illnesses such as:

- Arthritis;
- Diabetes;
- Emotional distress;
- Heart disorders;
- High blood pressure; or
- Ulcers.

Maintenance Drugs through Maintenance Choice Program at Retail or Mail Order Program

When you need to obtain maintenance drugs for medications that you take on a long-term basis, you have the choice of obtaining your prescription through Maintenance Choice pharmacies at retail, or through the mail order prescription drug program. A prescription must be for a supply of 84 days or more in order to be eligible to be filled through either of these programs. Maintenance Choice pharmacies are generally CVS retail pharmacies. You can call CVS Caremark at the number listed in the *Important Contact Information* Section on page 78 or on your Prescription Drug ID card to determine whether your Pharmacy is in the Maintenance Choice Program.

When you use either of these programs, you can receive a larger quantity of medication at one time for less than you would pay at a retail Pharmacy that is not in the Maintenance Choice Program. The amount you pay varies depending on the type of medication (generic or brand name), as shown on the *Schedule of Benefits.*

Example of How Using the Maintenance Choice or Mail Order Program Can Save Money: Jill has a prescription for a single-source brand name medication. Assuming she needs a 90-day supply (and that she has already met her prescription drug annual deductible), Jill can have her prescription filled:

- Once through the retail Maintenance Choice Program or the mail order program and pay $50; or
- Three times at a retail Pharmacy (that is not in the Maintenance Choice program) and pay $60 (that's $20 each time she goes to the Pharmacy).

By having her prescription filled through the Maintenance Choice Program or mail order Pharmacy, she saves $10. She may use any CVS retail Pharmacy, because they are Maintenance Choice pharmacies. Alternatively, she may use the mail order program, to have her medications delivered right to her home.

When you need to order medication through the mail order prescription drug program:

- Ask your Physician to prescribe a 90-day supply with refills.
- Mail the original prescription along with the appropriate form to the mail order drug program. You can obtain a form from the Welfare Fund.

Allow about 14 days from the time you mail in your order to receive your prescription(s).

If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions:

- A short-term supply that you can have filled right away at a participating retail Pharmacy; and
- A 90-day, refillable supply that you can have filled through the mail order prescription drug program.

Covered Prescription Drug Benefit Expenses

Covered expenses include legend drugs that require a written prescription from a Physician or dentist. A licensed pharmacist must dispense these prescriptions. Needles and syringes used for the injection of insulin and injectable insulin available by prescription are also covered.

Expenses Not Covered Under Prescription Drug Benefits

Prescription drug benefits are not paid for any of the following:

1. Vitamins, minerals, dietary supplements, or diet foods, whether prescribed or not.
2. Non-prescription (over-the-counter) medications.
3. Weight loss drugs, unless prescribed for Morbid Obesity.
4. Drugs associated with sexual dysfunction and infertility.
5. Drugs that do not specifically treat a disease or Illness.
6. Charges for any drugs that exceed the maximum recommended dosage or disease specific drug recognized by the manufacturer and approved by the federal Food and Drug Administration.
7. Cosmetic drugs, unless prescribed for a disease (not for prevention of a disease).
8. Hair loss medication, such as, but not limited to, Rogaine, Propecia, and Vaniqa.

Health Reimbursement Arrangement (HRA)

The Trustees have established a Health Reimbursement Arrangement (referred to as an HRA). The HRA is designed to permit active and retired participants and their eligible Dependents to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the HRA.

Funding of the HRA

The HRA will be entirely funded through Employer contributions at an hourly rate that is determined by each Union. Under Federal law, Employees are not allowed to contribute to an HRA.

Eligibility and Coverage

You and your eligible Dependents are eligible for participation in the HRA if you are otherwise eligible for coverage under the Health and Welfare Fund.

Waiving Future Reimbursements

If you have a HRA account balance, you and each eligible Dependent will have the option to permanently opt out of future reimbursements from your HRA account. This option will be provided annually. In addition, if you terminate employment, you may elect, effective on the date of termination, to forfeit your HRA account balance. Each of your eligible Dependents can forfeit his/her access to your HRA account balance as well.

You cannot have a HRA balance or be covered under this Plan and buy individual (not group) coverage through a state or federal Health Insurance Marketplace. You also cannot use any HRA funds toward the premiums for individual coverage from a Health Insurance Marketplace, an individual Medicare Supplement Plan, a Medicare Prescription Drug Plan, or a Medicare Advantage Plan.

Continued Eligibility

You and your eligible Dependents will continue to be eligible for coverage under the HRA as long as you continue to be eligible for coverage under the Plan and meet the requirements in the *Eligibility and Coverage* section above.

If you die while covered under the Plan, your eligible Dependents will continue to be eligible for reimbursement of Medical Care Expenses under the HRA with any remaining account balance in the HRA, as long as they remain covered under the Plan.

Retiree Eligibility

When you retire, you and your eligible Dependents will continue to be eligible for coverage under the HRA to the extent you and your Dependents are eligible for retiree coverage under the Health and Welfare Fund.

If you elect to opt-out of retiree coverage under the Retiree-In-and-Out Program, any balances in the HRA for you and your Dependents will be frozen until the date you opt back in. If only your Dependents opt out, then the HRA may not be used to reimburse any Medical Care Expenses for your Dependents until such date as your Dependents opt back in to the Health and Welfare Fund.

