Health and Welfare Plan

OPERATING 701 ENGINEERS

Summary Plan Description

June 2022

AGC-International Union of Operating Engineers Local 701 Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone: (866) 697-5750 or (503) 657-9740 • Fax (503) 657-9737 • Website www.agc-iuoe701trusts.com

Administered by
Welfare & Pension Administration Service, Inc.

March 12, 2024

TO: All Eligible Plan Participants in the AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund

RE: Employee Assistance Program

This is a summary of material modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully and keep this document with your 2022 Summary Plan Description Booklet.

The Board of Trustees of the is pleased to announce the addition of Employee Assistance Plan (EAP) benefits through First Choice Health EAP. This new benefit is available **effective January 1, 2024**. EAP services are fully covered by the Trust at no cost to you and are available 24/7 to all Trust participants and eligible dependents.

First Choice Health EAP provides free and confidential face-to-face or telehealth sessions with a qualified clinical expert who can assess your concerns and develop a plan of action. The benefit includes six sessions per issue per year. EAP providers can address a wide variety of concerns, including:

- Anxiety and Depression
- Couples/Relationship/Parenting
- Crisis Support
- Alcohol/Drug Problems
- Grief and Loss
- Work Conflict
- Compulsive Behaviors
- Domestic Violence
- Legal and Financial
- Childcare and Eldercare
- Home Ownership
- ID Theft
- Healthy Living Tips

Enclosed you will find information from First Choice Health EAP, including instructions on how to access these valuable services. Additional information and resources can be found on the First Choice Health EAP website (www.FirstChoiceEAP.com). Trust participants can login in with the username: **IUOE701**

Board of Trustees
AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund

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Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

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Administered by
Welfare & Pension Administration Service, Inc.

October 13, 2023

TO: All Eligible Participants
AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund

RE: Summary of Material Modifications and Notice of the End of the Public Health Emergency
Notice of Plan Changes – Tele-Dentistry

Effective June 1, 2023, the Trustees amended the Plan to exclude all Tele-Dentistry services or other remote dentistry services. All other Plan terms remain unchanged.

Notice Regarding the End of the Public Health Emergency

The Trust has provided coverage for COVID-19 tests and vaccines since March 2020 pursuant to federal law. The federal government has indicated that effective May 11, 2023, the COVID-19 national emergency will end. This means that health plans like the Trust are no longer required to cover COVID-19 tests, vaccines, and related services without any cost sharing.

Changes Effective May 12, 2023

As of May 12, 2023, the Trust will provide the following benefits for COVID-19 vaccines and testing:

- Vaccines from in-network medical or pharmacy providers will continue to be covered at 100% and at no cost to you. Vaccines from out-of-network medical or pharmacy providers covered according to Plan terms.
- COVID-19 tests from in-network providers will be covered subject to normal Plan terms, such as deductibles and co-insurance requirements.
- COVID-19 tests from out-of-network providers will not be covered.
- Over-the-Counter COVID-19 tests will no longer be covered.

Changes Effective July 11, 2023

During the COVID-19 national emergency, a number of time periods for taking Trust-related actions were extended to the lesser of one year or 60 days after the COVID-19 national emergency period ends (July 10, 2023). Accordingly as of July 11, 2023, the following time limits will revert to their normal lengths, as indicated in your Plan Booklet:

- The 30-day period or 60-day period to request HIPAA special enrollment for you or your dependents.

- The 60-day period for electing COBRA continuation coverage after a qualifying event.
- The period for making COBRA premium payments (45 days after election for first payment or the end of the month for which coverage is sought for subsequent payments).
- The 60 day period to notify the Plan of COBRA qualifying events involving divorce, legal separation, a child's loss of dependent status or disability determinations.
- The date within which individuals must file a benefit claim appeal under the Plan's claims procedures (180 days after denial).
- The deadline for requesting external review for adverse benefits determinations involving medical judgment (4 months after denial of claim appeal).

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (866) 697-5750.

Administration Office
AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund

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Administered by
Welfare & Pension Administration Service, Inc.

March 10, 2023

TO: All Eligible Participants
AGC-International Union of Operating Engineers Local 701
Health and Welfare Trust Fund

RE: Acupuncture Therapy Benefits, effective January 1, 2022

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

The Board of Trustees have amended the Plan to cover twenty-four (24) acupuncture therapy visits per calendar year, without medical necessity, when performed by a covered provider acting within scope of their license, **effective January 1, 2022.**

These benefits are subject to the Plan deductible and a $30 copay for in-network providers, and a $40 copay for out-of-network providers. Copays, deductibles, and coinsurance apply up to the Plan's out-of-pocket maximum.

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (866) 697-5750.

Administration Office
AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund

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Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

The AGC-International Union of Operating Engineers Local 701 Health and Welfare Plan ("Plan") provides for the following benefits:

- Self -funded medical, prescription, hearing aid, and dental benefits (collectively, "Medical Program")
- Insured medical and prescription benefits ("HMO Program")
- Insured dental benefits ("Willamette Dental Program")
- Self-funded vision benefits ("Vision Program")
- Insured life insurance benefits
- Insured accidental death and dismemberment benefits
- Self-funded weekly disability income benefits

This booklet is the summary plan description for participants and beneficiaries who are covered under the Plan's self-funded benefits, including the Medical Program. The summary plan description for participants and beneficiaries who are covered under the insured programs (Kaiser Permanente and/or Willamette Dental) consists of this booklet and the separate booklet provided by Kaiser Permanente and/or Willamette Dental that describes the applicable medical or dental plan benefits.

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected. The Board of Trustees has delegated to the Trust Administration Office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other plan provisions.

The Board of Trustees may also refer certain questions or plan administration issues to medical review organizations or other third-parties. In administering the Plan, the Trust Administration Office and any medical review organization used by the Trust may utilize its internal guidelines and medical protocols in determining whether specific services or supplies are covered under the terms of the Plan. Neither the Trust Administration Office nor any other third party has the authority to change the provisions of this Plan document. An interpretation of this Plan document by the Trust Administration Office or any other third party is subject to review by the Board of Trustees. No individual trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan.

Important Contacts And Resources

For Information About	Contact
Eligibility, benefits, claims and ID cards	Trust Administration Office (503) 657-9740 (866) 697-5750
Where to send claims	**Medical Program (other than prescription drug), Dental Program, and Weekly Disability Income Claims**: AGC-IUOE Local 701 H&W PO Box 34687 Seattle, WA 98124-1687 **Prescription Drug Claims:** OptumRx www.optumrx.com (855) 295-9140 TTY 711 **Vision Program Claims:** VSP www.vsp.com PO Box 385018 Birmingham, AL 35238-5018
PPO network providers or facilities	Premera Blue Cross, (800) 810-2583 www.premera.com/sharedadmin Select "Find a Doctor" from the list of links on the top of the page
Retail pharmacy network	OptumRx www.optumrx.com (855) 295-9140 TTY 711
Mail-order pharmacy	OptumRx www.optumrx.com (855) 295-9140 TTY 711
Precertification for hospital admissions (and other events specified on page 44) and case management services	Medical Rehabilitation Consultants (MRC) (800) 827-5058

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Summary of Benefits

Annual deductible	$150 per person $450 per family	
Annual out-of-pocket maximum	$5,300 per person medical $10,000 per family medical $700 per person prescription drugs $2,000 per family for prescription drugs	
Coinsurance	**PPO Network Provider**: Plan pays 80% of the preferred provider allowance (you pay the remaining 20%) for most covered expenses until your out-of-pocket maximum is reached. Then Plan pays most covered expenses at 100% of the preferred provider allowance for the rest of the calendar year. **Non-Network Provider**: Plan pays 50% of UCR charges (you pay the remaining 50%) for most covered expenses until your out-of-pocket maximum is reached. Then Plan pays most covered expenses at 100% of the UCR amount for the rest of the calendar year.	
Prescription Drug Benefits	**Retail 30-day supply, except where noted**	**Mail Order 90-day supply**
	Retail	**Mail Order**
Generic	$10 copay for 90-day supply $25 non-Preferred Pharmacy generic	$10 copay
Preferred Brand	$35 copay	$45 copay
Non-preferred Brand	$50 copay	$60 copay
Trust Dental Program Benefits		
Annual deductible	No deductible	
Covered services	See page 72	
Calendar year maximum	$2,500 per person (except for pediatric dental care)	
Orthodontia	80% of customary and reasonable amount up to $2,000 lifetime maximum. Benefits don't	

	count toward Dental Program's calendar year maximum.
Hearing Aid Benefit (Employees only)	Hearing exam and a hearing aid device each 36 months
Vision Program Benefits	
Eye Exam	One exam per person each 12 months* **VSP Network Provider**: no copay **Non-VSP Network Provider**: $45 allowance
Lenses	Once per person every 12 months* **VSP Network Provider**: $20 copay for prescription glasses **Non-VSP Network Provider**: $30-$65 allowance
Frames	Once per person every 24 months* **VSP Network Provider:** $20 copay for prescription glasses (combined with lenses copay) $150 allowance for a wide selection of frames $170 allowance for featured frame brands **Non-VSP Network Provider:** $70 allowance
Contacts (instead of glasses)	Available once every 12 months* **VSP Network Provider**: $150 allowance; $60 copay for fitting **Non-VSP Network Provider**: $105 allowance
ProTec Safety (employee only)	**VSP Network Providers only**
Frames – Must select frame from ProTec Eyewear collection	Once every 24 months*; $20 copay for frames and lenses
Lenses	Once every 12 months*; $20 copay combined with frame copay
Employee Life Insurance Benefit	$10,000
Employee Accidental Death and Dismemberment Benefit	$10,000
Dependent Life Insurance Benefit	Spouse: $2,000 Children: $200 - $2,000 per child depending on age

Employee Weekly Disability Income Benefit (Employees only)	$300 per week beginning the eighth day of disability for a maximum of 26 weeks

*from your last date of service.

VSP network – Children under age 18 have an unlimited frame and contact lens allowance. For adults, benefits are limited to a 12-month supply of contacts or lenses every 12 months or one frame every 24 months.

Non-VSP network – out-of-network benefits for frames and contacts are covered in full after a copay for children under age 18. Frequency limits apply.

Eligibility

Hourly Employees
This Plan is financed by contributions made by employers signatory to labor agreements with Local 701 for operating engineers who work for them.

If contributions are received on behalf of an Employee covered by a collective bargaining agreement, the Trust Administration Office will set up an Hour Bank on his/her behalf. The Trust will credit to the Employee's Hour Bank all hours worked in a job classification covered by a collective bargaining agreement and contributed on by your employer(s). It is your responsibility to check with your employer, the Trust Administration Office, or Local 701 to confirm that health and welfare contributions are being made for you by your employer.

Initial Eligibility Under a Collective Bargaining Agreement
Once you have had 300 hours reported and paid to the Plan within three consecutive months, coverage will begin on the first date of the following month. The work month is the month the hours are actually worked, the reporting month is the following month (lag month) and the eligibility month is month of coverage. The lag month provides sufficient time for receiving and processing employer reports. The following examples illustrates how initial eligibility and the lag month work

Examples:

Example 1		
1	2	3
You work 300 hours in this month…	Lag Month	You are eligible in this month.

Example 2				
1	2	3	4	5
You work 300 hours or more in three consecutive months.			Lag Month	You are eligible in this month.

Continuing Eligibility Under a Collective Bargaining Agreement
Once you satisfy the initial eligibility requirements stated above, 120 hours are deducted from your Hour Bank to provide one month of eligibility. The maximum number of hours in an Employee's Hour Bank may not exceed 720 hours (enough for six months of coverage). Any hours reported and paid above the maximum of 720 hours will not be added to your Hour Bank and will be used to fund the Plan. You will remain eligible as long as your Hour Bank does not fall below 120 hours.

Example:

Hours worked in month	160
Subtract coverage hours	-120
The 40 hours are added to your hour bank for future coverage	40 hours

If your coverage ends because your hour bank has less than the current hour bank deduction, the balance in your hour bank, if any, is carried for 12 months.

If during the twelve months beginning on the first day of the month in which you first lose coverage, you work and sufficient hours are added to your account, your eligibility will be reinstated on the first day of the second month after the account has the minimum required for a month of eligibility, i.e., eligibility must be effective no later than the first day of the fourteenth month after you lost eligibility.

If eligibility is not reinstated by the first day of the fourteenth month following the date coverage ends, you are required to satisfy the initial eligibility rules to again be covered under the Plan. In addition, beginning the first day of the fourteenth consecutive month in which you do not reinstate eligibility, all hours in your account will be forfeited.

If your Hour Bank is forfeited, you will be required to satisfy the initial eligibility rules to again be covered (see page 9).

If your coverage has been terminated because your hour bank has less than 120 hours but if, during those twelve months, you work and add hours to your hour bank, your eligibility will be reinstated

on the first day of the second calendar month after your hour bank has a total of 120 hours.

Participants who return to work for a participating employer after 12 months or more of no active eligibility are required to submit a new enrollment form to the Administration Office. If a new enrollment form is not received the Participant will automatically be enrolled into the Trust's self-funded Medical Plan and claims will be pended until an enrollment form is received at the Administration Office.

Termination of Eligibility
If your hour bank has less than 120 hours on the first of a month, you will not be eligible for coverage for that month and your eligibility is terminated.

If your eligibility terminates, you may be allowed to self-pay to continue your coverage under the Plan through COBRA (see page 20). If you enter the uniformed military or public health services of the United States, you and your dependents may be able to continue Plan coverage under USERRA (see page 30).

Your coverage may also be terminated retroactively in the event of your fraud or intentional misrepresentation of a material fact, both of which are prohibited by the Plan.

Working Nonunion
If you perform any hours of nonunion operating engineer work, your eligibility under the Plan will be terminated at the end of the month that you began that nonunion work and your Hour Bank will be temporarily frozen. You must promptly notify the Trust Administration Office of that nonunion work. Failure to do so may result in your account being retroactively terminated to the end of the month that you began working nonunion.

To return to active coverage, you must meet the initial eligibility requirements (300 work hours within a three-month period), without regard to your frozen hour bank, with an active coverage renewal date no later than the first day of the seventh month after the date you first worked nonunion. If you do not reestablish eligibility by that first day of the seventh month, you will permanently forfeit all remaining hours in your hour bank on that first day of the seventh month.

Associate and Flat Rate Employees
If your employer has signed an agreement that provides coverage for you as an associate or flat rate employee, you will be eligible for benefits from the Plan if (i) you are regularly scheduled to work for your employer as specified by the agreement, and (ii) your employer has paid contributions for you to the Trust.

The initial and ongoing eligibility requirements for Employees participating under an Associate/Flat Rate Agreement are the same as for active Employees participating under a Collective Bargaining Agreement.

Your eligibility will terminate at the end of the month after the month in which you cease working the qualifying hours for which contributions were paid. When your eligibility terminates, you may be allowed to self-pay to continue coverage under the Plan through COBRA (see page 20).

Dependent Eligibility
Your dependents are eligible when you are eligible except as specified below or in the **Taxable Coverage** section.

Your eligible Dependents are:

- Your legal spouse. The spouse must be legally married to the Employee as determined under federal law and must be treated as a spouse under the Internal Revenue Code. This includes a legally recognized same-sex spouse.
- Your same-sex Domestic Partner in the following situations:

  (i) You are covered by an insurance provider that contracts with the Plan (such as under the HMO Program) and is required by state law to cover same-sex domestic partners on the same basis as spouses;
  (ii) You are the employee of an Oregon public employer; or
  (iii) You are the employee of an employer that has a contract with the City of Portland, and you are working: (a) on work related to that contract; (b) within the City; or (c) on City-owned or -occupied property.

*Your Domestic Partner will be a dependent under this provision only during the employer's contract with the City, and you may be required to pay the cost of your Domestic Partner's coverage that exceeds the cost of that coverage if he or she were your spouse.

- Your opposite-sex Domestic Partner while you are the employee of an employer that has a contract with the City of Portland, in the situations and on the terms described immediately above.
- A natural child, stepchild, adopted child, child "placed for adoption" or "foster child" under the age of 26. The term, "placed for adoption," means you accept legal responsibility for total or partial support of the child in anticipation of adoption. The term "foster child" means a foster child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. "Child" also means your dependent's child or your grandchild who is under age 26 and for whom you or your spouse or Domestic Partner are legal guardian or who was eligible for coverage due to that legal guardianship and was enrolled in the Plan immediately prior to reaching age 19.
- A child the Plan is directed to provide benefits to by a qualified medical child support order issued by a court or state agency of competent jurisdiction. You or your dependents may obtain from the Trust Administration Office, without charge, a copy of the procedures you must follow that govern medical child support orders and determinations.
- A child age 26 or older and unable to engage in any substantial gainful activity by reason of a mental or physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months;
- The child was an Eligible Dependent and so disabled at the time of reaching the limiting age; and
    - Is dependent upon the Employee for support and maintenance; or

- Lives in an adult-care facility that provides care for the developmentally disabled who are otherwise unable to independently provide for their own support.

Evidence of the child's dependency and incapacity must be filed with the Trust Administration Office within 31 days after attaining the limiting age, and periodically thereafter. The Plan, at its own expense, has the right to designate a Physician to examine the Dependent when and as often as the Plan may reasonably require.

Additional Rules for Dependent Children
A child cannot be eligible for benefits under this Plan as both an employee and a dependent child. An adopted child will be eligible for coverage from the date of placement.

Coverage of grandchildren and children of dependent children is not automatic; you must make specific application to the Trust Administration Office.

The value of your dependent's Plan coverage is imputed taxable income to you if your dependent is neither your income tax dependent nor your child (as defined by the Code) under age 27 at the end of the year. You must prepay to the Trust Administration Office the income tax withholding and employee-payable payroll taxes due on that taxable coverage. Those prepayment requirements are described in the **Taxable Coverage** section on page 19.

Enrollment of Dependents
If you have eligible dependents, it will be necessary to complete an enrollment form within 30 days of your enrollment in order to avoid delay in processing claims. Enrollment forms can be obtained from the Trust Administration Office. Claims will not be paid until a completed enrollment form and all requested supporting documentation is received by the Trust Administration Office. In no event will claims be paid more than 12 months after the claims are incurred.

If you acquire new dependents while you have coverage, a new enrollment form must be completed and submitted along with the appropriate documentation. You should complete a new enrollment form and supply an appropriate marriage or birth certificate within 30 days of your marriage, the birth of the child, adoption or placement for adoption, or entry of court order granting legal

guardianship or custody as soon as reasonably practicable. Claims will not be paid until a completed enrollment form and all requested supporting documentation is received by the Trust Administration Office. In no event will claims be paid more than 12 months after the claims are incurred.

When Dependent Coverage Begins
Once all enrollment material is received and processed, eligibility for your dependents will be effective:

- On the date you become covered.
- On the date of birth, adoption, placement for adoption, placement of foster child or the date legal custody is awarded.
- On the first day of the first calendar month following the date of your marriage for your new spouse and stepchildren.
- If your coverage has lapsed, your dependent's coverage will begin on the first day of the month when your eligibility is reinstated.

Although your dependents may be eligible on the dates identified above, claims for dependents will be suspended until all required enrollment documentation has been received by the Trust. If the required documentation is not received within 12 months after the date the claims were incurred, the claims will be denied.

Mid-Year Changes for Eligible Dependents
You may add a dependent mid-year upon the following "special enrollment events":

- You declined to enroll a dependent because he or she had group health plan coverage and your dependent subsequently loses eligibility for that other coverage or the employer stops making contributions towards that coverage;
- You declined to enroll a dependent when initially eligible or at open enrollment because he or she was covered under Medicaid or under a state child health plan ("CHIP") and that dependent subsequently loses eligibility for that coverage;
- A dependent becomes eligible for government premium assistance under Medicaid or CHIP; or
- You acquire a new dependent.

You have 30 days following a dependent's loss of other health insurance or group health plan coverage to enroll that dependent for Plan coverage. You have 60 days following a dependent's loss of Medicaid or CHIP coverage or a dependent becoming eligible for government premium assistance under Medicaid or CHIP to enroll that dependent for Plan coverage. If you or a dependent experience one of the special enrollment events above, contact the Trust Administration Office as soon as possible.

