2025 SUMMARY PLAN DESCRIPTION

A guide to your healthcare coverage

• Medical • Dental
•Vision • Prescription

Effective February 1, 2025

IMPORTANT INFORMATION

Health & Welfare Fund Office
International Union of Operating Engineers
Local 399 Health & Welfare Trust
2260 S. Grove Street • Chicago, IL 60616-1823

Telephone: (312) 372-9870 Fax: (312) 842-0291

www.iuoe399.org

BCBSIL

Medical Preferred Provider (PPO) Network
Using BlueCross BlueShield (BCBS) Providers will maximize
your benefits and lower your out-of-pocket costs
Group #P14239
To Find a BCBS PPO Provider
Call (800) 810-2583
www.bcbsil.com

Claims Administrator
Medical and Disability Income Claims
Elite Administration
1300 W. Higgins Road • Suite 208
Park Ridge, IL 60068
(312) 243-1265
(800) 762-4166
www.eliteadmin.com

Elite Administration

Delta Dental

Dental Preferred Provider Network
Claims Administrator for your dental claims
Maximize your dental benefits by using a Delta Dental PPO Dentist
Group #20126
Delta Dental of IL
(800) 323-1743
www.deltadentalil.com

Pharmacy Benefit Manager
CVS Caremark is your prescription drug manager
CVS Caremark Customer Care Center
(833) 266-8151
www.caremark.com
Mail Order Address:
P.O. Box 52136
Phoenix, AZ 85072-2136

Pharmacy Manager

VSP Vision

Vision Care Plan
VSP
(800) 877-7195
www.vsp.com

Pre-Certification and Utilization Review
Your medical plan requires pre-certification for inpatient admissions, surgeries performed in an outpatient facility, physical, occupational and speech therapy and other medical services *(See Page 6)*

Call Vālenz
(800) 367-1934

INTRODUCTION

The Board of Trustees is pleased to provide this updated Summary Plan Description of the benefits available through the International Union of Operating Engineers Local 399 Health and Welfare Plan. Effective February 1, 2025, this book replaces any and all prior summary plan descriptions that were previously issued. Please read this booklet and keep it in a safe place for future reference. Please share this book with your spouse if you are married and all covered dependents.

In all areas of coverage, you are teamed with preferred providers who have agreed to provide their services at a reduced cost. This saves significant money for both you and the Health & Welfare Trust Fund. See the inside front cover of this book for a list of the Fund's contracted benefit partners.

This book is intended to give you an accurate summary of the benefits and provisions of the Local 399 Health and Welfare Plan. The Plan Document contains a detailed description of the rules, regulations, benefits and provisions of the Plan (available to view via the QR code below). If any discrepancy exists between this book and the Plan Document, the provisions of the Plan Document will govern. The Health & Welfare Fund Office staff can be reached by phone at (312) 372-9870 option 3 to answer any questions you may have about your benefits.

We also encourage you to refer to the Health and Welfare section of Local 399's website www.iuoe399.org for current and helpful information regarding your Plan.

Sincerely,

Board of Trustees
Local 399 Health and Welfare Trust

TABLE OF CONTENTS

Introduction 1

Eligibility 3

Important Medical Plan Provisions 6

Benefits Summary 7

Preventive Benefits 8

Covered Medical Expenses 9

Medical Plan Exclusions 12

Prescription Drug Program 14

Dental Benefits 17

Vision Benefits 20

Benefit Determination and Appeal Process 21

Coordination of Benefits (COB) 23

Subrogation and Third Party Reimbursement 25

COBRA Continuation Coverage 27

Miscellaneous Information 31

Definitions 33

Notice of Privacy Practices 37

ERISA Rights 38

Additional Information 40

Disability Income Benefit 44

Appeal Procedures for Disability Claims 45

Life Insurance/Death Benefit 47

Important Information 49

ELIGIBILITY

WHO IS ELIGIBLE?

You and your covered dependent(s) are eligible for benefits when you work for an employer who makes contributions to the Fund on your behalf. You become eligible for benefits on the first day of the month for which your employer makes contributions to the Fund on your behalf. This is generally the first day of the month following your date of employment, or in accordance with your collective bargaining agreement.

Your dependent(s) become eligible for coverage on the date you become eligible, or on the date the person becomes your eligible dependent, whichever comes later.

Definition of Dependent(s)

- The member's wife or husband as documented by a marriage certificate; or
- The member's natural or legally adopted children under age 26 as documented by birth certificate or legal adoption papers; or
- The member's step-child under age 26 through a current marriage, as documented by marriage and birth certificate; or
- The member's child under age 26 as defined as an alternate recipient in a divorce decree or under a Qualifed Medical Child Support Order (QMCSO); or
- The member's unmarried child over age 26 who has a permanent mental or physical handicap that began prior to age 26 and whose condition renders the child incapable of self-support. (The member, with supporting documentation from the physician, must prove to the Fund Office that the child meets these conditions when requested, but not more than once a year.) This handicapped adult dependent must be:
  - dependent for care and support mainly upon the member, and;
  - unable to engage in regular employment.

ENROLLMENT REQUIREMENTS

Enrollment Form for a Newly-Hired Member

You must obtain, complete, and sign a Plan Enrollment Form and provide the Fund Office with marriage and birth certificates and other requested documentation for your eligible dependents. When your enrollment is complete, you will receive identification cards and Plan reference information.

Enrollment Form for Adding a Dependent(s)

If you acquire a new dependent through marriage, birth or adoption, the dependent shall generally be eligible for coverage immediately on the date of such marriage, birth or adoption. However, the Employee must complete and submit a new Dependent Change Form within 90 days from the date the new dependent(s) would be eligible for enrollment. Documentation (marriage, birth certificate, etc.) will be required. If the Employee does not complete and submit the required documentation within this 90-day period, coverage will begin on the first day of the month after the Fund Office receives the required documentation (such as the marriage certificate, birth certificate, etc.).

Timely enrollment in this Plan is necessary to activate coverage for you, your current family and newly acquired dependents.

Note: You may choose to decline enrollment of a dependent at the time of marriage or birth or adoption of a child due to that dependent having other group coverage. It is advisable, however that you complete a Dependent Change Form for the newly-acquired dependent(s) and "decline" coverage on

the form. By declining coverage and identifying the other group coverage in place, you will be entitled to add this dependent if other group coverage ends (see following section regarding Special Enrollment).

Special Enrollment Due to Loss of Other Group Coverage

You may have declined coverage for your dependents because your dependents were covered under another group plan. The Plan provides you with special enrollment rights when your dependent's coverage ends due to:

- loss of eligibility for the coverage (not including a loss of eligibility due to failure to pay premiums); or
- an employer ceasing to make contributions for that coverage; or
- coverage under COBRA maximum period being exhausted.

To exercise this special enrollment right, the Employee must request to enroll their dependent within 90 days after the loss of coverage or the employer's cessation of Contributions for such coverage (or within 90 days in the case of the loss of coverage under Medicaid or SCHIP). There is no special enrollment right if the other coverage ceases due to an individual's failure to pay premiums or for cause such as filing fraudulent claims. Coverage for a Dependent who is enrolled under this special enrollment provision will begin on the first day of the month after the Fund Office receives the enrollment request, the completed Enrollment Form and documentation (such as the marriage certificate, birth certificate, etc.)

Only a dependent who meets the Plan's definition of an Eligible Dependent is eligible for special enrollment and coverage under the Plan.

LEAVE OF ABSENCE

Medical Leave of Absence

If you continue to be employed by an employer who contributes to the Plan, but you are on medical leave of absence for an injury or illness, your coverage (through employer paid contributions) may extend for a period of time in accordance with your collective bargaining agreement. When the employer obligation has ended, you may be eligible for COBRA continuation coverage (see page 27).

Family and Medical Leave Act of 1993 (FMLA)

You may qualify to take up to a 12-week unpaid leave of absence under the terms of the Family and Medical Leave Act (FMLA). You will maintain coverage for you and your dependents for the duration of the leave provided your employer grants the leave of absence under the terms of this Act and makes the required contributions to the Fund on your behalf. When the employer contractual obligation has ended, you may be eligible for COBRA continuation coverage (see page 27).

Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

You may continue coverage for you and your dependents during a military leave of absence of at least 30 days in accordance with the USERRA. If your employer ceases to make contributions on your behalf during your leave of absence, you may be eligible to make self-payments at the COBRA coverage rate for up to 24 months. If and when you later return to work with a contributing employer under the terms set forth in USERRA, you and your dependents will be reinstated in the Plan (see page 27).

WHEN COVERAGE ENDS UNDER THIS PLAN

Your coverage will end on the last day of the month that you last worked and the employer paid your Plan contribution. *Your coverage may also end on the last day of the month during which the employer paid your Plan contribution while you were on medical leave of absence (see above).*
Coverage may also end:

- if you elect COBRA continuation coverage but fail to pay for coverage within the time period allowed;
- if you are covered under COBRA continuation coverage and the maximum continuation period expires;
- if you elect COBRA and become entitled to Medicare;
- if you are expelled from membership (see Expulsion from the Plan below).

Coverage for you and your dependents will also end if the Health and Welfare Trust Fund's Board of Trustees terminates this Plan or amends the Plan to exclude you or your dependents from participation.

Coverage for your dependents will end on the last day of the month when:

- your coverage stops; or
- your dependent stops being an eligible dependent – for example, if your dependent becomes age 26 on September 15, your dependent's coverage would continue through September 30.

In the event of your death while you are covered under the Plan as a member, benefits for your spouse and covered dependent children will extend for a period of 90 days following the date of your death and will end on the last day of that month. This extension of benefits will not apply to spouses and dependents who have other group coverage or eligibility for Medicare at the time of the members' death (see page 24).

EXPULSION FROM THE PLAN

You or your dependent may be subject to expulsion from the Plan if you, he or she:

- accepts a benefit payment knowing you, he or she is not entitled to it, whether because you attempted to defraud the Plan or because the payment was issued in error; and/or
- provides incorrect information to the Fund Office or Claims Administrator or provider of medical services in order to receive benefits to which you, he or she is not entitled; and/or
- falsifies information on an Enrollment Form or any other documentation requested by the Fund.

If it is determined that a member or dependent may be subject to expulsion, the Fund will advise the party by letter of its findings.

RIGHT TO APPEAL TERMINATION OF COVERAGE

If you feel your (or your dependent's) participation from the Plan was declined or terminated erroneously, you have the right to appeal. See Benefit Determination and Appeal Process (see page 21).
In order to receive the maximum benefit for a particular service, you must obtain the necessary pre-certification prior to the applicable services and use a provider that participates in the Plan's preferred provider networks. Please also refer to the "Medical Plan Exclusions" section of this document (see page 12).

