Washington-Idaho Operating Engineers-Employers Health & Security Trust Fund

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 441-7574 or (800) 351-6480 • Fax (206) 505-9727 • Website: www.wa-idengineerstrustfunds.com

Administered by
Welfare & Pension Administration Service, Inc.

May 15, 2019

To: Active Participants and Non-Medicare Retirees of the Washington-Idaho Operating Engineers and Employers Health and Security Fund

Re: Telemedicine Provider Change Effective June 1, 2019

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description material.

Effective June 1, 2019, the Washington-Idaho Operating Engineers and Employers Health and Security Fund will move its telemedicine services from MDLIVE to SwiftMD.

SwiftMD is available to all Active participants and non-Medicare retirees. As a reminder, you can visit a doctor without leaving home. SwiftMD provides 24/7 access to a board certified, licensed family practice doctor or pediatrician via phone or video. SwiftMD is not a substitute for a primary care doctor, but can be used to diagnose and treat common, non-emergent medical issues that may arise such as:

Cold and flu	Headaches
Sore throat	Urinary tract infection
Rashes	Fever
Allergies	Respiratory infections

SwiftMD doctors can also write short term prescriptions and will send the script electronically to the pharmacy of your choice, when appropriate. After the visit, at your request, the doctor will send electronic chart notes to your primary care doctor.

You pay $0 copay and you do not have to satisfy your deductible. You will receive more information about this benefit the first week of June, including an identification card and instructions on how to register with SwiftMD. Watch your mail for more information!

Sincerely,

Board of Trustees
Washington-Idaho Operating Engineers and Employers Health and Security Fund

November 21, 2018

To: All Plan Participants
Washington-Idaho Operating Engineers-Employers
Health and Security Trust Fund

Re: New Pharmacy Benefit Manager and New Administrator
Effective January 1, 2019

New Pharmacy Benefit Manager

The Board of Trustees of the Washington-Idaho Operating Engineers-Employers Health and Security Trust Fund (the "Trust") selected OptumRx to replace CVS Caremark as the Plan's Pharmacy Benefit Manager (PBM) effective **January 1, 2019.** OptumRx will administer the retail, mail-order and specialty drug benefits for all participants. In the coming weeks, you will be receiving a Welcome Kit with additional information directly from OptumRx. Please watch your mail. Your benefits for prescription drugs will not be changing. However, there may be some changes to the plan's list of covered drugs, known as the plan's formulary. You will be notified by OptumRx if you are currently taking a prescription drug that will be affected by a formulary change.

New Administrator

Effective January 1, 2019, Welfare & Pension Administration Service, Inc. (WPAS) has been selected as the new Administrator for the Trust. This means WPAS will assume responsibility for administration of health plan enrollment, eligibility processing and claims payment. WPAS is a Union shop that specializes in the administration of Union benefit plans. Please note there are no changes to your medical, dental, vision, life/AD&D and time loss benefits. Premera will continue to be the preferred provider network (PPO) for medical services and VSP will continue as your vision coverage provider. You will also still have the option of electing dental coverage through Willamette Dental.

Beginning January 1, 2019, you can contact the Administration Office at:

WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203
(800) 351-6480 or (206) 441-7574
Hours: 8:00 a.m. – 5:00 p.m. PST

New Medical and Prescription Drug Identification Card (ID)

New ID cards identifying you as a Premera and OptumRx network member will be mailed to you directly from Premera in late December. **Use your new Medical/Prescription Drug ID card for services provided on or after January 1, 2019**.

If you have questions before January 1, 2019, please contact your current Benefits Administrator, Zenith at (509) 534-5625 or (800) 351-6480.

The Trustees and WPAS are making every effort to minimize disruption during this transition.

Board of Trustees
Washington-Idaho Operating Engineers-Employers
Health and Security Trust Fund

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

February 2018

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Hour Bank Freeze/Forfeiture – Effective March 1, 2018

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

The Trustees continuously review Plan benefit design and procedures. In the course of their review of the Plan the Trustees have updated eligibility provisions as follows:

ELIGIBILITY PLAN CHANGES

The following provision is added to page 14 of the Summary Plan Description which implements an hour bank freeze and forfeiture.

Hour Bank Freeze and Forfeiture

Work for a Non-Contributing Employer – Eligibility Freeze and Forfeiture

Notwithstanding any other provision or rule of this Plan, if you are eligible for benefits, your benefits will be frozen and forfeited if you work:

- In the industry, which means work for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and
- In a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or as an employee.

First Offense

Upon a participant's first offense, his/her benefits will be frozen. While your coverage is frozen, no benefits or claims are payable with respect to any expenses incurred by you or your dependents during the "freeze" period. For each month in which you continue to work for a non-contributing employer, you will permanently forfeit one month of coverage from your hour bank.

To reinstate frozen eligibility, you must return to work for a contributing employer and work at least the number of hours required by the Plan to maintain continuing eligibility. If you do not reinstate hour bank eligibility before your dollar bank is exhausted, you will be required to satisfy the initial eligibility rules to again be covered.

Second Offense

Upon a participant's a second offense, eligibility for benefits for a participant and his/her eligible dependents will terminate, and all hours accumulated in his/her hour bank will be forfeited, at the end of the month in which the participant becomes employed in the industry for a non-signatory employer, in a position which would otherwise be covered by an IUOE Labor Agreement.

These freeze and forfeiture rules do not apply if you are temporarily employed under a written agreement with any of the Operating Engineers local unions participating in the Plan. These freeze and forfeiture provisions do not affect COBRA rights for you and your dependents.

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding these changes, please contact the Administration Office at (800) 351-6480 or (509) 624-3257.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

May 2017

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Notice of Plan Changes – Effective May 1, 2017

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

MDLIVE - TELEHEALTH PROGRAM
The Trustees are pleased to announce a new MDLive Telehealth benefit with a $0 copay, available to eligible members and their eligible dependents

WHAT IS MDLIVE?
With MDLIVE, you can access a board-certified doctor via secure online video, phone or the MDLIVE App– anytime, anywhere, 24/7/365. MDLIVE was designed as an alternative to expensive urgent care visits or waiting days to get an appointment with your primary care doctor for non-emergency medical conditions. MDLive doctors can diagnose your symptoms, prescribe non-narcotic medication (if needed), and send e-prescriptions to your pharmacy of choice. (Note: currently, due to state laws, MDLive services in Idaho are limited to video only).

IS MDLIVE APPROPRIATE FOR EVERY MEDICAL CONDITION?
No. MDLIVE is designed to handle non-emergency medical conditions and can often substitute for a doctor's office, urgent care center or emergency room visit for common conditions like the flu or pink eye. However, it is not intended to replace your primary care doctor or to be used in life-threatening emergencies.

WHAT'S THE COST?
For eligible members and dependents, your Plan will cover the consultation fee at 100%, so there is no copay or out of pocket cost for the consultation.