If you change your residence and move out of the service area of your medical plan, you can request that your medical plan be changed to one which is in your new location. Contact the Trust Administration Office for assistance adding coverage for a spouse or other dependent or if you move out of the coverage area of your medical plan.

Changes in Status

You must notify the Administration Office if you have a change in your family status such as:

- Marriage or divorce.
- Birth of a child.
- Child no longer meets definition of an eligible dependent.
- Death of employee or eligible dependent.

Qualified Medical Child Support Orders

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

- Provides child support or health benefit coverage to a dependent child, or
- Enforces a state law relating to medical child support.

To be qualified, an order must clearly specify:

- The name and last known mailing address of the Employee,
- The name and mailing address of each dependent child covered by the order or the name and mailing address of the state official issuing the order,

- A description of the type of coverage to be provided by the Plan to each such dependent child,
- The period of coverage to which the order applies, and
- The name of each Plan to which the order applies.

An order will not be qualified if it requires the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan.

If a proposed or final order is received, the Trust Administration Office will notify the parties named in the order. A child may designate a representative to receive copies of notices with respect to the order. A proposed or final order will be reviewed to determine if it meets the definition of a QMSCO. A properly completed National Medical Support Notice issued by a state agency shall be deemed to be a QMSCO. Within a reasonable time, the parties named in the order will be notified of the decision.

If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire QMSCO and any required self-payments must be received prior to enrollment. Any child or children enrolled pursuant to the order will be subject to all provisions applicable to dependents under the Plan.

If an order is not qualified, the notice will give the specific reason for the decision. The party filing the order will be given an opportunity to correct the order or appeal the decision through the claims review procedures explained in the booklet.

Dependent Coverage Opt-Out

Adult Dependents (spouses and Dependent children age 18 or older) of Active Participants may elect to opt-out of Plan coverage. To make the election, a Dependent must submit a signed written request. The request must include the Participant's (employee) full name, date of birth, participant identification number (or social security number), and the Dependent's full name and date of birth. Send the request to the Trust Administration Office at the following address:

AGC-IUOE Local 701
Attn: Enrollment Dept.
P.O. Box 34203
Seattle, WA 98124-1203

The opt-out will be effective for all claims incurred on an and after the first of the month following the month in which the opt-out request is received by the Trust Administration Office. The opt-out will apply to all Plan coverage, including medical, prescription drug, life insurance, dental and vision.

An opt-out of Plan coverage is not a COBRA qualifying event and a Dependent who opts out will not be eligible for COBRA Continuation Coverage.

A Dependent who opts out of coverage may re-enroll by submitting a written request to the Trust Administration Office. In order to re-enroll, the Dependent must qualify as a Covered Dependent under the Plan. Re-enrollment will be effective the first day of the month following the month in which the enrollment request is received by the Trust Administration Office, provided the Participant has active eligibility on that date. If the Participant does not have eligibility, the Dependent's eligibility will be reinstated the first of the month the Participant's eligibility is reinstated

Termination of Dependent Eligibility
Your Dependents' eligibility terminates on the earliest of the following occurrences:

- On the date your coverage ends;
- On the last day of the month he or she no longer qualifies as a Dependent, as defined above;
- On the date the Dependent fails to submit to any required medical examination or provide proof of incapacity requested by the Plan;
- In the case of a dependent whose coverage is not excludable from your taxable income under Code Section 105(b), eligibility will terminate as of the last day of the month for which income tax withholding and employee-payable payroll tax amounts were paid to the Plan;
- In the case of the Employee's death, at the end of the month following the month in which your Hour Bank totals less than 120 hours; or
- On the date the Plan no longer provides benefits.

Your dependents may be eligible to extend coverage after it would otherwise end. Coverage termination due to your failure to timely

pay applicable income tax withholding and employee-payable payroll taxes is not an event that entitles your dependent to elect COBRA.

Taxable Coverage

Subject to the prepayment requirements described below and unless prohibited by law, a domestic partner who is eligible for and covered by the Plan, or parts thereof, will be covered to the same extent as a spouse. Except for in the Dependent Eligibility section and Income Tax Dependent definition, when the terms "spouse" and "stepchild" are used in this booklet, they generally include an employee's eligible and covered domestic partner and that domestic partner's child, respectively.

Contact the Trust Administration Office for more detailed information about Plan coverage of your enrolled domestic partner and his or her children.

The fair market value of Plan coverage provided to your domestic partner, to a child of your domestic partner, and any non-Income Tax Dependents is taxable income to you unless the covered individual is your qualifying child or qualifying relative. See the **Income Tax Dependent definition** for more information about those rules.

If the individual (domestic partner, child of your domestic partner, or other dependent) is your income tax dependent, you must certify that status to the Trust Administration Office on an annual basis. If you do not certify your eligible domestic partner or a child of your domestic partner as your income tax dependent, the Trust Administration Office will assume that individual does not qualify as your income tax dependent and will provide you with information about the fair market value of the Plan coverage to be provided to him or her. Under federal tax law, that value is imputed to you as taxable income (referred to in this section as "taxable Plan coverage").

If the Plan covers your eligible dependent who is neither your income tax dependent nor your child (as defined in Code Section 152 (f)) under age 27 at the end of the year, the value of that coverage is imputed to you as taxable income (referred to in this section as "taxable Plan coverage") and is subject to the following

prepayment requirements. You are required to notify the Trust Administration Office if your dependent's coverage is taxable Plan coverage. Failure to do so may constitute fraud and your Plan coverage may be retroactively terminated.

Before your dependent's taxable Plan coverage will become effective, and on a monthly basis thereafter, you must prepay to the Trust Administration Office the income tax withholding and employee- payable payroll taxes due on the taxable income imputed to you for that coverage. The Trust Administration Office will remit these amounts on your behalf to the Internal Revenue Service and the state Department of Revenue, and the withholding amount will be a credit against any income tax you owe for the year.

Your domestic partner's or other dependent's taxable Plan coverage is contingent on your timely prepayment of the required withholding and taxes. If, for any month of your dependent's taxable Plan coverage, including the first month of coverage, you fail to timely prepay to the Trust Administration Office the required amount, your dependent's taxable Plan coverage will end the last day of the month for which timely payment was made. If Plan coverage is terminated (or never becomes effective for a plan year) due to failure to timely prepay the required amount, your dependent who received (or would have received) taxable Plan coverage cannot be enrolled or reenrolled for Plan coverage until the following open enrollment period, or until one of the special enrollment events described on page 21, if earlier.

You must notify the Trust Administration Office immediately if your dependent's coverage becomes or ceases to be taxable Plan coverage.

COBRA Continuation Coverage

Under federal law, when certain events cause a loss of coverage under the Plan ("qualifying events"), employees covered under the Plan and lawful spouses and dependent children ("Dependent") have the right to continue coverage beyond the time coverage would ordinarily end. The rights and obligations regarding continuation of coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") are explained below.

COBRA Qualifying Events and your Dependents

As an employee covered under this Plan, you may self-pay to continue coverage under COBRA if you lose your Plan coverage because of a reduction in your hours of employment or the termination of your employment (other than by reason of your gross misconduct).

Your lawful dependent spouse and dependent child have the right to choose continuation coverage if he or she would otherwise lose eligibility for any of the following reasons:

- The Employee's termination of employment or reduction in hours of employment;
- Death of the Employee;
- Divorce or legal separation from the Employee;
- Employee becomes entitled to Medicare.

A dependent child also has the right to elect continuation coverage if eligibility would otherwise be lost because the child no longer qualifies as an eligible dependent under the Plan.

A child of the participating employee who is covered under the Trust's health plan pursuant to a qualified medical child support order (QMCSO) received during the Employee's period of covered employment is entitled to the same rights to elect continuation coverage as an eligible dependent child of the Employee.

Your Domestic Partner does not have COBRA rights described in this section, and may not elect COBRA coverage on their own as a result of the above events, but you may elect to continue Plan coverage for them under COBRA on the same basis that any active employee could elect Plan coverage for such individuals.

If your Dependent elects COBRA coverage, he or she will be entitled to add dependents during open enrollment periods or upon the occurrence of special enrollment events (described on page 21).

If a child is born to or placed for adoption with you during a period of COBRA coverage, the child is eligible for coverage like your other dependents. You have the right to elect COBRA coverage for the child under the Plan's generally applicable rules for adding newborn or adopted children. If the new child is added as a dependent, the child will have independent election rights and

second qualifying event rights just like your other dependents, as described below.

Spouses and stepchildren acquired after a qualifying event are not eligible for 36 months of coverage due to a second qualifying event.

Cost

There is a cost for COBRA. The cost for the coverage available through the Trust is set annually. The Trust can charge up to 102% of the total plan premium for COBRA coverage. If you or your Dependents are eligible for a disability extension of continuation coverage, as discussed below, the cost of the coverage may be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided. Information regarding the cost will be sent with the election forms.

Monthly Self-Payments Required

You or your Dependents are responsible for the full cost of COBRA. All payments must be sent to the Trust Administration Office at the address printed on the payment coupons. The first payment is due 45 days from the date the election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Eligibility for COBRA will not commence, nor will claims be processed until the initial payment has been made. You or your Dependents will lose the right to COBRA if the initial payment is not postmarked or received by the Administration Office by the due date.

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

Length of Continuation Coverage

Employees and Qualified Beneficiaries who lose coverage because of termination of employment or reduction in hours may continue Plan coverage under COBRA for up to 18 months. The 18-month period may be extended as provided below for "Disabled Individuals," "Second Qualifying Event," and "Medicare Entitlement."

For all other qualifying events (death of the participant, divorce or legal separation from the participant or a child no longer qualifying as a Dependent under the Plan) COBRA coverage may last for up to 36 months.

Continuation coverage will end on the last day of the monthly payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not postmarked or received by the Administration Office on a timely basis for the next monthly coverage period;
- You or your Dependent becomes covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a pre-existing condition of the individual seeking COBRA). You are required to notify the Administration Office when you become eligible under another group health plan;
- You or your Dependent provide written notice that you wish to terminate your coverage;
- You or your Dependent become entitled to Medicare after the date of the election of COBRA;
- The Plan terminates, or
- The Employee's employer no longer participates in the Plan, unless the employer or its successor does not offer another health plan for any classification of its employees that formerly participated in the Trust.

Length of Continuation Coverage – Disabled Individuals
If you or your dependent is determined by the Social Security Administration to be disabled either before an 18-month qualifying event, or within the first 60 days of COBRA coverage, you and your dependents can extend COBRA for up to an additional 12 months beyond the original 18 months, up to a maximum of 30 months. To obtain the additional months of coverage, you must notify the Administration Office in writing prior to the end of your initial 18-month period of COBRA coverage. A copy of the Social Security Disability Determination must be included with the written notice. Failure to give notice and provide the Social Security Disability Determination prior to the end of the initial 18-month period will

cause you and your Dependents to lose the right to extend COBRA. If the disabled individual is subsequently found not to be disabled, you must notify the Administration Office within 30 days of this determination.

Continuation coverage will end on the earlier of 30 months from the loss of coverage, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

Length of Continuation Coverage – Second Qualifying Event
Dependents who are entitled to COBRA as the result of a participant's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if any of the following second qualifying events occur:

- The participant's death;
- Divorce or legal separation from the participant, or
- Dependent child losing dependent status under the Plan.

If you or your dependent experiences a second qualifying event you or your dependent must notify the Administration Office in writing within 60 days of the second qualifying event. The notice must identify the qualifying event that occurred. Failure to give such timely written notice of a second qualifying event will cause the individual to lose the right to extend COBRA. In no event will COBRA extend beyond a total of 36 months.

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

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

Relationship Between COBRA and Medicare or Other Health Coverage
Your COBRA coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. If your Medicare or other group health coverage already

existed when you elected COBRA, however, you can be eligible for both.

If you have Trust coverage based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Trust will only pay secondary and coordinate with Medicare. Current employment status means you are still at work or have received short-term disability benefits for six months or less. If you have Medicare coverage based on end stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute.

In order to receive full Plan benefits you and your Dependent spouse MUST enroll in BOTH Medicare Parts A and B (or a Medicare Advantage Plan) when eligible for Medicare.

This Plan does not provide benefits for amounts that would have been reimbursed by Medicare Parts A or B. If you or your spouse fails to enroll in Medicare Parts A and B when eligible, the Plan will still pay as if you are enrolled in Medicare Parts A and B, which will result in significant out-of-pocket costs to you.

If you have other group health coverage, it will pay primary and the Trust's COBRA coverage will be secondary.

Notice Requirements

Your employer has the responsibility to notify the Trust Administration Office if Plan coverage ends due to your termination of employment, reduction in hours, or death.

If your spouse or dependent child loses Plan coverage due to divorce, legal separation, or a child's loss of dependent status under the Plan, you or your dependent has the responsibility to inform the Trust Administration Office of the event in writing within 60 days after the later of the date of the event or the date of loss of coverage. This notice must state the name of the Plan; the name, address, and Social Security number of the employee covered by the Plan; the names, addresses, and Social Security numbers of all dependents who lost coverage due to the qualifying event, and the type of qualifying event and date it occurred. The Trust Administration Office may require other documentation of the qualifying event. If you fail to provide timely notice, you will not be eligible for

COBRA continuation coverage and your eligibility under the Plan will be terminated.

If you are a dependent who is receiving 18-month continuation coverage because of the covered employee's termination of employment or reduction of hours, and you experience one of the second qualifying events and want to extend your coverage to a maximum of 36-months, you must notify the Trust Administration Office in writing of the occurrence of the second qualifying event within 60 days after the later of the second qualifying event or the date that coverage would be lost due to the event if the first qualifying event had not occurred.. The notice must be sent to the Trust Administration Office and must include the name of the Plan, the names, addresses, and Social Security numbers of the employee and affected dependents, the type of 36- month qualifying event, the date of the event, and proof of the event.

If one of your dependents is disabled at any time during the first 60 days of COBRA coverage, the dependent or a family member must notify the Trust Administration Office in writing of the Social Security Administration's disability determination within 60 days after the latest of (i) the date of the determination letter, (ii) the date of the qualifying event, or (iii) the date of loss of coverage, but no later than the date the original 18-month COBRA period would have ended. A dependent who is receiving extended coverage must also notify the Trust Administration Office in writing within 30 days after the Social Security Administration determines that the disabled dependent is no longer disabled. The notice must be sent to the Trust Administration Office and must include the name of the Plan; the names, addresses, and Social Security numbers of the employee and affected dependents; the type of qualifying event and the date it occurred; the name of the disabled dependent; the date of the Social Security disability determination; and a copy of the award letter of disability (or notice of cessation of disability) from the Social Security Administration. Failure to provide these notices eliminates the right to extend coverage for 12 months after the expiration of the first 18-month period of COBRA coverage.

Cost and Payment

There is a cost for COBRA. Information regarding the cost will be sent with the COBRA election forms. The first payment is due 45

days from the date the COBRA election form is sent to the Trust Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. **If the first payment is not made within the 45-day period, COBRA coverage will not commence.** If full, timely initial payment is made within the 45-day period, thereafter payments must be made monthly to continue COBRA coverage. All payments must be sent to the Trust Administration Office.

No claims for benefits will be processed for expenses incurred following the date of the qualifying event, until the appropriate, timely COBRA payment has been made for the applicable period of COBRA coverage.

Types of Benefits
The COBRA coverage available to you is coverage at the same level as your coverage under the Plan when the qualifying event occurred. However, any benefit changes that apply to active employees also apply to anyone with COBRA coverage under the Plan.

Each Qualified Beneficiary has a separate right to elect COBRA coverage and may choose one of the following two options:

- Medical only; or,
- Medical, Dental, and Vision.

Once an option is selected, you may not change it. However, you and your dependents may change from the Medical Program to the HMO Program (or vice versa) during an open enrollment period or upon the occurrence of one of the special enrollment events described on page 21.

The Trust Administration Office will advise you of the COBRA costs associated with each benefit option and where to send your monthly payment.

After receiving notice of a qualifying event, second qualifying event, or disability determination by the Social Security Administration, the Trust Administration Office will notify the Qualified Beneficiaries if they do not qualify for COBRA coverage or an extension of COBRA coverage, as applicable.

If you have HMO Program coverage, you and your dependents may be eligible during or at the end of COBRA coverage for a portability

plan or individual medical coverage. For additional information, contact the Trust Administration Office.

State Law Continuation Coverage Provisions
Under Oregon law, which may be applicable if you are covered under the HMO Program, COBRA's 36-month coverage limit does not apply if the qualifying event was your death, divorce, or legal separation, and if your surviving, divorced, or separated spouse was at least age 55 on the date of the qualifying event. Under those circumstances, coverage for your spouse and any dependent children will generally continue until the occurrence of the earliest of the following events:

- The premium is not paid when due (or within any grace period).
- The alternative plan is terminated, unless the insurer makes a different group policy available to group members.
- Your surviving, divorced, or separated spouse becomes insured under any other group health plan (through marriage or otherwise) or becomes eligible for Medicare.
- Your dependent child becomes insured under any other group health plan or loses dependent status under the terms of the alternative plan.

The Oregon continuation coverage period will not be longer than required by Oregon law. To be eligible for Oregon continuation coverage, your spouse or former spouse (or dependent child) must notify the Trust Administration Office within 60 days of the death, divorce, or legal separation and must elect Oregon continuation coverage within 60 days after receiving notice from the Trust Administration Office.

If a Qualified Beneficiary is eligible for other continuation of coverage privileges required by state law or as provided by this Plan, these extensions will run concurrently with COBRA coverage.

Expanded Continuation Coverage Provisions
In addition to the COBRA continuation coverage provisions required by law, the Board of Trustees has adopted the following expanded provisions:

- If you are prevented from working solely because of a physical or mental disability within 18 months after your hour bank or associate coverage ends, or if Social Security determines a covered family member is totally disabled within 60 days after your hour bank or associate coverage ends, you will be permitted to elect continuation coverage for yourself and your family for 30 months (rather than 29 as required by law) from the date your regular coverage expires. This coverage is not automatic; you or a covered family member must provide the Trust Administration Office a copy of the Social Security disability determination letter during the first 18 months of continuation coverage.
- A surviving spouse of an employee who dies while covered under the Plan may continue his or her Plan coverage and that of any dependent children beyond any time periods of continuation coverage required by law, until he or she remarries. (In no event will coverage be terminated due to remarriage if continuation coverage has been in effect for less than 36 months, as required by COBRA.)

Family or Medical Leave of Absence Under FMLA

If certain requirements are met, the Family and Medical Leave Act of 1993 ("FMLA") allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth of a child, or placement of a child with you for adoption or foster care;
- The care of a seriously ill child, spouse, or parent;
- The care of your own serious illness;
- Any qualifying exigencies (as determined by the U.S. Department of Labor regulations) arising out of the fact that a spouse, son, daughter, or parent is on active duty (or has been notified of an impending call of order to active duty) in the Armed Forces in support of a contingency operation; or
- The care of a spouse, son, daughter, parent, or next of kin who is a covered service member (you may take up to 26 weeks of leave during a single 12-month period).

Contact your employer for information regarding FMLA and the required documentation. Your employer must make arrangements with the Plan for your continued coverage during the FMLA leave.

Uniformed Service and USERRA

Under the Uniform Services Employment and Reemployment Rights Act ("USERRA"), you have certain rights to continue coverage if you enter military service. If you are an active Employee and you leave employment with a contributing employer for military service, you have the following options:

- You may elect to run-out your Hour Bank. When hours in your Hour Bank are less than the number required for one month of eligibility, you may elect to extend coverage by making self-payments for USERRA continuation coverage.
- You may elect to freeze your Hour Bank until you return from military service. If you freeze your Hour Bank, you still have the option of electing to self-pay for USERRA continuation coverage for up to 24 months.

