International Union of Operating Engineers Local 57

HEALTH & WELFARE PLAN

2019 SUMMARY PLAN DESCRIPTION

OPERATING ENGINEERS LOCAL 57 HEALTH & WELFARE PLAN

857 Central Avenue
Johnston, Rhode Island 02919
Telephone: (401) 331-9191
Fax: (401) 764-0015
Website: **iuoelocal57.org**

BOARD OF TRUSTEES

Employer Trustees	Union Trustees
Mr. James J. White, Chairman	Mr. Stephen A. Cardi, Secretary-Treasurer
Mr. Steven Rogers	Mr. Michael D. D'Ambra

Administrator

Shawn A. Houlihan

Assistant Administrator

Ryan J. White

Legal Counsel

Thomas C. Plunkett, Esq.
Kiernan, Plunkett & Redihan, LLP

Consultants and Actuaries

Segal Consulting

Accountant

Ward, Fisher and Company, LLP
250C Centerville Road
Warwick, RI 02886-4353

DEAR MEMBER:

As a member of the IUOE Local 57 Health & Welfare Plan (the "Plan"), benefits are an important segment of your total compensation package.

The Plan was first established on December 1, 1953. Over the years, it has been amended to increase benefits and comply with governmental regulations.

The Plan is maintained pursuant to collective bargaining agreement(s) (CBA(s)) between Participating Employers and the Labor Organization(s). The CBA(s) is available upon request at the IUOE Local 57 Plan Office. The full cost of the Plan is paid for by the Participating Employers and those monies are invested in the Plan to provide benefits to eligible members and pay Plan expenses. As a member, you are not required or permitted to make contributions to the Plan.

This Summary Plan Description (SPD) provides information about the Plan as amended through January 1, 2019, so you will have a clear understanding of how the Plan operates. Note, though, that this SPD is not intended to replace the official Plan documents or explain every technical detail or aspect of the Plan. In the event of any contradictions between this SPD and the official Plan documents, the official Plan documents will govern.

This SPD supersedes and replaces all previous SPDs issued regarding this Plan.

Only the full Board of Trustees is authorized to interpret the benefits described in this SPD. No Employer or any Union, nor any representative of any Employer or Union, is authorized to interpret this Plan orally or in writing—nor can such person act as an agent of the Board of Trustees.

The Trustees expect to continue this Plan indefinitely, but they reserve the right, in their sole discretion, to amend or terminate all or any part of the Plan at any time, to the extent allowed by law, provided it is not in violation of a CBA already in effect. Any material Plan amendment will be made in writing and must be approved by the Board of Trustees. All such amendments will be promptly communicated to you in writing, consistent with applicable federal law.

Please read this booklet in its entirety and keep it with your important papers for future reference. If you have any questions about your benefits, your Union Trustee or the Plan Administrator will be happy to answer them for you.

Sincerely,
BOARD OF TRUSTEES

TABLE OF CONTENTS

ACTIVE EMPLOYEE ELIGIBILITY

As an active employee, you are eligible for medical, prescription drug, dental, life insurance and accidental death and dismemberment benefits if you have worked a sufficient number of hours in Covered Employment. Covered Employment is any hour(s) you work for a Participating Employer, which is an Employer who is required to contribute to the Plan under the terms of a CBA with Operating Engineers' Local 57.

Note: For information about coverage of non-bargained employees, please contact the Plan Office.

Initial Eligibility

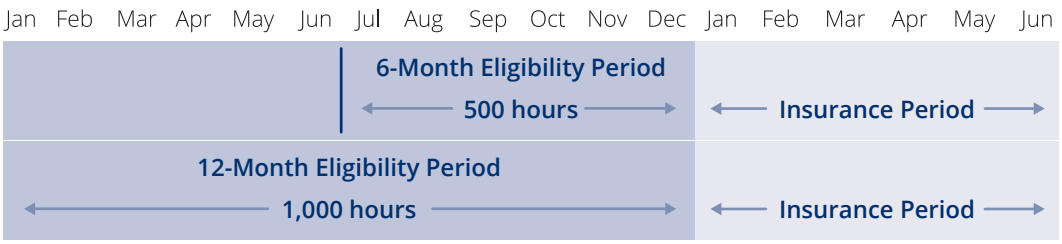
For insurance purposes, you initially become eligible for benefits under this Plan on the first day of an Insurance Period* immediately following:

- The *6-Month Eligibility Period*** in which you have accumulated at least 500 hours of Covered Employment; or
- The *12-Month Eligibility Period* in which you have accumulated at least 1,000 hours of Covered Employment, whichever is sooner.

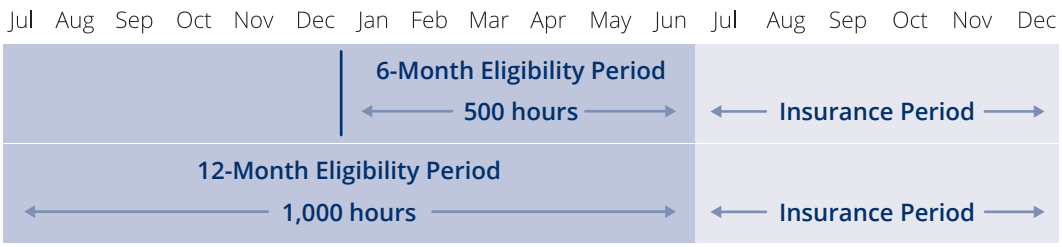
* *An* Insurance Period *is a period of 6 consecutive calendar months commencing on the first day of any January or July, as shown below.*

** *An* Eligibility Period *is a period of 6 or 12 consecutive calendar months commencing on the first day of any January or July, as shown below.*

January to June Insurance Period



July to December Insurance Period



Dependent Eligibility

Your eligible dependents are:

- Your legal spouse, according to the laws of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony and registering the marriage with the appropriate state or local official.
- Your common law spouse, according to the law of the state in which your marriage was formed. Your spouse by common law of the opposite gender is also eligible to enroll for coverage. To be eligible, you and your common law spouse must complete and sign an Affidavit of Common Law Marriage and provide required documentation to Blue Cross Blue Shield of Rhode Island.
- Your civil union partner, according to the law of the state in which you entered into a civil union. Civil Union partners may be enrolled only if civil unions are recognized by the state in which you reside.
- Your former Spouse. In the event of a divorce, your former spouse will continue to be eligible for coverage provided your divorce decree requires you to maintain continuing coverage under a family policy in accordance with state law. In that case, your former spouse will remain eligible on your policy until the earlier of:
  i. The date either you or your former spouse are remarried;
  ii. The date provided by the judgment for divorce; or
  iii. The date your former spouse has comparable coverage available through his or her own employment.
- Each of your and your spouse's children until the first day of the month following their 26th birthday.

Definition of "Children/Child"

For purposes of the Plan's definition of dependent, eligible "children" (or "child") includes your:

- Natural children;
- Stepchildren;
- Legally adopted children or children placed with you for adoption. "Placement for adoption" means the assumption or retention by you, or the legal duty for the total or partial support of the children; and
- Foster Children who permanently live in your home.

In addition, if you have an unmarried child of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of mental impairment or physical disability, which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months, that child is an eligible disabled dependent under the Plan. However, your child's disability must begin before the end of the month in which he or she reaches age 26. If you have a child whom you believe satisfies these conditions, you must verify the child's disabled status

and show proof of the disability. Periodically, you may be asked to show proof that this disabling condition still exists to maintain coverage for the child as a dependent.

Furthermore, the Plan's definition of eligible dependent also includes any unmarried child you have who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO).

A dependent child does not include:

- Any person who is in full-time military, naval or air service;
- Your legally separated spouse;
- Your grandchildren; or
- Any dependent who is eligible for coverage under this Plan as a covered employee.

Coverage Start Date for Eligible Dependents

Coverage for your eligible dependents starts on the date your coverage starts or on the date you acquire an eligible dependent, provided you notify the Plan Office of your new dependent within 30 days.