HOW DO I SIGN UP FOR MDLIVE OR ACTIVATE MY MDLIVE ACCOUNT?
You can easily sign up or activate your account by using one of the following methods:

1. Visit **mdlive.com/wioe**
2. Download the MDLIVE App, available for iPhone, Android, and Windows smartphones.
3. Call MDLive at (888) 854-2490 and choose Option #1. It will first describe the online activation, choose Option #1 again to activate your account with a representative. Your group ID is **WIOE.**

PLEASE SEE ATTACHED FLYER FOR ADDITIONAL INFORMATION

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 351-6480 or (509) 624-3257.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,
Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

October 2016

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Notice of Plan Changes – Effective February 1, 2017

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

The Trustees continuously review Plan benefit design and procedures. In the course of their review of the Plan the Trustees have updated coverage and appeals procedures as follows:

BENEFIT PLAN CHANGES

1) Gender Transformation Coverage

The Affordable Care Act's (ACA) final non-discrimination rule prohibits any explicit or categorical exclusion of coverage for all health services related to gender transformation. The Plan still requires that all services be determined medically necessary in order to be covered. Therefore, in compliance with the operation of the Plan and the ACA regulations, the Limitations/Exclusions section of the Plan is amended as follows:

KK. Any loss, Expense or charge for sex transformation except as determined medically necessary under the Plan.

2) Dosage Limit Waiver of Cialis for Treatment of BPH

The Plan currently covers prescription drugs for the treatment of erectile dysfunction (ED) with a dosage maximum of 10 pills per month. The FDA has approved the ED drug Cialis for treatment of an enlarged prostate or benign prostatic hyperplasia (BPH). Based on the FDA approval, the Plan will now cover charges for Cialis beyond the maximum of 10 pills per month for the treatment of BPH. This coverage requires prior authorization under the Plan. The maximum dosage limitation will remain in place for all other ED drugs and for the treatment of ED.

Claims and Appeals Procedure Changes

180-Day Statute of Limitations to File a Civil Claim

The Plan contains a Claims and Appeals procedure for benefit claim denials. After exhaustion of this internal procedure, a claimant, if still unsatisfied with the determination, has the right to pursue his or her claim through civil litigation pursuant to section 502(a) of the Employee Retirement Income Security Act (ERISA). ERISA does not contain a statute of limitations for which a claimant may pursue civil litigation under section 502(a). However, a Plan may implement its own limitation for filing such claims. The Board of Trustees adopted a 180-day statute of limitations to file a civil claim based on an adverse benefit determination. Page 56 of the Plan is therefore amended to read as follows:

Appeal of Board's Decision

If the claimant is dissatisfied with the written decision of the Board of Trustees, he or she shall have 180 days from the date the decision is issued to pursue his or her claim through civil litigation pursuant to section 502(a) of ERISA. The standard of review on appeal shall be whether, in the particular instance, the Trustees 1) were in error upon an issue of law; 2) acted arbitrarily or capriciously in the exercise of their discretion; or 3) whether their findings of fact were supported by substantial evidence.

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 351-6480 or (509) 624-3257.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

December 10, 2015

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Injectable Drug Coverage – Effective January 1, 2016

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

INJECTABLE DRUG COVERAGE

Beginning January 2016 the Trust will be changing the way benefits for some injectable drugs are administered. This will include insulin for diabetes and injectable drugs for Rheumatoid Arthritis and certain other conditions.

Currently members pay the full cost for these drugs at the pharmacy and then submit a claim to the Trust office. The Trust then reimburses the member subject to the medical deductible, coinsurance and annual out-of-pocket maximum.

Beginning January 2016, these drugs will process under the Trust's prescription drug benefit administered by CVS/Caremark. Members will pay only the applicable prescription drug deductible and copay at the pharmacy when they pick up the prescription. There will be no claims to file when using a CVS/Caremark pharmacy.

For active members, injectable drugs will be processed the same as any other prescription, subject to the prescription drug deductible, copay and $1,000 annual out-of-pocket maximum.

For retired members, injectable drugs will be processed the same as any other prescription, subject to the prescription drug deductible and copay. However, these injectable drugs will NOT be subject to the retiree maximum annual drug benefit of $1,000 per family. Instead, these drugs will be subject to a separate $1,000 per person out-of-pocket maximum. Once this maximum is met, these injectable drugs will be covered at 100% for the remainder of the calendar year. *Please note, if you have Medicare Part D coverage outside of the Trust, this change will not affect you. The Medicare Part D coverage will continue to be your primary drug coverage, and you will continue to submit claims to the Trust office for secondary coverage of your Part D out of pocket expenses.*

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 351-6480 or (509) 624-3257.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

October 2015

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Changes to Benefits and Retiree and Disability Self-Pay Rates

This is a summary of material modification describing changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

This notice includes information about upcoming changes to the Trust's medical and prescription drug benefits and changes to the self-pay contribution rate structure for the Trust's retiree and disability medical plan. Since these changes impact all Trust participants, it is being distributed to both Active and Retired Participants. Please read the notice carefully, especially if you are retired or are planning to retire in the near future.

MEDICAL BENEFIT CHANGES

The following changes will be made to the Trust's medical benefits effective with claims incurred on or after January 1, 2016:

1) Increase in Calendar Year Deductible.

The calendar year deductible for medical expenses will increase from $300 per person to $390 per person. The maximum family deductible will increase from $600 per family to $780 per family.

2) Increase in Calendar Year Maximum Out-of-Pocket.

The calendar year maximum out-of-pocket limit for medical expenses will increase from $2,500 per person to $3,250 per person. The maximum family out-of-pocket limit will increase from $5,000 per family to $6,500 per family. The out-of-pocket limit does not include deductibles or copayments.

3) Increase in Office Visit Copay.

The office visit copay under the medical plan will increase from $20 per visit to $25 per visit.

4) Increase in Emergency Room Copay

The emergency room copay for non-emergency care will increase from $75 to $95. The copay is waived if the covered person is admitted directly to the hospital from the emergency room, or if the emergency room visit is the result of an accident or life threatening illness.

PRESCRIPTION DRUG BENEFIT CHANGES

The following changes will be made to the Trust's prescription drug benefit plan administered by CVS/Caremark:

1) Dispense as Written (DAW) penalty.

Beginning January 1, 2016, if you are prescribed a brand name drug with a generic equivalent, and you choose to have the brand name drug filled, you will be responsible for the applicable coinsurance, plus the difference in cost between the brand name drug and the generic equivalent (penalty). If your doctor indicates the brand name drug is required, the penalty will not apply.

2) Prescription Drug Formularies

Beginning April 1, 2016 the Trust's prescription drug coverage will be subject to CVS/Caremark's Standard Formulary and Advanced Control Specialty Formulary. A formulary is a list of drugs covered by the plan. Drugs are included and/or excluded from the formulary based on cost and effectiveness. The formularies include generic, brand name and specialty drugs to treat all conditions. If you are currently using a drug that is not included in the formulary, you will need to work with your doctor to switch to a drug that is on the formulary. If your doctor believes a non-formulary drug is medically necessary for your specific circumstance, you and your doctor will need to work with CVS/Caremark to request an exception.

Watch your mail carefully. You will be receiving more detailed information directly from CVS/Caremark in advance of the effective date of the formularies, including notice of any medications you are taking which are non-formulary.