Notice of Military Service

You are responsible for notifying the Administration Office that you are entering military service. If you want to freeze your Hour Bank, you must notify the Administration Office within 60 days of beginning military service. If you do not provide timely notice, your Hour Bank will continue to be used for updating eligibility each month until it is run out.

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

Election of USERRA Continuation Coverage

After timely notification to the Administration Office of military service, you will be sent an election form to affirmatively elect USERRA continuation coverage. Your completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished.

If you do not return your election forms by the due date, you will not be allowed to elect USERRA continuation coverage.

Length of USERRA Continuation Coverage
If the Employee provides timely notice and properly elect to freeze his Hour Bank, it will be frozen the first of the month following the month in which he begins military service

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

If you decide to run-out your Hour Bank before commencing USERRA continuation coverage, USERRA continuation coverage will begin immediately following the date Hour Bank coverage ended, provided you properly elect USERRA continuation coverage and the required self-payments are made.

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

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

Available Coverage
The Employee may elect to self-pay for USERRA continuation coverage for himself, Employee and Dependents, or only the Employee's Dependents. Benefits are the same as those provided to similarly situated Active Employees. .

USERRA continuation coverage is not available for time loss benefits. If the Trust changes its benefits, USERRA continuation coverage will also change.

Monthly Self-Payments
If the Employee's military leave is less than 31 days, coverage is continued at no cost. The Employee will be credited with the hours necessary to keep coverage in effect as if he worked in covered employment with a contributing employer during the period of service.

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

The initial payment for USERRA coverage is due within 45 days from the date the Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made.

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

USERRA continuation coverage must be continuous and must immediately follow the date your Hour Bank coverage ended (or was frozen). If you elect to continue coverage, you will be required to pay not more than 102% of the full premium, except that if you perform uniformed service for less than 31 days, you will not be required to pay more than the employee share for the coverage.

Reinstatement of Eligibility Following Military Service
If the Employee properly elected to freeze his Hour Bank when he entered military service, the balance in the Employee's Hour Bank will be carried over until he has an USERRA qualifying discharge from military service. The Employee's Hour Bank eligibility will be reinstated the first of the month of the discharge, provided he has sufficient hours for a month of coverage. Following reinstatement, Hour Bank eligibility will terminate the first day of any month the

Employee's Hour Bank has less than the number of hours required for one month of eligibility at the current Hour Bank deduction rate, unless the Employee returns to employment with a contributing employer within the time period required by USERRA, as explained below.

If the Employee returns to employment with a contributing employer immediately following a qualifying discharge from military service and within the time period required by USERRA, the Employee's Hour Bank will be credited with the maximum number of hours allowed by the Plan (prior to deduction for the current month of eligibility), and eligibility will be reinstated the first of the month in which he returns to employment. If the Employee elected to freeze his Hour Bank, the frozen hours that remain on the date of reemployment, together with the credited hours, will not exceed the maximum number of hours allowed by the Plan (prior to deduction for the current month of eligibility). Hour Bank eligibility will terminate the first day of any month the Employee's Hour Bank has less than a month of eligibility. However, the Employee may be able to qualify for COBRA coverage.

If the Employee is on the out-of-work list at the local union, it is considered a return to employment with a contributing employer for purposes of reinstatement of eligibility.

The Employee is responsible for immediately notifying the Administration Office of his discharge from military service so that frozen hours can be reinstated on a timely basis. The Employee should also notify the Administration Office if he is reemployed within the time required by USERRA, so that his Hour Bank can be credited and eligibility reinstated without waiting periods.

Relationship of USERRA Continuation Coverage to COBRA
The Employee may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. See the COBRA Continuation Coverage section.

Your Trust Benefits

The Trust provides for the following programs:

- Trust's Plan (medical, prescription, dental and hearing aid benefits described in this booklet)
- HMO Program through Kaiser Permanente (insured medical and prescription drug benefits)
- Willamette Dental Program
- Vision Program
- Insured life insurance benefits
- Insured accidental death and dismemberment benefits
- Weekly disability income benefits

The medical coverage you elect–either through the Trust's Plan or the HMO Program – determines whether you will receive medical, prescription drug, and hearing aid benefits from the Trust's Plan or Kaiser. Participants are eligible for the Trust's dental, vision, employee and dependent life insurance benefits, AD&D benefits, and weekly disability insurance benefits, regardless of which medical program they elect.

Medical Benefit Options

As an alternative to the Trust's Plan benefits described in this booklet, you may elect medical coverage through Kaiser's HMO Program.

If you elect coverage under Kaiser's HMO Program, your medical benefits will be provided through the Kaiser Permanente insured plan instead of directly by the Trust through the Trust's Plan. Kaiser Permanente also handles claims processing and appeals under the HMO Program. You will receive a separate booklet describing the benefits provided under the HMO Program, including a description of the required copays for certain procedures and services. That separate HMO Program booklet, together with this booklet, make up the summary plan description for purposes of describing your Plan benefits. Please contact the Trust Administration Office if you do not receive the HMO Program booklet, or if you need another copy of the booklet.

Annual Open Enrollment
The Plan has an open enrollment period each year during which you can switch to a different medical plan.

Plan Benefits

The Trust offers comprehensive medical benefits to help members pay the cost of health care and to support your good health. You and the Plan share in many of the costs of services. The Plan offers several tools to help you make wise and cost-effective health care decisions.

- A preferred network of hospitals and doctors.
- Precertification of hospital admissions and certain services to determine medical necessity.
- Case management services to help ensure that you receive appropriate and cost-effective medical care for your situation.

Medical Benefits Summary

The chart below shows key features of your medical benefits at a glance. Please note, these are just the highlights — many details aren't included in this chart but are covered in the rest of this section.

Feature	PPO Network Provider	Non-Network Provider
Annual deductible	$150 per person $450 per family	
Coinsurance	Plan pays 80% of network provider allowed amount for most covered services (you pay the remaining 20%) until your out-of-pocket maximum is reached. Then Plan pays most covered expenses at 100% of preferred provider allowance for the rest of the calendar year (some exceptions apply).	Plan pays 50% of usual customary and reasonable (UCR) charges for most covered services (you pay the remaining 50%) until your out-of-pocket maximum is reached. Then Plan pays most covered expenses at 100% of UCR charges for the rest of the calendar year (some exceptions apply).
Annual out-of-pocket maximum	$5,300 per person $10,000 per family	

Feature	PPO Network Provider	Non-Network Provider
Office visits	You pay $30 copay per visit and 20% after deductible	You pay $40 copay per visit and 50% after deductible
Preventive care services See pages 56 and 57.	Plan pays 100%	You pay $40 copay per office visit and 50% after deductible (The Plan pays 100% if no PPO network provider provides that service)
Outpatient lab and X-rays	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
Hospitalization — inpatient Precertification is required	You pay 20% coinsurance after deductible and $150 copay per admission (waived if admission is pre-certified)	You pay 50% coinsurance after deductible and $150 copay per admission (waived if admission is pre-certified)
Emergency room	You pay 20% coinsurance after deductible and $50 copay per visit (waived if admitted to the hospital)	You pay 20%* coinsurance after deductible and $50 copay per visit (waived if admitted to the hospital)
Ambulance	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible for non-emergency medical condition services 20%* after deductible for emergency medical condition services
Acupuncture Precertification is required	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

Feature	PPO Network Provider	Non-Network Provider
Chiropractic services Limited to a maximum of 24 visits per year	You pay 20% coinsurance after deductible and $30 copay per visit	You pay 50% coinsurance after deductible and $40 copay per visit
Rehabilitation Physical, occupational, and/or speech therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
Mental health and chemical dependency treatment	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

*20% of the greater of the amount negotiated with PPO network providers and the UCR for the emergency services provided.

How Your Medical Benefits Work

The Plan has contracted with Premera Blue Cross for access to preferred provider arrangements through the Premera (Washington and Alaska) network and the national Blue Cross Blue Shield ("BlueCard") network (all other states). Under these preferred provider organization (PPO) arrangements, certain Hospitals, Physicians, and other health care professionals have agreed to discounted fees. Using PPO providers is important for several reasons:

- For covered services and treatments, the PPO provider has agreed to accept their discounted fee as payment in full for the service. They cannot bill you for any amount over their discounted fee.
- For covered services and treatments, the Plan recognizes the PPO discounted fee as the Allowed Amount, and benefits will be based on the discounted fee. For non-PPO providers, the Allowed Amount will be calculated based on usual, customary and reasonable (UCR) fee limits and the provider may bill you for any amount they charge over UCR.
- If you use a PPO provider, in most instances the Plan will pay at a higher coinsurance level, and your out-of-pocket costs will be lower.

- PPO providers will submit claims directly to the Plan, and the Plan will reimburse the provider, meaning less paperwork for you.

Finding a PPO Network Provider
Depending on where you live, your PPO network will be through either the Premera Blue Cross network or the BlueCard nationwide network:

- If you live in Washington or Alaska, your PPO network is Premera Blue Cross
- If you live in any state other than Washington or Alaska, you can use your local Blue Cross and/or Blue Shield network.

To find a PPO network provider or facility, go to www.premera.com/sharedadmin or call (800) 810-2583. PPO directories are also available from Premera Blue Cross.

How the Annual Deductible Works
A deductible is the amount you must pay toward certain covered benefits before the Plan pays benefits. The annual deductible is $150 per person, with a limit of $450 per family each calendar year.

Generally, each calendar year, you must satisfy a new deductible. However, there is a rollover provision for your annual deductible. If you do not meet the applicable annual deductible in a calendar year, any eligible expenses you have during the last three months of the year that are credited to your annual deductible will also be credited to the following year's annual deductible. For example, if you do not meet the annual deductible for a calendar year and you have $100 in covered services during December that are applied to the deductible, this amount will also count toward the next year's deductible. So at the beginning of the new year, you'll be credited with $100 toward the $150 annual deductible and will only have to pay another $50 that year before the deductible is satisfied.

What's a Copay?
A copay is the fixed dollar amount you generally pay at the time you receive a specified health care service or supply.

How Coinsurance Works

After you satisfy the deductible, you and the Plan share the remaining expenses. This is called "coinsurance." In general, coinsurance amounts for PPO and non-PPO providers are as follows:

Coinsurance	PPO Provider	Non-PPO Provider
The Plan Pays	80% of PPO Allowed Amount	50% of Usual, Customary and Reasonable (UCR)
You Pay	20% of PPO Allowed Amount	50% of Usual, Customary and Reasonable (UCR), plus any amount in excess of UCR

For certain services the coinsurance may be different as noted throughout this booklet.

For example, you have a $150 bill from a non-network lab. The UCR allowance is $100, and the Plan covers 50% of this amount, or $50. You must pay the other $100 — your 50% coinsurance ($50) plus the extra $50 above the UCR allowance. By using PPO network providers, you are protected against having to pay amounts the provider charges that exceed UCR for covered services.

Calendar Year Out-of-Pocket Maximum

Out-of-pocket maximums apply on both a per individual and per family basis. Once your total PPO out-of-pocket expenses for you (or any other individual family member) in a Calendar Year reaches the individual out-of-pocket maximum, the PPO out-of-pocket maximum will be considered met for you (or that family member) for the rest of the Calendar Year. Once your total PPO out-of-pocket expenses for two or more family members in a Calendar Year reaches the family maximum, the PPO out-of-pocket maximum will be considered met for any eligible family member for the rest of the Calendar Year. There is no out-of-pocket maximum for non-PPO providers. The Calendar Year out-of-pocket maximums are as follows:

Calendar Year Out-of-Pocket Maximum	PPO Providers and Non-PPO Providers*
Per Individual	$5,300
Per Family	$10,000

*For Non-PPO providers the out-of-pocket maximum applies to coinsurance only and excludes certain services and balance billed amounts.

For PPO providers - The Calendar Year out-of-pocket maximum includes deductibles, coinsurance (including pediatric dental/vision coinsurance) and copays that you are required to pay out-of-pocket. When your total out-of-pocket amount for covered PPO services incurred during a Calendar Year reaches the maximum, covered services from PPO providers are covered in full for the remainder of the Calendar Year.

For non-PPO providers – The out-of-pocket maximum only applies to coinsurance for non-PPO providers. Once you reach the out-of-pocket maximum, covered services are paid at 100% of the UCR allowed amount for the rest of that calendar year, but you may be balance billed for amounts that exceed the UCR charges. Charges balance billed by non-network providers are excluded from the Plan's annual out-of-pocket maximum and you will be responsible for those amounts.

If you receive treatments or services from a network provider or non-network provider, the following expenses do **NOT** count toward your annual out-of-pocket maximums, and you will always be required to pay these amounts:

- Charges that exceed the UCR allowed amount
- Penalties for failure to obtain required preauthorization
- Services and items not covered by the Plan

Example (In Network)
Here's an example of how the out-of-pocket maximum helps protect you. You are hospitalized and your total hospital bill is $40,000, your admission was pre-certified, and you received all your services from PPO network providers (your hospital, all doctors, the lab, etc.).

- Your PPO hospital bill totals $40,000.

- You pay the deductible ($150) plus 20% of the allowed amount for covered services and the Plan pays 80%.
- When your 20% reaches $5,150, you've reached the $5,300 out-of-pocket maximum.
- The Plan pays 100% of the allowed amount for the remainder of that calendar year. You pay amounts that exceed UCR and the charges for non-covered services.

Hospital bill	$40,000
You pay the deductible	- $150
	$39,850
You pay 20% up to the out-of-pocket maximum	- $5,150
	$34,700
Plan pays 80% up to the out-of-pocket maximum	- $20,600 0
Balance paid at 100% by the Plan	$14,100

The patient balance is $5,300 for the deductible and 20% coinsurance up to the out-of-pocket limit.

Protection From Balance Billing

The No Surprises Act, protects the Plan participants from balance billing for the following services:

- Emergency Services at an out-of-network facility
- Air Ambulance services
- Services provided at an in-network facility by an out-of-network provider (a common example is an anesthesiologist working at an in-network hospital).

If you go to non-PPO providers in other situations, they can still balance bill you.

The law provides that your costs for these services must be limited to no more than what you would have paid, had you gone to PPO provider. Your cost sharing under the health plan (such as your deductible or co-insurance) must count towards your annual deductible and out-of-pocket maximums.

The law's protections do not apply if you sign a consent to be balance billed by the non-PPO provider. Certain non-emergency physician specialties, however, cannot request you to waive your balance billing protection in any situation. Physicians and facilities which cannot ask you to waive your balance billing protections include assistant surgeons and hospitalists, anesthesiologists, pathologists, radiologist, laboratories, and other specialists that you typically do not select. **Always remember: You are never required to give up your protections from balance billing and you should review any document you are asked to sign regarding billing**.

If a health care provider requests your consent to balance billing:

- The written consent must be clear and understandable;
- Generally, the written consent form must be provided at least 72 hours prior to the date of the item or service;
- The written consent form must state that payment of the out-of-network bill may not accrue towards the individual's deductible or annual out-of-pocket maximum;
- The written consent form must state that by signing the consent, the individual agrees to be treated by the non-PPO provider and understand the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by the non-PPO provider; and
- The written consent form must document the time and date on which the individual received the written notice and the time and date on which the individual signed the written consent form.

You must also be provided with an estimate of the cost for the service or treatment and additional information. If you believe a provider has violated these requirements, please request a copy of your consent form and go to www.cms.gov/nosurprises.

Continuity of Care

Continuity of care is available when a health care provider or facility terminates its relationship with a Plan's PPO Network. When this occurs, the network provider or the Plan will contact you to inform you of the change. If you are undergoing a course of treatment for services or complex care, receiving institutional or inpatient care,

are scheduled for non-elective surgery, are pregnant or terminally ill, you can request that you can continue to use the provider and receive the same benefits as if they were an in-network provider for up to 90 days.

If you receive notice of a provider leaving the network, and you believe you qualify for a continuity of care accommodation, you should contact the Trust Administration Office.

Precertification and Case Management

The Plan requires you to precertify inpatient admissions and certain treatments whether you use PPO network or non-network providers. Precertification ensures that you are hospitalized only when medically necessary, and for the appropriate number of days. Precertification does not guarantee coverage – all services must be medically necessary covered expenses under the Plan to be eligible for benefits.

The following services always require precertification by Medical Rehabilitation Consultants (MRC)

Event	Your Doctor Must Contact MRC
Acupuncture or acupressure	Before treatment begins
Non-emergency hospital treatment, skilled nursing facility, or extended care facility admissions; hospice or home nursing care	At least 48 hours before your hospital stay or treatment program begins
Maternity or newborn stay that exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section	After 48 hours for a normal delivery or 96 hours for a cesarean section
Your doctor determines you require a longer stay in the hospital or skilled nursing facility	At least one day before your last approved day
Transplants	At least 48 hours before the transplant

Second Surgical Opinion

A second opinion is occasionally requested as part of the precertification process. If requested by MRC, you must receive the

second opinion in order to receive regular Plan benefits. You may choose the doctor that provides the second opinion. If the first and second opinions disagree, and you choose to receive the services, regular Plan benefits will apply if the admission was pre-certified. Charges for the second or third opinion and related diagnostic services requested by the consulting doctor will be paid at 100% of the allowed amount. The doctor providing the second or third opinion will not be eligible for any other benefits associated with a surgical procedure. This benefit is not subject to nor does it affect other Plan benefits or annual maximums.

Medical Rehabilitation Consultants Contact Information
Medical Rehabilitation Consultants.
111 W. Cataldo Ave Suite 200
Spokane, WA 99201-3203
Outside Portland: (800) 827-5058

If You Don't Precertify
Precertification is required by the Plan for the services listed above. If you do not pre-certify an admission or treatment when required, the Plan will reduce its benefit by $150 per admission even if the covered service is medically necessary. If the Plan determines the admission or treatment was not medically necessary, the Plan will pay no benefit and you will have to pay the entire cost, because only medically necessary services are covered by the Plan. If you do not get a second doctor's opinion when requested, the Plan will only pay 60% of all covered services and you will be responsible for the remaining 40% of the charges, even if the provider is in-network.

Case Management
The Plan has contracted with MRC to provide case management services in certain health care treatment situations. MRC representatives will work cooperatively with you, your physician, and the Trust Administration Office to consider effective alternatives to hospitalization and other high cost care to make the most efficient use of the Plan's benefits. The purpose of these services is to help ensure that you receive appropriate and cost-effective medical care and to provide assistance in navigating the health system if you have a catastrophic medical condition.

What's Covered by the Trust Plan
Covered medical charges are the charges for medically necessary services, supplies and treatments, ordered by a licensed provider used to diagnose of treat an illness or accidental injury. Coverage is subject to Plan provisions, including Plan exclusions and definitions set forth herein

Acupuncture and acupressure treatments that are pre-certified. See the **Precertification** section, on pages 44 and 45.

Ambulance Expenses for ambulance services are covered only when those services are for an Emergency Medical Condition as that term is defined in the Definitions chapter of this document or for Medically Necessary inter-facility transport.

Ground Ambulance Covered expenses include charges for professional ambulance transportation:

- To the nearest appropriate facility where treatment of the medical emergency can be delivered.
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance Covered expenses include charges for emergency transportation to the nearest appropriate hospital facility where treatment of the medical emergency can be delivered when medically necessary. The Allowed Amount for non-PPO air ambulance services will be based on UCR charges determined by the Plan for Medically Necessary Emergency Transportation.

Ambulatory (outpatient) surgical center benefits are provided for services and supplies furnished by an ambulatory surgical center.