Continuation of Eligibility

Your benefits coverage will continue during each Insurance Period if you have:

- At least 500 hours of Covered Employment in the last 6-Month Eligibility Period; or
- At least 1,000 hours of Covered Employment in the last 12-Month Eligibility Period.

Continuation of Coverage According to State Law

If your employment is terminated because of involuntary layoff or death, or as a result of the workplace ceasing to exist, or the permanent reduction in size of the workforce, your benefits may be continued in accordance with Rhode Island General Laws c. 27-19.1, provided you continue to pay the applicable premiums. Refer to Appendix A for details.

Termination of Eligibility

If you are an active Plan participant, your benefits will terminate on the last day of any Insurance Period:

- If you do not have at least 500 hours of Covered Employment in the most recent *6-Month Eligibility Period*; or
- If, within the most recent *12-month Eligibility Period*, you do not have at least 1,000 hours of Covered Employment.

If you are employed by a Participating Employer in a job classification for which the Union is the collective bargaining agent, and you move from the employ of one Participating Employer to that of another Participating Employer, your benefits will continue if you otherwise meet the rules for eligibility.

In general, your child is no longer eligible for coverage when he or she enters the military on a full-time basis, reaches the maximum coverage age or, if applicable, is no longer dependent upon you for support. You should notify the Plan Office as soon as possible when one of these events occurs.

If your child loses eligibility for medical coverage due to one of the aforementioned events, the child may be eligible to elect to continue his or her coverage under COBRA continuation coverage for up to 36 months. However, you or your child must notify the Plan Office within 60 days of the date your child no longer meets the Plan's eligibility requirements. For more information, refer to the section "Continuation of Health Coverage Under COBRA." For information on continuing health coverage during military leaves, refer to the section "Continuing Your Health Coverage Under USERRA."

Change in Family Status

After your benefits become effective, it is necessary to notify the Plan Administrator of any change in your family status by reason of marriage, birth of a child, adoption of a child, death, divorce or legal separation.

Failure to file the required information may delay payment of benefits, or you could be required to refund all monies paid in error.

Special Enrollment

Special enrollment is allowed for you or your dependents who originally declined medical coverage, if you or your dependents:

- Had other medical coverage and either you or your dependents later had a loss of eligibility for such coverage or employer contributions toward such other coverage were terminated;
- Were on continuing coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) under another plan, but you or your dependents' COBRA continuation coverage eligibility expired;
- Had other coverage under Medicaid or the State Children's Health Insurance Program ("CHIP") and later had a loss of eligibility for such coverage; or
- Became eligible to participate in a financial assistance program through Medicaid or CHIP for coverage under the Plan.

If you either enroll or do not enroll and decline medical coverage, and you later marry, have a birth child, or you adopt a child or have a child placed with you for adoption, you are entitled to special enrollment, along with the children placed for adoption or adopted child or birth child and your spouse.

Provided your (or your dependent's) application is received on time, if you become eligible for special enrollment, you will become eligible for coverage on the first day of the month following receipt of the properly completed application form, subject to the Plan Office's approval. A dependent eligible for special enrollment, including a spouse, birth child, child placed with you for adoption, or an adopted child, will become eligible to participate on the date the dependent is acquired.

Special enrollments must be requested within the later of 30 days of the date of the event described above, or within 60 days of the date of the event if that event is the loss of eligibility for Medicare or CHIP coverage or becoming eligible to participate in a financial assistance program through Medicaid or CHIP.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 60 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan.

The following situations will not be considered rescissions of coverage and do not require the Plan to give you 60 days advance written notice:

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

For any other unintentional mistakes or errors under which you and your spouse were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively—for the future—once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 60 days advance written notice.

OTHER ELIGIBILITY INFORMATION FOR ACTIVE EMPLOYEES

No Medical Examination or Age Restriction

No medical examination is required of any employee or dependent to secure his or her coverage, and all new employees who become eligible will have benefits coverage regardless of age.

Taking a Family and Medical Leave of Absence

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

- The birth or adoption of a child or placement of a child with you for foster care or adoption;
- The care of a seriously ill spouse, parent or child;
- Your serious illness; or
- An urgent need for leave because your spouse, son, daughter or parent is on active duty in the armed services (effective when final regulations have been adopted by the Department of Labor).

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

- Be your spouse, son, daughter, parent or next of kin;
- Be undergoing medical treatment, recuperation or therapy, for a serious illness or injury incurred in the line of duty while in the Uniformed Services; and
- Be an outpatient, or on the temporary disability retired list of the armed services for a serious illness or injury.

You are eligible for a leave under FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within a 75-mile radius of the employer's location.

The Plan will maintain your prior eligibility until the end of the FMLA leave, provided your employer properly grants the leave and makes the required notification and payment to the Plan.

You may be required to provide:

- 30-day advance notice of the leave, if possible;
- Medical certifications supporting the need for a leave; and/or
- Second or third medical opinions and periodic recertification (at your employer's expense) and periodic reports during the leave regarding your status and intent to return to work.

Your FMLA leave will end on the earlier of your return to work or 12 weeks. If you do not return to work within 12 weeks, you may qualify for COBRA continuation coverage.

Continuing Your Health Coverage Under USERRA

If you are called into the Uniformed Services for up to 31 days, your health coverage will continue as long as you make any required self-payment. If you are called into the Uniformed Services for more than 31 days, you may continue your coverage by paying the required self-payments for up to 24 consecutive months or, if sooner, the end of the period during which you are eligible to apply for reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Uniformed Services, as used in this section, means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Coverage under USERRA will run concurrently with COBRA continuation coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA continuation coverage. The procedures for electing coverage under USERRA will be the same procedures described in the "Continuation of Health Coverage Under COBRA" section beginning on page 14, except that only the employee has the right to elect USERRA coverage for himself or herself and his/her dependents, and that coverage will extend to a maximum of 24 months.

Your coverage will continue to the earliest of the following:

- The date you or your dependents do not make the required self-payments;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The date you lose your rights under USERRA (for instance, for a dishonorable discharge);
- The last day of the month after 24 consecutive months; or
- The date the Plan no longer provides any group health benefits.

You need to notify the Plan Office in writing when you enter the Uniformed Services. For more information about self-payments under USERRA, contact the Plan Office.

If You Do Not Continue Health Coverage Under USERRA

If you do not continue coverage under USERRA, your coverage will end immediately when you enter the Uniformed Services. Your dependents will have the opportunity to elect COBRA continuation coverage.

Reinstating Your Health Coverage

When you are discharged or released from the Uniformed Services, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your Employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of service in the Uniformed Services.

When you are discharged or released from service in the Uniformed Services that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a Participating Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a Participating Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for Participating Employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during your service in the Uniformed Services, you have until the end of the period that is necessary for you to recover to return to, or make yourself available for, work for a Participating Employer. Your prior eligibility status will be frozen when you enter the Uniformed Services until the end of the leave, provided your Employer properly grants the leave under the federal law and makes the required notification and payment to the Plan.

Honoring Qualified Medical Child Support Orders (QMCSOs)

A QMCSO is a court judgment, decree or order that creates or recognizes an alternative recipient—such as a child or stepchild—to be eligible for coverage under this Plan. The Plan must honor the terms of a QMCSO, provided it meets certain requirements. If the Plan receives an order which may be a QMCSO, the Plan Administrator will notify you (and all parties covered by the order), determine whether the order is QMCSO and, if it is, ensure that the alternative recipients are treated as beneficiaries under the Plan for ERISA reporting and disclosure. A copy of the Plan's procedures for handling QMCSOs is available to you at no cost from the Plan Office. If you have any questions about QMCSOs, please contact the Plan Administrator.

Keeping Your Plan Informed of Address Changes

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

RETIREE ELIGIBILITY

As a retiree, you will be eligible for medical, prescription drug, and life insurance benefits if you have worked the required number of hours in Covered Employment just prior to your retirement date and you satisfy the other requirements described in this section.