RETIREE SELF-PAY CONTRIBUTION RATE CHANGES

As a Participant in the Washington-Idaho Operating Engineers and Employers Health & Security Trust (the Trust), you have access to retiree and disability medical coverage at a discounted (subsidized) cost if certain criteria are met. The Trust subsidy is equal to the actual cost of providing the coverage less the self-pay rate. The retiree and disability subsidy is provided from the reserves of the Trust, and is only sustainable if sufficient reserves are maintained. The Trustees have been reviewing contribution rate options to provide a more financially sustainable and equitable distribution of the Trust subsidy over the long term. The goal is for coverage to be both affordable and equitable for the retiree and/or disabled member and sustainable for the Trust.

The Trustees have adopted a new contribution rate structure which will be effective beginning January 2016. The new structure is as follows:

1) Rules for qualifying for retiree and disability coverage will NOT change (see page 32 of the current SPD for full details).

- Totally and Permanently Disabled, or
- Age 55 or older and ten credits or 15,000 hours earned, including 3,000 hours accumulated in this Trust within the five years immediately preceding the commencement of retirement benefits from the Engineers-AGC Retirement Trust Fund of the Inland Empire or the Idaho Operating Engineers-Employers Pension Trust Fund.

2) Self-pay rates and subsidy will be based on age at initial retirement and total eligible hours accumulated in the Trust.

For Members Retiring on or after January 1, 2016 - Retiree self-pay rates will be equal to the actual cost of coverage multiplied by a percentage that is based on initial age at retirement and total eligible hours accumulated in this Trust. The more hours a member works during their career, and the later their initial retirement date, the greater the subsidy will be during their retirement. Conversely, a member with fewer hours who retires at a younger age will have a lower subsidy during their retirement, and therefore a higher self-pay rate. The self-pay percentage for an eligible spouse will be equal to the percentage for the retiree.

For Members Retired prior to January 1, 2016 – The Board of Trustees has approved a special "grandfathering" provision for current retirees and those retiring prior to January 1, 2016. These retirees will have the lowest self-pay percentage (highest subsidy level) based on hours worked, regardless of their actual age at retirement. The same percentage will apply for the eligible spouse of a retiree.

For Disabled Members – Members who are Permanently and Totally Disabled may qualify for coverage at any age provided all other requirements for eligibility are met. Because disabled members do not have the opportunity to continue earning a retiree subsidy by working additional hours, all disabled members who qualify for coverage will receive the highest level of subsidy regardless of their actual hours worked or age at disability.

The Table below shows the percent of the total cost a retiree or disabled member will self-pay during their retirement based on total eligible hours and age at initial retirement. The remaining amount of the cost is the subsidy provided by the Trust. For example, a member with over 45,000 eligible hours who retires at age 60 or over will pay 55% of the total cost (45% Trust subsidy). Members with a minimum 10 years credited service or less than 22,500 eligible hours who retire prior to reaching age 58 will be required to pay the full cost of coverage during their retirement (no Trust subsidy).

Retiree Self-Pay Table (% of Cost)

Age at Retirement	10 Years of Credited Service or 15,000 to 22,499 hours	22,500 to 29,999 hours	30,000 to 37,499 hours	37,500 to 44,999 hours	45,000+ hours and Disabled[1]
55	**100%**	**90%**	**85%**	**80%**	**75%**
56	**100%**	**85%**	**80%**	**75%**	**70%**
57	**100%**	**80%**	**75%**	**70%**	**65%**
58	**95%**	**80%**	**75%**	**65%**	**60%**
59	**90%**	**75%**	**70%**	**60%**	**55%**
60+	**85%**	**75%**	**65%**	**60%**	**55%**
Grandfathered[2]	**85%**	**75%**	**65%**	**60%**	**55%**

[1] Disabled self-pay percentage will be set at age 60+ amount.

[2] Self-pay percentage for retirees with retirement dates prior to January 1, 2016.

Non-Medicare Eligible Retiree Rates:

The following table shows the actual self-pay rates for 2016 for non-Medicare retirees and spouses. The amounts in the table are per individual per month (retiree or spouse).

Non Medicare Rates (Per Individual Per Month)

Age	10 Years of Credited Service or 15,000 to 22,499 hours	22,500 to 29,999 hours	30,000 to 37,499 hours	37,500 to 44,999 hours	45,000+ hours and Disabled[1]
55	**$495.00**	**$446.00**	**$421.00**	**$396.00**	**$371.00**
56	**$495.00**	**$421.00**	**$396.00**	**$371.00**	**$347.00**
57	**$495.00**	**$396.00**	**$371.00**	**$347.00**	**$322.00**
58	**$471.00**	**$396.00**	**$371.00**	**$322.00**	**$297.00**
59	**$446.00**	**$371.00**	**$347.00**	**$297.00**	**$272.00**
60+	**$421.00**	**$371.00**	**$322.00**	**$297.00**	**$272.00**
Grandfathered[2]	**$421.00**	**$371.00**	**$322.00**	**$297.00**	**$272.00**

[1] Disabled self-pay rate will be set at age 60+ amount.

[2] Self-pay rate for retirees with retirement dates prior to January 1, 2016.

Medicare Eligible Retiree Rates:
The following table shows the actual self-pay rates for 2016 for Medicare eligible retirees and spouses. The amounts in the table are per individual per month (retiree or spouse).

Medicare Rates (Per Individual Per Month)					
Age	10 Years of Credited Service or 15,000 to 22,499 hours	22,500 to 29,999 hours	30,000 to 37,499 hours	37,500 to 44,999 hours	45,000+ hours and Disabled[1]
55	**$283.00**	**$255.00**	**$240.00**	**$226.00**	**$212.00**
56	**$283.00**	**$240.00**	**$226.00**	**$212.00**	**$198.00**
57	**$283.00**	**$226.00**	**$212.00**	**$198.00**	**$184.00**
58	**$269.00**	**$226.00**	**$212.00**	**$184.00**	**$170.00**
59	**$255.00**	**$212.00**	**$198.00**	**$170.00**	**$160.00**
60+	**$240.00**	**$212.00**	**$184.00**	**$170.00**	**$160.00**
Grandfathered[2]	**$240.00**	**$212.00**	**$184.00**	**$170.00**	**$160.00**

[1] Disabled self-pay rate will be set at age 60+ amount.

[2] Self-pay rate for retirees with retirement dates prior to January 1, 2016.

Current retirees covered under the retiree medical plan will receive notification of their new self-pay rates, "grandfathered" at the lowest self-pay level based on hours worked. This notification will be provided by the Trust office prior to January 1, 2016.

3) New Three-year Break in Service Provision

Effective January 1, 2016 there will be a three-year break in service provision for active members. If a member does not have hours reported to the Trust for three consecutive calendar years, accumulation of hours for retiree eligibility and subsidy will reset to zero. One hour per year reciprocity credit will be granted for a member working outside the geographic area of this Trust fund for a union contractor under IUOE jurisdiction.

Please note that retiree and disability coverage, including any subsidy, is not a vested benefit. These benefits are available as long as it is economically feasible as determined by the Board of Trustees. The Trustees hope that these changes will allow retiree and disability coverage and subsidies to remain in place going forward.

The Trust is planning on conducting a series of member meetings in November to provide more information and answer your questions regarding the 2016 changes. You should have received a blue postcard regarding meeting dates and locations.