Anesthesia benefits are provided for anesthetics and its administration

Approved clinical trials. Benefits are provided for routine patient costs for items and services furnished in connection with an approved phase I, II, III, or IV clinical trial or a clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that would otherwise be covered by the Plan. The Plan generally will not cover:

- The investigational item, device, or service itself (except as provided below);
- Items and services solely for data collection that are not directly used in the clinical management of the patient; or
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

That Plan will cover the investigational item, device, or service itself if it is part of an approved clinical trial and meets the criteria in either Category 1 or 2 below:

Category 1

- The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center;
- The trial has been reviewed and approved by a qualified institutional review board; and
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies

Category 2

- The trial is to treat a condition too rare to qualify for approval under Category 1;
- The trial has been reviewed and approved by a qualified institutional review board;
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies;

- The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy; and
- There is no therapy that is clearly superior to the trial treatment

Bariatric (Weight loss) surgery for the treatment of morbid obesity including treatment of complications and reversal of weight loss surgeries, provided that the procedure is pre-certified. Qualifications for the surgery include the following:

- Over age 18
- Documentation of active participation in a medically supervised, non-surgical weight loss program

A BMI of at least 40, or a BMI of at least 35 with one of the following conditions: hypertension, dyslipidemia (a blood lipid disorder that contributes to diabetes and heart disease), Type 2 diabetes, coronary artery disease, or sleep apnea

Chemical dependency and mental health treatment provided by a licensed general hospital, health care facility, residential facility or program, day or partial hospitalization program, physician, psychologist, nurse practitioner, or clinical social worker.

The provider must be licensed and approved by the Oregon Mental Health Division, or an equivalent agency if services are received outside Oregon, or the Office of Alcohol and Drug Abuse Programs.

Chiropractic services by a licensed chiropractor, up to 24 visits per calendar year. ($30 copayment applies for in-network providers. $40 copayment applies for out-of-network providers).

Contraceptive devices. Contraceptive drugs, supplies or devices dispensed by a licensed pharmacy may be covered under the Plan's prescription drug benefit (see page 66). Intrauterine devices and other contraceptives that require placement or removal by a physician are also covered under this medical benefit.

Cosmetic Surgery
The Plan covers necessary services and supplies for cosmetic surgery only if required for:

- Repair of an accidental Injury that occurs while covered under this Plan and provided that the service or supply is provided within 1 year of the date of Injury.
- Reconstructive breast surgery following or coinciding with a mastectomy and performed as a result of an Illness or Injury, including all reduction stages of the non-diseased breast; and
- Congenital defects of newborn children.

Dental services for repair of damage to jaw and natural teeth as a direct result of and within six months after an accidental injury. Routine dental care is generally provided under your dental benefit (if eligible), not under this medical benefit. See **Dental Care Benefits** beginning on page 70.

Developmental Disorders. The Plan covers medically necessary charges for the evaluation and treatment of developmental disorders not classified as mental disorders in the ICD and DSM for dependents age twelve and under.

Diabetes self-management educational benefit under a program by health care professionals (such as physicians, nurses, pharmacists or registered dietitians) who are knowledgeable about the treatment of diabetes. The Plan covers 100% of the preferred provider allowance or the UCR charges, if the provider is out-of-network, for completion of one outpatient program for these services during the individual's lifetime. This benefit is not subject to the annual deductible.

Diagnostic X-ray and Laboratory Services. X-rays, imaging procedures, and other laboratory exams are covered if medically necessary for diagnostic purposes.

Dialysis Treatment

Dialysis Treatment – Inpatient. The Plan pays for medically necessary inpatient dialysis on the same basis as any other inpatient treatment. Non-emergency inpatient dialysis requires preauthorization.

Dialysis Treatment – Outpatient. The Plan pays for medically necessary outpatient dialysis on the same basis as other outpatient services.

End-Stage Renal Disease. If you are diagnosed with End-Stage Renal Disease (ESRD), you may be eligible for Medicare coverage by nature of your diagnosis. If you apply for Medicare, you are required to provide the Trust Administration Office with the effective date of your Medicare coverage so that the Plan can ensure the correct coordination of claims payments between the Plan and Medicare.

Durable Medical Equipment. The Plan provides benefits for crutches, trusses, braces, oxygen and rental equipment for its administration, diabetic equipment and supplies not covered under the prescription drug benefit, ostomy supplies and other similar appliances for medically necessary treatment prescribed by a covered provider.

Emergency Medical Conditions. The Plan covers all emergency services related to an emergency medical condition (as defined in the definitions section of this book) at the PPO rate for both PPO and non-PPO provider facilities.

Covered expenses include charges made by a hospital or a physician for services provided in an urgent care facility or emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit may cover:

- Use of urgent care or emergency room facilities;
- Physicians services;
- Nursing staff services;
- Radiologists, pathologists, and other medical provider services; and
- Expenses for Emergency Services includes the cost of the services to treat the medical emergency as well as the cost of post-stabilization services until the patient can consent and safely be moved to a non-emergent treatment location or facility.

Please contact a network provider after receiving treatment for an Emergency Medical Condition.

With the exception of Urgent Care described herein, if you visit a hospital emergency room for a non-emergency condition, the plan

will not cover your expenses. No other plan benefits will pay for non-emergency care in the emergency room.

Habilitative and Rehabilitation Therapy Services - Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.
Covered expenses include charges for therapy services when prescribed by a physician as described below.

The services have to be performed by a licensed or certified physical, occupational or speech therapist; a hospital, skilled nursing facility, or hospice facility; or a physician.

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

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

Habilitative and rehabilitative services are subject to the following conditions:

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

Benefits for rehabilitative and habilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy.

Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Booklet.

Habilitative and rehabilitative benefits do not include education training or services designed to develop physical function.

A "visit" consists of no more than one hour of therapy. Unless medically necessary, covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Home health care services are covered up to 50 intermittent home visits per condition each calendar year for care furnished and billed by a home health agency that is licensed or certified by the state in which it operates. Covered employees of a home health agency include a registered nurse, licensed physical, occupational or speech therapist and home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results). Each visit by a home health care provider counts as one visit with the exception of four hours of home health aide services which count as one visit.

Laboratory services, prescription drugs, medical equipment and supplies provided by a home health care provider or home health agency during a period of covered home health care are covered to the extent a physician certifies that these services or supplies would have been provided if the covered individual remained hospitalized. Such services, drugs, equipment and supplies are not subject to the 50 visits per condition benefit maximum.

To be covered, home health care must be provided according to a written treatment plan of care approved by a doctor and begin within seven days after the end of a hospital stay or as an alternative to an inpatient hospitalization or a stay in an extended care facility.

The Plan does not cover services, supplies or providers not included in the home health care treatment plan, services provided by family members or someone who normally lives in your home, custodial care, or transportation services.

Hospice care benefits provided by a hospice, hospice care team, hospital home health care agency, or extended care facility are covered for a terminally ill individual and his or her family members up to a maximum of 180 days.

To be covered, hospice care services must be provided under the terms of a hospice care program and billed through the hospice that manages that program. A doctor must provide a written referral to the Trust Administration Office. Hospice care services may include:

- Inpatient and outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual.
- Drugs, medicines, and other supplies prescribed for the terminally ill individual by any physician who is a part of the hospice care team.
- Instructions for care of the patient, counseling, and other supportive services for the family of the terminally ill individual.

The Plan does not cover hospice services not approved by the attending doctor, transportation services, custodial care, or services provided at any time other than the initial period of hospice care.

Hospital Expenses

The Plan covers expenses for inpatient room and board provided during your stay. Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem. Covered expenses may vary depending on the level of care received.

Room and board charges may also include:

- Services of the hospital's nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay.

Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services.
- Physicians and surgeons.
- Pre-admission lab tests and x-rays performed on an outpatient basis within 7 days before the patient is admitted to the hospital will be paid on the same basis as inpatient hospitalization.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Non-routine oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Not covered expenses include:

- Undocumented and unbundled charges for any services provided, even if Medically Necessary.

Massage Therapy The Plan covers massage therapy benefits provided by a covered provider. Benefits are limited to plan terms and conditions up to a maximum of 24 visits per calendar year. The visit limit is separate from the spinal manipulation benefit.

Mastectomy and breast reconstruction are provided for mastectomy necessary due to disease, illness or injury. For any participant electing breast reconstruction in connection with a mastectomy, this benefit will cover:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.

- Physical complication of all stages of mastectomy, including lymphedemas.

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

Maxillofacial services such as therapy, surgery or prosthetic devices recommended by a physician or dentist necessary to control or eliminate infection or pain, or to restore speech, swallowing, or chewing.

Medical supplies including surgical dressings, casts, splints, braces, crutches, artificial limbs, artificial eyes, blood, plasma, oxygen, or for rental or purchase (if more economical in the judgment of the Plan) of durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician for therapeutic use and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples include: crutches, wheelchairs, kidney dialysis equipment, hospital beds, traction equipment, and equipment for the administration of oxygen. The Plan will cover replacement if due to normal wear and tear.

Benefits are not provided for certain equipment including but not limited to: air conditioners, dehumidifiers, purifiers, heating pads, enuresis training equipment, exercise equipment, weights, or hot tubs.

Naturopathic care is covered when provided by a Provider acting within the scope of their license. The Plan will provide naturopathic benefits for Medically Necessary treatments of covered Preventive Care, Illnesses, Injuries or Traumas. Benefits for Naturopathic treatment are subject to the plan deductible and coinsurance.

Newborn care services including physician and approved nursery room charges for well newborns while hospitalized for routine care received within 72 hours of birth. No other physician or hospital charges are covered unless the infant is ill or injured.

Orthotics or other supportive devices for the feet are limited to braces, splints, insoles and supports prescribed by a physician as medically necessary. Impression casts required for the fitting of these devices are also covered. The device must be worn at all times that shoes are worn and not just for specific activities. Shoes that accompany braces are not covered.

Physician services for medical treatment and surgery received in the hospital, at home, in the physician's office or other medical facility.

Physical therapy when performed by a licensed physical therapist and covered under the Habilitative and Rehabilitative description above.

Preventive care services
The Plan covers 100% of the following preventive services when provided by a PPO network provider (or if no PPO network provider provides that particular service, then by a non-PPO network provider) in accordance with the applicable recommendations or guidelines. All preventive benefits may be subject to frequency and visit limits.

- Items or services with a rating of "A" or "B" in the recommendations of the U.S. Preventive Services Task Force ("USPTF"). Examples of covered services include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas;
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration. Examples

of covered services include annual well-woman visits, contraceptive methods and counseling, and breast-feeding support.

- Cancer screenings, including mammograms and pap tests, are covered either in accordance with the American Cancer Society guidelines, the USPTF recommendations, or your physician's recommendations based on risk.

The complete list of the in-network preventive services that will be provided and covered without any cost-sharing (such as a copayment, coinsurance, or deductible) can be found at:www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics. Note that the preventive services listed in the various federal recommendations and guidelines are subject to change, and an applicable guideline or recommendation becomes effective for plan years beginning one year after it is issued or later.

Health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Prescription Drugs Covered expenses include the cost of prescription drugs furnished to you while you are in an in-patient facility or Skilled Nursing Facility. See the Prescription Drug section for medications covered under the Prescription Drug program.

Nuclear Medicine and Radiation Therapy Services (Outpatient) Benefits are payable for technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy only when ordered by a Physician or Health Care Practitioner.

Registered nursing services.

Skilled nursing facility room, board, services and supplies up to 120 days for all confinements due to the same or a related injury or

sickness, provided the attending physician certifies that 24-hour nursing care is essential for recovery and in lieu of hospitalization.

Speech and occupational therapy when performed by a licensed speech or occupational therapist, to the extent that the therapy will restore and improve function following an illness, an injury, or surgery.

Sterilization services including vasectomies and tubal ligation but not reversals.

Surgical services. Charges for multiple surgeries performed during the same operative session that are not incidental or not part of some other procedure and that add significant time or complexity to the complete procedure, as determined by the Trust Administration Office, will be paid as follows:

- 100% of the PPO allowed amount or UCR allowance for the primary procedure.
- 50% of the PPO allowed amount or UCR allowance for the secondary or additional procedures.

Transplants. The Plan will pay covered charges for human organ transplants that are considered appropriate treatment using prevailing standards of community medical practice. Precertification is required and services must be approved by the Plan's review agency in place at the time of the procedure. Contact the Trust Administration Office for more information on precertification requirements and the criteria considered in the medical necessity review.

Urgent Care. Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition. Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact a network provider after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the plan will not cover your expenses.

Medical Plan Exclusions
Medical Program benefits will not be paid for any of the following:

- Acupuncture or acupressure treatment not pre-certified. See **Precertification** above.
- Charges for missed appointments.
- Charges for treatments or services not medically necessary.
- Balance billed charges for a service or supply furnished by a network or out-of-network provider in excess of the UCR allowed amount.
- Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the plan.
- Charges for services or supplies that are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded or billing charges.
- Charges that are not permitted by the provider's network agreement or applicable claims payment policies or charges made in violation of the provider's network agreement or applicable claims payment policies.
- Charges for claims that are submitted or completed more than one year from the later of the date of service or discharge.
- Any services or supplies that are contrary to guidelines adopted by the Trust or the Trust's Preferred Provider Organization, including guidelines concerning industry standards for diagnosis, treatment, prescription or billing practices.
- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
- Chelation therapy (except for acute arsenic, gold, mercury, or lead poisoning).

- Cosmetic services, treatment or surgery, including complications of cosmetic surgery, except for accidental injuries when surgery occurs within 12 months of the injury.
- Counseling: services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.
- Custodial care or non-medical care to assist individuals with the activities of daily living, e.g., bathing, meal preparation, etc.
- Dental service and materials (except as described in **What's Covered by the Trust Plan** section).
- Educational services:
  - Any services or supplies related to education, training or retraining services or testing including: special education, remedial education, job training and job hardening programs; and,
  - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills, except as otherwise covered by the plan.
- Education programs for individuals driving under the influence of alcohol or drugs, referred by the judicial system or volunteer support groups such as Al-Anon or Alcoholics Anonymous, are not covered.
- Examinations. Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which the Trust is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel; or
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity
- Experimental or investigational services and supplies (see page 103), except as specified in the **What's Covered by the Trust Plan section under "Approved clinical trials."**

- Eye exams for routine screening, vision materials, vision aids, orthoptics, vision training aids, or surgery to correct visual acuity (such as radial keratotomy or LASIK surgery).
- Facility charges for care services or supplies provided in:
    - assisted living facilities;
    - rest homes;
    - similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
    - health resorts;
    - spas, sanitariums; or
    - infirmaries at schools, colleges, or camps.
- Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally
- General nursing services (except as described in the **What's Covered by the Trust Plan** section).
- Habilitation services, except as specified in the **What's Covered by the Trust Plan** section.
- Hearing aids (except as described in the **Hearing Aid Benefits** section on page 79).
- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as exercise equipment, air purifiers, water purifiers, waterbeds, swimming pools; stair-glides, elevators, wheelchair ramps, or other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, or furniture.
- Infertility: except as otherwise covered by the plan, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

  - Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
  - Artificial Insemination;
  - Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian
  - Transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
  - Infertility services for couples in which 1 of the partners has had a previous sterilization procedure;
  - Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
  - Sperm or egg donors or any charges related to sperm or egg donation;
  - Surrogacy; or
  - Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.).
- Maintenance Care, except as otherwise covered by the plan.
- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer, regardless of whether You enrolled for Medicare upon entitlement.
- Miscellaneous charges for services or supplies including:
  - Annual or other charges to be in a physician's practice;
  - Charges to have preferred access to a physician's services such as boutique or concierge physician practices;
  - Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:

    - Care for conditions related to current or previous military service; or
    - Care while in the custody of a governmental authority.
- Services furnished to you by any person who lives in your home or is related to you by blood or marriage such as your spouse, parent, child or sibling.
- Maternity expenses for covered dependent children, including delivery, miscarriage, or complications of pregnancy but excluding preventive care services (as described herein and on page 45) when provided by a PPO network provider in accordance with the applicable recommendations or guidelines.
- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by the plan, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
- Routine foot care including callus or corn paring or excision, toenail trimming, orthopedic shoes, foot orthotics, or other supportive devices for the feet (except as specified in the **What's Covered by the Trust Plan** section).
- Therapies and tests: Any of the following treatments or procedures:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;

  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
  - Megavitamin therapy;
  - Primal therapy;
  - Psychodrama;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Sleep therapy; or
  - Thermograms and thermography.
- Services provided in connection with surrogacy maternity care or treatment if the surrogate receives compensation for the pregnancy.
- Services and supplies that are not medically necessary for the care and treatment of an illness or injury, including places of services such as inpatient hospital care (except as provided under the preventive care services or diagnostic x-ray and laboratory examination benefits).
- Shipping fees or charges.
- Smoking cessation programs or treatment except as provided under **Preventive Care Services**.
- Travel or transportation expense, whether by professional ambulance or otherwise (except as provided for in the **What's Covered by the Trust Plan** section), lodging, meals, rental car expense or other related charges or fees.
- Treatment or services for dyslexia including habilitative, educational or training services.
- Treatment or services which result from a sickness covered by workers' compensation or similar laws, or from an injury incurred while employed for wage or profit, whether you are working for yourself or others, and whether or not a claim was filed.

- Treatment or services of an injury or illness that resulted from the acts of another party, e.g., automobile accident, injury or fall, etc., and for which a third party is or may be responsible.
- Treatment or services that result from voluntary participation in criminal activities.
- Treatment or surgery for sex transformation surgery or any treatment related to sexual dysfunctions, except when necessary due to clinically documented illness or condition causing the dysfunction, or as except as provided by the Plan

Prescription Drug Benefits

The Trust Plan's prescription drug coverage is available through retail pharmacies and mail order pharmacies. Both programs are administered by OptumRx.

Retail and Mail Order Pharmacy Benefits	
Retail Pharmacy – up to a 30-day supply of covered medication, except where noted	
Generic drugs (up to 90-day supply)	$10 copay
Preferred Brands (up to 30-day supply)	$35 copay
Non-preferred brands (up to a 30-day supply)	$50 copay
Mail Order Pharmacy – up to a 90-day supply of covered medication	
Generic drugs	$10 copay
Brand name – no generic equivalent	$45 copay
Brand name – generic equivalent available	$60 copay
Annual Out-of-Pocket Maximum	$700 per person $2,000 per family

What's a Copay?
A copay is the fixed dollar amount you generally pay at the time you receive a specified health care service or supply.

What's the Annual Out-of-Pocket Maximum?
Each year, your individual prescription out-of-pocket maximum is $700, with an out-of-pocket maximum of $2,000 per family. This is the maximum amount you'll be required to pay in a single calendar year for prescription copays. Fees for prescription drugs that are not covered by the Plan do not count towards your out-of-pocket maximum.

The prescription annual out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies to the Plan's Medical benefits.

Covered Prescription Drugs
The following drugs are covered when prescribed by a doctor for the necessary care and treatment of injury or sickness:

- Prescription legend drugs.
- Compounded medications of which at least one ingredient is a prescription legend drug.
- Injectable insulin.
- Any other medicine or drug which, under the applicable state law, may only be dispensed with a written prescription of a doctor or other lawful prescriber.

Generic Prescription Drugs
You are not required to use generic drugs; however, your prescriptions will be filled with generic drugs unless specified by your doctor. If a generic drug is available and you elect to fill the prescription with a brand medication, you will be responsible for the plan copay plus the difference in cost between the brand and the generic medication.

If a brand name drug has been prescribed, the mail order pharmacy will call your doctor for permission to substitute a generic drug when an appropriate generic drug is available.

Using Network Pharmacies
A list of network pharmacies is available at www.optumrx.com or call 1-855-295-9140 TTY 771. If you visit a network pharmacy, simply present your Health and Prescription Drug ID card along with the physician's prescription to any network pharmacy and pay only the applicable copay.

Using Non-Network Pharmacies
If you use a non-network pharmacy, you are responsible for paying the pharmacist for the prescription drug. You must then send a claim form to OptumRx to receive reimbursement for covered expenses. You may receive a reduced reimbursement since you did not use the Health and Prescription Drug ID card. The copays will also be deducted from your reimbursement.

Using the Mail Order Pharmacy Service
Outpatient prescription drugs are covered when dispensed by a network mail order pharmacy. The Plan does not provide out-of-

network mail order pharmacy benefits. Each prescription is limited to a maximum 90 day supply when filled at by the network mail order pharmacy. Prescriptions for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network mail order pharmacy.