IMPORTANT MEDICAL PLAN PROVISIONS

Preferred Provider Network **BlueCross BlueShield (BCBS)**

The BlueCross BlueShield (BCBS) Preferred Provider (PPO) network is available to all participants. This is a very large national network of providers, which means greater doctor and hospital accessibility and choice for participants and their families. There are a number of ways for you to find a medical service provider, including the internet or the BCBS toll-free number listed below. Information about providers in the BCBS PPO network is available to you without charge.

BCBS (Provider Finder)
www.BCBSIL.com
(800) 810-2583

You have the right to see the provider of your choice. However, if you choose preferred providers for covered services, you will receive the maximum benefits allowable.

Pre-Certification **Vãlenz Health**

The Plan requires pre-certification of certain services by Vãlenz Health. Pre-certification means that certain services your physician recommends must be approved by Vãlenz Health before you receive the services. Hospital admissions must be pre-certified by Vãlenz Health prior to an elective admission and within two working days of an emergency inpatient admission. (For BCBS PPO inpatient stays, the provider is required to obtain pre-certification.) However, it is ultimately your responsibility to ensure that pre-certification is obtained. Pre-certification by Vãlenz Health does not guarantee payment of benefits. The Plan's normal coverage rules and limitations apply.

Vãlenz Health
Toll-Free Number: (800) 367-1934

The following services require pre-certification under the Plan:

- All hospital admissions including pre-scheduled 23-hour or overnight observations in a hospital;
- Surgical or other outpatient procedures performed in a hospital, network ambulatory surgical facility or surgical suite in a clinic;
- Speech therapy;
- Physical and occupational therapy for children under the age of 12, unless therapy immediately follows a related surgical procedure;
- Physical and occupational therapy following related surgical procedure that exceeds 24 therapies;
- Physical and occupational therapy, ages 13 and up that exceeds 12 therapies per medical condition that is non-surgical related;
- Intravenous (IV) therapy or injectible drugs administered in a physician's office;
- Home health or hospice services;
- Durable medical equipment; prosthetics;
- Foot orthotics *in excess* of one pair every three calendar years;
- Applied Behavioral Analysis therapy "ABA Therapy";
- Genetic Testing as allowed.

SCHEDULE OF MEDICAL BENEFITS SUMMARY

	In-Network	Out-of-Network
Calendar Year Deductible	$300 – Individual $1,200 – Family	$300 – Individual $1,200 – Family
Benefit Level	90%	70% of usual and customary
Out-of-Pocket Maximum	$5,000 – Individual	None
Chiropractic Annual Maximum	$1,000 – Individual	$1,000 – Individual
Acupuncture Annual Maximum	$1,000 – Individual	$1,000 – Individual
Ambulance	90%	90% of usual and customary
Emergency Room Co-Payment	$100*	$100

Notes:

- Family deductible can be met by four or more family members – no one individual will incur more than $300 deductible per calendar year; no one family unit will incur more than $1,200 deductible per calendar year.
- The annual out-of-pocket maximum is made up of the deductible and coinsurance amounts you pay for health care services provided by a preferred provider during a calendar year. Once you meet the annual out-of-pocket amount, the Plan will pay 100% of covered charges (*including the $100 emergency room copay) provided by a preferred provider, subject to Plan provisions, for the remainder of the calendar year.

The following out-of-pocket expenses do not apply to your annual out-of-pocket maximum:

- Out-of-network coinsurance;
- Prescription drug coinsurance;
- Charges for services or items which are not covered by the Plan;
- Any charge or portion of a charge which exceeds any individual benefit maximum or limitation.

PREVENTIVE BENEFITS FOR ADULTS

The Plan will provide the following benefit **only** when a preferred provider is used. The in-network benefit level is described on page 7.

Routine Annual Physical Examination

The Plan pays for an annual physical exam by your physician and related preventative testing for members, spouse and children over the age of 19. The Plan also pays routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC).

The Plan pays for charges in connection with well-child care for your eligible dependent children through age 18 for well-child examinations, immunizations and laboratory screening tests prescribed by the Physician.

The following benefits are subject to the in-network and out-of-network benefit levels as described on page 7*:

Women Preventive Benefits

Gynecological related physician exam for non-symptomatic women in accordance to the American College of Gynecological (ACOG) guidelines. The coverage includes periodic gynecological exam, pap smear and HPV screening.

Screening Mammogram for non-symptomatic women 40 years of age or older with a maximum of one screening mammogram per calendar year.

The Plan covers BRCA1 and BRCA2 genetic screenings for women with specific family histories that can increase the risk for breast cancer. The screenings must be in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations and pre-certified by Utilization Review Provider. For women whose BRCA screening results indicate a deleterious mutation (a mutation that indicates a higher breast cancer risk), the Plan would also cover a subsequent genetic counseling visit and interventions such as intensive screening procedures, prophylactic surgery or chemoprevention.

Male Preventive Benefits

The Plan pays for charges related to a PSA and the related physician exam for non-symptomatic men 45 years of age or older with a maximum of one exam/PSA per calendar year.

Colorectal Cancer Screening

The Plan pays for charges relating to fecal occult blood testing and charges relating to colonoscopy or sigmoidoscopy for persons 45 years of age or older with a maximum of one test every three calendar years. (Also applies for persons under age 45 classified as high risk for colorectal cancer due to first degree family member having a history of colorectal cancer, as pre-certified by Utilization Review Provider.)

Lung Scans for Participants with History of Smoking

The Plan covers annual screening for lung cancer with low-dose computed tomography (CT) for adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. As of the date of this SPD restatement, the USPSTF age guidelines are reflected.

***NOTE: Out-of-network surgical facilities are not covered under the Plan for any services, including colonoscopy.**

COVERED MEDICAL EXPENSES

Covered medical services are the reasonable charges actually incurred by a covered person for the following medical services, treatment and supplies which are medically necessary for and in connection with the treatment of the person for a non-occupational injury, sickness or to diagnose current medical symptoms. Benefits are payable at the level of benefits stated on the Schedule of Benefits Summary on page 7.

Professional Medical Services

Licensed medical professional services for:

- Office examination and consultation
- Surgery
- Anesthesia and its administration
- Emergency room examination
- Hospital visits
- Radiology and pathology interpretation
- Chemotherapy

Outpatient Facility Services

- Diagnostic testing performed to diagnose existing symptoms or to evaluate the status of an existing medical condition;
- Surgical room and related supplies in the outpatient department of a hospital or in a preferred provider network ambulatory surgical facility.* (Out-of-network surgical facilities are not covered.);
- Emergency room or urgent care center for treatment of an acute accident or illness that cannot be treated in a physician's office;
- Cardiac rehabilitation program operating under the direct supervision of a physician and following a cardiac episode;
- Radiation therapy; hemodialysis.

Inpatient Hospital/Facility Services*

- Acute care hospital
- Skilled nursing
- Physical rehabilitation
- Programs for treatment of mental health or substance abuse

Pregnancy, Childbirth and Well Newborn

- Hospital charges for childbirth and newborn dependent of the member
- Obstetrician charges for pre-natal, delivery and post-natal services
- Pediatrician exam in the hospital for newborn dependent of the member
- Circumcision
- Birthing center
- Midwife services in conjunction with a licensed physician

**requires pre-certification by Utilization Review Provider*

Other Professional Services

- Chiropractic subject to a calendar year maximum of $1,000 per participant. Adjustments and manipulations performed by other covered professionals will also be applied to this $1,000 calendar year maximum.
- Acupuncture subject to calendar year maximum of $1,000 per participant.
- Physical, occupational and/or speech therapy* performed by a licensed physical, occupational or speech therapist to include exercise physical therapy, occupational therapy and speech therapy that is prescribed by a physician and is restorative in nature. Benefits are limited to therapeutic exercise activity and the initial testing thereof that is designed to promote the restoration of useful physical function that was lost or impaired due to an illness or injury (see page 6 for specific pre-certification guidelines).
- Home health care* provided by a home health agency team. Home health care must replace an inpatient admission, be prescribed by the attending physician, be limited to the homebound and be therapeutic and curative in nature.
- Hospice services provided by a hospice agency team*.
- Applied Behavioral Analysis “ABA Therapy.”*
- Autism Treatment.

**requires pre-certification by Utilization Review Provider*

Other Benefits

- Ambulance to include medical transport from your home, the scene of an accident, or from an originating hospital, to the closest hospital equipped to provide appropriate medical services.
- Durable medical equipment* to include:
  - rental or purchase of equipment such as wheelchairs, hospital beds, walkers and crutches and the equipment used for the administration of oxygen;
  - repairs, adjustments or replacement of durable medical equipment when due to normal growth or normal wear and tear; and/or
  - supplies used in connection with the equipment.
- Oxygen and its administration;
- CPAP equipment (purchase only*);
- Sleep studies*;
- Medical supplies to include medically necessary supplies prescribed by a physician for the treatment of an acute illness or injury such as medical and surgical dressings, splints, casts, trusses, braces and colostomy supplies;
- Prosthetic devices to include fitting, repair and replacement of a natural limb or eye*;
- Diabetes self-management services and supplies to include training and education, and purchase of glucose monitor. (Insulin, syringes and needles, and test strips are covered under the prescription drug program.);
- Two nutritional counseling sessions by a registered dietician immediately following a diabetes diagnosis or mental or nervous disorder;
- Insulin pumps*;
- Allergy injections;
- Blood and plasma;
- Sterilization procedures;
- Injectable drugs administered in the physician’s office* that are FDA approved for the diagnosis being treated;
- Counseling by a Licensed Mental Health or Substance Abuse Professional;
- Telemedicine visits;
- Hearing Aids, up to a maximum of $2,000 per ear, every 3 years. Covered services also include hearing examination, consultation, initial fitting and follow-up appointments for adjustments.

**requires pre-certification by Utilization Review Provider*

Genetic Testing

The Plan will cover genetic testing at 90% (PPO) and 70% (Non-PPO) under the Major Medical Benefit. The maximum benefit available is $10,000 per lifetime. Please note this benefit maximum does not apply to BRCA genetic tests, which will continue to be covered by the Plan.

Genetic testing services* are covered under the Plan, provided the services are medically necessary and the following conditions are met:

1. The testing is (a) necessary to diagnose an existing medical condition; or (b) in connection with an actual treatment plan for a diagnosed illness.

2. The tests are performed prenatally within the recommendations established by the American College of Obstetrics and Gynecology (ACOG):

    a. First or second trimester screening tests for fetal aneuploidy disorders (e.g., Down Syndrome), or specific inherited disorders such as cystic fibrosis and sickle cell disease; and

    b. Follow-up diagnostic tests for the same conditions if an initial screening indicates a likelihood of a genetic defect.