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 351-6480 or (509) 534-5625.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

October 2015

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Autism and Habilitative Care Coverage – Effective August 1, 2015

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

BENEFIT PLAN CHANGES - AUTISM AND HABILITATIVE CARE COVERAGE

1) The Definitions section of the current SPD is amended to include the following:

Habilitative Care - Physical therapy, occupational therapy and speech therapy prescribed by the attending physician to the extent that the therapy will help a person to improve function or maintain function where significant deterioration in function would result without the therapy. Function means the ability to execute skills required for activities of daily living which would be normal and expected based on the age of the patient. The patient must continue under the care of the attending physician during the time the therapy is being provided. Services may be limited as described elsewhere in the Summary Plan Description. The Plan may periodically request a review of the services by a physician. Benefits will end when the Plan determines that no additional clinical improvement or maintenance of function is expected as a result of the therapy.

Rehabilitative Care - Physical therapy, occupational therapy and speech therapy prescribed by the attending physician to the extent that the therapy will significantly restore and improve a lost function(s) following an illness, injury or surgery. The services must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy. The patient must continue under the care of the attending physician during the time the therapy is being provided. Services may be limited as described elsewhere in the Summary Plan Description. The Plan may periodically request a review of the services by a physician. Benefits will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy.

2) On page 10 of the current SPD, the following definition is amended as noted below:

Mental Disorders/Alcohol and Drug Abuse and/or Substance Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases ("ICD") and the Diagnostic and Statistical Manual of Mental Disorders ("DSM") as a Mental Disorder. Items not included in this definition are conditions or diseases specifically excluded from the Plan.

3) On page 11 of the current SPD, the following definition is amended as noted below:

Physical Therapy means treatment for Habilitative and/or Rehabilitative Care by:

A. manual manipulation or other physical means; and
B. hydrotherapy; and
C. heat; and
D. biomechanical and neurophysiological principles and devices; used to:
    1. relieve pain; and
    2. restore and/or maintain bodily function; and
    3. prevent Disability arising from Injury or Sickness.

4) On page 12 of the current SPD, the following definition is amended as noted below:

Speech Therapy means treatment for the correction of a speech impairment resulting from an Injury, Sickness or surgery, or such treatment following surgery to correct congenital and developmental anomalies. Speech Therapy is covered only if there is a Physician's recommendation that Speech Therapy is required for a Covered Person and the therapy meets the definition of Habilitative and/or Rehabilitative Care.

5) On page 29 of the current SPD, the following benefit language is amended as noted below:

Speech Therapy
If while covered under the Plan a participant incurs Expenses for Speech Therapy, the Plan will pay benefits at 80% up to a maximum of $1,200 per Calendar Year, subject to deductible, and only if the therapy meets the definition of Habilitative and/or Rehabilitative Care and Medical Necessity has been established.

6) The SPD is amended to add the following benefit language:

Applied Behavioral Analysis (ABA) Therapy
The Plan will pay for covered Charges for ABA Therapy treatment for Covered Persons diagnosed with Autism Spectrum Disorder (ASD). To be covered, the person must be referred for ABA therapy treatment by a Physician, and all ABA services must be medically necessary and pre-approved by the Plan.

7) The following exclusions listed on page 54 of the current SPD are amended/removed as noted below:

DD. Any Expense or charge for Custodial Care or Developmental Care, unless otherwise listed as a covered Expense.

JJ. is removed: ~~JJ. Any loss, Expense or charge related to Mental Health Sickness which are classified as sexual deviations or disorders.~~

QQ. Any loss, Expense or charge which results from services for developmental Disability, except for those services which are Medically Necessary and meet the definition of Habilitative Care. In addition, some services such as Prescription Drugs, x-rays and lab tests may still be covered if Medically Necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration.

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 351-6480 or (509) 624-3257.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

October 2015

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Dialysis Benefit for End Stage Renal Disease (ESRD) – Effective June 1, 2015

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

DIALYSIS BENEFIT FOR END STAGE RENAL DISEASE (ESRD)

If you or your covered dependent is diagnosed with End Stage Renal Disease ("ESRD"), you may be eligible for Medicare coverage. Although you are not obligated by the Plan to apply for Medicare Part A and/or Part B, it is important to note that **enrolling in Medicare coverage may protect you from balance billing by providers of ESRD dialysis services**.

Dialysis benefits are currently paid by the Plan subject to the medical deductible and coinsurance. If you or your covered dependent is diagnosed with ESRD, **the following benefits will apply for dialysis services received on or after June 1, 2015**:

- Once you or your dependent becomes, or is eligible to become, qualified for Medicare ESRD coverage, and Medicare becomes, or is eligible to become, the secondary payer for ESRD services **(usually beginning with the 4th month of treatment), the Plan will pay claims for ESRD dialysis services at 150% of the then current Medicare allowable amount**. These services will not be subject to the Plan's deductible, coinsurance or copays

- Once you or your dependent becomes, or is eligible to become, qualified for Medicare ESRD coverage, and Medicare becomes, or is eligible to become, the primary payer for ESRD services **(usually beginning with the 34th month of treatment), the Plan will pay claims for ESRD services at 100% of the then current Medicare allowable amount**. These services will not be subject to the Plan's deductible, coinsurance or copays.

- Coverage for all other ESRD dialysis services will remain unchanged.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, members are required to provide the Administration office with the effective date of Medicare coverage. In addition, **it is highly recommended that members diagnosed with ESRD contact the Trust's medical management vendor, Innovative Care Management (ICM) at (800) 862-3338**. The ICM Case Management nurse can assist you in understanding your care options and how services will be covered by the Plan and/or Medicare.

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, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above. Any contractual agreement and/or change in payment terms with a provider of ESRD services will be at the sole discretion of the Plan.

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 351-6480 or (509) 624-3257.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
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Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

WASHINGTON IDAHO OPERATING ENGINEERS HEALTH & SECURITY TRUST

ZENITH AMERICAN SOLUTIONS
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 534-5625 FAX (509) 534-5910
1-800-351-6480

April 1, 2014

TO: All Participants of the Washington-Idaho Operating Engineers and Employers Health & Security Trust

FROM: Board of Trustees

RE: Medical PPO Network Change – Effective April 1, 2014
Precertification Vendor Change – Effective April 1, 2014

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Plan Booklet.

MEDICAL PLAN PREFERRED PROVIDER NETWORK CHANGE TO PREMERA BLUE CROSS

The Trust is currently utilizing the First Choice Health Network for medical providers.

Due to the high cost of health care benefits and increased utilization, the Trust reviewed medical plan Preferred Provider Network options available that would provide the largest network to members based on the Trust's current utilization as well as potential savings to members and the Plan. Based on the competitive bid process and network analysis, this is to advise you that **the Trustees have elected to change the medical PPO Network and utilize the Premera Blue Cross PPO Network effective April 1, 2014**.

The First Choice and Premera networks contain many of the same providers, however there may be some providers who are in one network but not the other. Feel free to visit the Premera website at www.premera.com, select find a doctor and select **BlueCard PPO** in the third menu option (also includes hospitals). You have access to the national Blue Card PPO network. All plans listed (i.e., Heritage, Heritage Plus 1, Foundation, etc.) are included in the Blue Card PPO network. Therefore, if your provider/facility is listed, they are included in the network.