Benefits and Reimbursement

The HRA will reimburse eligible Employees and retired Employees for Medical Care Expenses incurred by the Employee or retired Employee as well as his or her eligible Dependents up to the unused amount in the Employee's or retired Employee's HRA account.

A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before an Employee, retired Employee or eligible Dependent first becomes covered by the HRA are not eligible for reimbursement from the HRA.

"Medical Care Expenses" means expenses incurred by an Employee, retired Employee, or eligible Dependent for medical care, as defined in Code Section 213(d) (including, for example, amounts for certain hospital bills, doctor and dental bills, vision expenses, and prescription drugs), but do not include expenses that are described in Subsection 105(c) of

the Code. Medical Care Expenses include premiums for Part B of Title XVIII of the Social Security Act (Medicare Part B premiums), premiums for group health insurance covering medical care (including premiums for group Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies), COBRA premiums, or premiums for any qualified long-term care insurance contract as defined in Code Section 7702B(B) provided, however, that any such premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan. Reimbursements due for Medical Care Expenses incurred by the Employee or retired Employee or his eligible Dependents will be charged against the Employee's or retired Employee's HRA account.

Termination of Coverage

Coverage under the HRA will end when you are no longer eligible for coverage under the Plan. You may continue to submit claims for eligible Medical Care Expenses incurred before your coverage ended if you submit them within 12 months of the date the claims were incurred, as required in the *Reimbursement Procedure* Section. However, any expenses incurred after your coverage ended are not eligible for reimbursement.

Once your coverage under the Plan ends, the balance in your HRA will be maintained for an additional twenty-four (24) months, although you may only submit claims for reimbursement that were incurred prior to your termination date, and those claims must be submitted within 12 months of the date they were incurred.

For example, assume that your Plan coverage ends on April 30, 2016. You may continue to submit claims for reimbursement from the HRA of any eligible Medical Care Expenses incurred on or before April 30 of 2016. If you do not continue your Plan coverage through Self-Payment, including retirement or COBRA Continuation Coverage, and do not regain Plan coverage by April 30, 2018 (twenty-four months after coverage ended), your HRA balance will be forfeited and cannot be reinstated. However, if you do regain Plan coverage on or before April 30, 2018, the balance in your HRA will be reinstated.

COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, any Employee, retired Employee, or Beneficiary (Qualified Beneficiary) whose coverage terminates under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA), as set forth on page 16.

Medical Care Expenses Exclusions

"Medical Care Expenses" shall not include the following expenses even if they otherwise meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee's, retired Employee's, or Dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Premiums for fixed indemnity, cancer or hospital indemnity insurance.
- Premiums for individual market coverage or insurance plans purchased from a state of federal health insurance marketplace. Individual Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies are also not reimbursable.
- Reimbursements are limited to Copayments, Coinsurance, and deductibles for non-essential health benefits, if you have coverage through a group health plan other than this Plan where:
  - The other plan does not meet the minimum value standards required by the Internal Revenue Service; or
  - You have not provided proof of enrollment in another group plan that meets the minimum value standards.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code Section 213.
- Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan.

Medical Care Expenses can only be reimbursed to the extent that the Employee or retired Employee or eligible Dependent incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through another health insurance plan, other insurance, or any other accident or health plan.

Medical Expenses cannot be reimbursed or reimbursable from another source.

Establishment of Account

The Trustees will establish and maintain an HRA account with respect to each Employee and retired Employee but will not create a separate fund or otherwise segregate assets for this purpose. The HRA account so established will be a recordkeeping account with the purpose of keeping track of Contributions and available reimbursement amounts.

(a) ***Crediting of Accounts.*** An Employee's HRA account will be credited with an Employer Contribution made on his/her behalf in an amount equal to the dollar amount determined by the applicable Collective Bargaining Agreement.

(b) ***Debiting of Accounts.*** An Employee's (or retired Employee's) HRA account will be debited for any reimbursements of Medical Care Expenses.

(c) ***Available Amount.*** The amount available for reimbursement of Medical Care Expenses for an Employee or retired Employee is the amount credited to his or her HRA account under Subsection (a) reduced by prior reimbursements debited under Subsection (b).

(d) ***Carryover of Accounts.*** If any balance remains in an Employee's or retired Employee's HRA account at the end of a calendar year after all reimbursements have been made, such balance shall be carried over to reimburse the Employee or retired Employee for Medical Care Expenses submitted for reimbursement during a subsequent calendar year. After HRA coverage terminates, any balance remaining in an Account will be forfeited.

(e) ***Unclaimed Checks.*** In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) will be honored for 24 months after issuance and then will become property of the Fund if still uncashed at that time.

(f) ***Forfeiture of Accounts.*** A forfeiture of Employee's HRA account occurs 24 months after the date of termination of coverage or when you voluntarily waive or forfeit the balance in your account. Any amount in an HRA account that is forfeited will revert to the general assets of the Plan.

Reimbursement Procedure

(a) ***Deadline for Submission.*** A claim must be submitted up to twelve months after the date of occurrence; thereafter, it will not be eligible for reimbursement.

(b) ***Timing.*** Claims for reimbursement under the HRA will be treated as post-service medical claims. Within 30 days after receipt by the Fund of a reimbursement claim from an Employee or retired Employee, the Fund will reimburse the Employee or retired Employee for the claimed Medical Care Expenses (provided the Fund approves the claim), or the Fund will notify the Employee that his or her claim has been denied.