Prenatal tests may be performed and billed as a “panel” that screens for several diseases at once. When a covered test is included in a panel of tests that includes other non-covered tests, only the reasonable and customary amount (or the negotiated amount if the lab is in-network) for the covered test will be allowed.

Genetic testing excludes screening and testing of the following: (a) of family members, (b) by multiple methods for the same disorder(s), (c) multigene panels for diseases such as cancer, (d) tests to determine the child’s gender or hereditary predispositions (predictive tests) and (e) home testing kits.

**requires pre-certification by Utilization Review Provider*

How to File a Medical Claim

The provider should file your claim with the local BlueCross BlueShield (BCBS) Plan in your state, regardless of whether the provider is a participant in the BCBS PPO network. You should present your IUOE Local 399 BCBS identification card so the provider has the information required to submit your claim to BCBS. BCBS will then transmit your claim to the Plan’s claim administrator for processing. The above instructions also apply to any claims relating to mental health and substance abuse.

MEDICAL PLAN EXCLUSIONS

All Plan benefits are subject to the following exclusions. The interpretation and application of these exclusions will be at the sole discretion of the Fund. Benefits are not payable for:

1. Ambulatory surgical facility charges when the **facility is not in the preferred provider network.**
2. Services by a professional who **is not licensed by the appropriate state agencies**; any services or treatment by a professional acting outside the scope of said license; any facility that does not meet the definition of a hospital or is not sanctioned by the Joint Commission on Accreditation of Healthcare Organizations or Medicare; providers not specifically identified as covered by the Plan for the services being performed.
3. Services not directly related to the diagnosis or treatment of an illness or injury and/or any services provided when the patient **has no current symptoms**, except for those services specifically identified under Preventive Benefits; testing that is not recommended by the current U.S. Preventive Services Task Force for adults (A & B list).
4. Services, treatments and items that are **not medically necessary** for the treatment of an illness or injury.
5. Any charge, or portion of any charge, which exceeds that amount determined to be a **usual and customary** charge for the services or items provided.
6. Treatment of obesity, including obesity-related surgery unless specifically pre-certified by Utilization Review Provider. The Plan will cover **obesity surgery** if the covered person:
   - Has a body mass index (BMI) of 45 or greater and is 100 pounds or more over the medically desirable weight; and
   - Has a documented history of unsuccessful physician-directed weight loss programs; and
   - Has co-morbidities such as diabetes, heart disease or hypertension that are severe enough to be life threatening.
7. Services by a **naprapath**; naturopathic or homeopathic services and substances.
8. **Marriage counseling.**
9. **Dental** services covered under the dental plan provisions of the Plan; oral surgical procedures involving orthodontia, removal of impacted teeth, periodontal disease, implantation or preparing the mouth for the fitting of or continued use of dentures.
10. **Vision** services covered under the vision plan provisions of the Plan; LASIK surgery, radial keratotomy or other types of eye surgery done for the purpose of correcting visual acuity; vision therapy.
11. **Prescription medications** covered or excluded under the prescription drug provisions of the Plan including but not limited to stop smoking or weight loss products. Exception: The Plan will cover approved oral chemotherapy medication and immunizations. Insulin pumps and Continuous Glucose Monitors (CGM) are covered with prior-authorization.
12. **Nutritional Supplements** including but not limited to vitamins, minerals, food, food product, dietary substitutes, infant formula with or without a physician order.
13. **Hair loss** related items whether or not prescribed by a physician. Exception: The Plan will cover the purchase of one wig following chemotherapy or radiation treatment.
14. **Cosmetic surgery** unless (a) resulting from accidental injury that occurred 90 days prior to the surgery; (b) for repair of a congenital disease or anomaly that resulted from trauma, infection or other disease of the involved portion of the body; or (c) for reconstructive surgery incidental to or following surgery for any covered illness.
15. Treatment of **infertility** including but not limited to artificial insemination, in-vitro fertilization, embryo transfer, uterine embryo lavage, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer; immunotherapy for treatment of infertility; sperm harvesting and sperm freezing (cryopreservation); **reversal of sterilization** procedure.
16. Drugs, medical devices, procedures and research treatments performed for the purpose of clinical trials, or of an **experimental**/investigational nature and not generally considered acceptable as an appropriate means of treatment by the medical profession or that have not been approved by the

FDA for a specific condition or disease.

17. Care and treatment of an injury or sickness that is **occupational** and arises from work for wage or profit including self-employment for which benefits are compensable or for which settlement has been made by a worker's compensation carrier.
18. Expenses in connection with any disease or injury caused by an act of war, whether declared or undeclared; treatment of **military service-connected** disabilities for which the patient is eligible for treatment at Government expense.
19. Injury or sickness caused by or contributed to by engaging in an **illegal act** by committing or attempting to commit any crime, criminal act, assault, or other unlawful behavior or by participating in a riot or public disturbance.
20. **Custodial care**, whether provided in a hospital or other facility such as a nursing home.
21. Any service or supply **not specifically listed in this document as covered**, unless the service or supply was specifically pre-authorized by Utilization Review Provider and not excluded by any other Plan provision.
22. Any charges from a provider for only being available to a patient or only preparing to provide services to a patient, but no services to diagnose or treat a patient were directly provided (sometimes referred to as "**stand-by services"**).
23. Items used solely for **convenience**, comfort, or personal hygiene; disposable items; items that could be used for purposes other than medical care including but not limited to breast pump, air conditioners, air purification units and humidifiers, swimming pools, hot tubs or Jacuzzi; physical fitness equipment; blood pressure instruments, elastic bandages or stockings; orthopedic shoes; equipment which is free of charge from the American Cancer Society or other organizations, rental charges in excess of the purchase price; modifications to the structure of the home or vehicle; installation of equipment; repairs and/or replacement to equipment that result from misuse or abuse.
24. Physical or occupational therapy that is provided for any reason other than to restore loss or impairment of activity or to treat neurological and congenital conditions. Benefits are not payable for services by a non-licensed physical or occupational therapist, i.e., athletic trainer, massage therapist.
25. Therapy for developmental delay or learning disorders.
26. Speech therapy that is provided for any reason other than to restore loss of speech due to illness or injury or hearing loss.
27. Charges for claims received by the claims administrator more than **15 months** after the services were rendered.
28. Treatment for covered services by a professional provider when the professional provider is **related** by birth or marriage to the patient or resides in the patient's home.
29. Charges for ambulance services when the participant does not require medical attention or services during the transport; **travel** and accommodations, whether or not prescribed by a physician, except as defined as a covered expense.
30. Procedures, including surgical procedures, supplies and other services directed toward **sexual reassignment.**
31. Charges or portions of charges over the Plan's chiropractic or accupuncture individual annual maximum amount.
32. Charges for which there is no legal obligation to pay or for which you would not have been charged had there been no coverage.
33. Charges for infection control, medical waste disposal; failure to keep a scheduled visit; completion of claim forms; fees for phone calls, handling, service or late fees; services performed for educational or training purposes.

PRESCRIPTION DRUG PROGRAM

The Plan provides benefits for covered prescription drugs through a program administered by a pharmacy benefit manager, **CVS Caremark**. The program includes both a retail pharmacy network for short-term prescriptions and a mail order program for long-term prescriptions.

The prescription drug program is part of your Health and Welfare Plan, but is separate from your medical plan of benefits.

There is no calendar year deductible applied to the prescription drug benefit.

The Plan provides for two basic levels of coinsurance based on the drug prescribed for you and whether you obtain your prescriptions from the mail order facility.

Retail Pharmacy Prescription Drug Benefit

When your physician prescribes a drug you must take for 30 days or less and you use a network retail pharmacy*, the Plan will pay the following benefit for covered drugs:

- **70%** for a generic drug
- **60%** for a brand-name drug

**This Plan does not cover prescriptions filled at WalMart or Sam's Club pharmacies.*

Mail Order Prescription Drug Benefit

When your physician prescribes a drug you must take for more than 30 days or on an ongoing basis, and you use the mail order program*, you can receive up to a 90-day supply and the Plan will pay **70%** for the covered drug regardless of whether the drug is generic or brand-name.

*You can also receive a 90-day supply of certain maintenance medications at CVS retail pharmacies with the CVS90 Saver Program at the mail order benefit level.

Generic Equivalent Declined

If a brand-name drug is ordered when a generic is available and authorized by your physician, and you choose to decline the generic equivalent, the Plan will pay **50%** after you pay the difference between the cost of the brand-name drug and the generic drug.

More than 3 Fills at the Retail Pharmacy

If you continue to use a retail pharmacy after 3 short-term fills (the initial plus 2 refills) and do not use the mail order or CVS90 Saver Program, the Plan will pay **50%** of the generic or brand-name drug.

Non-Covered Prescription Drug Categories

- Non-prescription (over the counter);
- Fertility;
- Cosmetic;
- Gene Therapy;
- Weight loss; stop-smoking products, including those requiring a prescription;
- Impotency or similar categories used for sexual enhancement, e.g., Viagra;
- Vitamins; mineral or nutrient supplements;
- Charges for the administration or injection of any drug;
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual; drugs used for a purpose not approved by the FDA;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its

premises, a facility for dispensing pharmaceuticals;
- Medications used to treat conditions not payable in the Medical Plan Exclusions section.

HOW TO OBTAIN PRESCRIPTION DRUGS

Retail Purchases

- Present your CVS Caremark prescription drug card to the pharmacist with your prescription.
- The pharmacist will dispense your medication as ordered by the physician, substituting a generic drug when available and authorized by the physician.
- The maximum day supply that is covered on retail purchases is 30 days.
- If you refill an ongoing drug more than two times at the retail pharmacy, your benefit will be reduced for the next and ongoing fill of that prescription.

Mail Order Purchases

- Mail your original prescription and your Mail Order Form to:

CVS Caremark • P.O. Box 52136 • Phoenix, AZ 85072-2136

- You can receive up to a 90-day supply of drugs at a time through the mail.
- You will receive your drugs by standard postal delivery – usually within 14 business days for the first fill and between 7-10 business days for refills.
- Mail order service is generally used for long-term (over 30 days) or maintenance drugs. Most maintenance drugs are prescribed for a maximum of 12 months before you will need a new prescription from your physician.
- Refills can be obtained by calling CVS Caremark at (833) 266-8151, or by using the CVS Caremark website www.caremark.com or by mailing your refill order form to the mail service pharmacy.