Eligibility

If you are age 62, 63 or 64 and have 10 service credits from the Local 57 Pension Plan on your retirement date, you are eligible for Plan benefits if you:

- Were eligible for coverage (other than COBRA continuation coverage) at any time during the 12 months immediately before your retirement date; and
- Worked at least 3,500 hours in Covered Employment during the five years immediately before your retirement date.

If you are age 60 or 61 and have 30 service credits from the Local 57 Pension Plan on your retirement date, you are eligible if you:

- Were eligible for coverage (other than COBRA continuation coverage) at any time during the six months immediately before your retirement date; and
- Worked at least 3,500 hours in Covered Employment during the five years immediately before your retirement date.

Regardless of your age at retirement, if you retire(d) on or after January 1, 1998 and you have 35 service credits from the Local 57 Pension Plan on your retirement date, you are eligible if you:

- Were eligible for coverage (other than COBRA continuation coverage) at any time during the six months immediately before your retirement date; and
- Worked at least 3,500 hours in Covered Employment during the five years immediately before your retirement date.

If you qualify with 35 service credits, once you have exhausted active medical and prescription drug coverage, you will be eligible for retiree medical and prescription drug coverage for three years at no expense. Thereafter, you may continue your coverage until you reach age 65 by paying 25 percent of the monthly cost of the benefits. The copayment will be due on the 15th of the month preceding the month of coverage. However, you will have a 30-day grace period from that due date to make the monthly payment.

Note: Service credits earned in the hour bank are not counted toward eligibility for medical, prescription drug and life insurance coverage.

Termination of Eligibility

Your and your spouse's medical and prescription drug benefits coverage will terminate on the earlier of the first of the month of your 65th birthday or your entitlement to Medicare. At that point, your spouse will have the opportunity to purchase medical and prescription drug benefits coverage at Local 57 group rates under the COBRA plan. The purchased COBRA continuation coverage will continue until your spouse reaches age 65, or for 36 months, whichever comes first. The same right to purchase medical and prescription drug benefits coverage under the COBRA plan applies for any other eligible dependent covered by your insurance.

If you should die prior to reaching age 65 and while you are eligible for coverage, the Health & Welfare Plan will continue your eligible dependents' medical and prescription drug benefits for an additional 90 days after your death. After this, your spouse and other eligible dependents will have the opportunity to purchase medical and prescription drug benefits coverage at Local 57 group rates under the COBRA plan.

Retiree life insurance coverage will continue for the lifetime of the retiree.

Members who retire after age 65, but who meet other requirements for retiree coverage, will not be eligible for retiree medical and prescription drug benefits due to termination of eligibility (above). However, they will be eligible for retiree life insurance coverage.

MEDICAL AND PRESCRIPTION DRUG BENEFITS SUMMARY
(Active and Retired Employees)

Medical and Prescription Drug Coverage Through Blue Cross Blue Shield of Rhode Island (BCBSRI) Healthmate Coast-to-Coast

Your medical and prescription drug benefits are described in detail in the Healthmate Coast-to-Coast Subscriber Agreement provided by Blue Cross Blue Shield of Rhode Island (BCBSRI). The Subscriber Agreement is available on the Plan's website: **www.iuoelocal57.org**. You must read the Subscriber Agreement in order to understand what services are covered, the exact level of your coverage and what restrictions and exclusions exist. Information about copayments, deductibles, coinsurance, annual maximum out-of-pocket expenses, and other benefit limits are also described in the Subscriber Agreement.

If you have questions about your benefits, call the BCBSRI Customer Service Department at (401) 459-5000 or (800) 639-2227. You can also visit **www.BCBSRI.com** to find if your health care provider as a member of Preferred Blue. Preferred Blue is BCBSRI's designated BlueCard PPO network.

The Newborns' and Mothers' Health Protection Act

This Plan complies with federal law that prohibits restricting benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section. The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods.

The Women's Health and Cancer Rights Protection Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

WHCRA benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plan.

If you would like more information on WHCRA benefits, call BCBSRI directly at the telephone number listed on your insurance card.

The SwiftMD Program

A call to SwiftMD can possibly be the first call you make at the onset of illness or injury. Many common medical conditions can be safely treated by a SwiftMD physician over the phone or videoconference, including:

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

With the SwiftMD program, you and your family can speak with a doctor 24 hours a day, 7 days a week from your home, office, or on the road via phone or videoconference. You can also update and check your SwiftMD Personal Health Record online and get prescriptions for medications when appropriate.

All SwiftMD physicians are U.S.-trained and board-certified emergency and family practice physicians who are capable of quickly and accurately diagnosing and treating a host of medical issues. You will avoid drives across town, lengthy waits at the doctor's office, or sitting in an urgent care waiting room. You simply call the toll free number or log in online and answer a few simple health questions and your case will be forwarded to a SwiftMD physician. Within an hour, a SwiftMD physician will call you for a consultation. **There are no out-of-pocket costs, copayments or consulting fees for this service.**

Call (877) 999-7943 or go to **www.myswiftmd.com**. Feel free to call with any medical concern or question. However, if you believe you are experiencing an emergency, call 911 immediately.

DENTAL BENEFITS SUMMARY
(Active Employees Only)

Dental Coverage Through Delta Dental of Rhode Island

If you are an active employee, your dental benefits are described in detail in the Certificate of Coverage provided by Delta Dental of Rhode Island. The Certificate of Coverage is available on the Plan's website: **www.iuoelocal57.org**. Retired employees are not eligible for dental benefits.

You must read the Delta Dental Certificate of Coverage in order to understand what services are covered, the exact level of your coverage and what restrictions and exclusions exist. Information about copayments/coinsurance, deductibles and annual/lifetime maximum benefits and other benefit limits are also described in the Certificate of Coverage.

To learn if a dentist participates with Delta Dental, call the Delta Dental Customer Service Department at (401) 752-6100 or (800) 843-3582. Customer Service representatives are available Monday through Thursday from 8 a.m. to 7 p.m. E.T., and Friday from 8 a.m. to 5 p.m. E.T. A listing of dentists participating with Delta Dental is also available from the Plan Office as a separate document.

CONTINUATION OF HEALTH COVERAGE UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, also called "COBRA," you and/or your dependents may continue your medical, prescription drug, and dental benefits past the date when coverage normally would end due to a "Qualifying Event." In general, COBRA continuation coverage is identical to the health coverage you had under the Plan when enrolled as an active employee. COBRA continuation coverage may last for 18, 29 or 36 months, depending on the Qualifying Event and who elects the coverage.

Qualified Beneficiaries

By law, only "Qualified Beneficiaries" are entitled to COBRA continuation coverage independent of your enrollment in COBRA. Qualified Beneficiaries are individuals covered at the time your COBRA continuation coverage begins. Qualified Beneficiaries are considered to be you, your spouse and your dependent child(ren) who were covered by the Plan on the day before the Qualifying Event.

A child who becomes a dependent child by birth, adoption or placement for adoption with you during a period of COBRA continuation coverage is also a "Qualified Beneficiary." Refer to the paragraph in this section entitled "Special COBRA Enrollment Rights" for more information.

One or more of your family members may elect COBRA even if you do not. However, to independently elect COBRA continuation coverage, the family member(s) must be "Qualified Beneficiaries" covered by the Plan on the day before the Qualifying Event. A parent may elect or reject COBRA continuation coverage on behalf of dependent child(ren) living with him or her.