(c) ***Minimum Amount.*** A claim must be for a minimum of $200 except to close out an HRA after the Plan coverage has terminated. In addition, you may submit a request for reimbursement for claims totaling less than $200 once per year each February if your total claims for the prior year are not going to reach the $200 minimum.

(d) ***Claims Substantiation.*** An Employee, retired Employee, or eligible Dependent who seeks reimbursement of a Medical Care Expense may apply for reimbursement by submitting on an approved form to the Fund Office setting forth:

  (1) The person or persons on whose behalf Medical Care Expenses have been incurred;

  (2) The nature and date of the Medical Care Expenses so incurred;

  (3) The amount of the requested reimbursement; and

  (4) A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health flexible spending account coverage, if any, for such expenses has been exhausted and that no tax deduction will be taken for such expenses. The application shall be accompanied by EOBs, bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Fund may request.

(e) ***Claims Denied***. For reimbursement of claims that are denied, see the appeals procedure on page 42.

In the Event of Disability or Death

To help provide financial protection for you and your family, the Plan provides benefits to you in the event of your disability or your Dependent's death and to your Beneficiary in the event of your death. This section describes these benefits.

Injury and Illness Weekly Benefit

For Active Employees Only

Contact the Welfare Fund if you become disabled. To be eligible for benefits, you must provide a written statement from your Physician that you are not able to perform major duties of your occupation. Submit these items within 90 days of the occurrence for an Injury or Illness.

The Plan provides a weekly benefit for disability as a result of a non-occupational covered Injury or covered Illness, shown on the Schedule of Benefits. In order to be eligible for this benefit, you must provide written proof from your Physician that you are not able to perform the major duties of your occupation. You must also be under the regular care of a Physician.

Benefits for a non-occupational covered Injury or covered Illness begin on the:

- First day of disability due to Injury; or
- Eighth day of disability due to Illness.

Benefits continue for up to a maximum of 26 weeks during any one period of disability, but will terminate earlier upon retirement or death.

During partial weeks of disability, you will be paid at a daily rate of one-seventh of the weekly benefit.

Two or more periods of disability are considered as one unless:

- Between periods of disability you returned to active full-time work for at least two weeks; or
- The disabilities are due to entirely unrelated causes and begin after you returned to active full-time work.

Loss of Time Benefits are subject to FICA tax (Social Security) and Medicare withholdings the same as wages. Therefore, the actual loss of time benefit will be reduced by the FICA and Medicare taxes payable by an Employee. The FICA and Medicare taxes, which would normally be paid by an employer, will be paid by the Plan. At the end of each calendar year, each Employee who received any Loss of Time Benefits during the year will receive a W-2 from the Plan Office indicating the amount of Social Security and Medicare tax withheld.

You will be considered to have returned to active work when you secure a release from your attending Physician to return to full-time work.

Death Benefits

For Employees and Retired Employees

In the event of your death, your designated Beneficiary will receive a lump sum benefit. The amount of the benefit is listed in the *Schedule of Benefits*.

Your designated Beneficiary must contact the Fund Office for a claim form. A death certificate and other documentation as required by the Welfare Fund must be submitted along with the claim form before the benefit will be paid.

Dependent Death Benefits

For Dependents of Active and Retired Employees

The Dependent Death Benefit is paid in the event the death of your Spouse or Dependent child under age 19. The amount of the Dependent Death Benefit is listed on the *Schedule of Benefits*.

You must contact the Fund Office for a claim form. A death certificate and other documentation, as required by the Fund, must be submitted along with the claim form before the benefit will be paid.

Generally, benefits are paid to you. However, in the event you are not living, the Dependent Death Benefit for your Spouse is paid to your Spouse's estate. If you and your Spouse are not living at the time of your Dependent child's death, the benefit will be paid in equal shares to the child's surviving brothers and sisters, or if none, to the child's estate.

Accidental Death and Dismemberment (AD&D) Benefits

For Active Employees Only

The Plan provides an Accidental Death and Dismemberment (AD&D) Benefit that is payable for the accidental loss of life, limb(s), or entire and irrecoverable loss of sight of one or both eyes. The Dependent Death Benefit is for Dependents of active Employees Only and the amount is listed on the *Schedule of Benefits*.

Benefits are paid only if the loss:

1. Results directly from bodily Injuries sustained solely through accidental means (work-related or non-work-related) while covered by the Plan; and
2. Occurs within 90 days after the date of the accident.

Benefits will be paid directly to you, if living, or, otherwise, to your named Beneficiary.

If more than one loss is sustained as the result of the same accident, benefits will be paid only for the loss with the greatest benefit amount.

> At the end of the calendar year each individual and/or designated Beneficiary will receive a tax document (1099R) from the Plan Office indicating the amount of Death Benefit and/or Accidental Death and Dismemberment Benefit Received.

Loss of:

- Hand(s) means severance at or above the wrist joint;
- Foot or feet means severance at or above the ankle joint;
- Thumb or index finger means irrecoverable loss and severance of two or more entire phalanges of both the thumb and index finger;
- Eye or eyes means the total and irrecoverable loss of sight.