CVS90 Saver Program

Maintenance drugs (medications that you take for a chronic condition) can be filled at a CVS retail pharmacy with the same benefit you currently have through the mail order process. Bring your prescription for up to 90-day fill (generally with 3 refills) to any CVS pharmacy for the same lower cost benefit you have through the mail order facility.

Specialty Drugs

CVS Caremark specialty pharmacy, **CVS Specialty**, is designed to assist individuals who have chronic and complex conditions that are being treated with specialty medications. These medications are often very expensive and require special handling. CVS Specialty has clinical experts to personally guide patients through their prescribed treatments to ensure safe, effective and timely adminisration. Education on all specialty medications offered is available, including injection teaching, proactive refill reminders and fast, free home delivery making it easy for patients to adhere to their treatments. CVS Specialty will provide review of your diagnosis, treatment protocols and potential alternate methods of treatment prior to dispensing the specialty medication being prescribed.

Note: Oral oncology drugs (chemotherapy taken in pill form) used for a specific condition or purpose approved by the FDA are a covered medical expense delivered through the **CVS Specialty** Pharmacy program.

Prior Authorization on Certain Drugs in the CVS Caremark Program

If you are prescribed or taking a medication that is on a CVS Caremark non-covered drug list, your physician can request coverage by completing a prior-authorization questionnaire specific to the excluded medication. This form will request documentation that you have tried comparable medications with unsuccessful results and/or that you have a medical condition that prevents you from taking alternate medication to the one being prescribed. You have the right to appeal a denial of coverage for medication that is on the CVS Caremark prior-authorization drug list (see Benefit Determination and Appeal Process on page 21). The prior-authorization process will also be applied to certain compounded prescription drugs.

Note: Insulin pumps and Continuous Glucose Monitors are a covered medical expense through Pharmacy prior-authorization process with CVS Caremark.

Vaccinations

Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) when provided by a registered licensed pharmacist. This includes COVID-19 vaccination.

The plan will pay 90% for any covered vaccinations (as described) that you received from a participating retail pharmacy.

If you receive a covered vaccination from a non-participating retail pharmacy, the Plan will pay 70%.

THIS AREA INTENTIONALLY BLANK

DENTAL BENEFITS

The following section describes the dental benefits provided by the Plan. Delta Dental is the claims administrator for all dental claims. Delta Dental also serves as the Plan's Dental PPO. Delta Dental will determine the extent that services and supplies are covered, based upon the following criteria:

- They are necessary and customarily employed nationwide to treat a dental related condition; or
- They are appropriate and meet professional standards of quality; or
- They are within a reasonable and customary allowance.

DENTAL BENEFIT MAXIMUMS:

Annual Maximum: $1,500 per calendar year

Orthodontic Maximum: $2,000 for orthodontic treatment rendered to a dependent child under age 19

Calendar Year Deductible: $50 per individual for Type II and Type III services

DENTAL BENEFIT LEVELS:

100%

Preventive Care (Type I) Provided by a Delta Dental PPO provider:

Including but not limited to:

- Oral examinations, twice in a calendar year
- Prophylaxis, twice in a calendar year
- X-rays - if professionally indicated
  (full mouth x-rays once in any consecutive 36-month period)
- Topical fluoride application for dependent children under age 19
- Emergency (palliative) treatment for relief of pain
- Space maintainers
- Sealants for dependent children under age 19

50%

Preventive Care (Type I) not provided by a Delta Dental PPO provider:
As defined above

Restorative (Type II) and Replacement (Type III) Services

Including but not limited to:

- Fillings; amalgams, resins, composite
- Extractions; simple, partially or fully impacted, including extractions performed in the course of orthodontia treatment
- Orthodontia (dependent children under 19)
- Endodontic treatment e.g., root canal
- Periodontic treatment e.g., osseous surgery, periodontal prophylaxis
- General anesthesia
- Consultations; examinations by a specialist
- Repair of existing dental implants or prosthodontics; recementing of crowns or bridges, occlusal adjustments, night guards for bruxism
- Crowns in the presence of disease when teeth cannot be restored with another filling material
- Bridges
- Partial and complete dentures
- Implants

Orthodontia

- All necessary procedures relating to the proper alignment of teeth, including an initial consult by the orthodontist;
- The initial payment, limited to no more than 25% of the charge for the entire orthodontia course of treatment, will be payable when the orthodontic appliance is installed;
- Subsequent payments will be made in equal intervals of 50% of the submitted fee, upon receipt of a claim, not to exceed the $2,000 lifetime maximum per eligible active covered dependent child under age 19.

Dental Plan Exclusions

- Services performed for purely cosmetic purposes; services or supplies which improve, alter, or enhance appearance;
- Services or supplies which are included as covered under the medical provisions of this Plan;
- Education or training, supplies used for personal oral hygiene or dental plaque control, dietary or nutritional counseling, infection control;
- Replacement of lost, stolen or discarded appliances; personalization of dentures;
- Duplication of dentures;
- Whitening or bleaching of teeth;
- Services by a professional provider, such as a dentist, where the professional provider is related by birth or marriage to the patient;
- Charges incurred for failure to keep a scheduled service with a dentist or hygienist; charges incurred for the completion of any forms relating to claims for Plan benefits;
- Claims received more than 15 months after services were provided.

DELTA DENTAL PPO

The Plan participates in the Delta Dental PPO program. The Plan allows you to have services by the dentist of your choice regardless of whether the general or specialty dentist is in or out of the Delta Dental PPO network.

Your benefits will be maximized if you receive care from a Delta Dental PPO dentist. The Plan provides a 100% benefit, within the calendar year maximum, for covered preventive services provided to you and your family if the dentist is in the Delta Dental PPO program. In addition, the payment to a Delta Dental PPO dentist is based on a pre-set reduced fee schedule that reduces your out-of-pocket expense for Type II & III services and orthodontia.

Removal of Impacted Teeth

The benefit for removal of fully impacted teeth will not be applied to the $1,500 individual calendar year dental maximum. Services relating to removal of fully impacted teeth will continue to be administered by Delta Dental and all other dental plan provisions will apply.

How to File a Dental Claim

The provider should file your dental claim using a standard dental claim form with clear identification of your name, The Local 399 Health and Welfare Plan, identification number and family participant who received the dental services. The Plan's Group Number with Delta Dental is 20126. Your identification number will be the same unique number that is shown on your medical identification card.

All dental claims should be mailed to:

Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

The claim should be submitted to Delta Dental of Illinois regardless of whether the general or specialist dentist participates in the Delta Dental program.

If you feel your claim has been reduced or declined erroneously, you have the right to a claim appeal as explained in the Appeal Procedure section of this book (see page 21).

VISION BENEFITS

The Plan contracts with VSP Vision Care to provide an annual eye examination, lenses, and frames every calendar year. Your benefits will be maximized if you have your vision-related services by a VSP contracted doctor.

Your benefit at a VSP provider (every calendar year)

- Eye examination after a $10 copay;
- Prescription spectacle lenses* after a $20 copay;
- Frames up to $200 allowance and 20% off the amount over the allowance (Additional $50 allowance available for VSP featured frame brands); and/or ($110 Costco® frame allowance)
- Contact lenses (instead of glasses) up to a $200 allowance for the contacts and contact lens exam (fitting and evaluation).

* *Limited to single vision and lined bifocal/trifocal lenses*

Your benefit at a non-VSP provider (every calendar year)

A total allowance of up to $150 (less copays) is available every calendar year if you choose a non-VSP provider. This allowance can be applied toward an exam, lenses, frames and contact lenses but will not duplicate the benefit you may receive from a VSP provider.

How to Use the VSP Plan

- Select a doctor of your choice from the VSP contracted providers. You can locate a VSP provider by calling VSP at (800) 877-7195 or go to www.vsp.com and register as a member.

- When you call the VSP provider, state that you are a VSP member and provide the office with your alternate identification number (found on your BCBS or CVS Caremark card). After your examination, your VSP provider will itemize your balance due, including copays.

Non-VSP Provider Reimbursement

- If you choose to go to a non-VSP provider, you are responsible for the non-VSP provider's full charges. VSP will reimburse your covered expenses at 80% up to $150 per calendar year (less copays).

- Download and complete an out-of-network claim form from Local 399's website (www.iuoe399.org) or the VSP website (www.vsp.com) or call VSP at (800) 877-7195 or the Fund Office to obtain this form. Attach your itemized bill and mail to VSP, P. O. Box 495918 • Cincinnati, OH 45249-5918 within six months of your services. Use your H&W Plan alternate ID number when completing this form. Complete one claim form for each member of your family.

Non-Covered Vision Services and Supplies

- Over-the-counter lenses, frames, sunglasses or supplies; or
- Services provided without a prescription from a vision related provider; or
- Services covered under the medical portion of this Plan; or
- Charges for services provided by Wal-Mart or Sam's Club.

BENEFIT DETERMINATION AND APPEAL PROCESS

Your claims will be paid as quickly and as accurately as possible. Accurate information is required on all claims before your benefit payments can be determined. Instructions for filing claims is listed in each benefit category on preceding pages.

As provided by Federal legislation, participants are entitled to notification of the Local 399 Health and Welfare Plan determination regarding an application for benefits as follows:

Urgent claims

Participants are entitled to benefit notification no later than 72 hours after receipt of the claim by the Plan, unless the participant (or their authorized representative) fails to provide sufficient information to determine whether, or to what extent, services are covered or payable under the Plan. An adverse benefit notification may be provided orally within the timeframe specified, with written notification to be furnished no later than 3 days after the oral notification.

Pre-service claims

Participants are entitled to benefit notification no later than 15 days after receipt of the claim by the Plan. If necessary, the Plan may extend this an additional 15 days, provided the participant is notified of the need and reason for the extension to make a claim determination*:

*If information is needed from the participant to make a benefit determination, the participant must be given 45 days from receipt of the notice within which to provide the needed information. A written adverse benefit notification will be furnished to the participant within the timeframes specified.

Post-service claims

Participants are entitled to benefit notification no later than 30 days after receipt of the claim by the Plan. If necessary, the Plan may extend this an additional 15 days, provided the participant is notified of the need and reason for the extension to make a claim determination*.

*If information is needed from the participant to make a benefit determination, the participant must be given 45 days from receipt of the notice within which to provide the needed information. A written adverse benefit notification will be furnished to the participant within the time frames specified.

Adverse Benefit Determination

When the Plan denies a claim in full or in part, the Participant will receive an explanation as to why the claim was denied, You have the right to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules as described in the following section, Appeal Procedure.

If an appeal involves a medical judgment, such as whether treatment is medically necessary, the Board of Trustees will consider the opinion of a medical professional who is qualified to render an opinion on the issue, and who was not the same professional (or a subordinate of that person) for purposes of the appeal.