Qualifying Events/How Long Continuation Coverage Lasts

When Plan coverage is lost due to any of these Qualifying Events, the employee and each Eligible Dependent may be eligible to self-purchase group health benefits:

Qualifying Event	Who May Purchase	Maximum Length of Continuation Coverage
Employee loses eligibility due to a termination of employment or a reduction in hours of employment (including retirement)	Employee and each Eligible Dependent	18 Months
Employee becomes entitled to Medicare	Each Eligible Dependent	36 Months
Employee dies	Each Eligible Dependent	36 Months
Employee is divorced or legally separated from spouse	Spouse	36 Months
Child ceases to be a dependent child as defined under the Plan	Dependent child	36 Months

Disability Extensions

If you or your Eligible Dependents are disabled (as determined by Social Security) at any time within the first 60 days of your COBRA coverage, and you notify the Plan in writing within 60 days of Social Security's disability determination and before the end of the initial 18-month COBRA coverage period, you and your Eligible Dependents will be eligible to continue COBRA for up to an additional 11 months (for a total of 29 months).

Remember, to qualify for this 11-month extension of COBRA coverage, you must notify the Plan of the Social Security determination of disability:

- Within 60 days after the determination; and
- Before the end of the first 18 months of COBRA coverage.

If you (or your dependent(s)) are eligible for the 11-month disability extension, your COBRA premiums may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This disability extension period of COBRA coverage will end on the earlier of:

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

If you recover from your disability before the end of the initial 18 months of COBRA continuation coverage, you will not have the right to purchase extended coverage. In addition, you must notify the Plan Office within 30 days of:

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

Second Qualifying Events

If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected spouse or dependent(s) may extend coverage for another 18 months if:

- You get divorced or legally separated;
- You become entitled to Medicare;
- You die; or
- Your child is no longer a dependent under the Plan's definition.

For example, suppose a member stops working (termination of employment—the first Qualifying Event), and enrolls him/herself and his/her family in COBRA continuation coverage for 18 months. Three months after his/her COBRA continuation coverage begins, the member's child reaches the Plan's maximum age limit and longer qualifies as

a dependent child under the Plan's definition (loss of dependent eligibility—the second COBRA Qualifying Event). Provided the member (or the dependent) gives the Plan timely notice of the Second Qualifying Event, the child can continue on COBRA coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

Keep in mind, however, that under COBRA, the maximum period of coverage for a spouse or dependent is 36 months, even if the individual experiences a second Qualifying Event while already covered under COBRA. The maximum coverage period for a member/participant is 18 months (unless you or a family member are entitled to an additional COBRA continuation coverage because of a disability, in which case the maximum coverage period will be 29 months.)

You (or your spouse or dependent) must notify the Plan Office, in writing, within 60 days of the date a second Qualifying Event occurs. If you do not notify the Plan of the event within this timeframe, your spouse's and/or dependent's COBRA coverage will not be extended.

When Continuation Coverage May Be Cut Short

The law also provides that COBRA continuation coverage may be cut short for any of the following reasons:

1. The Employer no longer provides group health coverage to any of its similarly situated employees;
2. You do not pay the applicable premium for your COBRA continuation coverage on time;
3. After electing COBRA, the covered person becomes entitled to Medicare;
4. After electing COBRA, the covered person becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any pre-existing condition of that covered person, or by law, may no longer apply its preexisting condition limitation or exclusion to that covered person; or
5. The Employer that you worked for before the qualifying event has stopped contributing to the Plan; and the Employer establishes one or more group health plans covering a significant number of the Employer's employees formerly covered under the Plan; or the Employer starts contributing to another multiemployer plan that is a group health plan.

How the COBRA Election Takes Place

STEP 1. You or your family must inform the Plan Office in writing within 60 days of the following Qualifying Events:

- The employee's death,
- The employee's divorce or legal separation, or
- A child losing dependent status under the Plan's eligibility rules.

To notify the Plan of your Qualifying Event, send a letter to the Plan Office with your name, the type of Qualifying Event and the date of the Qualifying Event.

Your Employer is responsible for notifying the Plan Office within 30 days of the other Qualifying Events. Those events are the employee's termination of employment or reduction in work hours, the employee's death and the employee's entitlement to Medicare.

Upon receipt of a notice that a Qualifying Event has occurred, the Plan Office will then send you, your spouse and/or dependent child(ren) a COBRA election form and information about continuation coverage. Important: If you don't notify the Plan Office of a Qualifying Event within 60 days of the date of the event, you will lose your right to elect COBRA coverage entirely.

If you and/or your Eligible Dependents become eligible to self-purchase this coverage due to any other event, the Plan Office will notify you and will send the election form and information.

NOTE: THE PLAN INTENDS TO PROVIDE YOU WITH NOTIFICATION OF YOUR LOSS OF ACTIVE COVERAGE BY FIRST CLASS MAIL TO YOUR LAST ADDRESS ON FILE AT THE PLAN ADMINISTRATOR. THEREAFTER, THE PLAN ASSUMES NO RESPONSIBILITY OR LIABILITY IF YOU ALLOW YOUR COVERAGE TO TERMINATE. IF YOU HAVE ANY REASON TO BELIEVE THAT YOUR ELIGIBILITY WILL TERMINATE, OR HAS TERMINATED, IT IS YOUR RESPONSIBILITY TO CONTACT THE PLAN ADMINISTRATOR TO VERIFY YOUR ELIGIBILITY STATUS.

TO PROTECT YOUR FAMILY'S RIGHTS TO COBRA CONTINUATION COVERAGE, YOU SHOULD ALWAYS KEEP THE PLAN OFFICE INFORMED OF ANY CHANGES IN YOUR ADDRESS OR THOSE OF YOUR FAMILY MEMBERS. YOU SHOULD ALSO KEEP A COPY, FOR YOUR RECORDS, OF ANY CORRESPONDENCE OR NOTICES YOU SEND TO THE PLAN OFFICE.

Within 60 days of the event that would cause you to lose your health coverage, you must inform the Plan Office that you want continuation coverage. No evidence of insurability is required.

The Plan will cancel coverage as of the date that coverage would otherwise be lost due to the Qualifying Event and retroactively reinstate it (as COBRA coverage) upon a timely election and payment for COBRA coverage. Claims incurred by a qualified beneficiary during the election and 45-day initial premium payment periods will not be paid until COBRA coverage is elected and any required premium payment for coverage has been made.

STEP 2. Once the Plan Office sends you your COBRA election materials, you have 60 days to make an election. This 60-day period is measured from the later of the date you lost coverage due to the Qualifying Event or the date you received the COBRA election notice and related information.

STEP 3. Once the Plan Office receives your election material, they will notify you of the amount of premium you owe. You will have 45 days from the date you made your COBRA election to make payment for all premiums owed for the period. If payment is not received, COBRA coverage will be cancelled retroactively to the date your coverage under the Plan terminated.

STEP 4. Your monthly payments are due on the 1st day of each month. You will have a 30-day grace period in which to pay. Payments should be mailed to the Plan Office. If you do not make payment by the 1st day of the month, your coverage will be cancelled and retroactively reinstated upon timely payment for COBRA coverage.

NOTE: UNDER NO CIRCUMSTANCES WILL THE OPTION TO MAKE A SELF-PAYMENT TO THE HEALTH & WELFARE PLAN BE PERMITTED ON A RETROACTIVE BASIS. PAYMENTS MUST BE MADE CONTINUOUSLY AND WITHOUT INTERRUPTION. FAILURE TO MAKE THE MONTHLY PAYMENT WHEN DUE (INCLUDING THE GRACE PERIOD) WILL RESULT IN THE TERMINATION OF YOUR COBRA HEALTH COVERAGE.

Confirmation of Coverage Before Election or Payment of COBRA Premiums

If a health care provider requests confirmation of coverage and:

1. You, your spouse or dependent child(ren) have elected COBRA but have not yet paid the premium (and the grace period is still in effect); or
2. You, your spouse or dependent child(ren) are within the COBRA election period but have not yet elected COBRA;

then COBRA coverage will be confirmed to your health care provider but with notice that the premium has not been paid and that no claims will be paid until the amount due has been received by the Plan.

Additionally, your provider will be informed that if the amount due is not received by the end of the grace period, your coverage will terminate retroactively.