Benefits are not paid for:

1. Any loss caused by suicide or any attempt at suicide whether sane or insane.
2. Injuries received while operating or riding any aircraft, except:
    a. While riding as a passenger in a commercial aircraft that is on a regularly scheduled passenger flight; or
    b. While piloting, riding as a passenger in, or boarding or alighting from an aircraft owned by an Employer, provided the Injuries are received while the Employee is traveling for the purpose of furthering business of the Employer.

Designating Your Beneficiary

You can designate any person, or a Trust as your Beneficiary; however, you may not designate a partnership, association, corporation, or other entity (such as a funeral home) as your Beneficiary.

To designate your Beneficiary(ies), you must complete an Information Card available from the Welfare Fund. If you want to designate more than one Beneficiary, you should allocate the percentage to be paid to each Beneficiary; otherwise, Beneficiaries will share equally.

If any Beneficiary dies before you, his or her share will be paid equally to the other designated Beneficiaries that survive you, unless you have made a written request to the contrary.

You can change your Beneficiary(ies) at any time, unless you make an irrevocable designation of your Beneficiary. The initial designation or change of designation will take effect on the date you sign the form.

It is important that you designate a Beneficiary(ies). If you do not, or your designated Beneficiary(ies) does not outlive you, your benefit will be paid to your:

- Surviving Spouse; or if none,
- Surviving children in equal shares; or if none,
- Surviving parent(s) in equal shares; or if none,
- Surviving brothers and sisters in equal shares; or if none,
- Estate.

By the term "surviving children" we mean only natural or adopted children, similarly, by "surviving brothers and sisters" we mean siblings by birth or adoption only.
By "surviving parents" we mean your parents and not in-laws or step-parents.

General Plan Information

Coordination of Benefits

The Plan has been designed to help you meet the cost of Illness or Injury. It is not intended, however, that you receive greater benefits than your actual health care (medical and prescription drugs) expenses. The amount of benefits payable under this Plan will take into account any coverage you or a covered Dependent has under other plans.

Specifically, in a calendar year, this Plan will always pay to you either its regular benefits in full, or a reduced amount that, when added to the benefits payable to you by the other plan or plans, will equal the total Allowable Expenses. However, no more than the maximum benefits payable under this Plan will be paid.

Allowable Expenses
Any necessary, usual, and customary item of expense, at least part of which is covered under one of the plans covering you, your Dependent Spouse, or your Dependent child for which benefit payment is made. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an Allowable Expense) will be considered both an Allowable Expense and a benefit paid.

If you or your Dependents are covered under another plan, you must report such duplicate group health coverage to the Fund Administrator to secure reimbursement of Allowable Expenses incurred.

Other plan means any plan providing benefits or services for medical care that are provided by:

- Group, blanket, or franchise insurance coverage;
- Group practice, group hospital, group medical, or other prepayment coverage on a group basis;
- Coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit organization plan;
- Coverage under government programs, including Medicare, and any coverage required to provide by any statute, but not coverage under Medicaid;
- Other arrangements of insured or self-insured group coverage; and
- Any coverage under the Health Insured for an Aged and Disabled provision of the United States Social Security Act (Medicare). The Plan Rules regarding coordination with Medicare are set forth in Article XIII.

Allowable Expense

For Coordination of Benefit provisions, Allowable Expense means any necessary Usual and Customary charges incurred by an Participant during a calendar year and while eligible under this Plan for health care or treatment, part or all of which would be covered under this Plan or the other plan, including deductibles and Copayments that are covered in full or in part by any of the plans involved except for items excluded that are not Medically Necessary such as private rooms and extra meal trays.

If the other plan is primary and denies a benefit on the basis that the benefit has been exhausted or maximums reached under the terms of its plan, this Plan will cover the benefit as if it is the primary Plan, subject to this Plan's Copayment limitations as well as any other applicable Plan maximum or limitation, except that such benefit will not be subject to this Plan's deductible.

If the other plan is primary and denies a benefit on the basis of non-compliance such as services out of network, failure to comply with cost containment requirements, no preadmission testing, and/or not seeking a required second surgical opinion, then this Plan will cover the benefit as if it is the primary plan, subject to this Plan's Usual and Customary charge, deductibles, Copayment, and out-of-pocket maximum limitations as well as any other applicable Plan maximum or limitation.

When the other plan is primary, this Plan will pay 80% of the other plans' deductible and will pay the balance after the deductible of covered charges, if such charges are covered by this Plan. If this Plan does not have a benefit that the primary plan has, this Plan will not process or make any payment on the claim. If the other plan is primary, but does not cover a benefit that this Plan covers, this Plan will pay as if it is the primary Plan, taking account of any deductibles, out-of-pocket limitation and Copayment limitations as well as any other applicable Plan maximum or limitation.

If a person has a High Deductible Health Plan (HDHPs), and that person contributes to a health savings account, the primary HDHP's deductible that is reimbursed by the health savings account, is not an Allowable Expense, except for any health care expenses incurred that may not be subject to the deductible as described in the Internal Revenue Code.

Order of Payment

If you or your Dependent is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust their benefit payment so that the total benefits payable do not exceed 100% of the Allowable Expense incurred.

The following rules determine which plan is the primary plan:

1. A plan that does not have a coordination of benefits rule is always primary over a plan that does have coordination of benefit rules.
2. A plan that covers an individual as an Employee is primary over a plan covering that individual as a Dependent.