You can also contact customer service at 1-800-810-BLUE (2583) to determine if your providers are participating in the network. You may still use any licensed provider of your choosing, however, preferred contracted providers have agreed to reduce their charges. This could result in lower out of pocket costs to you and savings to the Trust.

There is no change to the prescription drug plan or network being utilized through Caremark.

There are no changes to the actual plan benefits currently in place. This is a medical network change only and all other plan provisions, including the medical necessity requirements, will apply.

NEW IDENTIFICATION CARDS

New ID cards will be sent to you directly from Premera.

PRECERTIFICATION VENDOR CHANGE

Precertification is required for all inpatient hospitalizations prior to admission. If an emergency admittance, you, your representative or the hospital must call within two (2) business days following the admittance or as soon as reasonably possible.

Effective April 1, 2014, Innovative Care Management (ICM) will assume responsibility for the hospital management and preauthorization program. ICM can be reached at (800) 862-3338. This information is also reflected on your new identification (ID) cards. As of April 1, 2014, you should begin using the new cards for accessing all Plan benefits.

NOTE: Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 351-6480 or (509) 624-3257.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Sincerely,

Board of Trustees

Washington-Idaho Operating Engineers and Employers Health & Security Trust

Zenith American Solutions, Inc.
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 624-3257 or (800) 351-6480

Summary of Material Modification
January 1, 2013

TO: All Active, Retired and COBRA Eligible Participants and Their Dependents
Washington-Idaho Operating Engineers and Employers Health & Welfare Plan

RE: Notice of Plan Changes Effective January 1, 2013

The Washington-Idaho Operating Engineers and Employers Health & Welfare Plan ("Trust") has made certain material modifications to the Plan; these changes are outlined below. **This notice provides VERY IMPORTANT information to you and your Eligible Dependents**. Please take the time to read it carefully and keep it with your important paperwork.

ANNUAL MEDICAL MAXIMUM BENEFIT INCREASE

Effective January 1, 2013, the annual benefit limit is $2,000,000 for active and retired participants.

BENEFIT ENHANCEMENT – VSP VISION BENEFITS (ACTIVE PLAN ONLY)

Effective January 1, 2013, several enhancements have been added to the VSP Plan as follows:

Contact Lens Benefit: The contact lens benefit design will separate the contact lens exam (fitting and evaluation) from the material coverage. Members choosing contact lenses will now receive a covered-in-full contact lens exam after a not-to-exceed $60 co-pay. This co-pay applies to both standard *and* premium fit contact lens wearers. Members will also continue to receive a 15% discount on all contact lens exam services. This new benefit design offers more value by allowing members to use their full contact lens allowance toward contact lenses.

Diabetic Eyecare Plus: The Diabetic Eyecare Plus Program provides coverage for additional eyecare services targeted specifically for members with type 1 and type 2 diabetes. The copay for these additional services is $20.

VSP Affiliate Program: Benefits will now be covered through VSP affiliate providers such as Costco and Eye Care Centers of America. A separate summary of this plan is included with this notice. Please keep in mind that not all Costco providers and locations participate. Check with the location you would like to utilize prior to having services done to confirm whether they are participating in this program or not.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at 1.800.351.6480. or 509.624.3257.

Sincerely,
Board of Trustees
Washington-Idaho Operating Engineers-Employers Health & Security Trust

Washington-Idaho Operating Engineers and Employers Health & Security Trust

Zenith Administrators, Inc.
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 624-3257 or (800) 351-6480

DATE: **March 15, 2011**

TO: **All Participants**

RE: **Eligibility and Benefit Changes to Your Health Care Plan**

ELIGIBILITY AND BENEFIT CHANGES REQUIRED UNDER HEALTH CARE REFORM

Effective January 1, 2011, the Board of Trustees approved eligibility and benefit changes required to comply with the Patient Protection and Affordable Care Act (PPACA). The following table shows current eligibility requirements and benefit provisions, and the changes which have gone into place in accordance with PPACA:

ELIGIBILITY/ BENEFIT PROVISION	CURRENT	EFFECTIVE JANUARY 1, 2011
Dependent Child Coverage	Up to Age 19, provided the child is unmarried, resides with the participant and is primarily dependent upon the participant for support; if over 19, up to age 23, if enrolled as a fulltime student in accredited educational institution; coverage will continue after age 19 or 23, if dependent is incapable of self-sustaining employment due to physical or mental handicap	Up to Age 26, regardless of marital status or financial dependency. Children are not eligible for coverage under this Plan if they have other group health plan coverage available through their own employment, or their spouse's employment *(The spouse and children of a dependent child are not eligible for coverage under this Plan.)*
Medical Lifetime Maximum Benefit (Applies to all Medical benefits)	$1,000,000 lifetime max benefit, up to $1,000 annual reinstatement of benefit	No lifetime maximum *(Benefit specific lifetime maximums will still apply unless otherwise stated in this notice.)*

ELIGIBILITY/ BENEFIT PROVISION	CURRENT	EFFECTIVE JANUARY 1, 2011
Medical Annual Maximum Benefit per person(Applies to all Medical benefits)	None	No annual limit *(Benefit specific annual maximums will still apply unless otherwise stated in this notice.)*
Prescription Annual Maximum	None	No annual limit
Health Education and Community Wellness Classes	Not covered	No benefit specific limit
Chemical Dependency Treatment	$5,000 annual and $10,000 lifetime maximum	No benefit specific limit
Organ Transplants	No annual limit	No benefit specific limit
Well Child Care	$300 annual limit	No annual limit
Physical Exams	$100 annual limit	Limited to one physical exam per year ($100 annual limit removed)
Vision Care *Active Coverage Only*	One exam per year; One set of lenses or contact lenses, and one set of frames per year	**For dependent children under age 19 only**, lenses are no longer subject to the annual maximum. All other limits remain unchanged. *(There is no change in benefits for employees, spouses, or dependent children age 19 and over.)*
Dental Care *Active Coverage Only*	Per schedules. 80% if due to injury or accident; 80% up to $55 per bony impacted tooth for benefits not covered under dental plan *This information does not apply to*	**For dependent children under age 19 only**, no annual maximum dental benefit. All other limits remain unchanged. *(There is no change in benefits for employees, spouses, or dependent children age 19 and over.)* *Willamette Dental Services*

Only the benefits listed above have been revised. All other Plan limitations and exclusions currently listed in the March 2009 Summary Plan Description and subsequent notices remain unchanged.

Notice of corrected wording for the Health Benefit Plan booklet

Page 31 of the Health Plan Booklet dated March 2009 contains incorrect wording regarding Coordination of Benefits for the Prescription Drug Plan. Page 31 of the booklet will now read as follows:

Coordination of Benefits

If the insured employee or an eligible dependent is entitled to benefits under any other Group Plan which will pay part or all of the expense incurred for necessary, reasonable and customary charges for prescription drugs, the amount payable under this Plan and any other Group Plan will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. In no event will the Plan pay more than the amount that would have been paid if no other plan were involved.