To use the mail order pharmacy:

1. Ask your doctor to write a prescription for up to a 90-day supply of each medication (plus refills for up to a year, if appropriate).
2. Fill out a OptumRx Prescription Mail-In Order Form. Order forms can be obtained online at www.optumrx.com or by calling 1-855-295-9140 TTY 771
3. Send the completed order form, your prescription, and your required copayment for each prescription to the address on the OptumRx Prescription Mail-In Order Form.

OptumRx Specialty Pharmacy

All Specialty drugs must be filled through OptumRx's Specialty Pharmacy. Specialty Drugs are high cost drugs used to treat serious conditions such as Rheumatoid Arthritis, Hepatitis C and Cancer. Many of these drugs are not stocked at retail pharmacies. You will pay the retail copay amounts for Specialty Drugs and will be limited to a 30-day supply each time you fill a prescription.

If you are prescribed a Specialty Drug, OptumRx's Specialty Pharmacy will work with you and your doctor to deliver the medication to your door as well as provide patient support should you have questions about taking the medication or side effects. You can contact OptumRx Specialty Pharmacy at 1-855-427-4682.

What the Prescription Drug Benefit Does Not Cover (Exclusions)

Prescription drug charges will not be paid for any of the following items:

- Any medicine or drug delivered or administered to an individual by the prescriber.
- Any medicine or drug used to treat a condition that is not covered under the Plan, as described in the Trust Plan's Benefits section.

- Any prescription refilled in excess of the number specified by the physician.
- Drugs labeled "Caution limited by federal law to investigational use," or experimental drugs, even though a charge is made to an individual, except as provided for approved clinical trials.
- Immunization agents, biological sera, blood or blood plasma, injectables, or any prescription directing parenteral administration or use (other than insulin); vitamins, vitamin prescriptions (other than legend vitamins) except as provided for under Preventive Care Services, medical foods.
- Medication taken or administered to an individual in whole or in part in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution.
- Medications used to treat sexual dysfunction.
- Non-legend drugs, infertility medications, patent or proprietary medicines or drugs not requiring a prescription (other than injectable insulin), or charges for the administration or injection of any such medicine or drug.
- Prescription drugs in excess of a 90-day supply.
- Smoking cessation drugs except as provided for under Preventive Care Services.

Dental Care Benefits

Employees enrolled in the Trust Plan may elect coverage under the Dental Program, whose benefits are described in this booklet, or may elect coverage under the Willamette Dental Program, an insured dental plan.

If you elect coverage under the Willamette Dental Program, your dental benefits will be paid by Willamette Dental according to the terms of its insurance contract with the Trust, instead of directly by the Trust through the Dental Program. Willamette Dental also handles claims processing and appeals for that program. You will receive a separate booklet describing the benefits provided under the Willamette Dental Program, including a description of the required copays for certain procedures and services. That separate Willamette Dental Program booklet, together with this booklet, make up the summary plan description for purposes of describing your Plan benefits.

Please contact the Trust Administration Office if you elect coverage under the Willamette Dental Program and do not receive that plan booklet, or if you need another copy of the booklet.

How Your Dental Benefits Work

Dental Program benefits are covered up to $2,500 per person each calendar year with no deductible, except pediatric dental care is not subject to an annual dollar limit. Dental benefits for orthodontia are limited to a separate, lifetime maximum of $2,000 per participant. The Dental Program does not have a network of dentists – you may use any licensed dentist.

The Plan pays 80% of the UCR amount for covered dental and orthodontia services, subject to limitations noted in the schedule below. Preventive pediatric dental is paid at 100% UCR.

Subject to the **Benefits After Dental Coverage Ends** section below, the Plan pays only for services received while you or your eligible dependents are covered by the Plan. The date treatment or service begins for covered services is as follows:

- Root canal therapy: The date the pulp chamber is opened and the pulp canal explored to the apex.

- Crowns, fixed bridgework, inlays, or onlay restoration: The date the tooth or teeth are fully prepared.
- Full or partial dentures: The date the master impression is made.
- All other services: The date the treatment or service is performed.

Predetermination of Benefits

If your dental treatment (other than emergency treatment) is expected to cost more than $400 for you or a covered dependent, ask your dentist to file a dental treatment plan (see page 102) with the Trust Administration Office before treatment begins. This predetermination of dental benefits will allow you to know in advance what procedures are covered, how much the Plan will pay, and how much you will have to pay for the dental treatment or service.

Dental claim forms are available from the Trust Administration Office. Return completed forms to the Trust Administration Office and a predetermination of benefits form will be sent to your dentist with a copy to you.

Benefits After Dental Coverage Ends

After dental coverage for you and your dependents ends, the Plan will pay 80% of the UCR amount for the following dental services received within two months after the date coverage ends for you or a dependent:

- Root canal therapy: If the pulp chamber was opened and the pulp canal explored to the apex while covered under the Plan.
- Crowns, bridges, inlays, or onlay restorations: If the tooth or teeth were fully prepared while covered under the Plan.
- Full or partial dentures: If the master impression was made while covered under the Plan.

To qualify for extended dental coverage, you or a dependent:

- Must qualify for benefit payment under the Plan had your coverage remained in force, and
- The treatment or service must begin while you or a dependent were covered under the Plan.

Extended benefits will not be paid for treatment or service received on or after the date you or your dependents become eligible for other group dental coverage.

Covered Dental Services

The Dental Program covers the dental services described below, subject to any noted limitations. Please note that not all covered dental services are listed.

Diagnostic and Preventive

- Oral Examinations, once every 6-month period.
- Routine Prophylaxis (cleaning and scaling of teeth), once each 6-month period.
- Fluoride treatment, covered for children age 18 and under once each 12-month period.
- Dental x-rays to include:
  - Intraoral complete series including bitewings, once each 3-year period
  - Intraoral periapical x-rays, once each 6-month period
  - Occlusal x-ray
  - Bitewing x-rays, once each 6-month period
  - Panoramic x-ray, once each 6-month period
- Dental sealants, covered for children under age 14 once each 4-year period.
- Space Maintainers, covered for children under age 14

Minor Restorations

- Restorations, amalgam
- Restorations, resin
- Pin retention

Major Restorations

- Crown buildup
- Crowns, porcelain
- Crowns, porcelain fused to metal
- Crowns, stainless steel
- Gold inlays and onlays
- Recement crown
- Recement inlay

Endodontics

- Apicoectomy
- Pulp cap direct or indirect
- Root Canal Therapy, includes treatment plan, clinical procedures and follow up car. Excludes final restoration.
- Root recovery
- Vital Pulpotomy

Periodontics

- Free soft tissue grafts
- Gingivectomy per quadrant
- Osseous surgery per quadrant
- Periodontal maintenance
- Periodontal scaling, root planning, service per quadrant once each 6-month period

Prosthodontics

- Bridges
- Clasps and rests
- Dentures, full
- Dentures, partial
- Dentures, replacement of missing or broken tooth (per tooth)
- Recement bridge
- Relining, adjustment and rebase of dentures

Oral Surgery

- Alveoplasty, per quadrant
- Extraction, simple
- Extraction, surgical, including extraction of impacted teeth
- Frenectomy
- General Anesthesia
- Incision and drainage of abscess – intraoral

Orthodontic Treatment

The Plan pays up to 80% of UCR for orthodontic treatment up to a lifetime maximum of $2,000 per covered individual.

What the Dental Program Does Not Cover (Exclusions)

Dental benefits will not be paid for any of the following items:

- Charges for any treatment or service for replacement of an existing partial or full removable denture or fixed bridgework unless satisfactory evidence is provided to the Trust Administration Office that:
  (i) The existing denture or bridgework was installed at least five years prior to its replacement and the existing denture or bridgework cannot be made serviceable, or
  (ii) The existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the immediate temporary denture.
- Charges for removable prosthodontics that are additional charges for overdentures or for precision or semi-precision attachments.
- Crowns if the tooth can be restored by a filling. For replacements, at least three years must have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion are not covered.
- Dental implants and related services above $1,575 per implant (and subject to the calendar year and lifetime maximums).
- Denture reline less than one year after the initial installation and then not more often than once per two-year period.
- Drugs and medicines except for antibiotic injections.
- General anesthesia except when required for complex oral surgical procedures covered under the Dental Program and performed outside a hospital.
- Gold restorations if the tooth can be restored by an amalgam filling. For replacements, at least five years must have elapsed since the last replacement.
- If the Plan determines that more than one procedure could be performed to correct a dental condition, covered charges will be limited to 70% of the UCR amount for the least expensive procedure that provides professionally acceptable results.
- Instructions for plaque control, oral hygiene, or diet.

- Personalization of dentures or crowns (or any other treatment that is primarily cosmetic), implants, or any procedure that does not have uniform professional endorsement.
- The services of any person who is not a dentist, dental hygienist, or denturist or the services of any person in your immediate family.
- Treatment or service covered by workers' compensation or similar laws or is due to injury from employment for wage or profit, whether you are working for yourself or others.
- Treatment or service for benefits covered under the Medical Program, as described in the **Medical Program Benefits** section.
- Any charges in excess of the benefit, dollar or supply limits stated in this Booklet.
- Treatment or service that results from war, act of war, or from voluntary participation in criminal activities.
- Treatment or service that would be provided at no charge if the patient had no insurance, that is paid for or furnished by the United States government or any agency thereof (except as required under Medicaid provisions or federal law).
- Treatment or service to alter vertical dimension, restore occlusion, or duplicate a lost or stolen prosthetic device.

Vision Program Benefits

Employees enrolled in the Medical Program are covered under the Trust's Vision Program, whose benefits are described in this booklet. The Trust has contracted with Vision Service Plan ("VSP") to administer the Vision Program.

Employees enrolled in the Kaiser HMO Program are eligible only for the vision benefits provided as part of the Kaiser HMO Program.

How Your Vision Program Benefits Work

A list of VSP network providers is available from the Trust Administrative Office or www.vsp.com. If you choose a VSP provider, that provider will verify your eligibility and coverage and obtain any authorization needed for services and materials. (If you are not eligible, the VSP provider should notify you of that.) If eyewear is needed as a result of the examination, the VSP provider will coordinate the prescription with a VSP-approved laboratory. The Plan will pay the VSP provider directly for covered services and materials.

You also may choose a non-VSP provider, but you will pay more out-of-pocket costs and will need to file a claim form with VSP in order to be reimbursed for the covered expenses. To be eligible for reimbursement, documentation of the claim must be submitted to VSP at the address in the **Benefit Payment and Claim and Appeal Procedures** within one year of the date the services were provided.

Covered vision benefits include eye exams and the eyewear listed below. Charges for vision-related services are covered only when performed by a physician or legally licensed ophthalmologist or optometrist.

What's Covered by the Vision Program

In Network Coverage	Copay	Frequency
WellVision Exam	$0	Every 12 months
Prescription Glasses	$20	See frame and lenses
Frame • $150 allowance for a wide selection of frames	Included in Prescription	Every 24 months

In Network Coverage	Copay	Frequency
• Children under age 18 have an unlimited frame allowance • $170 allowance for featured frame brands	Glasses copay	
Lenses • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses copay	Every 12 months
Lens Enhancements • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses	$55 $95-$105 $150-$175	Every 12 months
Contacts (instead of glasses) • $150 allowance for contacts; copay does not apply. • Children under age 18 have an unlimited contact lens allowance. • Contact lens exam (fitting and evaluation copay applies)	Up to $60 for contact lens exam (fitting and evaluation)	Every 12 months
Diabetic Eyecare Plus Program	$20	As needed
ProTec Safety® (Employee only) **Frame** • Covered by copay when frame is from ProTec Eyewear® collection Lenses • Prescription single vision, lined bifocal, and lined trifocal	$20 for frame and lenses	Every 24 months Every 12 months

Out of Network Coverage	Plan Allowance
WellVision Exam	Up to $45
Frame	Up to $70
Single Vision Lenses	Up to $30
Lined Bifocal Lenses	Up to $50
Lined Trifocal Lenses	Up to $65
Progressive Lenses	Up to $50
Contacts	Up to $105

If you choose a non-VSP provider, out-of-network benefits will be covered in full after a copay for pediatric lenses, frame, or medically necessary contact lenses for children up to age 18.

What the Vision Program Does Not Cover (Exclusions)
Vision benefits will not be paid for any of the following items:

- Eye examinations required by an employer.
- Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet.
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.
- More than one complete eye examination during any 12-consecutive month period.
- More than one pair of lenses during any 12 consecutive month period, not including the ProTec Safety lenses.
- More than one set of frames during any 24-consecutive month period, not including the ProTec Safety frames.
- Personalization of lenses or frames such as beveled edges, oversize lenses, etc.
- Special procedures such as orthoptics or vision training.
- Treatment or services covered by workers' compensation or similar laws, or due to injury incurred during any employment for wage or profit, whether you are working for yourself or others.
- Treatment or services not recommended or performed by a physician or legally licensed ophthalmologist or optometrist.
- Treatment or services that result from voluntary participation in criminal activities.
- Treatment or services which are compensated for or furnished by the United States government or any agency thereof (except as required under Medicaid provisions or federal law).

Hearing Aid Benefits

The Trust Plan' hearing aid benefit covers charges for hearing evaluation examinations and hearing aid devices for employees only. Spouses and dependents are not eligible for this benefit.

Enrollees in the HMO Program are eligible only for any hearing aid benefits provided under that program.

What the Hearing Aid Benefit Covers
The Plan will pay for a hearing evaluation examination and a hearing aid device at 100% of the usual, reasonable and customary ("UCR") charges (not to exceed actual charges) for each ear, once every 36 consecutive months.

The Plan requires you to certify your hearing loss before any benefits will be paid. Submit written certification from a physician that you are suffering from a hearing loss that may be lessened by the use of a hearing aid to the Trust Administration Office.

Covered charges include the following:

- An otologic examination by a physician.
- An audiologic examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation.
- A hearing aid (monaural or binaural) prescribed as a result of such examination including: ear molds, the hearing aid instrument, the initial batteries, cords, and other necessary ancillary equipment, a warranty, and follow-up consultation within 30 days following delivery of the hearing aid.

Repair and Replacement
If your hearing aid is damaged, the Plan will pay 100% of the UCR amount for the cost of repair, up to $100 once every 12 months. If the hearing aid cannot be repaired, the Plan will pay 100% for a replacement hearing aid, if it has been at least 36 months since your initial purchase.

What the Hearing Aid Benefit Does Not Cover (Exclusions)
Hearing aid benefits will not be paid for any of the following items:

- A hearing aid exceeding the specifications prescribed for correction of hearing loss.

- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid.
- Expenses incurred after coverage ends under this Plan, except expenses for a hearing aid ordered prior to termination and delivered within 30 days after the date of termination.
- Servicing or alteration of hearing aid equipment.
- Repairs (except as specifically provided in the **Repair and Replacement** section above).
- Replacement of a hearing aid for any reason more than once in a 36-consecutive month period.

Employee Life Insurance Benefits

The Plan provides an insured life insurance benefit through LifeMap. The life insurance benefit under this Plan pays $10,000 to your beneficiary if you die for any reason while you are an employee participating in the Plan. Contact the Trust Administration Office for information on how to submit a claim.

Your Beneficiary

Your beneficiary for insurance may be any person or persons you name on your beneficiary designation form. You may change your beneficiary at any time by contacting the Trust Administration Office and asking for a new beneficiary designation form.

If you name your spouse as your beneficiary for life insurance benefits, and later divorce, the designation will automatically be canceled on the effective date of the divorce unless there is a legal order that names your former spouse as your beneficiary or prohibits you from changing your beneficiary on file with the Trust Administration Office.

If you do not name a beneficiary, or if your beneficiary dies before you, life insurance benefits will be paid in the following order:

- Person designated as beneficiary under the Defined Contribution Plan of the AGC-International Union of Operating Engineers Local 701 Pension Trust Fund.
- Person designated as beneficiary under the Defined Benefit Pension Plan of the AGC-International Union of Operating Engineers Local 701 Pension Trust Fund.
- Person designated in the beneficiary card file maintained by Local 701 according to its bylaws.
- Spouse.
- Child, or children equally.
- Parent, or parents equally.
- Beneficiaries named in your last will admitted to probate.
- Your estate.

Extended Life Insurance During Total Disability
If you become totally disabled, your life insurance coverage (but not AD&D insurance coverage) may continue at no cost to you until you reach age 65. To qualify, you must meet all of the following conditions:

- Your disability must begin before age 65 while you are covered under this Plan.
- You must be totally disabled due to injury or sickness and be completely unable to engage in any work or occupation for which you are or become qualified by reason of education, training, or experience.
- Initial proof of a total disability must be submitted within one year after your coverage ends or the date of your total disability, whichever is later, and must be approved by LifeMap.
- Proof of the continuation of the disability must be periodically submitted to LifeMap.

The Trust Administration Office can provide information about the requirements for submission of proof.

Extended life insurance coverage for disability will end on the earlier of the following dates:

- You are no longer totally disabled.
- You fail to provide proof of total disability on request.
- You reach age 65.

Converting to an Individual Policy if You Lose Coverage
If your eligibility for the life insurance benefit under this Plan ends or is reduced, you have 31 days during which you may convert to an individual life insurance policy without providing proof of good health.

The maximum amount of life insurance that can be converted is the lesser of $10,000 and the amount of life insurance in force when your eligibility for the benefit ended or when the reduction occurred.

You may select any type of individual policy then customarily being offered by LifeMap except term insurance or a policy containing disability or other supplementary benefits. The premium is based on

the current LifeMap rate according to the form and amount of the policy and your gender and age on the date of issue.

The individual policy will be effective on the 32nd day following the date your eligibility for group life insurance under this Plan ends.

The individual policy will be issued only if your application and payment of the first premium are made within 31 days after the date your group life insurance coverage under this Plan ends. Contact the Trust Administration Office for assistance in converting to an individual policy.

If you die during the 31-day conversion period, your beneficiary will be paid the amount of insurance you were entitled to convert, whether you applied for an individual policy.

When Coverage Ends

Your life insurance coverage under the Plan will end of the earliest of the following dates:

- The plan is discontinued or the group policy ends.
- You are no longer an employee.
- You no longer qualify for the extension of life insurance coverage for total disability.
- You voluntarily stop of your coverage.
- You are no longer eligible for coverage.
- You or the Trust fails to pay a required premium.
- The group life insurance policy is terminated, unless you are totally disabled.
- You enter the military service (except temporary duty of less than 30 days)

Employee Accidental Death and Dismemberment Insurance Benefits

Eligible employees (not dependents) have group accidental death and dismemberment (AD&D) insurance coverage under the Plan. Benefits are payable if the Injury occurs while you are covered by the Plan and your death or loss occurs within 365 days of the Injury. These benefits are insured and administered by LifeMap.

Loss	Amount Payable
Life	$10,000 paid to your beneficiary
One hand, one foot, sight of one eye, the use of both legs (paraplegia), or the use of one side of body (hemiplegia)	$5,000 paid to you
Both hands, both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye, one foot and sight of one eye, use of both arms and legs (quadriplegia)	$10,000 paid to you

Loss of a hand or foot must be by complete severance through or above the wrist or ankle. Loss of sight means the entire and irrevocable loss of sight. Loss of the use of both arms and legs means total and permanent quadriplegia. Loss of the use of both legs means total and permanent paraplegia. Loss of the use of one side of body means total and permanent hemiplegia. No more than $10,000 will be paid for all losses due to the same accident.

Accidental injury means an injury caused by external, violent, and accidental means. The injury must occur while you are covered under the Plan. The loss must result from the injury directly and independently of all other causes and must occur within 365 days after the injury.

Contact the Trust Administration Office for information on how to submit a claim for AD&D benefits.

Exclusions
AD&D insurance benefits will not be paid for an injury resulting from:

- Any war or act of war declared or undeclared.
- Bodily infirmity or disease from bacterial infection (except accidental ingestion of contaminated foods) other than infection caused from an injury covered under the Plan.
- Intentional self-inflicted injury.
- Taking part in an assault, riot, or felony.
- Military service.

Dependent Life Insurance Benefits

The dependent life insurance benefit pays the following amount to you if your eligible dependent dies from any cause while covered under the Plan.