Notwithstanding any provisions of the Plan to the contrary, the Fund Administrator of the Plan or the Board of Trustees, in its sole discretion, may make exceptions to the coverage and limitations set forth in this Plan in a particular case where (1) the exception permits a covered person to receive coverage for services that are not covered but have expected medical or therapeutic benefits of covered services; and (2) the expected cost to the Plan of expanded coverage permitted by the exception is less than the expected cost to the Plan if the covered person obtains services that are covered by the Plan.

APPEAL PROCEDURE

If you feel your claim for benefits was reduced or denied erroneously, or your participation from the Plan was declined or terminated erroneously, and believe you can show just cause why your case should be reconsidered, you have the right to appeal.

Urgent Care

If you feel your claim for urgent care was denied erroneously, you have the right to an expedited appeal process. You and/or your authorized representative may submit your appeal by phone, fax, or if you prefer, by U.S. mail. You must request a review of your case, detailing the circumstances involved which you feel have a direct impact on your case and should be evaluated during the review. You must include all information supporting your case, such as any pertinent documents (e.g. medical records) and any events, listed chronologically. Your appeal will be reviewed by the Board of Trustees. We will advise you of the outcome of your appeal within 72 hours from receipt of your appeal.

Non-Urgent Care

To begin the appeal procedure (for non-urgent) claim denials or reductions or Plan participation terminations, you or your authorized representative must write a letter to the Board of Trustees and mail it to:

IUOE Local 399 Health and Welfare Fund
Attn: Fund Administrator
2260 S. Grove Street
Chicago, IL 60616-1823

In the letter, you must request a review of your case, detailing the circumstances involved which you feel have a direct impact on your case and should be evaluated during the review. You must include all information supporting your case, such as any pertinent documents (e.g. medical records) and any events, listed chronologically. Your request must be received within 180 days from the date you receive notice that your claim was reduced or denied or participation terminated.

You and/or your authorized representative, may request to appear in person before the Board of Trustees. If the Trustees grant your request, any costs incurred for you or your representative's appearance must be at your expense.

Your appeal will be reviewed by the Board of Trustees or a Review Committee of the Board of Trustees. For appeals of pre-service claims, the Board of Trustees will make a decision regarding your case within 30 days after receipt of your request for review. For appeals of post-service claims or Plan participation terminations, the Board of Trustees will make a decision regarding your case within 60 days after receipt of your request for review. The decision of the Board of Trustees shall be final and binding on the parties in all matters.

In deciding your appeal, the Board of Trustees will consider all written comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial.

You will be notified by letter of the Board of Trustees' decision, which will describe the specific reasons for the decision. If after appeal, you still feel your claim for benefits was wrongfully reduced or denied, or your participation terminated erroneously, you are free to pursue remedies available under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). Any lawsuit must be filed within 6 months from the month of the Plan's notification that your appeal or claim has been denied.

COORDINATION OF BENEFITS (COB)

The Plan's coordination of benefits provision is intended to avoid duplication of covered benefits when a person is covered by two or more insurance plans. When the Plan coordinates its benefits, it means the Plan and the other insurance plan work together in providing their combined benefits so that the total benefit payments do not exceed the actual medical charges.

One of the plans involved will pay benefits first – that plan is primary. The other plan will pay benefits next – that plan is secondary. If this Plan is primary, it will pay benefits as if it were the only plan involved. Benefits under this Plan will not be reduced because benefits are payable under the other plans. If this Plan is secondary, the benefits it pays will be reduced because of benefits paid by another primary plan.

In most cases, this Plan will be the primary plan for you, the participant. However, it is important that you notify the Fund Office or the Claims Administrator immediately if you have another group coverage with another employer or if your spouse or eligible dependent children:

- have another insurance plan available to them; or
- drop or terminate medical and/or dental coverage with another plan; or
- change insurance plans.

This applies to both medical and dental benefit plans. The Fund Office and the Claims Administrator reserve the right to request coordination of benefits (COB) information from you on a periodic basis.

There is no coordination of benefits (COB) provision applicable to the prescription drug program or the vision care program.

WHICH GROUP PLAN IS PRIMARY?

There are rules to determine which plan is primary and which plan is secondary when benefits are payable under more than one plan.

- The plan that has no coordination of benefits provision will be primary to a plan that has a coordination of benefits provision.
- The plan that covers the person as other than a dependent (e.g., as an employee, a member, subscriber, retiree) is primary, and the plan that covers the person as a dependent is secondary provided the other plan has the same rule.
- The plan that covers the member (or as that member's dependent) as an actively working employee is primary, and the plan that covers the member as an inactive (laid off, terminated, retired, etc.) is secondary.
- If a husband and wife are covered under this Plan both as a member and as a dependent, benefits will be paid on behalf of each member as if there were two separate plans applying the order of benefit rules in this section.
- The plan covering the person as an employee, participant or subscriber or as that person's dependent will be primary to the plan covering the person under COBRA continuation coverage.
- If the parents are married or living together and their child is covered as a dependent under two plans, the plan of the parent who has the earlier birthday in a calendar year will be primary to the plan of the parent whose birthday is later in the calendar year. (Year of birth does not apply.) This is known as the birthday rule.
- If the birthday rule above would apply except that the other plan does not have the same rule based on birthday, then the other plan is primary.
- If the child is covered as a dependent under two or more plans of divorced or legally separated parents, the rule that applies depends upon whether there is a court order giving one parent financial

responsibility for the medical and/or dental coverage of the dependent child. A Qualified Medical Child Support Order (QMCSO) or divorce decree/court order will override all other provisions.

- If there is no QMCSO, the plan of the parent with custody of the child will be primary to the plan of the parent without custody of the child; if the natural parent with custody is married, the plan of the step-parent with custody will be primary to the plan of the parent without custody.
- If a determination of which plan is primary cannot be made by any of the above rules, then the plan which has covered the person for the longest time will be primary.

WHEN IS MEDICARE PRIMARY?

If a participant or a dependent is also eligible for Medicare, Medicare's rules determine whether the Plan or Medicare is the primary coverage. The following is a brief summary of those rules:

- The Plan is primary while the person is actively employed and rendering compensated service; or
- Medicare is primary during any period when the person is still covered under the Plan but the person is not actively employed; or
- If eligible for Medicare due to end stage renal disease, this Plan is primary during the first 30 months of Medicare eligibility. After 30 months, Medicare is primary.

OTHER COB INFORMATION

If the total payments made by the Plan are more than should have been paid under this provision, the Plan will have the right to recover the excess, from any of the persons it has paid or for whom it has paid, or from insurance companies or other organizations.

The Plan reserves the right to suspend benefit payments for you and your dependents' claims if you do not disclose relevant information that would enable the Fund Office or the claims administrator to determine the correct order of benefits in accordance with this provision.

If this Plan is secondary on a covered person's claim under its order of benefit determination rules, but the person's primary plan has a rule allowing it to pay less than its normal benefits when there is secondary coverage, without regard to whether the lesser benefits are payable under the terms of sub-plan or wrap-around provision, then such person will be deemed covered under this Plan's sub-plan. The maximum payable by this Plan for all claims incurred by a person covered under the sub-plan is $1,000 per calendar year, or, if less, the amount payable after application of this Plan's coordination of benefits rules.

If the primary plan has a no-loss provision, and if the sum of the primary plan's sub-plan benefits, plus this Plan's sub-plan benefits, plus any additional benefits payable by the primary plan's regular benefit plan under its no-loss provision, is less than the sum of the benefits otherwise payable under this Plan's regular benefit plan, then this Plan's regular benefit plan will pay the difference.

If the primary plan pays its normal benefits for the person's claim, that is, the benefits it would have paid if the person was not also covered under this Plan, then the person will be deemed covered under this Plan's regular benefit plan, and this Plan will coordinate its regular benefits as the secondary payer to the other plan.

SUBROGATION, REIMBURSEMENT AND THIRD PARTY RECOVERY PROVISION

The Plan is not obligated to pay benefits or claims where a third party is liable for the injury that resulted in the claim for benefits. The Plan may withhold payment of benefits in connection with accidental injuries when any party other than the covered person or this Plan may be liable for expenses, until the liability is legally determined.

The Plan, in its sole discretion, may make payment of benefits before a finding of liability is made, subject to the agreement of the covered person and his or her counsel, if any, to hold any proceeds of litigation, settlement or judgment in trust for the Fund and to acknowledge that the proceeds are a Plan asset. Payment of benefits is conditioned upon receipt of a Subrogation and Constructive Trust Agreement signed by the covered person and his or her legal representative. For any payment for services under this Plan, the Fund will be subrogated to all the rights of recovery of the covered person and will be entitled to immediate payment of amounts due before any distribution to or on behalf of the covered person. The covered person will be required to reimburse this Fund for any and all benefits paid under this Plan out of any monies recovered as a result of judgment, settlement or any other claim or demand for payment in favor of the covered person regardless of whether the covered person or dependent has been made whole.

The Subrogation and Constructive Trust Agreement must be signed and returned to Elite Administration & Insurance Group before bills can be processed. It is a document written by the Trustees as an eligibility requirement for benefits and is a contractual promise to reimburse the Fund.

After any monies recovered are received by the covered person or the covered person's legal representative, the monies recovered will become an asset of the Fund. The covered person and the legal representative will hold the monies recovered as a result of judgment, settlement, or any other cause in trust for the Fund. The Fund is entitled to payment in full, without any offset for attorney's fees, of 100% of benefits paid, whether or not the covered person or participant is made whole. The Plan is a self-insured employee benefit plan governed by ERISA 29 USCA 1001 et seq. The covered person acknowledges that the Plan does not recognize and is not subject to the Illinois common fund doctrine or any equitable doctrine or state statute which automatically reduces the amount owed to the Plan.

The Trustees may, in their sole discretion, compromise the amount due under this provision when, in their judgment the compromise is more likely to result in a higher recovery for the Fund than if no compromise were made.

The covered person must take such action, furnish information and assistance, execute and deliver all necessary instruments as the Fund may require to facilitate the enforcement of its rights. If the covered person fails to cooperate with the Fund in the enforcement of its rights, the Fund may suspend payment of all Plan benefits subject to subrogation, enforce its right to restitution of amounts paid and to equitable enforcement of the medical plan, and seek legal or equitable relief of which it is entitled. In addition, if the covered person fails to cooperate with the Fund in the enforcement of its rights, the Fund may offset all present and future payments due to the covered person under the medical plan against amounts paid pursuant to the Agreement.