The following rules determine which plan's benefits are primary if a Dependent child is covered under more than one plan:

1. If the parents are not divorced or separated:
    a. The plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, is primary.
    b. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period is primary.
    c. If a plan does not use the "birthday rule" to determine which plan pays first, that plan will pay its benefits first.
2. If the parents are separated or divorced or have never been married and are not living together, the order of payment used to determine the primary plan is as follows:
    a. ***Where there is a court decree*** that establishes financial responsibility for medical expenses, the plan covering the Dependent children of the parent who has that legal responsibility will pay first;
    b. ***Where there is a court decree*** that does **not** establish financial responsibility for medical expenses, the parent with legal custody, or if joint custody, the plan covering the Dependent children of the parent that has physical custody will pay first;
    c. ***Where there is no court decree,*** the plan of the Parent with custody is primary; or
    d. ***Where there is no court decree,*** and the parent with custody has remarried, the order of benefit coordination will be:
        i. The plan of the parent with custody;
        ii. Step-parent, if applicable, with custody of the child pays second; and
        iii. Parent not having custody of the child pays third.

If none of the above rules apply, the plan that has covered the person making the claim for the longest period will pay benefits first, except that a plan that covers the patient as other than a laid-off or retired employee (or a dependent of such and employee) will pay first when:

1. One plan covers the person making the claim as a laid-off or retired employee or dependent of such an employee; or
2. The other plan includes this rule for laid-off or retired Employees (or is issued in a state that requires this rule by law).

Coordination of Benefits with Medicare

Medicare is a multi-part program:

- **Medicare Part A:** Officially called "Hospital Insurance Benefits for the Aged and Disabled" primarily covers hospital benefits, although it also provides other benefits.
- **Medicare Part B:** Officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled" primarily covers Physician's services, although it, too, covers a number of other items and services.
- **Medicare Part C:** Called "Medicare Advantage" is Medicare managed care offering. If you are covered by an HMO, the Plan will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.
- **Medicare Part D:** Called "Medicare Prescription Drug Coverage" is Medicare's prescription drug coverage that is offered through private companies to all Medicare-eligible individuals.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow, or have chronic End-Stage Renal Disease (ESRD). Special rules may apply if you are eligible for Medicare based solely on permanent kidney failure (ESRD). Contact the Welfare Fund for more information.

Generally, this Plan is primary while you are actively working, even if you are over age 65. The Plan is secondary when you are not actively working.

This Plan is primary if you are an active Employee or Dependent of an active Employee, including a Dependent who is eligible for Medicare on account of disability, as provided by law.

Any benefits payable to you or your Dependents under any portion of the Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your Dependents are older than age 65 and have elected Medicare as the primary plan over this Plan for the same Injury or Illness, regardless of whether or not you have received or made application for such benefits or compensation.

Information Gathering

To implement the provisions in this Coordination of Benefits section, the Trustees or the Fund Administrator may, in accordance with applicable law, without the consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, that the Fund deems to be necessary for such purposes. Any person claiming benefits under this Plan will provide to the Trustees or to the Fund Administrator such information as may be necessary to implement the provisions of this section or to determine their applicability.

Restitution and Subrogation

If you or your Dependent are Injured in an accident for which someone else is liable, that person or his/her insurance may be responsible for paying your or your Dependent's related medical expenses and these expenses would not be covered under this Plan. However, waiting for a third party to pay for these Injuries may be difficult; recovery from a third party may take a long time (you may have to go to court) and your creditors may not wait patiently. Because of this, as a service to you, the Fund will advance you or your Dependent benefit payments related to such accident based on the Fund's rights of restitution and subrogation. This means, the Fund must receive restitution by you if you obtain recovery from any person or entity.

> This restitution and subrogation program provides for the early payment of benefits and also saves the Fund money (which saves you money, too) by making sure that the responsible party pays for your Injuries.

The Fund will receive restitution for all benefit payments made as the result of the Illnesses or Injuries that are caused by the actions of a third party and that give rise to a court ordered financial award or out-of-court settlement to you or your Dependent from a third party tort-feasor, person, or entity. This Fund will provide benefits, otherwise not payable under this Fund, to or on behalf of you or your Dependent, only under the following terms and conditions:

1. In the event of any payment by this Fund, the Fund will be subrogated to all of your or your Dependents' rights of recovery against any person or organization. This means that the Fund has an independent right to bring an action in connection with such Illness or Injury in your or your Dependents' name and also has a right to intervene in any such action brought by you or your Dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy.
2. Consistent with the Fund's rights set forth in this section, if you or your Dependent submits claims for or receives any benefit payments from the Fund for an Illness or Injury that may give rise to any claim against any third-party, you and or your Dependent will be required to execute a *Subrogation Assignment of Rights, and Restitution Agreement* affirming the Fund's rights of restitution and subrogation with respect to the benefit payments and claims. This form will assist the Fund in recovering benefits paid from a third party who was responsible for the Injuries giving rise to the claims. This *Agreement* must also be executed by you or your Dependent's attorney, if applicable.

   Because benefit payments are not payable unless you sign a *Subrogation Agreement*, you or your Dependent's claims will be denied and will not be paid until the fully signed *Agreement* is received by the Fund.