The Coverage Available if You Elect COBRA

The benefits available to individuals eligible to elect to continue coverage are identical to the health benefits available to Eligible Employees and Eligible Dependents. You may elect medical and prescription drug coverage only or medical and prescription drug coverage together with dental benefits. More specific information will be provided to you when you become eligible for continuation coverage.

The Cost of COBRA Coverage

Employees and/or their Eligible Dependents are required to pay the entire cost of continued group coverage at group rates. In general, the cost will not exceed 102% of the cost of these benefits to the Plan.

Specific cost information will be given to you when you become eligible for continuation coverage.

Special COBRA Enrollment Rights

If you marry, have a newborn child, adopt a child or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll that spouse or child for coverage for the balance of the period of COBRA continuation coverage. You must enroll your new dependent within 31 days of the marriage, birth, adoption or placement for adoption.

In addition, if you are enrolled for COBRA continuation coverage and your spouse or dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 30 days after the termination of the other coverage. To be eligible for this special enrollment right, your spouse or dependent child must have been eligible for coverage under the terms of the Plan but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage.

Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA continuation coverage. To find out about COBRA rates, contact the Plan Office.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Keep Your Plan Informed of Address Changes

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

If You Are Not Sure About Electing COBRA Coverage

When considering whether or not to elect COBRA continuation coverage, you should take into account that not continuing your group health coverage will affect your future rights under federal law.

First, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

Second, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of the maximum COBRA continuation coverage period.

Plan Contact Information

If you have any questions or need additional information about COBRA coverage, please contact the Plan Administrator, at:

I.U.O.E. Local 57 Plan Office
857 Central Avenue
Johnston, Rhode Island 02919
Telephone: (401) 331-9191

If you change your marital status or add new dependents, or if you or your spouse or other dependents change addresses, please notify the Plan Office immediately.

If You Have Questions

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA continuation coverage, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

LIFE INSURANCE BENEFIT
(Active Employees and Retirees)

Life Insurance Coverage

If you die from any cause while you are insured, the proceeds, as shown below, will be paid to your beneficiary:

- Active employees who die on or after July 1, 2012 **$40,000**
- Retirees who die on or after August 1, 2010 **$5,000**

Refer to the Union Labor Life Insurance Company's Certificate of Insurance for more information. The Certificate of Insurance is available on the Plan's website: **www.iuoelocal57.org**.

Designating a Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the completed form is received by the Plan Administrator.

If You Become Totally and Permanently Disabled

If you become Totally and Permanently Disabled before age 60, your life insurance will continue at no cost to you for 12 months from the date to which premiums were paid on your behalf. Coverage will further continue during such disability, without payment of premium, if:

- You send written proof of your disability to the Union Labor Life Insurance Company (the "Company") no later than 12 months after the start of your disability; and
- The proof shows that you were Totally and Permanently Disabled for at least nine months and that such disability will presumably continue to exist.

Premiums will be waived every 12 months if you submit proof of continuing Total and Permanent Disability each year, within three months before the anniversary of the date the initial proof of your disability was received by the Plan Administrator.

The Amount of Insurance That is Continued

The amount of life insurance that will be continued, while you are Totally and Permanently Disabled, will be the amount that was in force at the time premium payments were discontinued on your behalf as a result of your disability.

The Meaning of "Totally and Permanently Disabled"

"Totally and Permanently Disabled" means that, due solely to a bodily injury or illness, you are prevented from engaging in any business, occupation or employment for remuneration or profit.

Termination of Coverage

Coverage will automatically terminate:

- On the date you are no longer Totally and Permanently Disabled; or
- On the date you fail to furnish the Company with proof of your continued disability (which must be within three months before the anniversary of the date the initial proof of disability was received by the Company); or
- Upon your failure to be examined by a Physician designated by the Company, when so requested by the Company. Such an examination will not be required more than once a year after your insurance has been continued under this extension for two full years.

Your Conversion Privilege

If you are no longer eligible for group life insurance because you no longer belong to an eligible insured class or if you terminate your employment, you may convert that benefit to any form of individual life insurance usually offered by the Company, except for term insurance or insurance that provides disability or other supplemental benefits.

You will not need a medical examination. However, you must complete the application form and send it with the first premium payment to the Company no later than 31 days after your group life insurance has terminated.

The face value of your new policy cannot be more than the amount you had under the group plan. The rate you pay will depend upon your age (at the nearest birthday to the date of issue of the individual policy), your class of risk at the time of your conversion and the form and amount of your new policy.

You may also convert if your life insurance benefits terminate because the policy terminates, or because life insurance benefits for your class terminate. In this case, however, you must have been covered under the group plan for at least five years. You may convert the LESSER of the following amounts:

- The amount of life insurance you had under this Plan, less any new amount you may have or for which you may become eligible under another group plan within 31 days of the termination; or
- $2,000.

If you should die during the 31-day period after your group life insurance has terminated, the Company will pay the amount of life insurance you could have converted to the last beneficiary you named, whether or not you applied for an individual life insurance policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
(Active Employees Only)

If you are an active employee, the Accidental Death and Dismemberment (AD&D) benefit will be payable if, while insured, you sustain any of the losses listed below as a result of an accident. For benefits to be payable, the loss must take place within 90 days from the date of the Injury. This benefit is in addition to any other benefits under this Plan.

Refer to the Union Labor Life Insurance Company's Certificate of Insurance for more information. The Certificate of Insurance is available on the Plan's website: **www.iuoelocal57.org**.

AD&D Coverage

For loss of life, benefits will be paid to the beneficiary you name. For any other loss, the benefits will be paid to you.

For Loss of:	The Benefit is:
Life	The Principal Sum
Two Hands	The Principal Sum
Two Feet	The Principal Sum
Sight of Two Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot	One-Half the Principal Sum
Sight of One Eye	One-Half the Principal Sum

If you suffer more than one loss in any one accident, payment will be made only for that loss for which the largest amount is payable.

- Effective July 1, 2012, the Principal Sum is $20,000.
- Loss of hand or foot means that the entire hand or foot is severed at or above the wrist or ankle joint, respectively.
- Loss of sight means the total and irrecoverable loss of sight.

Designating a Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the form is received by the Plan Administrator.

Losses That Are Not Covered

No benefit is payable under this section if your death or any loss is caused directly or indirectly, wholly or partly, by:

- Bodily or mental illness, or disease of any kind, or medical or surgical treatment thereof;
- Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- Intentional self-destruction or self-inflicted injury, while sane or insane;
- Participation in the commission of a felony;
- War or an act of war, whether declared or undeclared;
- Service in any military, naval or air force of any country while such country is engaged in war; or
- Police duty as a member of any military, naval or air organization.

COORDINATION OF BENEFITS WITH MEDICARE

Active Employees and Their Eligible Dependents

An active employee, age 65 or older and eligible for Part A of Medicare, and an active employee's spouse, age 65 or older and eligible for Part A of Medicare, may continue to have the Plan pay medical claims as the primary carrier. Medicare would then consider a claim for any remaining expenses (provided you registered for Part A and enrolled in Part B). If the employee's spouse is still working and covered under another plan, that plan is primary to this Plan and Medicare pays third.

This Plan is also the primary payor and Medicare is the secondary payor of benefits for an active employee, or the eligible dependent of an active employee, who is under age 65 and eligible for Medicare benefits.

Disability Due to End-Stage Renal Disease (ESRD)

If you are actively employed and you or any of your eligible dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

- The month in which Medicare ESRD coverage begins; or
- The first month in which the individual receives a kidney transplant.

Then, starting with the 31st month, Medicare pays first and this Plan pays second.

Any covered charges incurred by such disabled individual should be submitted to this Plan for payment. Afterward, any unpaid balance should be submitted to Medicare, for its consideration.

Retired Members and Their Eligible Dependents

Your benefits under the Retiree Health Benefits Program terminate at the earlier of age 65 or your entitlement to Medicare. Therefore, if you fall into this category, there would not be any coordination of benefits with Medicare as you would no longer be eligible for benefits.