Spouse	$2,000
Children (age at death): 14 days to (but not including) 6 months	$200
6 months to (but not including) 2 years	$400
2 years to (but not including) 3 years	$800
3 years to (but not including) 4 years	$1,200
4 years to (but not including) 5 years	$1,600
5 years through 23 years	$2,000

You are automatically the beneficiary of dependent life insurance. If your eligible dependent dies while covered under the Plan, but after your death, benefits will be paid to the beneficiary you named for life insurance (or the default beneficiary as described on page 81, if no life insurance beneficiary is designated).

When Dependent Life Insurance Coverage Ends

Life insurance coverage for your spouse or other dependent will end at the earliest of the following dates:

- The dependent is no longer eligible as your dependent under the Plan: for example, if a child reaches the age limit, or otherwise loses dependent eligibility.
- For your spouse, the effective date of the divorce.
- You or the Trust fails to pay a required premium.
- Your coverage under the Plan ends.
- The date your life insurance premiums are waived as described in the **Extended Life Insurance During Total Disability** section on page 82.
- The group dependent life insurance policy is terminated.

Converting to an Individual Policy

If your spouse's eligibility ends, your spouse's insurance can be converted to an individual life insurance policy, without submitting proof of good health, under the following conditions:

- If your spouse's life insurance ends due to divorce, separation, your death, or your loss of life insurance coverage, the maximum amount of life insurance your spouse may convert is the amount of dependent life insurance in force when eligibility for the benefit ended, minus any individual amount purchased earlier under these rights.
- If, after your spouse has been insured for at least five years, the group life insurance policy terminates or is amended to eliminate dependent life insurance or your insurance class, the maximum amount your spouse may convert is the lesser of $2,000 and the amount of the spouse's dependent life insurance in force on the date of termination or elimination, less any amount for which the spouse becomes eligible under any other group life insurance policy within 31 days.

Your spouse may select any type of individual policy then customarily being offered by LifeMap except term insurance or a policy containing disability or other supplementary benefits. The premium is based on the current LifeMap rate according to the form and amount of the policy and your spouse's age on the date of issue. The individual policy will be effective on the 32nd day following the date your spouse's eligibility for group life insurance under this Plan ends.

The individual policy will be issued only if your spouse's application and payment of the first premium are made within 31 days after the date your spouse's group life insurance coverage under the Plan ends. Contact the Trust Administration Office for assistance in converting to an individual policy.

If your spouse dies within the 31-day conversion period, you will be paid the amount of life insurance, if any, your spouse was entitled to convert whether or not your spouse applied for an individual policy.

Employee Weekly Disability Income Benefits

Weekly disability benefits help replace lost income if you are ill or injured and can't work. These benefits are available to eligible employees – not dependents. The weekly benefit is $300.

Under this Plan, to qualify for a weekly benefit you must be continuously disabled due to an injury or illness, unable to perform the duties of your occupation, and not engaged in any other occupation for wage or profit. You must also be under the care of a physician. Benefits are not payable if you are unable to work because of an injury or illness covered under workers' compensation or if you are receiving unemployment benefits.

Benefits begin on the eighth day of disability and are payable for a maximum of 26 weeks for one period of disability.

Periods of disability due to the same cause are considered the same period of disability unless they are separated by your return to full-time work for a continuous period of at least one week of employment.

Social Security and Medicare Tax (FICA)
Weekly disability benefits paid by the Plan are subject to Social Security and Medicare taxes ("FICA tax"). The Trust pays your share of the FICA tax so you will receive the full $300 weekly benefit. You will receive a W-2 from the Trust Administration Office at year end which you will need to report any weekly disability benefit payments received from the Trust, and the FICA tax paid by the Trust on your behalf will appear as taxable income on your W-2.

Exclusions
Benefits are not payable for any disability due to sickness that is covered by workers' compensation or similar laws, or due to injury incurred in the course of performing any employment for wage or profit, whether you are working for yourself or others. Benefits are not payable while you are receiving unemployment benefits.

How Your Benefits Coordinate With Other Group Health Plans and Third-Party Payers

Coordination of Benefits ("COB") refers to how the Plan coordinates benefits when you or your dependents have medical, dental or vision coverage under more than one plan. This means that when you are covered by this Plan and another plan, your providers are not paid more than the total cost of the services provided.

Definitions
The following definitions apply only with respect to this section.

Allowable expense – Any necessary, usual, customary and reasonable item of expense at least a portion of which is covered under at least one of the plans covering an individual for whom a claim is made. If a plan provides benefits in the form of service (such as through a health maintenance organization) rather than a cash payment, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

Plan – A plan that provides medical, prescription drug, vision, and/or dental benefits. The plan's benefits must be provided through group insurance, any other arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), an individual policy of insurance, coverage (excluding student accident policies) sponsored by, or provided through, an educational institution, or automobile coverage in accordance with applicable state laws.

"Plan" also includes any coverage required by statute and any government program including Part A and Part B of Medicare.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Separated or Divorced – Legal separation or divorce of spouses and termination of a domestic partnership.

"Primary Plan"/ "Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans. No plan pays more than it would without the coordination provision.

Order of Benefit Payment Determination

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any group plan that does not use these same rules always pays its benefits first.

In the event that this Plan is the secondary plan and its payment is reduced to consider the primary plan's benefits, this amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and the other.

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a dependent, for example, as an employee, retiree, member or subscriber as is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as a retired employee; then the order of benefits is reversed, so that the plan covering the person as a dependent pays

first; and the plan covering the person as a retired employee pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose birthday falls earlier in the Calendar Year pays first; and the plan that covers the parent whose birthday falls later in the Calendar Year pays second, if:

1. the parents are married;
2. the parents are not separated (whether or not they ever have been married); or
3. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "birthday" refers only to the month and day in a Calendar Year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose birthday falls earlier in the Calendar Year pays first, and the plan that covers the parent whose birthday falls later in the Calendar Year pays second.

E. If the parents are not married, or are separated (regardless of whether they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care

services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

1. The plan of the custodial parent pays first; and
2. The plan of the spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last; and
5. If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the Calendar Year pays first, and the plan that covers the parent whose birthday falls later in the Calendar Year pays second.

Rule 3: Active/Retired

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a retired employee, or as that retired employee's dependent, pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

1. in the amount or scope of a plan's benefits;
2. in the entity that pays, provides or administers the plan; or
3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: Other Plan has no COB rules

If the other coverage has no COB rules, this Plan will always pay secondary.

Right to Collect and Release Needed Information

In order to receive benefits, the claimant must give the Trust any information that is needed to coordinate benefits. With the claimant's consent, the Plan may release to or collect from any person or organization any needed information about the claimant.

Facility of Payment

If benefits which this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts

reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

Coordination with Medicare
If you are an active employee, this Plan is your primary plan and Medicare will be your secondary plan.

If you are Medicare-eligible and you select Medicare as your primary plan for yourself and your Medicare-eligible spouse this Plan will not pay any of your medical expenses not paid by Medicare. If you have questions about this election, please contact the Trust Administration Office.

Coordination with Medicaid
The following rules will apply to any individual covered under the Plan who is eligible for Medicaid benefits:

- Payments by this Plan for benefits will be made in compliance with any assignment of rights made by or on behalf of the covered individual as required by a state Medicaid program.
- Where payment has been made by the state under Medicaid for medical assistance in any case where this Plan has a legal liability to make payment for such assistance, payment for the benefits will be made in accordance with any state law which provides that the state has acquired the rights with respect to an individual covered under the Plan to such payment for such assistance.
- In enrolling any eligible individual under the Plan, or in determining or making any benefit payments to or on behalf of any covered individual, the Plan will not take into account the fact that the individual is eligible for or provided medical assistance under a state Medicaid program.

End Stage Renal Disease and Medicare Coverage for Eligible Individuals
If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end stage renal disease ("ESRD"), the Plan generally pays primary and Medicare pays secondary for 30 months starting the earlier of the first of the month in which the Medicare ESRD coverage begins, or the first of the month in which the individual receives a kidney transplant. Starting

with the first day of the 31st month after a kidney transplant or the start of Medicare coverage, Medicare pays primary and the Plan pays secondary.

Right of Recovery

If the Plan makes a payment for you or your dependents to which you or your dependents are not entitled due to your, your dependents or your employer's providing inaccurate or incomplete information or your or your dependent failure to observe a Plan provision, the Plan has the legal and equitable right to recover the payment from the eligible individual paid or anyone else who benefited from it, including the individual or the provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the plan that has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid from future benefits payable on behalf of the participant or beneficiary of the overpayment or any other individual whose eligibility is established by or through the participant or beneficiary.

You and Your Dependents Must Submit Information

The Trust Administration Office may require you or your dependent to submit information when necessary to process claims for benefits under the Plan. The Trust Administration Office may also require you or your dependent to authorize any hospital or provider to furnish information concerning a condition for which you or your dependent claims benefits. This Plan retains the right to review information received by or provided to the Trust Administration Office.

Benefits Not Transferable

The right to receive benefits under this Plan is not assignable or transferable to any other party. Any attempted assignment or transfer will not be binding on this Plan.

Third-Party Liability & the Plan's Right to Reimbursement

The Plan will not provide benefits for any injury or illness if any third party or parties (including an insurance company) is or may be responsible for the injury or illness or for payment or reimbursement of any expenses arising out of the injury or illness. A claim against any such third party is called a "third-party claim." A Workers'

Compensation claim is a third party claim regardless of whether it is resolved through a disputed claim settlement or otherwise. If a covered person (including you and your covered dependents) has or may have any claim or right for indemnification, damages, or any other payment against any third party or parties because of any injury or illness, the covered person is not entitled to any benefits from the Plan for that illness or injury. Subject to the following conditions, however, the Plan may, but need not, advance benefits to the covered person until the third party makes payment to or on behalf of the covered person.

The Plan may require a covered person, his or her spouse, and any attorney representing the covered person, to sign the plan's third-party liability agreement as a condition of advancing Plan benefits. The Plan will have all of the rights and interests described in this section regardless of whether such an agreement is signed.

The Board of Trustees has full discretionary authority to interpret the provisions of this Plan, including this section. The Board may, but need not, agree to waive some or all of the Plan's rights under this section on such terms and in such cases as it considers appropriate in its sole and exclusive discretion. The Board's waiver of or failure to enforce any of the Plan's rights under this section with respect to any third-party claim, regardless of the reason, will not constitute a waiver of any other right with respect to that third-party claim, nor will it constitute a waiver of any of the Plan's rights with respect to any other third-party claim.

If a covered person or any other person claims any benefits under this Plan for any treatment or service or loss of income because of an injury or illness with respect to which a third party is or may be responsible, then the following will apply:

- The plan excludes medical, prescription drug, dental and time loss benefits for any injury or illness caused by the act or omission of a third party, where a potential opportunity for recovery exists from the third party, including, but not limited to, an injury or illness potentially covered by any liability policy of a third party or first party coverage available under an automobile insurance policy (including coverage for underinsured or uninsured motorist), homeowner's policy or commercial premises policy. If an eligible individual has a

potential right of recovery for which a third party or insurer may have legal responsibility, the plan, as a convenience to the eligible individual, may advance benefits pending the resolution of the claim. However, the plan's payment of benefits is conditioned upon reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the plan, but not to exceed the amount of the recovery.

- If the plan provides benefits, the plan is entitled to reimbursement of all benefits paid, regardless of whether the eligible individual is made whole by the recovery, and regardless of the characterization of the recovery, except that if the eligible individual complies with the terms of the plan and any agreement to reimburse, the plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, as described below. Costs incurred solely for the benefit of the eligible individual shall be the responsibility of the eligible individual. The plan's deduction for attorney fees and costs is contingent on compliance with the plan's reimbursement provisions and/or the agreement to reimburse.
- Prior to advancing funds on the eligible individual's behalf, the plan can require that an eligible individual and the eligible individual's attorney execute an agreement acknowledging this plan's reimbursement right, and provide the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved, a factual description of the accident and/or injury or illness, and any other information requested by the plan to protect its reimbursement interest.
- When any recovery is obtained from a third party or insurer, an amount sufficient to satisfy the plan's reimbursement amount must be paid into a trust account or escrow and held there until the plan's claims are resolved by mutual agreement or court order. The eligible individual shall request written permission from the plan prior to distribution of any settlement funds prior to satisfaction of the plan's reimbursement interest. The obligation to place the reimbursement amount in trust is

independent of the obligation to reimburse the plan. If the funds necessary to satisfy the plan's reimbursement amount are not placed in trust, the eligible individual, or the individual who receives or distributes the recovery funds shall be liable for any loss the plan suffers as a result.

- The plan may cease advancing benefits, if there is a reasonable basis to determine that the eligible individual or the eligible individual's attorney will not honor the terms of the plan or the agreement to reimburse, or there is a reasonable basis to determine that the agreement is not enforceable.
- After recovery by the eligible individual, and pending reimbursement to the plan, the plan may elect to recoup the reimbursement amount from benefit payments, including benefit payments for the eligible individual's family members, by denying such payments until the amount of benefits provided has been recovered. The plan may also seek to recoup the reimbursement amount from the source to which benefits were paid.
- If the plan is not reimbursed, it may bring an action against the eligible individual to enforce its right to reimbursement and/or the agreement to reimburse, or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits. If the plan is forced to bring a legal action, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.
- If the covered person, spouse, or dependents fail to honor the Plan's right to reimbursement:

  (i) The covered person will be liable to the Plan for all costs of enforcement and collection, including attorney and paralegal fees through and including any appeals; and

  (ii) The Plan may, at its election, offset future benefits otherwise payable under the Plan with respect to any injury or illness sustained by the covered person, spouse, or dependents until such time as the Plan's right to reimbursement has been fully satisfied by such offset or otherwise.

If the covered person, spouse, or dependents obtain any settlement or recovery that bars the covered person, spouse, or dependents from further recovery with respect to the third-party claim, the Plan will not provide benefits for any continuing treatment or additional expenses incurred in connection with, or arising out of, the third-party claim.

Motor Vehicle Accidents

A motor vehicle accident in which you or your dependent may have a legal right to recover payment from a third party (including an insurance company) is a form of third-party liability. Therefore, the rules described above apply to claims against third parties in these situations.

The plan will not pay benefits for health care costs to the extent that the eligible individual is able to, or is entitled to, recover from motor vehicle insurance, including payments under a PIP policy. Benefits will not be provided to the extent an eligible individual has failed to acquire PIP coverage where required to do so by law or PIP coverage has been terminated before being exhausted for failure to cooperate or otherwise for cause. The plan will pay benefits toward expenses over the amount covered by motor vehicle insurance subject to the plan's Third-Party Reimbursement Provision.

If the plan pays benefits before motor vehicle insurance payments are made, the plan is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to the eligible individual and, when applicable, the plan may recover benefits the plan has paid directly from the motor vehicle insurer or out of any settlement or judgment which the eligible individual obtains in accordance with the plan's Third-Party Reimbursement Provisions.

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

Medical bills will be paid by your own automobile insurance carrier for the first year after your accident, up to the statutory limit. No benefits will be advanced for motor vehicle accident injuries until your PIP coverage, if any, has been used up or PIP has denied the claim. Nothing precludes a beneficiary from submitting the claim

to the Plan at any time, and all claims are subject to the Plan's applicable time limitations.

Disputed Workers' Compensation Claims

The Plan does not provide benefits for expenses incurred in connection with accidental bodily Injury or Illness arising out of or in the course of employment, or which are compensable under any workers' compensation or occupational disease act or law. If a dispute arises concerning whether an Injury or Illness is work-related, and the covered person appeals the denial of the claim by a state or federal workers' compensation agency or insurer, the Plan may advance payment of benefits pending resolution of the appeal, provided the covered person submits documentation indicating the basis for denial of the claim and signs and returns an agreement to reimburse the Plan 100% of the amount of such benefits, or the amount recovered if less, upon recovery on the workers' compensation claim. Reimbursement is required regardless of whether recovery is through acceptance of the claim, award, settlement, or disputed claim settlement, or any other method of recovery, and regardless of whether the covered person is made whole by the recovery. The amount to be reimbursed to the Plan shall not be reduced for attorney fees or costs incurred by the covered person. The covered person shall do nothing to prejudice the Plan's right to reimbursement and the Plan may offset future benefit payments, including those of family members, by denying such payments until the benefits provided under this provision have been repaid. Following recovery on the workers compensation claim, no further benefits will be provided related to the Injury or Illness.

Repayment of Improperly Paid Benefits

If the plan mistakenly makes a payment for you or your dependents to which they are not entitled, if the plan pays an individual who is not eligible for benefits at all or if an eligible individual fails to observe the plan's Third-Party Reimbursement provisions, the plan has the right to recover the payment from the eligible individual paid or anyone else who benefited from it, including the individual or the provider of services.

Unrelated to Third Party Reimbursement, the plan may also pursue recovery from any individual or entity responsible for providing

misinformation to or failing to provide necessary information to the plan that has resulted in the payment of improper benefits. The plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits payable to the affected eligible individual or any other individual where eligibility is established through the same eligible individual. The plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes. By accepting benefits from the plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Recovery of Overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

Definitions

Allowed Amount — the fee negotiated by the PPO if a service or supply is provided by a PPO network provider or, if no PPO agreement exists (non-PPO network provider), the reasonable and customary amount explained below in this section. The allowed amount is the maximum amount on which the Plan will base its payment for covered services.

Chemical dependency — an addiction to any drug or alcohol agent which interferes with the individual's social, psychological, or physical adjustment to common daily problems. This dependency may be characterized by a physical or psychological relationship or both.

Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

Code -- Internal Revenue Code of 1986, as amended.

Coinsurance — The percentage of the total cost you are responsible for paying (for example, after you meet your deductible you pay 20% coinsurance and the Plan pays 80% when you visit a PPO network provider).

Copay — the fixed dollar amount you generally pay at the time you receive a specified health care service or supply.

Cosmetic Surgery — surgery to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structures of any feature of the human body, performed primarily for psychological purposes or not correcting or materially improving a bodily function.

Reconstructive breast surgery performed because of mastectomy will not be considered cosmetic surgery.

Dental Treatment Plan — the attending dentist's written treatment plan which:

- Itemizes the dental procedures required for the necessary care of the individual,
- Shows the charges for each procedure, and

- Is accompanied by any appropriate diagnostic materials (such as x-rays) as required by the Trust Administration Office.

Domestic Partner — a person who has entered a domestic partnership if that domestic partnership has not terminated. A domestic partner and his or her children who are eligible and enrolled for Plan benefits are members of the employee's "family" as that term is used in this booklet.

Domestic Partnership — is established when two people of the same sex register as domestic partners in Oregon's domestic partnership registry. If the employee's employer has a contract with the City of Portland, as specified in the **Dependent Eligibility** section, then a registered domestic partnership also is established when two people of the same or opposite sex register as domestic partners with an Oregon governmental body pursuant to local law authorizing such registration.

Emergency Medical Condition means a medical condition or injury with acute symptoms of sufficient severity (including severe pain) that, lacking immediate medical attention, could reasonably be expected to result in the health of the person (including an unborn child) being placed in serious jeopardy or result in serious impairment or dysfunction of any bodily organ or part.

ERISA — Employee Retirement Income Security Act of 1974, as amended.

Experimental or **Investigational** service or supply:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given for regular non-experimental or non-investigational purposes at the time the drug or device is furnished.
- The drug, device, medical treatment, or procedure has been determined to be an experimental or investigative procedure by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status.

- Federal law classifies the drug, device, medical treatment, or procedure under an investigative or experimental program.
- Reliable evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or II clinical trials; is the research, experimental, study, or investigational arm of on-going phase II clinical trials; or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with standard means of treatment or diagnosis.
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.
- Chemotherapy drugs that have not been granted FDA approval for general public use in the treatment of a condition. However, if the claims administrator or MRC determines that reliable evidence demonstrates that a drug is effective or shows promise of being effective for a condition, the drug may be covered by the Plan.