   This means that, if you file a claim and your Subrogation Agreement is not received promptly, the claim will be denied and will not be paid.
3. You or your Dependent will do whatever is necessary to secure the Fund's subrogation rights and will do nothing after the loss to prejudice these rights. You or your Dependent must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent chooses not to pursue the liability of a third party, you or your Dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your Dependent chooses not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action for restitution for what it has paid, the acceptance of benefits obligates you or your Dependent (and your attorney if you have one) to cooperate with the Fund in seeking restitution, and in providing relevant information with respect to the accident.
4. You or your Dependent will agree to cooperate with the Fund and/or any representatives of the Fund in completing any required forms and in giving any required information surrounding any accident as the Fund or its representatives deem necessary to investigate the incident fully. Failure to execute the necessary forms will result in no benefits being paid.
5. The Fund is also granted a right of restitution from the proceeds of any settlement, judgment, or other payment obtained by you or your Dependent. This right of restitution is cumulative with and not exclusive of the subrogation right granted in (1) above, but only to the extent of the benefits paid by the Fund.
6. The Fund's right of restitution and subrogation provide the Fund with first priority to any and all recovery in connection with the Illness or Injury, whether the recovery is full or partial and no matter how the recovery is characterized, why, or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable.

   This right of subrogation is specifically and unequivocally pro tanto subrogation, that is, subrogation from the first dollar received by you or your Dependent, and the pro tanto subrogation is to take effect before the entire debt is paid to you or your Dependent. In addition to its pro tanto rights, the Fund is entitled to restitution of the full amount of benefits paid, regardless of whether you or your Dependent is made whole by the third party for all damages.
7. The Fund's rights of restitution and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance, or order regardless of whether the third party is found responsible or liable for the Illness or Injury, and regardless of whether you or your Dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance, or order.

   The Fund, by payment of any proceeds, is granted an equitable lien on the proceeds of any settlement, judgment, or other payment received by you or your Dependent, and you or your Dependent consents to this lien and agrees to take all steps necessary to help the Fund Administrator secure the lien.

The Fund will have a lien on any amount received by you, your Dependent, or a representative of you or your Dependent (including your attorney) that is due to the Fund under this section, and any such amount will be deemed to be held in a constructive trust by you or your Dependent for the benefit of the Fund until paid in full to the Fund.

8. The subrogation and restitution rights and liens apply to any recoveries made by you or your Dependent as a result of the Injuries sustained or Illness suffered, including but not limited to the following:
    a. Payments made directly by the third party tort-feasor, any insurance company on behalf of the third party tort-feasor, or any other payments on behalf of the third party tort-feasor;
    b. Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured, under-insured motorist policy, or medical pay provisions on the insured's behalf; and
    c. Any payments from any source designed or intended to compensate an insured for Illness, Injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.
9. It is the obligation of you or your Dependent to:
    a. Notify the Fund within 10 days of any accident or Injury for which someone else may be liable;
    b. Notify the Fund in writing of any Illness, Injury, disease, or disability for which the Fund has paid medical expenses on behalf of you or your Dependent that may be attributable to the wrongful or negligent acts of another person;
    c. Notify the Fund in writing if you or your Dependent retains services of an attorney, and of any demand made or lawsuit filed on behalf of you or your Dependent, and of any offer, proposed settlement, acceptance settlement, judgment, or arbitration award;
    d. Notify the Fund before accepting any payment before the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund advanced you, you will still be required to repay the Fund, in full, for any benefits paid on your behalf;
    e. Notify the Fund within 10 days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment, or payment relating to the accident in any lawsuit initiated to protect the Fund's claims;
    f. Promptly provide restitution to the Fund for benefits paid on behalf of you or your Dependent attributable to Illness, Injury, disease, or disability, once you or your Dependent have obtained money through settlement, judgment, award, or other payment.
10. You or your Dependent will not make any settlement that specifically excludes or attempts to exclude the expenses paid by the Fund.
11. The Fund's right of recovery will be a prior lien against any proceeds recovered by you or your Dependent; this right will not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Fund's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
12. You or your Dependent will not incur any expenses on behalf of the Fund in pursuit of the Fund's rights, specifically, no court costs or attorney's fees may be deducted from the Fund's recovery without the prior express written consent of the Fund. This right will not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or any other such doctrine purporting to reduce the Fund's recovery amount.
13. If you or your Dependent fails to notify the Fund, as required, then upon recovery made, whether by suit, judgment, settlement, compromise, or otherwise, by you or your Dependent, the Fund will be entitled to restitution to the extent of the benefits paid by the Fund, immediately upon demand, and will have the right to recovery thereof, by suit or otherwise. Jurisdiction for any such suit will be in Vigo County, Indiana.
14. If you or your Dependent refuses to provide restitution to the Fund from any recovery or refuses to cooperate with the Fund regarding its subrogation or restitution rights, the Fund has the right to recover the full amount of all benefits paid by methods that include, but are not limited to, offsetting the amounts paid against your future benefit payments under the Fund. Non-cooperation includes the failure to execute a *Subrogation, Assignment of Rights, and Restitution Agreement* and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other Injury relating to the Fund's rights of restitution and subrogation.

15. If you or your Dependent is compensated for your Injury or Illness, you are responsible for any and all future medical benefits that are a result of this Injury or Illness.