Washington-Idaho Operating Engineers and Employers Health & Security Trust

Zenith Administrators, Inc.
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 624-3257 or (800) 351-6480

Summary of Material Modification
February 4, 2010

The following is notice of recent changes to the Routine Physical Examination Benefit and the Wellness Exam benefit

1. The **Routine Physical Examination** benefit has been changed. The benefit language, at page 27 of the Plan Booklet, ***ROUTINE PHYSICAL EXAMINATION (FOR EMPLOYEE ONLY),*** has been deleted, and the benefit has been replaced as part of the ***WELLNESS EXAM*** benefit described below, effective January 1, 2010.

2. The ***WELLNESS EXAM*** **benefit** has been changed, effective January 1, 2010. The benefit, found at page 27 of the Plan Booklet, has been amended as follows:

   WELLNESS EXAM - FOR PARTICIPANTS AND DEPENDENTS AGE FIVE AND OLDER

   The Plan will pay 80% of the office visit for wellness exams, as well as related tests, for participants, and for dependents age 5 and older. This benefit will limit some tests and routine exams as follows:

   A. One routine physical examination per year;
   B. One mammogram per year
   C. One pap smear per year
   D. One prostate test per year

Please make note of these changes. Should you have any questions regarding this material modification to the Plan, please contact the Trust Administration Office at (509) 624-3257.

Sincerely,

Board of Trustees of the Washington-Idaho Operating
Engineers-Employers Health & Security Trust

Washington-Idaho Operating Engineers and Employers Health & Security Trust

Zenith Administrators, Inc.
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 624-3257 or (800) 351-6480

Summary of Material Modification
January 1, 2010

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Beginning January 1, 2010, the Washington-Idaho Operating Engineers-Employers Health & Security Trust fund will comply with the Mental Health Parity and Addiction Equity Act of 2008. The new law does not require health plans to provide mental health and substance abuse benefits. However, health plans that provide such benefits must provide parity (treat the same) between mental health and substance abuse benefits and medical/surgical benefits.

This Plan previously provided Mental Health and Substance abuse benefits on a limited basis. Beginning, January 1, 2010, the Plan will cover these expenses the same as other medical condition.

SKILLED NURSING CARE (facility services)

The current benefit is as follows, and can be found on page 22 of the Plan Booklet:

The Plan will pay for covered Charges made in connection with confinement in a Skilled Nursing Care Facility provided:

A. Such confinement commences within 14 days and after at least five continuous days of confinement in such Hospital;
B. Covered Charges will be payable up to $20 per day; and
C. In no event will benefits be payable beyond a maximum of 180 days…

Beginning effective February 1, 2010, part A above will be changed to read as follows:

A. Such confinement commences within 14 days and after at least three continuous days of confinement in such Hospital;

Please make note of these changes. Should you have any questions regarding this material modification to the Plan, please contact the Trust Administration Office at (509) 624-3257.

Board of Trustees of the Washington-Idaho Operating
Engineers-Employers Health & Security Trust

WASHINGTON-IDAHO OPERATING ENGINEERS-EMPLOYERS HEALTH & SECURITY TRUST FUND CONTACT INFORMATION

TRUST OFFICE
Zenith Administrators, Inc.
111 W. Cataldo, Suite 220
Spokane, WA 99201

Submit all claims to:
PO Box 68
Spokane, WA 99210

Submit all correspondence and payments to:
111 W. Cataldo, Suite 220
Spokane, WA 99201

Washington-Idaho Operating Engineers Health & Welfare Plan Claims Customer Service
Telephone……..(509) 624-3257
Toll-Free……(800) 351-6480
Fax…….…....(509) 328-8623
Washington-Idaho Operating Engineers Health & Welfare Plan Eligibility Customer Service
Telephone……..(509) 624-3257
Toll-Free……(800) 351-6480
Hospital Pre-Certification (First Choice Health Network)
Telephone……..(800) 328-7304

WEBSITE
www.zenithadmin.com
This website contains:

A. Helpful information about your Plan
B. Notices about Plan changes
C. Printable versions of claim forms, change of address form and enrollment forms
D. Links to Preferred Providers
E. Summary Annual Report
F. Eligibility

Please contact the Trust Administrative Agent if you need a password.

Caremark Prescription Drug Service
Telephone……..…(888) 739-7985

First Choice Health Network (FCHN)
To find a Preferred Provider near you……..**…**(800) 231-6935
Website……..…www.fchn.com

Vision Service Plan (VSP)
To find a Preferred Provider near you……..(800) 877-7195
Website……...www.vsp.com

To All Eligible Employees:

The Board of Trustees is pleased to present you with this new Summary Plan Description, describing the medical, prescription drug, dental, time loss, life and accidental death and dismemberment benefits available to you and your family through the Washington-Idaho Operating Engineers and Employers Health and Security Trust.

Please read this booklet carefully so you understand your benefits. Only the Trust Administrative Agent, Zenith Administrators, Inc., represents the Board of Trustees in administering the Plan and providing information relating to eligibility, the amount of benefits and other Plan provisions. No participating employer, employer association, labor organization or individual employed thereby, has authority in this regard.

If you have any question about your Plan, please contact the Trust Administrative Agent for assistance.

Sincerely,

The Board of Trustees

NOTICE:
Trustee Discretion Retained. The Board of Trustees reserves the maximum legal discretionary authority to construe, interpret and apply the terms, rules and provisions of the Plan covered in this booklet. The Trustees retain full discretionary authority to make determinations on matters relating to eligibility for benefits, on matters relating to what services, supplies, care, drug therapy and treatments are experimental, and on matters which pertain to Participants' rights. The decisions of the claims adjustors, Trust Administrative Agent and the Board of Trustees as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or application of such to any claim for benefits, shall receive the maximum deference allowed by law and will be final and binding on all interested parties.

Amendment and Termination of Plan. The Board of Trustees expects to maintain this Plan indefinitely. However, the Trustees may, at their sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits covered by the Plan and/or the governing Trust Agreement and/or any Policies. If the Plan is terminated, the rights of the Participants are limited to benefits incurred before termination. All amendments to this Plan shall become effective as of a date established by the Board of Trustees.

TABLE OF CONTENTS

The key sections of your booklet appear in the following order.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully under the General Exclusions and Limitations in this booklet. This includes, but is not limited to, the Trust Administrative Agent's determination that: care and treatment is Medically Necessary; that charges are Usual and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Definitions section of this document.

The Plan is a plan that contains Preferred Provider Organizations.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Preferred Providers. These Preferred Providers have agreed to charge reduced fees to persons covered under the Plan.

Therefore, when an Insured Person uses a Preferred Provider, that Insured Person will owe a lesser amount than when a Non-participating Provider is used. It is the Insured Person's choice as to which Provider to use.

Additional information about this option, as well as a list of Preferred Providers will be given to covered Employees and updated as needed.

DEDUCTIBLES

Deductibles are dollar amounts that the Insured Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Insured Person. Typically, there is one deductible amount per person and it must be paid before any money is paid by the Plan for any covered services.