The Plan has the right to recover against any proceeds from other sources received in connection with the accident or injury, including, but not limited to, unisured or underinsured policy of insurance that apply to the covered person.

If a covered person takes no action to recover any money from any source, the Trustees may initiate a direct action for recovery of benefits paid. If the Trustees take such action, they will be allowed to retain the amount of benefits paid as well as attorney's fees and costs incurred from any settlement or judgment award by the court or paid by a third party in satisfaction of the claim.

Offset

In the event any payment is made by the Plan to or on behalf of an individual who is not entitled to such payment or to the full amount of such payment, the Trustees have the right to take such action as they deem appropriate to recover such payment, including but not limited to the right to reduce future payments due to or on behalf of such person by the amount of any erroneous payment. This right of offset will not limit the rights of the Plan to recover such erroneous payments in any other manner.

THIS AREA INTENTIONALLY BLANK

COBRA CONTINUATION COVERAGE

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The Plan Administrator is the International Union of Operating Engineers Local 399 Health and Welfare Trust at 2260 S. Grove Street, Chicago, IL 60616-1823, (312) 372-9870. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA continuation coverage is a continuation of medical, prescription drug, vision, and dental coverage that would otherwise end because of a qualifying event. COBRA continuation coverage is offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, participants, spouses of participants, and dependent children of participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a covered person, you become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events occurs:

- Your hours of employment are reduced so that your eligibility terminates; or
- You have a loss of coverage due to provisions in the Agreement with the employer regarding a leave of absence or FMLA; or
- Your employment or coverage ends for any reason other than your gross misconduct.

If you are the spouse of a covered person, you become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:

- Your spouse dies; or
- Your spouse's hours of employment are so reduced that eligibility terminates; or
- Your spouse loses coverage due to provisions in the collective bargaining agreement regarding extension of employer contribution in the event of a medical leave or FMLA; or
- Your spouse's employment or coverage ends for any reason other than gross misconduct; or
- You become divorced from your spouse.

Dependent children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- The participant dies; or
- The participant's hours of employment are so reduced that eligibility terminates; or
- The participant's employment or coverage ends for any reason other than gross misconduct; or
- The participant becomes divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the participant, the employer must notify the Plan Administrator of the qualifying event within 60 days. Information will be sent to the participant, or family, if applicable, regarding the option to enroll in COBRA continuation coverage.

For the other qualifying events (divorce of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you, the spouse or the dependent child must notify the Fund Office within 60 days after the qualifying event occurs. You must send this notice to the COBRA Coordinator. You, the spouse or the dependent child must send this notice to:

COBRA Coordinator
International Union of Operating Engineers
Local 399 Health & Welfare Fund
2260 S. Grove Street
Chicago, IL 60616-1823
(312) 372-9870

Failure to provide notification to the Fund Office within 60 days of loss of dependent coverage will result in the loss of rights to elect COBRA continuation coverage.

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event; or on the date that Plan coverage would otherwise have been lost.

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

When the event is the expiration of the participant's coverage due to termination or reduced hours, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as described in the next section.

If you become covered by Medicare while you are an active employee and you later experience a qualifying event (for example, you experience a reduction in your hours or you retire), your dependents may be eligible for continued coverage until the later of:

- 36 months from the date you first became covered by Medicare while an active employee; or
- The maximum coverage period for the qualifying event (18 months in the case of termination of coverage due to retirement).

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If the Social Security Administration determines that you or any of your covered family members are disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Fund Office in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

You must make sure that the Fund Office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must provide a copy of the Social Security Administration's determination to the COBRA Coordinator (see address above).

You must also notify the Fund Office within 30 days of the date the Social Security Administration determines that you are no longer disabled.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If your family experiences another qualifying event while covered under an 18-month COBRA continuation period, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. The extension is available to the spouse and dependent children if the former participant dies, or gets divorced. The extension also is available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA Coordinator (see page 26). If you do not notify the Fund Office within 60 days of one of these events, you forfeit your COBRA rights. Verbal notice is not binding until you confirm it in writing.

If a child is born to you (the covered person), adopted by you or placed with you for adoption during the first 18-month continuation period, that child will have the same election rights when a second qualifying event occurs as a person who was your dependent on the day before the first qualifying event.

Election Period

Both you and the Fund have responsibilities if qualifying events occur that make you and your covered dependents eligible for COBRA continued coverage.

When you notify the Fund Office that a qualifying event has occurred, the Fund Office will give you and/or your qualified beneficiary an election form to complete. The election form explains a qualified beneficiary's right to continued coverage under COBRA.

You and your covered dependents have 60 days in which to elect COBRA continued coverage, beginning on the later of the date:

- Your coverage terminates because of the qualifying event; or
- You or your covered dependents are notified of the right to elect COBRA continued coverage.

You have 45 days from the date you elect continuation coverage to pay your initial COBRA premium.

Type of Coverage

While you are receiving COBRA continuation coverage, your medical, prescription drug, dental and vision benefits under COBRA will remain the same as the applicable benefits offered to similarly situated active employees, including any changes that are made to the Plan. Weekly disability income, unless the disability income benefit began while actively employed, life insurance and AD&D benefits are not continuing coverages through COBRA.

Cost of COBRA Continued Coverage

In most cases, you and your covered dependents will be required to pay 102% of the full group cost for COBRA continued coverage. If you or a qualified beneficiary are eligible for extended COBRA coverage due to disability (as determined by the Social Security Administration), you or your qualified beneficiary will pay 150% of the full group cost for COBRA continued coverage from the 19th through the 29th month of coverage.

You must pay for coverage in monthly installments, and you must make your first payment no later than 45 days after the date you elect to continue coverage. Subsequent payments will be due on the first of each month, with a 30-day grace period. Contribution rates are effective each January 1st for the following 12-month period. If the cost of these benefits for active employees changes in the future, these cost changes may affect the cost of your COBRA continuation coverage. You will be notified in advance of any changes in the cost of coverage.

Early Termination of COBRA Continued Coverage

Your right to purchase COBRA continued group coverage may end before the expiration of the maximum coverage period if:

- The required premium is not paid on time; or
- The Fund terminates the Plan for all employees; or
- You or your covered dependent(s) become entitled to Medicare (except that if a covered person becomes entitled to Medicare, covered family members may continue COBRA coverage for up to the maximum time period allowable); or
- You or your covered dependent(s) become covered under another group health plan (as an employee or otherwise).

COBRA continuation coverage may also be terminated for any other reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA continuation coverage (such as fraud).

Important Information for Dependents

The spouse and dependent child have independent rights to elect COBRA continuation coverage during the Election Period if the member loses coverage.

A dependent losing eligibility under this Plan can notify the Plan Administrator within 60 days of the loss of dependent status, i.e., divorce, or reaching maximum age as a dependent child. Failure to notify the Plan Administrator in writing within 60 days of becoming an ineligible dependent will result in loss of rights to elect COBRA continuation coverage.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through:

- The Health Insurance Marketplace (or insurance exchange)*; or
- Other group plan coverage options (such as a spouse's plan) through what is called a "special enrollment period"; or
- Medicaid or Medicare.

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

*In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

Questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to:

IUOE • Local 399 Health & Welfare Trust Fund (Plan Administrator)
Attn: COBRA Coordinator
2260 S. Grove Street, Chicago, IL 60616-1823
(312) 372-9870 - H&W Option #3

Keep your Plan Administrator Informed of Address Change

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

MISCELLANEOUS INFORMATION

Affect of Medicare on the Plan

When you reach age 65 you will become eligible for Medicare due to your age. (You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease.)

If you or your spouse become eligible for Medicare and you remain actively employed and render compensated services, generally this Plan will be unaffected.

It is important that you or your spouse contact the Social Security Administration to enroll for and accept Medicare Part A insurance three months prior to your 65th birthday. There is no premium for Part A Medicare. It is your choice as to whether you enroll in Medicare Part B insurance or Medicare Plan D prescription coverage while you are covered under this Plan. There is a premium for Medicare Part B and for Medicare Plan D. If you delay enrollment in Part B or Plan D Medicare while you are actively working, you may enroll in Part B or Plan D when you retire. You should contact the Social Security Administration before you retire for further information.

If you or your spouse are age 65, you have the option to decline coverage under this Plan and have Medicare be the primary carrier. If you are actively working and elect this option, you should contact the Fund so that the appropriate declination form can be completed.

See the Coordination of Benefits (COB) Section for additional information (see page 23).

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a type of court order, usually issued as part of a divorce decree, that provides benefit coverage for the child of a participant. The court order usually identifies the child as an “alternate recipient” who will be recognized in his or her own rights when receiving Plan benefits for information regarding the Plan.

Upon receipt of a QMCSO, the Fund will notify both the participant and each alternate recipient of the receipt of the order and whether the order is determined to be “qualified.” If requested, the Fund will furnish an explanation of the Plan’s procedures for making this determination of “qualification.”

The alternate recipient, or court designated custodian thereof, named in a qualified QMCSO will be considered a participant under the Plan for all reporting and disclosure provisions of ERISA and notification requirements of COBRA.

The Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996

This Act states that pre-certification cannot be required by a medical plan unless the admission for childbirth extends past 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, this Act 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).

Women’s Health and Cancer Rights Act (WHCRA) of 1998

The Women's Health and Cancer Rights Act was signed into law to provide greater benefits and safeguard the rights of breast cancer patients. This law includes important protections for mastectomy patients who elect breast reconstruction in connection with a mastectomy.

The Plan provides coverage for services delivered in connection with a mastectomy. Specifically, for a person who elects breast reconstruction following a mastectomy, the Plan will cover:

- Medically necessary reconstruction of the breast on which the mastectomy has been performed; or
- Medically necessary surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

Trustee Authority and Right

Under the Trust Agreement creating the Health and Welfare Fund and under the Plan of Benefits, the Trustees or persons acting for them, such as a claim review committee, have sole authority to make final determinations regarding any application for benefits. The Trustees also have sole authority over the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if the Board of Trustees or persons delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to trust that the Trustees' decision is to be upheld unless it is determined to be arbitrary or capricious.

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them. The Trustees have the authority to increase, decrease or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted you under the Plan are legally enforceable.

DEFINITIONS

When the following terms are used in this booklet, these definitions, as interpreted and applied in the sole discretion of the Fund, apply:

ALTERNATE RECIPIENT: Any child of a participant who is recognized under a medical child support order or National Medical Support Notice as having a right to enrollment under a group health plan with respect to such participant.

AMBULATORY SURGICAL CENTER: A specialized facility operated under the supervision of a licensed physician and established and equipped to operate, and operates, in accordance with applicable laws in the area it is located. The Center must maintain a written agreement with at least one area hospital to immediately accept patients who develop complications or require post-operative confinement. Note: Ambulatory surgical centers that are not in the preferred provider network are **excluded** under this Plan.

