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

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Administered by
Welfare & Pension Administration Service, Inc.

July 2, 2015

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

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

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

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

Coverage of Preventive Care

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

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

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

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

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

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

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

Benefits Payable for Covered Preventive Care

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

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

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

Out-of-Pocket Maximum

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

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

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

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

Emergency Services Received in a Hospital Emergency Department

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

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

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

Coverage for Costs Associated with Certain Clinical Trials

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

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

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

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

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

Outpatient Dialysis Treatment Benefits for ESRD

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

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

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

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

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

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

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

Appeal Procedures

Appeal Procedures

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

Amendment Effective September 1, 2015

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

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

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

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

Preliminary Review of External Review Request

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

Review by Independent Review Organization

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

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

Clarification of Hearing Care Expenses

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

Non-Grandfathered Status Under Affordable Care Act

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

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

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

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