WASHINGTON-IDAHO OPERATING ENGINEERS AND EMPLOYERS HEALTH AND SECURITY TRUST SCHEDULE OF BENEFITS

SERVICES	BENEFITS
MAXIMUM LIFETIME BENEFITS AMOUNT:	**$1,000,000**
DEDUCTIBLE, PER CALENDAR YEAR	**$300 per person, Maximum $600 per family**
MAXIMUM OUT OF POCKET PER CALENDAR YEAR	**$2,500 per person, Maximum $5,000 per family** **Excluding the deductible and Co-Payments**
HOSPITAL SERVICES	
Room and Board **Intensive Care Unit** **Emergency Room** **Outpatient Services**	80% of the semiprivate room rate 80% of the Hospital's ICU charge 80% after $75 co-pay for non emergency care 80%
Skilled Nursing Facility	80%
PHYSICIAN SERVICES (NOTE: ALL PHYSICIAN'S SERVICES ARE SUBJECT TO THE USUAL AND CUSTOMARY CLAUSE EXCEPT WHEN PERFORMED BY PPO PROVIDERS.)	
Office Visits **Inpatient Visits** **Surgery**	$20 co-pay then 80% 80% 80%
Home Health Care **(must meet Plan requirements. Refer to page 22.)**	80% up to 100 visits per Calendar Year Maximum of $4,000 per Calendar Year
Hospice Care **(must meet Plan requirements. Refer to page 22.)**	80%
Ambulance	80% Commercial airline transportation may be covered if medically necessary
Spinal Treatment	80% up to $1,200 per family per Calendar Year
Outpatient Physical Therapy	80% up to 15 visits per family per Calendar Year
Speech Therapy	80% up to $1200 per family per Calendar Year
Durable Medical Equipment Rental (DME)	80% rental up to the purchase price
Orthotics	80% up to $250 per Calendar Year
Temporomandibular Joint Disorder (TMJ)	80% up to maximum lifetime $500
MENTAL DISORDERS **Inpatient** **Outpatient**	 80% up to 20 Inpatient visits/days per Calendar Year (is not subject to the deductible nor does 20% accumulate toward Out Of Pocket maximums) 50% up to 20 office visits per Calendar Year (is not subject to the deductible nor does 50% accumulate toward Out Of Pocket maximums)
Alcoholism & Drug Abuse	80% up to $5,000 per Calendar Year not to exceed $10,000 lifetime maximum
Dental Care	80% if due to an Injury or accident 80% up to $55 maximum per bony impacted tooth for benefits not covered under Dental Plan
Pregnancy (Employee and Spouse only)	80%
Well Child	80% up to $300 per Calendar Year (up to age 5 only)
Routine Physical Exam (Employee only)	80% up to $100 per Calendar Year
Wellness Exams (All Participants)	80% 1 per year per Covered Person
Attention Deficit Disorder	80%
Acupuncture	80%
Surgical Services	80%
Artificial Insemination, In Vitro Fertilization	80% up to lifetime maximum of $2,500
Infertility (Diagnostic services)	80% up to lifetime maximum of $2,500
Hearing Aid Benefit	80% up to $700 per ear every 3 years
Automatic Lifetime Maximum Reinstatement Up to $1,000.00 Annually	

DEFINITIONS

When used in the booklet:

ADEA Employer means an employer which:

A. is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
B. has 20 or more Employees each working day in 20 or more calendar weeks during the current or preceding Calendar Year.

Acupuncture means the practice of insertion of needles into specific exterior body locations:

A. To relieve pain; and or
B. to induce surgical anesthesia; or
C. for therapeutic purposes.

Active Work or Actively at Work means at work or available for work for a Contributing Employer on a full-time basis performing regular and customary duties.

Adopted Child means a minor child, under the age of 19, placed for adoption with you. The child will be covered from the moment the child is placed in your custody.

Age 65 means the age attained at 12:01 a.m. on the first day of the month in which the Covered Person's 65th birthday occurs.

Bodily Organ means any of the following:

A. kidney;
B. heart;
C. heart/lung;
D. liver;
E. pancreas (when the condition is not treatable by use of insulin therapy);
F. bone marrow; and
G. cornea.

Brand Name Drug means a covered proprietary Drug approved by the Federal Food and Drug Administration.

Calendar Year is January 1st to December 31st of the same year.

Certificate means the HIPAA Certificate of Insurance form and all other documents that describe insurance coverage under the Plan and are made a part of the Plan.

Charges mean reasonable and customary Charges which are commensurate with the fees and prices customarily charged for the services and supplies generally required in the area for the treatment of cases of comparable severity and nature.

Claim period means part or all of a Calendar Year during which the claimant is covered under the Plan.

Claimant means the Covered Person for whom the claim is made.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Contributing Employer means any person or entity that pursuant to a collective bargaining agreement is making payments to the Trust for the purchase of health and welfare benefits for Employees in job classifications covered by such bargaining agreement.

Co-payment means an amount which the Covered Person must pay before benefits are payable, and which is incurred on the date the covered drug or service is received. **Co-Payments do not satisfy the deductible or the major medical stop-loss limit.**

Cosmetic Surgery means any surgical procedure performed primarily to improve physical appearance without materially correcting a bodily malfunction.

Covered Person means you and/or your Dependents who are covered under the Plan.

Covered Drug means:

A. Drug or medicine which requires a Physician's written prescription; and
B. insulin; and
C. contraceptive drugs which require a Physician's written prescription.

Covered Expense means the Usual and Customary Charge for any medically necessary health care service or supply which is covered at least in part by any of the Plans involved during a claim period. Where the Plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of the service or supply during a claim period will also be considered a covered Expense. The difference in cost of a private Hospital room and the cost of a semiprivate room is not considered a covered Expense unless the claimant's stay in a private room is considered medically necessary by at least one of the Plans involved.

Dentist means a person who is licensed to practice in the state where the dental procedure is performed, operating within the scope of his or her license and performing a service which is payable under the Plan.

Where required to cover by law, Dentist means any other licensed practitioner who is acting within the scope of his or her license and performing a service which is payable under the Plan when performed by a Dentist.

A Dentist does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse.

Dependent means only (a) an Employee's spouse, and (b) an Employee's unmarried child or children, including step-children, foster children or other children residing with the Covered Person in a parent/child relationship, and dependent upon the Covered Person for support, up to 19 years of age, or less than 23 years of age, with respect to any unmarried child who is attending an educational institution full time, provided he/she is chiefly dependent upon the Covered Person for financial support. The term "Dependent" shall not include any person who is in active full-time military service. Dependent also does not include divorced or legally separated spouses or domestic partners.

If a covered Dependent child upon attainment of the limiting age for Dependent children is and continues to be:

A. incapable of self-sustaining employment by reason of mental or physical handicap; and
B. chiefly dependent on the individual for support and maintenance,

Medical coverage for such child shall be continued beyond the limiting age during such continuing dependency provided proof of such incapacity and dependency is furnished to the Trust Administrative Agent by the Employee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the Trust but not more frequently than annually after the two year period following the child's attainment of the limiting age.

When both husband and wife are Covered Persons as Employees, their children are eligible for benefits not to exceed 100% of the cost of services provided.

Disability as used herein shall mean, with respect to an Employee, the period of Disability due to physical or mental limitations, and beginning with cessation of active, full-time employment and ending with the day the Employee returns to active, full-time work or becomes available for such work; with respect to the Dependent, all periods of Disability arising from the same cause including any and all complications resulting from this Disability. However, if the Dependent resumes normal activities, without further treatment or examination for a period of six months, any subsequent period or causes shall be considered a new period of Disability.