AUTHORIZED REPRESENTATIVE: A person designated by a participant to act on behalf of the participant. The Fund shall have final authority to determine if an individual qualifies as an authorized representative.

CALENDAR YEAR: A period of one year beginning January 1st and ending December 31st.

CARDIAC REHABILITATION: A comprehensive exercise, education and behavioral modification program designed to improve the physical and emotional condition of patients with heart disease.

CLAIM: A request for a plan benefit or benefits, made by a participant (or the participant's authorized representative) that complies with the Plan's procedure for making benefit claims, including a request for benefit reimbursement for services rendered, for pre-certification or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

- **Urgent claim:** A claim for medical care or treatment that, if normal pre-service standards are applied, would seriously jeopardize the life or health of the participant, or the ability of the participant to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, subject the participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.
- **Pre-service claim:** Any claim for a benefit for which the Plan requires pre-certification.
- **Post-service claim:** Any claim for benefits for which services have already been rendered.

CLAIMS ADMINISTRATOR: The company that, pursuant to a contractual agreement with the Board of Trustees, acts as an external administrator, provides claims processing services, handles coordination of benefits, and provides services in connection with subrogation, utilization management and complaint resolution assistance.

The claims administrator for medical and disability income claims is Elite Administration, 1300 W. Higgins Road, Suite 208, Park Ridge, IL 60068.

The claims administrator for dental claims is Delta Dental of Illinois, P.O. Box 5402, Lisle, IL 60532.

The claims administrator for vision claims is VSP, P.O. Box 495918, Cincinnati, OH 45249-5918.

COBRA CONTRIBUTION: That monthly amount determined by the Fund which non-active and terminated participant and/or their dependents must pay to maintain COBRA continuation coverage.

CO-INSURANCE: The percentage a participant pays for covered services after the deductible or co-payment (if applicable) has been applied.

COSMETIC: Those procedures or services that affect appearance only, or which are performed for a purely superficial benefit.

COSMETIC SURGERY: An elective surgical procedure that is performed to reshape normal structures of the body in order to improve the body's appearance. Commonly performed cosmetic surgery includes face lifts, breast enlargement and liposuction.

CUSTODIAL CARE: The type of care which takes place at that time when a participant is not under a specific therapeutic program that has a reasonable expectancy of effecting improvement in the participant's condition within a reasonable period of time and which does not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed.

DEDUCTIBLE: The amount of covered charges incurred by a participant which must be paid by the participant before Plan benefits are payable.

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

EMERGENCY: An accident or a sudden, unexpected medical condition that, without immediate medical attention, could result in death, impairment of bodily functions, or other serious and permanent medical consequences.

ERISA: Employee Retirement Income Security Act of 1974. ERISA creates certain rights for Plan participants and imposes duties upon the people who are responsible for the operation of the Plan.

EXPERIMENTAL, INVESTIGATIONAL, AND UNPROVEN SERVICES: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by the Fund (at the time it makes a determination regarding coverage in a particular case) to be: (1) Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the American Medical Association Drug Evaluations as appropriate for the proposed use, or (2) subject to review and approval by an Institutional Review Board for the proposed use, or (3) the subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed. The Fund reserves the right to make final judgment regarding coverage of experimental, investigational and unproven procedures and treatments.

FDA (Food and Drug Administration): A consumer protection agency whose mission is to promote and protect the public health by helping safe and effective products (including medicines and medical devices) reach the market and monitoring products for continued safety after they are in use.

FIDUCIARY: Those persons or entities who exercise discretionary control or authority over plan management or plan assets, have discretionary authority or responsibility for the administration of a plan, or provide investment advice to a plan for compensation or have any authority or responsibility to do so. The primary responsibility of fiduciaries is to run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses.

FUND OFFICE: International Union of Operating Engineers Local 399 Health & Welfare Trust, 2260 S. Grove Street, Chicago, IL 60616-1823

FUND ADMINISTRATOR: The person the Board of Trustees has delegated certain responsibilities for the Plan's day-to-day operations.

HOME HEALTH CARE AGENCY: A public or private agency which specializes in giving nursing or therapeutic services in the home; is licensed or certified as a Home Health Care Agency; and operates within the scope of its license.

HOSPICE AGENCY: A public or private agency, specializing in care for the terminally ill and their families; that is licensed and operates within the scope of their license.

HOSPITAL: An institution that holds a license as a hospital (if required in the state in which it is located); is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patients expense; and is accredited as a hospital by the Joint Commission, a recepient of National Integrated Accreditation for Healthcare Organization (NIAHO) accreditation through Det Norske Veritas Healthcare, Inc. (DNVHC); or an approved provider with the Centers for Medicine and Medicaid Services (CMS).

BOARD OF TRUSTEES: A governing body of members comprised of a Chairman, employer representatives, and members appointed by Local 399 as union representatives.

LICENSED SUBSTANCE ABUSE PROFESSIONAL: A psychiatrist (MD), a psychologist (Ph.D), a licensed clinical social worker (LCSW), and a certified addictions counselor (CAC) credentialed and licensed by the state.

LICENSED MEDICAL PROFESSIONAL: A medical physician (MD, DO), a podiatrist (DPM); an optometrist (OD) when treating an acute medical (sudden onset) condition; a chiropractor (DC) acting within the scope of their license; a nurse practitioner (NP), physician assistant (PA), and certified registered nurse anesthetist (CRNA) acting within the scope of their license and under the direction of a medical physician.

LICENSED MENTAL HEALTH PROFESSIONAL: A psychiatrist (MD), a psychologist (PhD, Psy.D.), a licensed clinical social worker (LCSW or equivalent), a licensed clinical professional counselor (LCPC or equivalent), a licensed clinical marriage and family therapist (LMFT or equivalent), and licensed clinicians with Masters' degrees or better.

LICENSED SURGEON: A medical physician (MD or DO) who is licensed to practice surgery and a podiatrist (DPM) or an oral and maxillofacial surgeon (OMD, DMD) who is performing surgery within the scope of his license.

MEDICALLY NECESSARY: Those health services which are determined by the Trustees, based on the opinion of a qualified medical professional, to be medically appropriate according to the standards of good medical practice and is (1) necessary to meet the basic needs of the participant; (2) rendered in the cost-efficient manner to meet the participant's essential health needs and in the type of setting appropriate for the delivery of health services*; (3) consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research and health care coverage organizations and government agencies that are accepted by the Trustees; (4) consistent with the symptoms or diagnosis and treatment of the participant's condition; (5) required for reasons other than the comfort or convenience of the participant, the physician or hospital; and (6) is not experimental or investigative.

**When more than one alternative is available that can meet the participant's health needs, the cost of the most cost-effective will be covered.*

OUT-OF-POCKET: The coinsurance amounts which you pay for health care services covered under the Plan during a calendar year. Note: The annual out-of-pocket maximum in this Plan applies to charges incurred by a network provider.

PARTICIPANT: Any member or dependent currently covered by the Plan who qualified for coverage by virtue of the member's past or current employment status and/or his or her past or current status.

PARTICIPATING PROVIDER: A hospital or professional provider which has a written agreement with the Plan's preferred provider organization to provide services to participants, with economic incentives for using designated providers of health care services.

PLAN: Refers to the benefits and provisions for payment of same as described herein. The Plan is the International Union of Operating Engineers Local 399 Health and Welfare Plan.

PLAN ADMINISTRATOR: International Union of Operating Engineers Local 399 Health & Welfare Trust, 2260 S. Grove Street, Chicago, IL 60616-1823.

PPO (Preferred Provider Organization): A network of doctors, hospitals and/or dentists that has agreed to accept a discounted fee for their services from the Plan.

PRE-CERTIFICATION: Obtaining approval for certain services before the services are rendered.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO): A court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding, that requires a plan to cover a participant's non-dependent child under the Plan.

REASONABLE CHARGES: An amount established by the Plan, in its sole discretion, to be a fair and appropriate charge for the services provided. In determining reasonable charges, the Plan considers the actual charges of providers for identical or similar services and items provided in the same or similar general locality. Reasonable charges for preferred providers refers to the amount the provider agrees to charge the Plan for services to covered participants.

SUBROGATION: The right of the Plan to recover from a third party the amount the Plan paid in benefits.

THERAPEUTIC: Treatment of, for, or contributing to the cure, or to halt the progression, of disease or impaired physical function.

NOTICE OF PRIVACY PRACTICES

The Plan is in compliance with all applicable provisions of the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and the U.S. Department of Health and Human Services (HHS) regulations thereunder (the "HIPAA Privacy Rules"). This section describes how medical information about you may be used and disclosed under the requirements of the HIPAA. Further, this notice tells you how you can get access to your personal health information (PHI).

The following is a **summary** of the Plan's privacy rules and procedures:

You have the right to:

- Get a copy of your health and claims records
- Correct your health claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Choose someone to act for you
- Choose the way we use and share information as we answer coverage questions from your family and/or friends
- File a complaint if you believe your privacy rights have been violated

The Plan may use and share your information as we:

- Help manage the health care treatment you receive
- Run our Fund Office
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Comply with the law

The Plan will not disclose your PHI other than described above without your authorization. (Note that genetic information is PHI and will also be protected.)

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

You have the right to request and receive a paper copy of the Plan's full Notice of Privacy Practices at any time. To obtain a paper copy or electronic copy, contact the Health & Welfare Fund Office. You may also download the notice from Local 399's website: www.iuoe399.org.

ERISA RIGHTS

As a participant in the IUOE Local 399 Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may impose 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.
- A complete list of the employers sponsoring the Fund may be obtained by participants, covered dependents and beneficiaries upon written request to the Board of Trustees and is available for examination by participants, covered dependents and beneficiaries, as required by Department of Labor regulations 29 C.F.R. Sections 2520.104b-1 and 2520.104b-30. Participants and beneficiaries may also receive from the Board of Trustees, upon written request, information as to whether a particular employer or employee association is a sponsor of the Plan and, if the employer is a Plan sponsor, the sponsor's address.
- Because this Plan is maintained pursuant to collective bargaining agreements, a copy of any agreement under which this Plan is maintained may be obtained by participants, covered dependents and beneficiaries upon written request to the Board of Trustees and is also available for examination by participants, covered dependents and beneficiaries upon written request to the Board of Trustees and is also available for examination by participants, covered dependents and beneficiaries in accordance with Department of Labor regulations 29 C.F.R. Sections 2520.104b-1 and 2520.104b-30. This right includes a "superseded" collective bargaining agreement if such agreement controls any duties, rights or benefits under the Plan.
- The names of the union trustees, the employer trustees and the designated Benefit Fund Administrator are available in this document.