Failure to comply with the subrogation conditions outlined in this section may result in:

1. The Fund's withholding payment of future benefits; and
2. An obligation by you or your Dependent to pay costs, attorney's fees, and other expenses incurred by the Fund in obtaining the required information or restitution.

Privacy Policy

The Plan is required to protect the confidentiality and security of your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the rules issued by the U.S. Department of Health and Human Services. The privacy rules are effective as of April 14, 2003.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations. The Plan will distribute its Privacy Notice periodically, as required by HIPAA rules, or when changes are made to the policies and procedures.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations, and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other Plan benefit or employee benefit plan.

The Plan hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates," to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your PHI include the right to:

- Receive confidential communications of your health information, as applicable;
- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

Protection and Security of PHI

The Plan Sponsor:

- Implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensures that an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures;
- Ensures that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
- Reports to the Plan any security incident of which it becomes aware concerning electronic PHI.

If you need a copy of the Privacy Notice, please contact the Welfare Fund.

Plan's Use and Disclosure of PHI

The Plan will use your PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your Beneficiary. With an authorization, the Plan will disclose PHI to a retirement plan, disability plan, reciprocal benefit plan, and/or workers' compensation insurers for purposes related to administration of these plans.

Payment Defined

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for Plan coverage and provision that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g., benefit cost, Plan maximums, and Copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participant (and/or authorized representatives) inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if applicable;
- Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, concurrent review, and retrospective review; and
- Reimbursement to the Plan.

Health Care Operations Defined

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives, and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration or development or improvement of methods of payment or coverage policies; and
- Business management and general administrative activities of the entity, including, but not limited to:
    - Management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;
    - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
    - Resolution of internal grievances; and

- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

Plan's Disclosure of PHI to the Board of Trustees

For purposes of the Plan's privacy rules, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor as long as this Summary Plan Description/Plan Document incorporates the following provisions. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as otherwise required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;
- Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make the information available that is required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI:

- The Plan Administrator; and
- Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Plan Information

Plan Name

Mid Central Operating Engineers Health and Welfare Fund

Plan Numbers

The Plan serial number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 35-0917610.

Plan Year

The accounting records of the Plan are kept on a Plan Year basis beginning each August 1 and ending the following July 31.

Plan Sponsor and Plan Administrator

A Board of Trustees is responsible for the operation of this Plan. Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrative Management service, as claims agent under an administrative services contract. The Fund Administrator is responsible for maintaining eligibility records, accounts for Employer Contributions, answering Participant inquiries, processing claims and benefit payments, and handling other routine administrative functions. The Fund's Auditor (a certified public accounting firm) is responsible for preparation of certain required government reports. The Board of Trustees consists of Employer and Union representatives selected by the Employers and Unions who have entered into collective bargaining agreements that relate to this Plan. If you want to contact the Board of Trustees, you may use the address and phone numbers below:

Mid Central Operating Engineers Health and Welfare Fund
1100 Poplar Street
P.O. Box 9605
Terre Haute, Indiana 47808
(812) 232-4384 or Toll Free Bookkeeping (877) 299-7099

If you want to inspect or receive copies of additional documents relating to this Plan, contact the Board of Trustees. You will be charged a reasonable fee to cover the cost of any document you request.

Board of Trustees

The Trustees of this Plan are:

Employer Trustees

Steve Crider
Crider & Crider, Inc.
1900 Liberty Drive
Bloomington, IN 47403

James W. Bruner
United Contractors Midwest
3151 Robbins Road
Springfield, IL 62791

James L. Burdick
Wabash Valley Asphalt Co., LLC
400 N. 10th St.
Terre Haute, IN 47807

Holly Bailey
Howell Paving Inc.
1020 North 13th Street, P.O. Box 1009
Mattoon, IL 61938-1009

Union Trustees

John Ballard
International Union of Operating Engineers Local No. 103
6814 East 21st Street
Indianapolis, IN 46219

Ronald Stahlhut
International Union of Operating Engineers Local No. 318
3310 Water Tower Road
Marion, IL 62959

Darrin Smith
International Union of Operating Engineers Local No. 649
6408 West Plank Road
Peoria, IL 61604

Tom Ridge
International Union of Operating Engineers Local No. 841
P.O. Box 2157
Terre Haute, IN 47802-2157

Fund Administrator

Cheryl Cottrell
Executive Administrator
Mid Central Operating Engineers Health and Welfare Fund
P. O. Box 9605
Terre Haute, IN 47808-9605

Dawn Kasemeyer
Asst. Executive Administrator
Mid Central Operating Engineers Health and Welfare Fund
P. O. Box9605
Terre Haute, IN 47808-9605

Mail should be sent to:

Mid Central Operating Engineers Health and Welfare Fund
P.O. Box 9605
Terre Haute, Indiana 47808-9305

The Welfare Fund is located at (for UPS deliveries or in-person visits):

Mid Central Operating Engineers Health and Welfare Fund
1100 Poplar Street
Terre Haute, Indiana 47807

Welfare Fund Contact Information

- General Number: (812) 232-4384
- Bookkeeping Department: (877) 299-7099 (toll-free)
- Claim Department: (877) 299-3699 (toll-free)
- Fax Number: (812) 232-4386
- Website: www.midcentral.org

Collective Bargaining

Current parties to the Collective Bargaining Agreement are:

- International Union of Operating Engineers Local No. 103
- International Union of Operating Engineers Local No. 318
- International Union of Operating Engineers Local No. 649
- International Union of Operating Engineers Local No. 841

Those Employers who are not members of or represented by such Associations but that enter into an individual collective bargaining agreement with the local Union are also parties to the collective bargaining agreement.