For purposes of this section, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

The Board of Trustees or its designee may rely on the advice of medical professionals in determining whether a drug, device, medical treatment, or procedures is experimental or investigational.

Hospital — a legally-operated institution providing inpatient care and treatment through medical, diagnostic, and major surgical facilities on its premises, under supervision of a staff of doctors and with 24-hour-a-day nursing service, or one accredited as a hospital by the Joint Commission on Accreditation of Hospitals. Hospital

also includes a licensed, state-recognized birthing clinic and a state-recognized mental health institution provided treatment is given in accordance with a prescribed treatment program which is medically related to injury or illness and the treatment is in lieu of similar treatment by a physician.

Hospital does not include a nursing home or an institution, or part of one, used mainly as a facility for convalescence, nursing, rest, the aged, or care for drug or alcohol addiction.

Hospitalization Charges — reasonable and customary charges for care of an individual covered under the Plan by:

- A hospital for semiprivate room and board and for other customary hospital services and supplies required for purposes of treatment, and
- A physician for the administration of anesthesia to a covered individual while confined to the hospital.

The above applies if the covered individual is confined in the hospital for any period of time while undergoing a surgical operation, while receiving emergency care as a result of and within 24 hours after an accident, or for a period of at least 15 consecutive hours for any cause.

Hospital Confinement Authorization means approval by MRC of a physician's report of:

- A proposed hospital admission (for other than a medical emergency), or
- A hospital admission for a medical (including mental health or substance abuse) emergency. The report may be either oral or written. It must include:
- The reason for the hospital admission and confinement,
- The significant symptoms, physician findings, and treatment plan,
- The procedures performed or to be performed during the hospital confinement, and
- The estimated length of hospital confinement.
- The report must be provided to MRC:
- Prior to a proposed hospital admission (for other than a medical emergency), or

- Within two working days (or as soon as reasonably possible) following a hospital admission for a medical emergency.

In addition, a hospital confinement authorization may be extended if additional hospital confinement is necessary. An additional physician's report must be furnished to and approved by MRC. The additional report must include:

- The reasons for requesting additional hospital confinement,
- The procedures to be performed during the confinement, and
- The estimated length of the additional hospital confinement.

The report must be provided to MRC prior to the expiration of the hospital confinement authorization currently in force.

Income Tax Dependent
For purposes of the Plan, an individual is your federal income tax dependent if he or she is your "qualifying child" or "qualifying relative" as those terms are defined by the Code. A qualifying child is an individual who:

- Is your child (including a stepchild, adopted child, child placed for adoption, and an eligible foster child), sibling, step-sibling, or a descendant of any of these individuals;
- Lives with you for more than half of the year (a child away at college is treated as living at home if the child generally intends to return home and a child of divorced or legally separated parents is treated as living with you, if the custody and support requirements described below are met);
- Is younger than you and younger than age 19 (younger than age 24 if a full-time student) and will be as of the upcoming December 31 (this age restriction does not apply if a child is permanently and totally disabled);
- Has not provided more than half of his or her own support during the year; and
- Is not married and filing a joint return (other than only to claim a refund).

A child of divorced or legally separated parents (or parents who live apart at all times during the last six months of the calendar year) is

treated as a tax dependent of both parents if one or both parents have custody for more than half the calendar year, together the parents provide more than half of the child's support, and the child is a qualifying child or qualifying relative of one of the parents. If an individual may be claimed as a qualifying child by two or more taxpayers and the individual's tax dependent status cannot be determined under the special rule for divorced or legally separated parents, a special "tiebreaker rule" applies. Under the tiebreaker rule, if both taxpayers are parents of the individual and do not file a joint return, the individual is treated as the qualifying child of (i) the parent with whom the child lived for the longest period during the tax year or (ii) if the child lives with both parents for the same amount of time during the tax year, the parent with the highest adjusted gross income. If one of the taxpayers is not the individual's parent, the individual is treated as the qualifying child of the taxpayer who is the parent of the individual; provided, however, that if no parent claims the individual as a qualifying child, the individual is treated as the qualifying child of the nonparent if the nonparent's adjusted gross income is higher than the adjusted gross income of any parent. If neither taxpayer is the parent of the individual, the individual is treated as the qualifying child of the taxpayer with the highest adjusted gross income for the taxable year.

A qualifying relative is an individual who:

- Is related to you in a certain way (such as child or descendant of a child (including a stepchild, adopted child, child placed for adoption, and eligible foster child), sibling, step-sibling, parent, ancestor of a parent, stepparent, nephew, niece, aunt, uncle, and certain in-laws) or, if not related to you, lives with you as a member of your household for the taxable year and the relationship between you and that individual does not violate local law;
- Receives more than half of his or her support from you during the year (the special rule for divorced or legally separated parents described above applies); and
- Is not a qualifying child of any taxpayer. An individual is not a qualifying child of any taxpayer if the individual's parent (or other person with respect to whom the individual

is defined as a qualifying child) is not required to file a federal income tax return and either

(i) does not file a return or

(ii) files a return solely to obtain a refund of withheld income taxes.

Under both the qualifying child and qualifying relative definitions, your income tax dependent must be a citizen or resident of the U.S. or a resident of Canada or Mexico. (There is an exception for adopted children.)

If anything described above is inconsistent with "qualifying child" or "qualifying relative" as defined by the Code, the Code definitions of those terms will control.

Medically Necessary — those services and supplies that are:

- Appropriate by treatment setting and level of care and in amount, duration, and frequency of care for, and consistent with, the symptoms or diagnosis and treatment of your or your dependent's condition;
- Appropriate with regard to widely accepted standards of good medical practice;
- Not primarily for the convenience of you or your dependents or a provider of services or supplies; and
- The least costly of the treatment settings, alternative supplies, or levels of service that can be safely provided to the patient. This means, for example, that care rendered in a hospital inpatient setting or by a nurse in the patient's home is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility, without harm to the patient.

The fact that a professional provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.

Medically necessary care does not include care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills; for example, help in bathing, eating, dressing, or getting in or out of bed.

Medically necessary dental care is treatment of any dental disease, injury, or defect that, in the Plan's judgment, is necessary to meet accepted dental practice standards in our service area.

Pediatric – services to an individual who is under age 19.

Physician or Provider — a physician licensed under state law to practice medicine (M.D. or D.O.) and perform surgery. The term also includes:

- A **dentist, podiatrist, physical therapist, nurse practitioner, physician's assistant, naturopath,** or **chiropractor** duly licensed by state law and acting within the scope of his or her license.
- A **psychologist** who is legally licensed under state law to practice psychology and is in private practice.
- A qualified **social worker** who is legally licensed or certified by the state in which he or she practices and is acting within the scope of his or her license.
- A **nurse midwife** who:
  (i) Is a registered nurse,
  (ii) Is legally licensed under state law to perform services for which benefits are provided under the Plan, and
  (iii) Acts within the scope of such license in performing these services.

Benefits are payable for charges by a nurse midwife only if such charges are in lieu of charges by a physician.

- A certified **registered nurse** who:
  (i) Is legally licensed or certified by the state,
  (ii) Is legally licensed to perform services for which benefits are provided under the Plan, and
  (iii) Acts within the scope of such license in performing these services.

Benefits are payable for charges by a certified registered nurse only if such charges are in lieu of charges by a physician.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* hospitals, Physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

PPO Network Provider — a hospital, physician, or other provider who has an effective preferred provider plan contract with Premera Blue Cross Blue Shield or providers in the local Blue Cross and/or Blue Shield Licensee's network.

Residential Treatment Facility. An institution that meets all of the following requirements:

- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Admissions are approved by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week and 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation.
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the UM provider's credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.

Semi-Private Room Rate. The room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, the Plan will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility — an institution, or a distinct part thereof, which is licensed pursuant to state or local law and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or sickness, and which:

- Has organized facilities for medical treatment and provides 24-hour nursing service under the full-time supervision of a physician or a registered nurse,
- Maintains daily clinical records on each patient and has available the services of a physician under an established agreement,
- Provides appropriate methods for dispensing and administering drugs and medicines, and
- Has transfer arrangements with one or more hospitals, a utilization review plan in effect, and operational policies developed with the advice of and review by a professional group including at least one physician.

The above excludes any institution which is other than incidentally a rest home, a home for the aged, or a facility for the treatment of mental disease or drug or alcohol addiction.

Substance Abuse. This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (as defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Totally Disabled: a state of incapacity due to an Injury or Illness, and:

- You are unable to work at your normal job.
- Your dependent's is unable, due solely to Illness or Injury, to engage in all of the normal activities of an individual of like age and sex who is in good health.

Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

Usual, Customary and Reasonable (UCR) Amounts

Usual, Customary and Reasonable (UCR) charge means the amount payable to a non-PPO provider as determined by the Plan for a particular service, and subject to the following:

1. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR regardless of the amount billed;
2. In no event will the UCR charge exceed the amount billed or the amount for which the covered person is responsible;
3. UCR may not reflect the actual billed charges and does not take into account the Covered Provider's training, experience or category of licensure;
4. The Plan's UCR methodology may vary from one particular claim to the next based on the facts and circumstance of the claim, the services provided and the expected cost-savings;
5. The Plan may hire a third-party reviewer to determine the UCR amount consistent with this provision; and
6. Irrespective of the Trust's methodology or UCR determination, the Plan reserves the right to negotiate an acceptable UCR amount directly with a Covered Provider.

For properly billed non-PPO professional service charges, the UCR charge shall be no higher than the 90th percentile identified by a commercially available database selected by the Plan. When there is, in the Plan's determination, minimal data available from the database for a covered service, the Plan will determine the UCR charge by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare). In the event of an unusually complex covered service, a covered service that is a new procedure or a covered service that otherwise does not have a relative value that is in the Plan's determination applicable, the Plan will assign one.

For properly billed non-PPO facility charges, UCR means the amount determined by the Plan based on one or more of the following considerations: CMS reported cost-to-charge ratios,

historically acceptable reimbursement amounts by similarly situated providers, commercially available benchmarks, Medicare reimbursements amounts, and other CMS-provided statistics.

Any charges that exceed UCR will not be covered or eligible charges under the Plan

Benefit Payment and Claim and Appeal Procedures

Getting Plan benefits paid and filing a claim and appeal are easy if the steps described in this section are followed. If a bill is submitted to the Plan for payment and that bill is denied in whole or in part, you may file a benefit claim to request a review of that denial. If that benefit claim is denied, there is a process to appeal that denial to the Board of Trustees or its authorized representative.

Important: You must go through each stage of the Plan's claims procedure to be entitled to go to the following stage, to have an external review of the claim, or to make a court challenge of a claim. No court action with respect to the Plan or a benefit under the Plan can be filed more than two years after the date the initial claim was filed or, if later, the date the claim arose.

The Plan's claims procedure does not apply to the HMO Program or Willamette Dental Program. The separate booklet provided to participants in those programs describes the claims rules that apply to those benefits.

Payment of Benefits

All payments for services by PPO providers will be made directly to such providers. In the case of non-PPO providers payments will be made, at the Trust's option, to the participant, to his or her estate, to the provider or as required under federal law, including qualified medical child support orders. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Benefits will be paid by the Plan only if the bill or benefit claim is timely submitted. **Bills must be submitted within 90 days from the date on which covered expenses were first incurred. A benefit claim must be filed within 180 days after the explanation of benefits ("EOB") or other notice of action on a bill is received.** Such time limit will not apply if you show it was not reasonably possible to submit the bill or benefit claim within that limit, but in no event will benefits be allowed and paid if the bill or the benefit

claim and all necessary information is submitted beyond one calendar year from the date on which expenses were incurred.

Benefits payable under the Plan will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, you may request that benefits due be paid to an institution or provider.

Submitting a Bill (Versus Filing a Claim)
Many Medical, Dental, and Vision Program benefits are sent directly by the provider of the service to the Plan. *A bill sent by a provider is not a benefit claim to which these claim procedures apply*. If a bill is submitted and payment is denied, in whole or in part, you (or your authorized representative) may request review of that denial by filing an actual benefit claim as described in the **Filing an Initial Benefit Claim** section below.

As noted earlier, bills must be submitted within 90 days from the date on which covered expenses were first incurred (unless you show it was not reasonably possible to submit the bill within 90 days, but in no event will benefits be paid if the bill and any necessary documentation are submitted or the legal benefit claim is made beyond one calendar year from the date on which expenses were incurred).

Medical Bills
Generally, if a PPO provider is used for medical care, there are no forms for you to submit a medical bill. You should show the PPO provider your Plan identification card so he or she knows where to submit the bill.

For *PPO services obtained in Washington or Alaska*, mail bills to:
Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

For PPO services obtained in Oregon, mail bills to:
Regence BlueCross BlueShield of Oregon
PO Box 1106
Lewiston, ID 83501

If you used a *non-PPO network provider*, mails bills to the Trust Administration Office at:

AGC-International Union of Operating Engineers
Local 701 Health and Welfare Trust Fund
PO Box 34687
Seattle, WA 98124-1687

Bills for *hearing aids* should be mailed to the Trust Administration Office at the address immediately above.

Retail Pharmacy Bills
For reimbursement when you do not use your Plan card to purchase a prescription or you have purchased your prescription at a pharmacy that is not in the OptumRx network, you will need to send a copy of the itemized receipt showing the patient's name, prescription number, name of prescribing doctor, name of medication, quantity, and strength, along with a completed reimbursement form, to OptumRx at:

OptumRx Claims Department
PO Box 650334
Dallas, TX 75265-0334

To request a reimbursement form, call OptumRx at 1-855-295-9140. A copy of the OptumRx Prescription Reimbursement form is also available on the Trust website, www.agc-iuoe701trusts.com. You will be reimbursed the cost of the drug, if covered, less the copay.

Dental Bills
For reimbursement of benefits under the Dental Program, you should mail an itemized billing statement that includes:

- Employee name and address
- Identification number
- Patient name and address
- Provider name and Provider Tax ID number
- Date(s) of service
- Type of service (preferably with code numbers and tooth numbers)
- Charge for each service

The itemized billing statement should be mailed to the Trust Administration Office at:

AGC-International Union of Operating Engineers
Local 701 Health and Welfare Trust Fund
PO Box 34687
Seattle, WA 98124-1687

Vision Bills
For reimbursement when you use a non-VSP provider for benefits under the Vision Program, you should mail a copy of the itemized receipt along with the Plan's name; the patient's name, relationship to the covered employee, date of birth, and contact information; and the covered employee's name and social security number to:

VSP
PO Box 385018
Birmingham, AL 35238-5018

Filing an Initial Benefit Claim
If the bill that you or your provider submitted to the Plan is denied, in whole or in part, and you want the Plan to review that denial, you or your authorized representative would need to file an initial benefit claim by following the steps below. Any reference to "you" in this Claims and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

As noted earlier, claims must be filed within 180 days after the explanation of benefits ("EOB") or other notice of action on the bill is received (unless you show it was not reasonably possible to submit the bill within 180 days, but in no event will benefits be allowed if the bill and any information requested is submitted or the legal benefit claim is made beyond one calendar year from the date on which expenses were incurred).

To file an initial claim for Plan benefits:

- Obtain a claim form from the Trust Administration Office, the Local 701 office, or your business agent.
- Complete the claim form with all information requested and attach copies of all bills or receipts relating to the service provided. Make sure each bill clearly identifies the service or supply, the fee, the patient's name, the date of service, and the diagnosis:
- Mail your claim form and attached documents to the applicable claim reviewer identified below:

Medical (including prescription and hearing aids), Vision, Dental, and Weekly Disability Income Claims:

AGC-International Union of Operating Engineers
Local 701 Health and Welfare Trust Fund
PO Box 34687
Seattle, WA 98124-1687

Employee Life, Accidental Death and Dismemberment, and Dependent Life Claims:
Contact the Trust Administration Office for assistance with any type of life insurance or accidental death and dismemberment claim.

- Any claim for an insured benefit must be filed with the insurance carrier under contract with the Plan to provide that benefit (e.g., Kaiser).
- Special rules apply to "urgent care claims," as defined below. Urgent care claims may be made by telephone, facsimile, or other similar method. In addition, a health care professional with knowledge of your medical condition may act as your authorized representative with respect to urgent care claims.
- Special rules also apply to claims for weekly disability income benefits. These are described in the **Claim and Appeal Procedures for Disability Benefits** section below.

Filing Health Claims under the Plan
For purposes of these claims procedures, "medical benefits" includes medical, dental, vision, hearing aid, and prescription drug benefits. If your claim was for medical benefits, you will be given a written or electronic notice of the decision on the claim within the time periods described below, depending on the type of claim.

Pre-Service and Post-Service Medical Claims
If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

If services that require preauthorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to the Plan's an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Urgent Care Claims
An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject

you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Concurrent Care Decisions.
If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment (other than by Plan amendment or termination) before the end of the specified period or number of treatments will be treated as a claim denial. You will be notified of such a denial in time to allow you to appeal and obtain a determination on review before the course of treatment is reduced or terminated.

If you request that an ongoing course of treatment be extended beyond the previously approved time period or number of treatments, and your request constitutes an urgent care claim, your claim will be decided as soon as possible, taking into account the medical exigencies. If your request was made at least 24 hours before the end of the prescribed period of time or number of treatments, you will be notified of the decision within 24 hours after the Plan received the request. An appeal from a denial of a request to extend the course of treatment will be governed by the procedures for pre-service, post-service, and urgent care medical claims, described above.

Weekly Disability (Time Loss) Claims
The Trust Administration Office will ordinarily process a properly filed claim for weekly disability (time loss) benefits within 45 days

of receipt. If additional time is necessary due to matters beyond the control of the Trust, the Administration Office may extend the 45-day period by an additional 30 days if a notice is provided to the claimant within the initial 45-day period. If additional time is necessary due to matters beyond control of the Trust, prior to the end of the first 30-day extension period, the Administration Office may extend the initial 30-day period for up to an additional 30 days, provided that the Administration Office notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. A notice of extension shall advise the claimant of the circumstances requiring the extension of time and the date by which the Administration Office expects to render a decision.

If any extension is necessary because additional information is needed to decide the claim, the claimant will be notified and given 45 days from the date the notice is received to provide the additional required information. The time period for making a benefit determination will be tolled (i.e., will not run) from the date the Administration Office sends the request for additional information until the earlier of the date the Administration Office received the requested information or 45 days from the date the most recent extension notice has passed

Remedies Available if a Claim is Denied – Appeal Procedures

Initial Appeal

Any Participant or beneficiary (hereafter "claimant") who applies for benefits and is ruled ineligible by the Trustees (or by the administrator acting for the Trustees), or who believes he did not receive the full amount of benefits to which he is entitled, or who is otherwise adversely affected by any action of the Trustees, will have the right to appeal to and request review of the matter by the Board of Trustees or Appeals Committee, provided that he makes such a request, in writing, within 180 days after the Board's action or within 180 days after receipt of the adverse notification or decision.

Notice of Denial of Claims

The notice of denial of a claim will provide the following information:

- The specific reason or reasons for the denial, including the denial code, if applicable, and its corresponding meaning.
- A statement regarding the availability of the diagnosis and treatment codes upon request, if applicable.
- Information sufficient to identify the claim, including the date of service, health care provider and claim amount, if applicable.
- A reference to the specific plan provisions on which the decision is based.
- A description of any additional material or information needed to perfect the claim and an explanation of why such material or information is necessary.
- If an internal rule, guideline, protocol or similar criterion has been relied on in denying the claim, a statement that any such internal rule, guideline protocol or other criterion is available free of charge on request.
- If the denial is based on medical necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant's medical circumstances, will be provided free of charge upon request.
- An explanation of the Trust's appeal procedures and available external review process. In the case of a denial concerning a health claim involving urgent care, the explanation will include a description of the expedited review process applicable to such claims.

The Administration Office, the Utilization Review Manager or life/AD&D insurer will mail notice of denial to the claimant at his or her last known address. In the case of a denial concerning a health claim involving urgent care, the Utilization Review Manager may provide the information to the claimant orally within the time frame for notice of decision on urgent care claims, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

The claimant or his or her authorized representative may upon request and free of charge have reasonable access to, and copies of,

all documents, records, and other information relevant to the claimant's claim for benefits.