Continue Group Health Plan Coverage

In certain cases, you can 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 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the 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 (EBSA). You may find answers to your questions and list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material

You can read the material listed above by making an appointment at the Fund Office during normal business hours. This same information can be made available for your examination at certain locations other than the Fund Office. The Fund Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also copies of the material will be mailed to you if you send a written request to the Fund Office. There may be a small charge for copying some of the material. Call the Fund Office to find out the cost. If a charge is made, your check must be attached to your written request for the material.

Required Notice: Notice Regarding Grandfathered Status

The Trustees of the IUOE Local 399 Health and Welfare Plan have determined that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to cover preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Local 399 Health and Welfare Plan, 2260 S. Grove Street, Chicago, IL 60616-1823, telephone (312) 372-9870, fax (312) 842-0291. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ADDITIONAL INFORMATION

Name, Address and Phone Number of the Plan Administrator

International Union of Operating Engineers Local 399 Health & Welfare Trust
2260 S. Grove Street
Chicago, IL 60616-1823
Phone: (312) 372-9870 • Fax (312) 842-0291

Note: It is often referred to in this booklet as the "Local 399 Health and Welfare Plan", the "Plan", "IUOE Local 399 Health and Welfare Fund" or the "Fund".

Agent for Legal Process

Johnson & Krol
311 S. Wacker Drive • Ste 1050
Chicago, IL 60606-6604

Service of legal process may also be made upon any Trustee of the Board. Note: The Fund's Legal Counsel advises the Trustees about what must be done to assure that all operations of the Fund comply with Federal and state laws.

Employer Identification Number: 36-6198426 **Plan Number:** 501

Plan Type

The International Union of Operating Engineers, Local 399 Health and Welfare Trust is classified as a welfare benefit plan, providing benefits of the type described below.

The Fund provides medical, surgical, hospital, prescription drug, dental, vision and disability benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant, beneficiary or service provider. The self-insured benefits payable by the Fund are limited to the Fund assets available for such purposes.

Cost of Plan Administration

The Plan is not an insurance policy and no benefits other than the life insurance and accidental death and dismemberment insurance are insured.

Plan Year

The financial records of this Plan are based on a fiscal year which begins June 1st and ends May 31st.

Source of Contributions and Funding

Employer contributions and COBRA contributions are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses. The Fund may also receive fees from its prescription benefits manager.

Plan Details

The Plan's provisions relating to eligibility to participate and termination of eligibility as well as a description of the benefits provided by the Plan are described in more detail in the Plan Document.

The Union that founded the Board of Trustees and that appoints the Union members of the Board of Trustees is the International Union of Operating Engineers Local 399. Employers who are bound by the Trust Agreement also appoint Trustees to represent all employers on the Board of Trustees.

Plan Termination

The Fund reserves the right at any time and for any reason to change, amend, interpret, modify, withdraw or add benefits, or terminate this Plan or the Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. For example, the Plan could be terminated if future collective bargaining agreements do not require employer contributions to the Plan.

If the Plan is terminated, benefits for covered expenses incurred before the termination date fixed by the Trustees will be paid to covered persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Information to be Furnished by Plan Participants

Participants under the Plan must furnish the Fund with such evidence, data or information as the Fund considers necessary or desirable to administer the Plan. A fraudulent misstatement or omission of fact made by a participant on an enrollment form or on a claim for benefits may be used to cancel coverage and/or deny claims for benefits.

Recovery of Benefits

In the event a participant receives a benefit payment under the Plan which is in excess of the benefit payment which should have been made, the Fund shall have the right to recover the amount of such excess from such participant. The Fund may, however, at its option, deduct the amount of such excess from any subsequent benefits payable to, or for, the participant.

No Surprises Act

Effective June 1, 2022, several modifications have been made to the Plan to comply with the No Surprises Act. The No Surprises Act generally protects patients from "balance billing" for out-of-network emergency services, certain ancillary services provided by out-of-network providers at in-network facilities, out-of-network care provided at in-network facilities without the patient's informed consent, and air ambulance services (collectively, "No Surprises Act Services").

Generally, Participants and Dependents receiving No Surprises Act Services will only be responsible for paying their in-network cost sharing. Furthermore, cost sharing for No Surprises Act Services will count toward in-network deductibles and out-of-pocket maximums.

For example, if you are in an emergency medical condition and receive emergency services from an out-of-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post stabilization services.

When you receive services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most those providers may bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or internists services.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in the Plan's network and are encouraged to do so when possible.

If you believe you have been wrongly billed under the No Surprises Act, you can appeal the adverse benefit determination in accordance with the Plan's claims and appeals procedures. If your health care claim involving compliance with cost-sharing and surprise billing protections is denied under the internal appeals procedures, you have the right to file a request for an external review by and independent review organization with the Fund Office within four months of the date of the internal appeal decision.

If you have any other questions or concerns regarding the No Surprises Act, you may contact the Fund Office or the No Surprises Help Desk at 1(800) 985-3059.

ADDITIONAL BENEFITS

Disability Income Benefit

The Local 399 Health and Welfare Plan provides you with a basic level of income if you become disabled and cannot work because of a non-occupational injury or illness that began while you were in an active work status.

- Waiting Period: 14 consecutive days
- Length of Benefit: *26 weeks
- Benefit: $250 per week

This benefit is payable to eligible participants who become injured or ill and unable to work while covered under the Health and Welfare Plan. The benefit is limited to claimants who are not receiving income from the employer during any portion of the benefit period.

You will be considered totally disabled if you are unable to work as an Operating Engineer or job for which you are suited by education, training or experience. You must be under the care of a medical physician during the period of your disability and submit satisfactory proof to the Plan Administrator or Claims Administrator.

The Plan pays this benefit for each period of non-occupational illness or injury. Successive periods of disability, due to same or related cause are considered one period of disability, unless separated by a return to active full-time work for five consecutive days. Successive periods of disability due to entirely different and unrelated causes are considered one period of disability, unless separated by at least one day of active full-time work.

**Benefits will end if you retire and receive your pension and/or your Social Security annuity. Applicable taxes will be deducted which are required by law.*

How to File a Claim for Disability Income Benefits

Obtain a disability income claim form from the Fund Office or download a claim form from Local 399's website www.iuoe399.org, Health and Welfare. Complete the claimant section, have your employer complete the employer section and have your physician complete the attending physician section. Mail the claim form to: IUOE Local 399 Health & Welfare Trust Fund, c/o Elite Administration, 1300 W. Higgins Road, Suite 208, Park Ridge, IL, 60068. Fax (312) 243-8678

It is important that you advise the Fund Office or the Claims Administrator when you have or are returning to work or when you retire.

This benefit is administered by the Claims Administrator, Elite Administration and is self-funded by Local 399's Health & Welfare Trust Fund. If you are declined benefits, and wish to appeal the denial, please refer to the Appeal Procedure on next page.

APPEAL PROCEDURES FOR DISABILITY CLAIMS

The following changes apply to the "Benefit Determination and Appeal Process" section as it relates to disability benefits.

Denials of disability claims, and denials of appeals for disability benefits will include additional information, starting with claims filed on or after April 1, 2018. Specifically, these notifications will include:

- A statement regarding the rights of the claimant and an authorized representative.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination (claim denial), without regard to whether the advice was relied upon in making the benefit determination; and a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan that were relied upon in making an adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.
- If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Prior to issuing a denial of an appeal with respect to a disability claim, the Plan will provide you, free of charge, with any new or additional evidence considered or generated by the Review Committee, and the rationale for the adverse decision. The Plan will provide you such information as soon as possible and sufficiently in advance of the required date for providing an adverse review decision in order to provide you with a reasonable opportunity to respond prior to that date.

This page intentionally left blank

Life Insurance/Death Benefit
$10,000

The Local 399 Health and Welfare Plan pays a benefit to your beneficiary if you die while you are a person in an employment relationship with an employer who is contracted to pay Health and Welfare contributions on your behalf. This benefit is not available to participants enrolled in COBRA continuation coverage due to termination of employment.

The Plan also pays an Accidental Death and Dismemberment (AD&D) benefit. AD&D is payable if you sustain an accidental injury resulting in the loss of your life, a limb, or your eyesight within 90 days after the accident, according to the following schedule:

Additional amount payable if death due to accident:	$10,000
Amount payable if loss of limbs:	$10,000
Amount payable if loss of one hand, foot or sight of one eye:	$ 5,000

ReliaStar Life Insurance Company underwrites this benefit*. Upon your death, ReliaStar Life Insurance Company pays the benefit to the designated beneficiary shown on your most current Health and Welfare Plan enrollment form. Please be sure your beneficiary information is up to date at the Fund Office. If you wish to change your beneficiary at any time, please contact the Fund Office for a Beneficiary Change Form or download a form from Local 399's website: www.iuoe399.org, Health and Welfare Page – Forms.

**A life insurance policy, with full details of the benefit provisions including exclusions, is available upon request to the Fund Office.*

How to File a Death Benefit or AD&D Claim:

- Notification of the participant's death can be made to the Fund Office at (312) 372-9870.
- ReliaStar Life Insurance Company will be notified of the death claim. A death certificate is required.
- The beneficiary will receive the death or AD&D benefit directly from ReliaStar Life Insurance Company.

This page intentionally left blank

IMPORTANT INFORMATION

IUOE Local 399 Officers

Patrick J. Kelly, President & Business Manager
Lloyd Osborne, Vice President
Vincent T. Winters, Recording Corresponding Secretary
Roger F. McGinty, Financial Secretary
John F. Hickey, Treasurer

Health & Welfare Fund Office

International Union of Operating Engineers
Local 399 Health & Welfare Trust
2260 S. Grove Street
Chicago, IL 60616-1823

Telephone: (312) 372-9870

Fax: (312) 842-0291

www.iuoe399.org

HEALTH & WELFARE BOARD OF TRUSTEES

UNION TRUSTEES

Patrick J. Kelly, Chairman

Valerie Jo Colvett • Roger F. McGinty

International Union of Operating Engineers • Local 399

EMPLOYER TRUSTEES

Eric Centazzo	Maureen Ehrenberg	Laura Bossert
Marriott International	Lessen	CBRE

Fund Administrator

Carrie Gath
RN, BSN, MBA

Phone: (312) 372-9870 • Ext. 3137

International Union of Operating Engineers

LOCAL 399

Health & Welfare Trust

2260 S. Grove Street • Chicago, IL 60616

(312) 372-9870 Option 3