Participants and Dependents may obtain, upon written request to the Welfare Fund, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan. The Welfare Fund will provide you, upon written request, with a copy of the collective bargaining agreements or such provisions of the agreements that you may request in writing. The Plan may make a reasonable charge for the cost of copying these documents.

Reciprocity Agreements

Notwithstanding anything to the contrary, any reciprocity agreement entered into by the Board of Trustees with a national, state, or local fund, that is effective on or before the adoption of the Plan will apply for the period of effectiveness of the agreement. The terms of the Plan will be modified to the extent set forth in the agreement. The Board of Trustees has the power to amend the Plan to reflect the termination of any existing reciprocity agreement or any reciprocity agreement entered into by the Board of Trustees after the adoption of the Plan; provided, however, that in no event will the amendment result in reduced benefits for claims incurred under the Plan provisions on the date the amendment is made.

Plan Funding

Employer Contributions and Self-Payments finance the benefits described in this booklet. All Employer Contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the Union and Associations and those Employers who are not members of, or represented by, such Associations but that enter into an individual collective bargaining agreement with the Local Union. A copy of the collective bargaining agreement under which you are covered is available from the Welfare Fund.

The labor agreements specify the amount of contributions, due date of Employer Contributions, type of work for which contributions are payable, and the geographic area covered by these labor agreements.

The Plan's benefits are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund Assets is allocated for reserves to carry out the objectives of the Plan.

The Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the Plan.

Plan Type

This Plan is a welfare plan maintained for providing medical, prescription drug, disability, and death benefits for Participants and their Dependents who meet the eligibility requirements described in this booklet.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits is shown in this booklet. Circumstances that may cause a Participant to lose eligibility are also explained. Your coverage by this Plan does not constitute a guarantee of your continued employment and you are not vested in the benefits described in this booklet.

Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board at the address of the Mid Central Operating Engineers Health and Welfare Fund. However, such documents may also be served upon any individual Trustee.

Plan Termination

The Board of Trustees expects that the Welfare Fund will be permanent. However, the Trustees have the right to change, modify, or terminate all or any part of the Plan at any time, in accordance with the Trust Agreement and the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Board of Trustees will notify you in writing if the Plan is amended or terminated. If all or a part of the Plan is terminated, the Trustees would provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plan and distribute the balance of the assets in a manner consistent with the purpose of the Fund.

Board of Trustees' Discretion and Authority

The Board of Trustees has full and broad discretion and authority to interpret the terms of all documents establishing this Plan, including, but not limited to, the rules of eligibility. The decision of the Board of Trustees will be accorded judicial deference in any subsequent court or administrative proceeding, provided it does not constitute an abuse of discretion. The Board also decides any factual question related to eligibility for and the type and amount of benefits. The decision of the Board of Trustees is final and binding.

Your ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's and at other specified locations, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description/Plan Document (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (You or your Dependents may have to pay for such coverage; review this Summary Plan Description/Plan Document and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.); and

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Summary Plan Description/Plan Document 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 Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. 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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA at:

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
(866) 444-3272

Nearest Regional Office (Northern Indiana):

Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago, IL 60606
(312) 353-0900

Nearest Regional Office (Southern Indiana)

Employee Benefits Security Administration
Cincinnati Regional Office
1885 Dixie Highway, Suite 210
Ft. Wright, KY 41011
(859) 578-4680

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website of the EBSA at www.dol.gov/ebsa.

Important Contact Information

The Plan is sponsored and administered by the Board of Trustees. The Trustees have delegated administrative responsibilities to other individuals or organizations as follows.

- Welfare Office (Fund Administrator):
  - Maintains eligibility records;
  - Accounts for Employer and Self-Payment contributions;
  - Administers all benefit claims;
  - Answers Participant inquiries; and
  - Handles other routine administrative functions.
- Anthem Blue Cross Blue Shield provides access to Preferred Providers for medical care. For a list of providers go to the Anthem website at www.anthem.com and click on "Find a Doctor" on the right side.
- CVS Caremark administers the prescription drug program, including prescription drug claims and appeals.

The chart that follows shows the contact information for the various organizations that provide services under our Plan.

If You Have A Question Or Need Information About:	Contact:	Phone Numbers:	Web Site:
Eligibility, Updating Personal Information and Benefits	Welfare Fund	(812) 232-4384	www.midcentral.com
Preferred Providers	Anthem Blue Cross Blue Shield	(800) 810-2583	www.anthem.com
Prescription Drug Benefits	CVS Caremark	(800) 796-8675	www.caremark.com
Pre-Certification	Medical Cost Management Corp.	(800) 367-1934	

Other Important Contact Numbers

- I. U. O. E. Local Union #103 Local Union Fund (317) 353-1308
- I. U. O. E. Local Union #318 Local Union Fund (618) 993-0318
- I. U. O. E. Local Union #649 Local Union Fund (309) 697-0070
- I. U. O. E. Local Union #841 Local Union Fund (812) 299-1177
- Central Pension Fund Pension Fund (202) 362-1000 www.cpfiuoe.org.

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