RESTRICTIONS ON PAYMENT OF BENEFITS

Workers' Compensation

This Plan does not provide benefits if the medical, prescription drug, or dental expenses are covered by workers' compensation or occupational disease law.

If an employer contests an application for workers' compensation for an illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your Eligible Dependent must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator.

Motor Vehicle Coverage

If you or your Eligible Dependent is involved in an automobile accident covered by a motor vehicle insurance policy, the automobile insurance carrier will initially be liable for lost wages, medical, surgical, hospital and related charges and expenses up to the greater of:

- The maximum amount of the basic reparation benefit required by applicable law; or
- The maximum amount of the applicable insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective plan in which you are provided coverage. Before related claims will be paid under this Plan, you and your eligible dependent will be required to sign a reimbursement agreement.

If you or your eligible dependent fails to secure insurance or fails to have such insurance in force at the time of an accident, you and your eligible dependent will be considered as being self-insured and must pay the amount of the expenses for yourself and/or your eligible dependents arising out of any accident.

THIRD PARTY LIABILITY AND RIGHT OF REIMBURSEMENT

Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover nor is it liable for any expenses for services or supplies incurred by an eligible employee or eligible dependent for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party. However, subject to the terms and conditions of this section as outlined herein, the Plan will advance payment after receipt of a properly executed reimbursement agreement and Consent to Lien in accordance with the Plan of Benefits until it is determined whether or not a third party is required to pay for those services or supplies.

By accepting an advance of benefits paid by the IUOE Local 57 Health & Welfare Plan, you, your spouse and/or any of your dependent children (hereafter called "covered person") jointly and severally agree that:

- The Plan has a priority lien against the proceeds of any such settlement, judgment, arbitration or recovery to assure that reimbursement is promptly made;
- The Plan will be subrogated to every covered person's right of recovery from that third party or that third party's insurer to the extent the Plan advances any benefit payments; and
- They will, jointly and severally, reimburse the Plan for any and all amounts paid or payable to any or all of them by any third party or that third party's insurer to the extent of the entire amount advanced for related claims to the accident or injury by the Plan.

The Plan's reimbursement and/or subrogation rights will include all claims, demands, actions and rights of recovery of all covered persons against any third party or insurer, including any workers' compensation insurer or governmental agency, and will apply to any and all advance payments made or to be made by the Plan.

Subrogation

1. **Advance on Account of Plan Benefits**

   The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent, wrongful or other act, but it will advance payment on account of Plan benefits (hereafter called an "Advance"), subject to its right to be reimbursed to the full extent of any Advance payment from the covered employee and/or dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:

   - Even if the recovery is not characterized in a settlement or judgment as being paid on account of the expenses for which the Advance was made;
   - Even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule);
   - Without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule);

- Regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule); and
- Even if recovery was reduced due to the negligence of the covered employee or covered dependent (sometimes referred to as "contributory negligence"), or any other common law defense.

2. **Reimbursement and/or Subrogation Agreement**

   The eligible employee and/or any eligible dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Plan. If the ill or injured dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or designee.

   If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.

3. **Cooperation with the Plan by All Covered Individuals**

   By accepting an Advance, regardless of whether or not an Agreement has been executed, the eligible employee and/or eligible dependent(s) each agree:

   - To reimburse the Plan for all amounts paid or payable to the eligible employee and/or eligible dependent(s) or that third party's insurer for the entire amount Advanced;
   - That the Plan has the first right of reimbursement from any judgment or settlement;
   - To do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights;
   - To not assign the right of recovery to any third party without the specific consent of the Plan;
   - To notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
   - To inform the Plan Administrator or designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

By accepting an Advance, the eligible employee and/or eligible dependent(s) jointly agree that the Plan will be subrogated to the eligible employee and/or Eligible Dependent's right of recovery from a third party or that third party's insurer for the entire amount advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the eligible employee and/or eligible dependent(s), but only to the extent of the amount of the Advance.

Under its subrogation rights, the Plan may, at its discretion:

- Start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the eligible employee and/or Eligible Dependent(s), but in doing so, the Plan will not represent, or provide legal representation for the eligible employee and/or Eligible Dependent(s) with respect to their damages that exceed any Advance; or
- Intervene in any claim, legal action or administrative proceeding started by the eligible employee or Eligible Dependent(s) against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

Remedies Available to the Plan

If the eligible employee or Eligible Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

- Apply any future Plan benefits that may become payable on behalf of the eligible employee and/or Eligible Dependent(s) to the amount not reimbursed; or
- Obtain a judgment against the eligible employee and/or eligible dependent(s) for the amount advanced and not reimbursed, and garnish or attach the wages or earnings of the eligible employee and/or eligible dependent(s).

CLAIM FILING AND REVIEW PROCEDURES

1. **MEDICAL INSURANCE CLAIMS:**
   Insurance Carrier—Blue Cross Blue Shield of Rhode Island (BCBSRI)
   - Refer to the BCBSRI Subscriber Agreement for details on claims and appeals procedures. The Subscriber Agreement is available on the Plan's website: **www.iuoelocal57.org**.
2. **DENTAL INSURANCE CLAIMS:**
   Insurance Carrier—Delta Dental of Rhode Island
   - Refer to the Delta Dental Certificate of Coverage for details on claims and appeals procedures. The Certificate of Coverage is available on the Plan's website: **www.iuoelocal57.org**.
3. **LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLAIMS**
   Insurance Carrier—Union Labor Life Insurance Company
   - Refer to the Union Labor Life Insurance Company Certificate of Insurance for details on claims and appeals procedures. The Certificate of Insurance is available on the Plan's website: **www.iuoelocal57.org**.

To obtain the appropriate claim form, please contact the Plan Office.

In the event a claim has been denied in whole or in part, you or your beneficiary can request a review of your claim by the Union Labor Life Insurance Company. This request for review should be sent to Group Insurance Claims Review at the address of the Union Labor Life Insurance Company office that processed the claim.

Appeals of Medical and Dental Claim Denials Based on Eligibility

This section describes the procedures for filing claims for benefits from the Plan. This section applies only to claims denied based solely on eligibility under the Medical and Dental plans. For claims and appeals procedures for your medical and dental benefits for any reason other than eligibility issues, please refer to the BCBSRI Subscriber Agreement and/or the Delta Dental Certificate of Coverage.

How to File a Medical/Dental Claim Denial Based on Eligibility

All claims and appeals must be submitted in writing. The claim (or appeal) must be made in accordance with the Plan's established claims and appeals procedures, as follows:

Appeal of Medical/Dental Claim Denial Based on Eligibility

Submit a letter explaining the reasons you (or your dependent) are eligible for Plan benefits and therefore, the claim should be submitted (or re-submitted) to the insurance carrier for additional consideration. You should include your name, the claimant's name (if different), the specific claim being appealed and the date(s) of the service. You may submit written comments, documents or other information in support of your appeal, and you will have access, upon your request, to all relevant documents in the Plan's possession free of charge. For more information, see "Appeals Process" later in this Section.

Note: Oral inquiries about the Plan's provisions will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

When Appeals of Medical/Dental Claim Denial Based on Eligibility Must Be Filed

All appeals of Medical/Dental claims denied based on eligibility must be filed with the Plan Administrator, using the Plan's procedures, within 180 days of their occurrence.

Note: Any claims (or appeals of Medical/Dental claims denied based on eligibility) received after the above deadlines will be considered late and denied on that basis.

Where to File Claims and Appeals

You may either hand deliver your claim or appeal to the Plan Office at the address below or mail it to the Plan Office via U.S. First Class Mail. The Plan Office is located at:

International Union of Operating Engineers' Local 57 Health & Welfare Plan
857 Central Avenue
Johnston, Rhode Island 02919
Telephone: (401) 331-9191

When Claims and Appeals Are Considered "Filed"

Hand-delivered claims and appeals will be considered filed on the date received by the Plan Office, as long as they are delivered on a regularly scheduled workday during normal business hours. Otherwise, they will be considered filed on the next regularly scheduled workday.