The procedures specified below are the exclusive procedures available to a claimant who is dissatisfied with a benefit claim denial or partial benefit award, rescission, or any other adverse determination (within the meaning of Department of Labor regulations). These appeal procedures must be exhausted before a claimant may file suit under section 502(a) of ERISA.

Claimants must appeal a benefit claim denial or rescission within 180 days from the date the claimant receives the notice of a benefit claim denial, notice of rescission or other advance determination. Failure to file an appeal within the 180-day period will serve as a bar to any claim for benefits or for any other form of relief from the Trust.

The appeal must be submitted by the claimant or the claimant's authorized representative. The appeal must identify the benefit determination involved, set forth the reasons for the appeal and provide any information the claimant believes is pertinent. Appeals will be accepted from an authorized representative of the claimant only if the appeal is accompanied by a written statement signed by the claimant (or parent or legal guardian where appropriate) which identifies the representative and authorizes him or her to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

Requests for appeal should be sent to the Trust Administration Office at the following address:

Appeals Department
c/o WPAS, Inc.
P.O. Box 34203
Seattle, WA 98124-1203

The appeal will be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees, which has been allocated the authority for making a final decision in connection with the appeal.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the Plan at

the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Scheduling of Appeal.
Except for claims involving pre-service and urgent care, the Trustees will review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within 30 days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustee's receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination will be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustee's receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for a hearing on the appeal, then prior to the commencement of the extension, the Plan will notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

The Trustees will review a properly filed appeal of a pre-service claim within 30 days after receipt of the appeal.

Appeal Procedures.
A claimant is generally entitled to present the claimant's position and any evidence in support thereof, at an appeal hearing. Notwithstanding the foregoing, in order to expedite review, the appeal may be held telephonically by the Trustees. The claimant may request postponement of the Trustees' review if the claimant wishes to appear in person at a hearing.

A claimant may be represented by an attorney or by any other authorized representative of his choosing at his own expense.

The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits.

The Board of Trustees or Appeals Committee may, in its discretion, direct that a stenographic record be made of any testimony provided. The Board of Trustees or Appeals Committee may, in its discretion,

set any other conditions upon the conduct of the hearing, the testimony or attendance of any individual or address other procedural matters which may occur during a specific hearing.

If the claimant does not elect to appear, the Board of Trustees or Appeals Committee will determine the appeal based on the administrative file and the comments of any witnesses consulted.

The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Decision after Appeal Hearing

The Trustees will issue a written decision on review of a claim (other than a pre-service claim) as soon as possible, but not later than 5 business days following the conclusion of the Board of Trustees or Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. Notwithstanding the foregoing, a decision on review of a pre-service claim will be made within 30 days after receipt of the appeal. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits.
- A statement of the claimant's rights under ERISA § 502(a).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.
- If the denial was based on medical judgment, an explanation of the medical judgment applying it to the claimant's case or a statement that such information is available.
- The review is de novo and without deference to the initial determination.

External Review of Trustees' Decision

A claimant who remains dissatisfied after exhausting the appeal procedures may request external review by an Independent Review Organization (IRO). A denied claim is eligible for external review only if it involves (i) medical judgment (including, but not limited to, a denial based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or (ii) its determination that a treatment is experimental or investigational) or rescission of coverage (regardless of whether the rescission has any effect on any particular benefit at the time).

Your request for an external review must be submitted in writing to the Trust Administration Office within four months after the date you receive the Plan's notice of decision. If there is no corresponding date four months after the date of receipt of such notice, then your request must be filed by the first day of the fifth month following your receipt of the notice. Failure to file a request

for external review within this time period will end the claimant's ability to seek external review.

You may also bring a civil action under ERISA § 502(a). A claimant must exhaust the Internal Appeals Process prior to requesting external review by an IRO or bringing a civil action.

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

Review by an IRO
If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review. If an urgent care claim is submitted to an IRO, a decision will be made within 72 hours.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a).

Expedited External Review
You may request an expedited external review in the following circumstances:

- You received an initial benefit denial (i.e., at the Plan's first level of review) and filed a request for an expedited review under the Plan's appeals procedures (i.e., optional second level of review) but the claim involves a medical condition where the timeframe for completing an expedited appeal

under the Plan's procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

- You received a final benefit denial from the Plan and either (i) you have a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or (ii) the denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

The process and rules described above for a standard external review will apply, subject to the following:

- The Plan's preliminary review of whether the request meets the reviewability requirements will be conducted immediately upon receiving a request for expedited external review, and the Plan will immediately send you a notice concerning its eligibility determination.
- The Plan will provide or transmit all documents and information it considered in its benefits denial to the assigned IRO electronically, by telephone or facsimile, or any other available expeditious method.
- The IRO must provide notice of its final decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after receiving the request for expedited external review. If the notice is not in writing, the IRO must provide you and the Plan with written confirmation of the decision within 48 hours after providing that notice.

Civil Action for Denied Benefits or Coverage — Deadline for Filing Lawsuit

If the claimant exhausts the claim appeal procedures, and remains dissatisfied with the decision on appeal by the Board of Trustees or Appeals Committee, he or she has the right to pursue a civil action under section 502(a) of ERISA (29 U.S.C. § 1132(a)).

No legal or equitable action for benefits or coverage may be brought later than one year after the date of the notice of the Appeals Committee's decision to the claimant.
In the case of an adverse appeal decision by the insurance company for Life and Accidental Death and Dismember benefits, see the subscriber booklet for rules that may require filing a lawsuit within a specific period of time after the insurance company makes its decision on appeal.

If a claimant requests an external review (see *External Review of Certain Health Claim Appeal Decisions*, above), the deadline for filing a civil action is one year from the date the independent review organization issues its decision.

Sole and Exclusive Procedures
The Plan's Claim and Appeal Procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. The Claim and Appeal procedures must be exhausted prior to filing any legal action.

Review of Board of Trustees' Decision
Any further review by an arbitrator, a judge, or otherwise (except for an external review by an IRO) of the decision by the Board of Trustees (or claim reviewer) will be based on the record considered by the Board of Trustees (or claim reviewer) and limited to whether the Board of Trustees (or claim reviewer) acted arbitrarily or capriciously in the exercise of its discretion. In no event will any further review (other than an external review by an IRO) be on a de novo basis, as the party making the decision has discretionary authority to determine eligibility for benefits under and to construe the terms of this Plan.

The Plan, at its own expense, will have the right and opportunity to examine the person of you or your covered dependent when and so often as it may reasonably require during the pendency of any claim, and also, the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Plan.

You do not have any right or claim to benefits from the Plan, except as specified in this Plan. Any dispute as to eligibility, type, amount or duration of benefits under this Plan or any amendment or modification hereof will be resolved by the Board of Trustees (or its authorized representative) under and pursuant to this Plan and the Trust Agreement, and, subject to the claims and appeal procedures described in this booklet. The Board of Trustees' (or its authorized representative's) decision of the dispute will be final and binding upon all parties to the dispute. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim therefore has been submitted to and finally determined by the Board of Trustees (or its authorized representative

Consistent Application

The Board of Trustees will establish administrative processes and safeguards to ensure and verify that claim determinations are made in accordance with the Plan documents and that Plan provisions have been applied consistently with respect to similarly situated claimants.

Dissatisfaction With Insurer's Benefit Claim Decision

If you are dissatisfied with the written decision of an insurance carrier or other party under contract with the Plan with respect to a disability benefit, your recourse will be limited solely to the pertinent provisions specified in such contract.

Board of Trustees has Exclusive Authority to Determine Eligibility

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected.

Privacy Policy and Procedures

The Trust's privacy practices were effective April 14, 2003, and are administered in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR § 164. The Board of Trustees adopted the following provisions:

Protected Health Information
The term "Protected Health Information" ("PHI") has the same meaning as in 45 CFR § 164.501.

Request, Use and Disclosure of PHI by Trustees
The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following Administration functions:

- To make or obtain payment for care received by Eligible Individuals.
- To facilitate treatment which involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to Eligible Individuals.
- In connection with judicial or administration proceedings in response to an order of a court or administration tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other plan Administration functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.

- For authorized activities by health oversight agencies, including audits, civil, Administration or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to an Eligible Individual's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
- For specified government functions under 45 CFR Part 164.
- To the extent necessary to comply with laws related to workers' compensation or similar programs.

Trustee Certification

The Plan will only disclose PHI to a Trustee upon receipt of a certification that these procedures have been adopted and the Trustees, as Plan sponsor, agree to the following:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or as required by law.
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.
- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by these procedures of which they become aware.
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.
- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or

destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests
The Trustees will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Adequate Separation
The Trustees represent that adequate separation exists between the Plan and the Trustees so that PHI will be used only for Plan administration. Each Trustee will certify that he has no employees, or other persons under his control that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance
Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

HIPAA Security
In compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement 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 group health plan,
- Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

NOTICE OF PRIVACY PRACTICES

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

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

Protected Health Information

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

Use And Disclosure Of Health Information

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the minimum necessary, as defined under the Privacy Rules.

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use your health information to pay claims, or share information regarding your coverage or health

care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating Physician to another treating Physician for the purpose of obtaining x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Health care operations include such activities as: contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings. If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes. The Trust will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes,

including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Trust may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

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

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

To Your Personal Representative. The Trust may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Trust may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

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

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the Plan. The Trust may also disclose information to the Trustees regarding whether you are participating or enrolled in the Plan.

Authorization To Use Or Disclose Health Information
Other than as stated above, the Trust will not disclose your health information other than with your written authorization. Authorization forms are available from the Privacy Officer, listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Officer, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

Your Rights With Respect To Your Health Information
You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Officer listed below.

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

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

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Officer, listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of

disagreement, and the Trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Officer listed below. The request should specify the time period for which you are requesting the information, but may not start earlier than **April 14, 2003** when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Officer, listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its website, www.agc-iuoe701trusts.com.

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

Privacy Officer. To exercise any of these rights related to your health information you should contact the Privacy Officer listed below.

Privacy Officer
Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: (206) 441-7574 or Toll Free: (800) 331-6158
Fax No: (206) 441-9110

Duties Of The Trust

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

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

Effective Date

The effective date of this notice is January 1, 2010.

Plan Administration

The Board of Trustees has the responsibility and the full and absolute discretion and authority to control and manage the operation and administration of the Plan, including without limitation, the authority to:

- make and enforce such rules and regulations as it shall deem necessary or proper for the efficient administration of the Plan;
- interpret and apply the provisions of this Plan, and any writing, decision, instrument or account in connection with the operation of the Plan or otherwise;
- determine all considerations affecting the eligibility of any individual to be or become covered under the Plan;
- determine eligibility for and amount of benefits under the Plan for any covered individual;
- determine all other questions or controversies, of whatsoever character, including factual determinations, arising in any manner or between any parties or persons in connection with the administration or operation of the Plan;
- authorize and direct all disbursements of benefits under the Plan; and
- delegate and allocate specific responsibilities, obligations and duties of the Board of Trustees, to one or more employees, agents or such other persons, including without limitation third party administrators, as the Board of Trustees deems appropriate.

The decision of the Board of Trustees shall be final and binding upon all persons dealing with the Plan or claiming any benefit under the Plan.

No employer or local union, no representative of any employer or local union, and no individual Trustee is authorized to interpret the Plan nor can any such person act as an agent of the Board of Trustees to guarantee benefit payments. No agreement between an employer and a union may change, override or otherwise affect the Plan any way, except as the Board of Trustees may permit expressly by resolution.

The Board of Trustees also has the power to purchase contracts or policies of insurance for the purpose of providing benefits under the Plan. To the extent benefits of the Plan are insured, the eligibility for and amount of benefits are determined based upon the terms and subject to the conditions of the governing insurance contract or policy, by the appropriate party designated in the policy or contract.

Amendment and Termination of Benefit Plan

The Board of Trustees has the sole and exclusive right, at any time and from time-to-time, for any reason, without prior notice to, and without the consent of any person, to amend, suspend, modify or terminate the Benefit Plan in whole or in part. This includes the right to amend, suspend, modify or terminate the benefits, deductibles, maximums, exclusions, limitations, definitions, eligibility for coverage and eligibility for benefits described in the Benefit Plan and the policies of administration adopted by the Board of Trustees. If the Benefit Plan is amended, suspended, terminated, or modified, the rights of participants and covered dependents are limited to eligible charges incurred before the effective date of the amendment, suspension, modification or termination.

Important Plan Information

ERISA requires that certain information be furnished to each eligible participant in an employee benefit plan. The following section contains additional information required by ERISA.

Name of Plan
AGC-International Union of Operating Engineers
Local 701 Health and Welfare Trust Fund

Name and Address of Plan Sponsor
This plan is sponsored and administered by a joint labor-management Board of Trustees, the name, address and telephone number of which is:

Board of Trustees
AGC-International Union of Operating Engineers
Local 701 Health and Welfare Trust Fund
c/o Welfare & Pension Administration Service, Inc.
Street Address:
7525 S.E. 24th Street, Suite 200
Mercer Island, WA 98040

Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203
(503) 657-9740
(866) 697-5750

Employer Identification Number and Plan Number
The EIN assigned to the Trust Fund by the IRS is: 93-6022485
The plan number is: 501

Type of Plan
This Plan is a health and welfare plan that provides medical, dental, vision, hearing aid, prescription drug, life, accidental death and dismemberment, and disability benefits.

Type of Administration
This Plan is administered by the Board of Trustees, with the assistance of Welfare & Pension Administration Service, Inc., a contract administrative organization.

Plan Administrator
The plan administrator is the Board of Trustees of the AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund. This Plan is administered by the Board of Trustees, with the assistance of the Trust Administrative Office:

Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
(503) 657-9740
(866) 697-5750

Agent for Service of Legal Process
Welfare & Pension Administration Service, Inc. is the agent for service of legal process. Service of process may be made on the agent at the same address as the Board of Trustees.

Each member of the Board of Trustees is also an agent for purposes of accepting service of legal process on behalf of the Trust. The names and addresses of the Trustees are listed below.

Board of Trustees

Employer Trustees	Union Trustees
Effective April 2020	
John Anderson (Secretary) Ness & Campbell Crane, Inc. 5730 NE 138th Avenue Portland, OR 97320	**James Anderson(Chairman)** IUOE Local 701 555 East First Street Gladstone, OR 97027
Kyle Izatt (Vice Secretary) Advanced American Const. PO Box 83599 Portland, OR 97283 Advanced American Construction 8444 NW St. Helens Road Portland, OR 97231	**Nate Stokes (Vice Chairman)** IUOE Local 701 555 East First Street Gladstone, OR 97027

Employer Trustees	Union Trustees
Ryan McDonald McDonald Excavating, Inc. 2719 Main Street Washougal, WA 98671-4109	**Scott Anderson** IUOE Local 701 555 East First Street Gladstone, OR 97027
Bob Timmons AGC Oregon-Columbia Chapter 9450 SW Commerce Circle, Suite 200 Wilsonville, OR 97070	**Ron Lee** IUOE Local 701 555 East First Street Gladstone, OR 97027

Description of Collective Bargaining Agreements

This Plan is maintained pursuant to more than ten separate collective bargaining agreements. Copies of such agreements may be obtained by participants and beneficiaries upon written request to the Board of Trustees. Further, such agreements are available for examination by participants and beneficiaries at the Trust Administration Office, and at Local 701 offices, upon ten days' advance written request. The Board of Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

Information Regarding Plan Sponsors

The plan sponsor of the Plan is the Board of Trustees. You or your beneficiary may receive from the Trust Administration Office, upon written request, information as to whether a particular employer is a contributing employer to the Plan and, if the employer is a contributing employer, the employer's address.

Participation, Eligibility, and Benefits

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements described above and if their employer makes contributions to the Trust Fund on their behalf. Also, certain non-bargaining unit employees (associate employees) are entitled to participate pursuant to special agreements between their employers and the Board of Trustees. The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth in this booklet. Eligible dependents will be

terminated if they cease to meet the definitions of dependents as defined by the Plan.

This Plan contains provisions whereby benefits may be reduced or denied even though an employee or dependent is covered. These provisions include, but are not limited to:

- The failure to file a claim with the Trust Administration Office within 12 months of the date the expense is incurred.
- Failure to submit a complete and truthful benefit application.
- Where the eligible individual has other coverage, benefits may be reduced or denied.

The Board of Trustees has the authority to terminate the Plan. The Plan will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust Fund. In the event of termination of the Plan, any and all monies and assets remaining in the Trust Fund, after the payment of expenses, will be used for the continuance of benefits by then existing plans, until such monies and assets have been exhausted.

Source of Contributions

The Plan is funded through employer contributions, the amount of which is specified in the underlying collective bargaining agreements or special agreements.

Entities Used for Accumulation of Assets and Payment of Benefits

The employer contributions and the employee self-payments are received and held by the Board of Trustees in the Plan's Trust Fund pending the payment of benefits and administrative expenses. Weekly disability benefits, Medical Program benefits (including prescription drug benefits and hearing aid benefits), Dental Program benefits, and Vision Program benefits are paid directly from the Plan's Trust Fund. Employee life insurance, accidental death and dismemberment benefits, and dependent life insurance are insured by LifeMap under a group insurance contract with the Board of Trustees.

Alternative medical benefits are insured by Kaiser Permanente, 500 NE Multnomah Boulevard, Kaiser Permanente Building, Suite 100, Portland, OR 97232

Alternative dental benefits are insured by Willamette Dental Insurance, Inc., 6950 NE Campus Way, Hillsboro, OR 97124

Plan Year
This Plan is on a calendar year basis. The end of the calendar year is December 31.

Future of Plan
It is expected that this Plan will be continued. However, the Trustees reserve the right to change, modify, or terminate the Plan at any time.

The Trustees may change eligibility requirements, benefits, self-pay contributions, or any other Plan provisions in accordance with the terms of the Trust Agreement.

Statement of ERISA Rights
As a participant in the AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The plan administrator may make a reasonable charge for the copies.

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

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

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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees. If you are dissatisfied with the determination of the Trustees, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified

status of a medical child support order, you may file suit in Federal court.

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

Assistance with Your Questions

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

Newborns' and Mothers' Health Protection Act of 1996

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

Women's Health and Cancer Rights Act of 1998
On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. One of the provisions of this act requires group health plans to notify health plan members of their rights under this law.

What benefits does the law guarantee?
Under this law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This includes:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The law also states that "the services will be considered in a manner determined in consultation with the attending Physician and the patient." In other words, you and your Physician will determine the most appropriate treatment for your individual situation.

Coverage of these services is subject to the terms and conditions of the Plan, including the Plan's normal copayment, annual deductibles and coinsurance provisions.

Amendment and Termination
The Board of Trustees has the sole and exclusive right to amend, suspend, modify or terminate the Plan in whole or in part. See *Amendment and Termination of Benefit Plan*, page 142.

Upon voluntary termination of the Trust, all assets remaining in the Trust after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets have been depleted.

Benefits Not Guaranteed
None of the benefits provided by this Plan are insured by any contract of insurance, except the life insurance and accidental death and dismemberment benefits. There is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amount in the Trust collected and available for such

purpose. No employee or dependent shall have any accrued or vested rights to benefits under this Plan.

Information Available to You

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Administration Office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Plan Administrator will state the charge for specific documents on request so that you can find out the cost before ordering.

The foregoing is a Summary Plan Description required by federal law. Of necessity, many of the substantive plan provisions mentioned in the Summary Plan Description have been set forth in summary or capsulized form. For a complete and detailed description, please refer to the material contained in this booklet.

All questions with respect to Plan participation, eligibility for benefits, or the nature and amount of benefits, or with respect to any matter of Trust Fund or Plan administration, should be referred to the Administration Office.

The only party authorized by the Board of Trustees to answer questions concerning the Trust Fund and Plan is the Administration Office. No participating employer, employer association, no labor organization, nor any individual employed thereby, has any authority in this regard.

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