Claims and appeals submitted via U.S. First Class mail will be considered filed on the date postmarked.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In such case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be decided on the basis of the information the Plan has and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice for 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information or at the expiration of the 45 days if you do not respond, the Plan will make a decision on the claim and you will be notified within 30 days.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule, or a statement that such rule was relied upon in deciding the claim, and that a copy will be provided to you upon request; and
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

The Appeal Process

The appeal process for denied Medical/Dental claims based on eligibility is as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person other than the one who made the initial claim decision will conduct the review of the denied claim. The reviewer will not be the subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeals

Medical/Dental Claim Denial Based on Eligibility: A decision on your appeal will be made within specific timeframes. The deadline will depend on the nature of the underlying health claim that caused the denial of benefits based on a determination of lack of eligibility, as follows:

- **Urgent Health Care Claims:** A determination will be made within 72 hours from receipt of your appeal;
- **Pre-Service Claims:** A determination will be made within 30 days from receipt of your appeal; and
- **Post Service Claims:** Decisions on appeals of denied Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your claim appeal has been reached, you will be notified in writing as soon as possible, but no later than five days of the meeting at which the decision was reached.

Notice of Decision on Appeal

The decision on any review of your appeal will be given to you in writing. The notice of a denial of an appeal will state:

- The specific reason(s) for the determination.
- Reference to the specific plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that such rule was relied upon in deciding the claim, and that a copy will be provided to you upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- You and the Plan may have other voluntary dispute resolution options, such as mediation. One way to find out is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Authorized Representatives

An authorized representative, such as your spouse, may complete a claim form or submit a letter of appeal for you if you are unable to complete them yourself and you previously designated the individual to act on your behalf. You can obtain a form from the Plan Office to designate an individual as your Authorized Representative. The Plan may also request additional information to verify that this person is, in fact, authorized to act on your behalf.

Exhaustion of Remedies

The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner. Similarly, you must follow the Plan's claims and appeals procedures completely before initiating a legal action to obtain benefits. This means you cannot start a lawsuit under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) to obtain Plan benefits until after you have requested an appeal and a final decision has been reached on the appeal, or until the appropriate time frame described above has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

The law also permits you to pursue your remedies under ERISA without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which eligibility for medical or dental services was denied.

PROTECTED HEALTH INFORMATION

Use and Disclosure of Protected Health Information

A. Use and disclosure of Protected Health Information (PHI): The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

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

1. Determination of eligibility, coverage and cost sharing amounts (e.g., cost of a benefit, plan maximums and copayments as determined for an individual's claim);
2. Adjudication of health benefit claims;
3. Determining appeals and other payment disputes;
4. Coordination of benefits;
5. Subrogation of health benefit claims;
6. Establishing contribution rates for contributing employers;
7. Establishing employee contributions as necessary;
8. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
9. Billing, collection activities and related health care data processing;
10. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes;
11. Responding to member and beneficiary (and their authorized representatives) inquiries about payments;
12. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
13. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
14. Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;
15. Reimbursement of overpayments to the Plan; and
16. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan).

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

1. Quality Assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives, and related functions;
3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
7. Business management and general administrative activities of the entity, including, but not limited to:
    - Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
    - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
    - Resolution of internal grievances;
    - Filing Form 5500 and 990 and other activities necessary to ensure compliance with applicable federal laws, including the Internal Revenue Code; and
    - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

B. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the following for purposes related to administration of these plans: Plan staff when processing a claim for the AD&D and/or life insurance benefits, the pension plan, the annuity plan, contributing employers, the Union and disability and workers' compensation insurers.

C. For purposes of this section, the Board of Trustees of the Operating Engineers' Local 57 Health & Welfare Plan is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the plan document or as required by law;

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

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

1. The Plan Administrator to oversee the administration of the Health Plan;
2. The Assistant Plan Administrator for the administration of the Health Plan;
3. Health Plan staff responsible for determining eligibility, adjudicating claims or responsible for the administration of the Plan; and
4. Staff designated by the Plan Administrator based on their job title and function.

E. The persons described in section D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan, unless additional use or disclosure is authorized by the individual.

F. If the persons described in section D do not comply with privacy guidelines outlined in this SPD, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

G. For purposes of complying with the HIPAA's Privacy Rule, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions, including the AD&D and life insurance. The Plan designates that its health care components that are covered by the Privacy Rule include only health benefits and no other plan functions or benefits.

NOTICE OF PRIVACY PRACTICES

Section 1: Purpose of This Notice and Effective Date

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

This Privacy Notice applies to the protected health information received and maintained by the Plan Office of the Operating Engineers' Local 57 Health & Welfare Plan (the "Plan"), and the services that the Plan provides through Blue Cross Blue Shield of Rhode Island ("BCBSRI"), Delta Dental and other business associates of the Plan. It does not pertain to how your medical providers, including your treating physician, may use, disclose or protect such information.

Effective date: The effective date of this Notice is April 14, 2003.

The Plan needs to create, receive and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your medical benefits. The notice tells you the ways the Plan may use health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

This Notice is required by law. The Plan is required by law to take reasonable steps to ensure the privacy of your PHI and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your rights to privacy with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS); and
5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The Plan's privacy policy and practices protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). PHI includes information maintained by the Plan in oral, written or electronic form. Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- For **treatment, payment or health care operations.** The Plan and its business associates will use PHI in order to carry out:
  1) Treatment;
  2) Payment; or
  3) Health care operations.

  Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating surgeon the name of your treating physician so that the surgeon may ask for necessary health information.

  Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorizations).

  For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a doctor that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

  Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

  For example, the Plan may use information about your claims to refer to into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

- **Disclosure to the Plan's Trustees.** The Plan will also disclose PHI to the Plan Sponsor, the Board of Trustees of the Operating Engineers' Local 57 Health & Welfare Plan, for purposes related to treatment, payment and health care operations, and has amended the Summary Plan Description to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal.

  In addition, the Plan may disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Plan's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experience by individuals for whom a Plan Sponsor such as the Board of Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

- **To a Business Associate.** Certain services may be provided to the Plan by third party administrators known as "business associates." In that event, the Plan will require its business associates, through contract, to appropriately safeguard your health information.
- **At your request.** If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- **When required by applicable law.**
- **As required by HHS.** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- **Public health purposes.** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- **Domestic violence or abuse situations.** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- **Health oversight activities.** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- **To an individual involved in your care or payment for your care.** The Plan may disclose PHI to a close friend or family member involved in or who helps to pay for your medical care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.
- **Legal proceedings.** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- **Law enforcement health purposes.** When required for law enforcement purposes (for example, to report certain types of wounds).
- **Law enforcement emergency purposes.** For certain law enforcement purposes, including:
  1) Identifying or locating a suspect, fugitive, material witness or missing person, and
  2) Disclosing information about an individual who is or is suspected to be a victim of a crime.
- **Determining cause of death and organ donation.** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

- **Military and Veterans.** If you are or become a member of the U.S. Armed Forces, the Plan may release medical information about you as deemed necessary by military command authorities.
- **Funeral purposes.** When required to be given to funeral directors to carry out their duties with respect to the decedent.
- **Research.** For research, subject to certain conditions.
- **Health or safety threats.** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- **Workers' Compensation programs.** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Any other Plan uses and disclosures not described in Section 2 of this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan must generally obtain your written authorization before:

- Using or disclosing psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan is not likely to have access to or maintain these types of notes.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

When You Can Object and Prevent the Plan from Using or Disclosing PHI

Disclosure of your PHI to family members, other relatives, your close personal friends and any other person you choose is allowed under federal law without your written consent or authorization if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You either have agreed to the disclosure or have been given an opportunity to object and have not objected.

Other Uses or Disclosures

The Plan may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Section 3: Your Individual Privacy Rights

Breach Notification

If a breach of your unsecured PHI occurs, the Plan will notify you.

You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to:

Privacy Official
International Union of Operating Engineers' Local 57 Health & Welfare Plan
857 Central Avenue
Johnston, Rhode Island 02919
Telephone: (401) 331-9191

You May Request Confidential Communications

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Plan's Privacy Official (at the address listed above).

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You also may request a summary of your PHI.

The Plan must provide the requested information within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. You may be charged a reasonable, cost-based fee for creating or copying the PHI, or preparing a summary of your PHI. Requests for access to PHI should be made to the Plan's Privacy Official (at the address listed above).

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and HHS.

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You Have the Right to Amend Your PHI

You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Plan's Right to Amend Policy (available on request from the Plan's Privacy Official) for a list of exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Plan's Privacy Official (at the address listed above). You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of certain disclosures by the Plan of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Plan's Accounting for Disclosure Policy (available on request from the Plan's Privacy Official) for the complete list of disclosures for which an accounting is not required.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Plan's Privacy Official (at the address listed above). This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Plan Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse of a member to be the personal representative of an individual covered by the plan. In addition, the Plan will consider a parent or guardian as the personal representative of a dependent child covered by the plan, unless applicable law requires otherwise. A spouse or parent of a dependent covered child may act on an individual's behalf, including requesting access to their PHI. Spouses and dependent covered children may, however, request that the Plan restrict information that goes to family members as described above at the beginning of Section 3 of this Notice.

You should also review the Plan's Policy and Procedure for the Recognition of Personal Representatives (available upon request from the Plan's Privacy Official) for a more complete description of the circumstances where the Plan will automatically consider an individual to be a personal representative for purposes of exercising your rights under this Privacy Notice.

Section 4: The Plan's Duties

Maintaining Your Privacy

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices. In addition, the Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

This notice is effective beginning on April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is materially changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

The Privacy Notice will be provided via first class mail to all named participants. Any other person, including dependents of named participants, may receive a copy upon request.

If material changes are made to this Notice, it will be posted on the Plan's website no later than the effective date of the revision and thereafter sent in the Plan's next annual mailing. "Material changes" are changes to:

1. The uses or disclosures of PHI;
2. Your individual rights;
3. The duties of the Plan; or
4. Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment;
2. Uses or disclosures made to you;
3. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA;
4. Uses or disclosures required by law; and
5. Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

1. Does not identify you; and
2. With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Section 5: Your Right to File a Complaint With the Plan or the Secretary of HHS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the following Privacy Official (at the address listed above).

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Filing instructions are available at **www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**.

The Plan will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the Plan Office.

Section 7: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Your Rights Under ERISA

As a participant in the Operating Engineers' Local 57 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security act of 1974. ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents, governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may

fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instances, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits 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 Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

Plan Administrator/Plan Sponsor

Trustees of the International Union of Operating Engineers'
Local 57 Health & Welfare Plan
857 Central Avenue
Johnston, Rhode Island 02919
Telephone: (401) 331-9191

The joint Board of Trustees, which administers the Plan, consists of two Union and two Employer representatives. The Trustees are listed on the inside cover of this booklet. You may contact them at the above address.

Plan Sponsor's Employer Identification Number

05-0269242

Plan Name

International Union of Operating Engineers' (IUOE) Local 57 Health and Welfare Plan

Plan Number

501

Fiscal Year/Plan Year End Date

December 31

Type of Plan

The IUOE Local 57 Health & Welfare Plan is a welfare benefit plan providing medical, prescription drug, dental, life insurance, and accidental death and dismemberment insurance benefits to participants and, where applicable, their dependents who meet the eligibility requirements described in this SPD.

Type of Plan Administration

As Plan Sponsor and Plan Administrator, the Board of Trustees has delegated Plan administrative responsibilities as follows:

- The IUOE Local 57 Plan Office: Maintains eligibility records, accounts for employer contributions, answers participant inquiries, may process certain claims and handles other general administrative tasks related to the Plan.
- Blue Cross Blue Shield of Rhode Island, Delta Dental of Rhode Island, and Union Labor Life Insurance Company provide claims administration and other services under group insurance contracts.

Agent for Service of Legal Process

Thomas C. Plunkett, Esq.
Kiernan, Plunkett & Redihan
91 Friendship Street
Providence, Rhode Island 02903

You may also serve legal process upon any of the Trustees.

Employer Trustees	Union Trustees
Mr. Stephen A. Cardi Cardi Construction Corporation 400 Lincoln Avenue Warwick, RI 02888	Mr. James J. White IUOE Local 57 857 Central Avenue Johnston, RI 02919
Mr. Michael D. D'Ambra D'Ambra Construction 800 Jefferson Boulevard Warwick, RI 02886	Mr. Steven Rogers IUOE Local 57 857 Central Avenue Johnston, RI 02919

Labor Organization

International Union of Operating Engineers' Local 57 Health & Welfare Plan
857 Central Avenue
Johnston, Rhode Island 02919
Telephone: (401) 331-9191

A list of labor organizations covered under the Plan is available from the Plan Administrator upon written request, as is a list of names and addresses of employers who participate in the Plan.

Discretionary Authority of the Board of Trustees and/or Its Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and any other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated by the Board, will have broad discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Funding Medium

The Health & Welfare Plan is a separate trust for the purpose of paying the benefits provided under the Plan.

Benefits are provided from the Plan's assets, which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in a trust for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Medical and prescription drug benefits are underwritten by Blue Cross Blue Shield of Rhode Island. Dental benefits are underwritten by Delta Dental of Rhode Island. Life insurance and accidental death and dismemberment benefits are underwritten by Union Labor Life Insurance Company.

The majority of the Plan's assets and reserves are presently invested in U. S. government and other fixed income securities in accordance with the guidelines of the Board of Trustees.

Source of Contributions

All contributions to the Plan are made by employers in accordance with their collective bargaining agreements (CBAs) with the Labor Organization. The CBAs require contributions to the Plan at fixed rates per payroll hour. You are not required or permitted to contribute to the Plan.

The Plan Office will provide you, upon written request, with information as to whether a particular employer is contributing to this Plan on behalf of employees working under a CBA and, if so, with that employer's address.

Availability of Certain Documents

As a member, a copy of the collective bargaining agreement(s), plan documents, insurance contracts and documents filed with the Department of Labor are available for your inspection during business hours at the labor organization headquarters, 857 Central Avenue, Johnston, Rhode Island. You may also make a written request to receive a copy of these documents from the Plan Administrator.

No Liability for Practice of Medicine

Neither the Plan, the Plan Administrator or any of their designees are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, of any health care services provided or delivered to you by any health care provider. Similarly, neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

The Trustees have selected Blue Cross Blue Shield of Rhode Island ("BCBSRI") to provide an exclusive contracted panel of hospitals and physicians throughout your area who are ready to offer a complete continuum of care. BCBSRI represents that it selected these health care providers based on their demonstrated commitment to providing and maintaining the highest quality of care. BCBSRI and the physicians and providers in its network are independent and separate entities, not affiliated with or under the control of the Board of Trustees of the Plan. The Trustees cannot take responsibility for the quality of care or treatment decisions received through BCBSRI or its providers nor will the Trustees interfere in the professional relationship between a member and his or her physician.

Plan Information

The Plan's requirements, with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are described earlier in this SPD.

Insurance Policies and Plan Regulations

The complete terms of the insured benefits are set forth in the insurance policies (certificates) or contracts with the following organizations:

MEDICAL AND PRESCRIPTION DRUG BENEFITS:

Blue Cross Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699

DENTAL BENEFITS:

Delta Dental of Rhode Island
10 Charles Street
Providence, RI 02904-2208

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910

NOTICE OF GRANDFATHERED STATUS

The Trustees of the IUOE Local 57 Health & Welfare Plan (the "Plan") believe 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 the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding 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 Plan Office at:

International Union of Operating Engineers' Local 57 Health & Welfare Plan
857 Central Avenue
Johnston, Rhode Island 02919
Telephone: (401) 331-9191

Individuals may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**.


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