Drug means any substance prescribed by a Physician taken by mouth; injected into a muscle, the skin, a blood vessel or a cavity of the body, or applied to the skin to treat or prevent a disease, and specifically includes Drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS.

Durable Medical Equipment means equipment which:

A. can stand repeated use;
B. is mainly and customarily used for a medical purpose;
C. is not generally useful to a person in the absence of an Injury or Sickness; and
D. is suited for use in the home.

It does not include equipment with a non-medical use, such as sun or heat lamps, heating pads, whirlpool baths, exercise devices, ramps or handrails, or air conditioners, purifiers, humidifiers, waterpicks or commodes.

Emergency Services means otherwise covered health care services Medically Necessary to evaluate and treat a Medical Emergency condition, provided in a Hospital emergency room.

Employee means any Employee of an Employer participating in the Trust Fund who qualifies for coverage in accordance with the Eligibility Program section.

ERISA means the Employee Retirement Income Security Act of 1974, a Federal statute, which – together with other Federal laws and regulations – governs the administration of the Trust Fund and Benefit Plan.

Expense means the Expense incurred for a covered service or supply which has been ordered or prescribed by a Physician. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge:

A. for a service or supply which is not Medically Necessary; or
B. which is in excess of the Usual and Customary Global Charge for a service or supply.

Foster Child means a child, under age 19, you are raising as your own, who lives in your home, who is chiefly dependent on you for support and for whom you have taken full parental responsibility and control.

A Foster Child is not a child temporarily living in your home, placed with you in your home by a social service agency which retains control of the child, or whose natural parent is in a position to exercise or share parental responsibility and control.

Generic Drug means a Covered Drug, regardless of the manufacturer, which is bioequivalent to a Brand Name Drug and which is approved by the Federal Food and Drug Administration. Not all Brand Name Drugs have a generic equivalent.

Global Charge means the single Expense incurred for the combination of all necessary medical services normally furnished by a Physician or other covered provider (or multiple Physicians or other covered providers) before, during and after the principal medical service. The Global Charge will be based on a complete description of the covered medical service, rather than a fragmented description of that service. The Global Charge will not exceed the Usual and Customary Charge allowed by us. The determination of what is included in the Global Charge will be made by us.

Home Health Care Services means services which are:

A. approved by a Home Health Agency;
B. are in the Covered Person's home; and
C. in accordance with a Home Health Care Plan.

Home Health Agency means a public or private agency or organization which:

A. administers and provides Home Health Care Services; and
B. is either:
    1. certified as such by the Washington Department of Social Services; or
    2. licensed or certified as such by the state where the services are rendered.

Home Health Care Plan means a Plan of continued care and treatment of a Covered Person;

A. who is under the care of a Physician; and
B. whose Physician certifies that, without the Home Health Care, confinement in a Hospital or skilled nursing care facility would be needed.

The Home Health Care Plan must be:

A. established by a Physician within 14 days after the Home Health Care begins; and
B. certified by a Physician every 30 days after the Home Health Care begins.

Hospice Agency means a public or private agency or organization which:

A. administers and provides Hospice care; and
B. is either:
    1. certified as such by the Washington Department of Social and Health Services; and
    2. is licensed or certified as such by the state where services are rendered; and
    3. is certified to participate as such under Medicare; or
    4. accredited as such by the Joint Commission on the Accreditation of Hospitals or the National Hospice Organization.

Hospice Care Services means palliative (pain controlling) and supportive medical, nursing and other health services provided:

A. by a Hospice Agency; and
B. is in the Covered Person's home or in an Inpatient Hospice unit or facility; and
C. is in accordance with a Hospice Care Plan

Hospice Care Plan means a Plan of continued care of a Terminally Ill Covered Person who is under the care of a Physician;

A. which is established by a Physician within 14 days after the Hospice care begins; and
B. is certified by a Physician every 30 days after the Hospice care begins.

Hospital means any of the following facilities which are licensed by the proper authority in the area in which they are located:

A. a place which is licensed as a General Hospital; and
B. a place which:
    1. is operated for the care and treatment of resident Inpatients; and
    2. has a registered graduate nurse (RN) always on duty; and
    3. has a laboratory and x-ray facility; and
    4. has a place where major surgical operations are performed; or
C. a facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical Disability. Such facility need not have major surgical facilities.

When treatment is needed for Mental Sickness/Alcohol and Drug Abuse and/or Substance Abuse, Hospital can also mean a place which meets these requirements:

A. has rooms for resident Inpatients; and
B. is equipped to treat Mental Sicknesses/Alcohol and Drug Abuse and/or Substance Abuse; and
C. has a resident Physician on duty or on call at all times; and
D. has a regular practice of charging the patient for the expense of confinement; and
E. is licensed by the proper authority of the area in which it is located.

A Hospital does not include a Hospital or institution or part of a Hospital or institution which is licensed or used principally as a convalescent home, rest home, nursing home, home for the aged, halfway house, onboard and care facility, residential treatment center (except as required under Chemical Dependency Benefits), "wilderness" program, treatment group home or "boot camp".

Hospital Confinement means a Medically Necessary Hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service. These requirements apply even if the Hospital does not charge for daily room and board. How the Hospital classified the stay is irrelevant as well.

Any Hospital Confinement satisfying this definition will be subject to all Plan provisions relating to Inpatient Hospital services or admissions, including any applicable preadmission, review requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

Injury means an accidental bodily Injury which is the direct result of a sudden, unexpected and unintended external force or element, such as a blow or fall that requires treatment by a Physician. It must be independent of Sickness or any other cause, including, but not limited to, complications from medical care.

Inpatient means a person who, while confined in a Hospital, is assigned to a bed in any department of the Hospital other than its out-patient department and to whom a charge is made by the Hospital for bed and board.

Jaw Joint Disorder means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint. It includes:

A. temporomandibular joint dysfunction (TMJ), arthritis or arthrosis; and
B. other craniomandibular joint disorders; and
C. myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an Injury.

Legend Drug is a Drug which requires a Physician's prescription in order to be dispensed.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons.

Medicare Benefits means benefits for services and supplies which the Covered Person receives or is eligible for under Medicare.

Medical Emergency means the emergency and acute onset of a symptom or symptoms, including severe pain that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in:

A. serious impairment to bodily functions; or
B. serious dysfunction of a Bodily Organ or part; or
C. placing the person's health in serious jeopardy.

Medical Necessity means a service or supply which is ordered by a Physician and which We determine is:

A. provided for the diagnosis or direct treatment of an Injury or Sickness; and
B. is appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Covered Person's Injury or Sickness; and
C. is provided in accordance with generally accepted medical practice on a national basis; and
D. is the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, Inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care.

The fact that the Covered Person's Physician prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary and covered by the Plan.

Mental Health Facility means an agency which:

A. is licensed as such by the proper authority of the state in which it is located; and
B. has in effect a plan of quality assurance and Peer Review; and
C. provides treatment under the supervision of a Physician or licensed psychologist.

Mental Disorders/Alcohol and Drug Abuse and/or Substance Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder. Items not included in this definition are conditions or diseases specifically excluded from the Plan.

We may include special benefits for any one or more of the conditions included in this definition. If We do, only those special benefits relating to those conditions are available for that condition.

Our, We, or Us means the Washington-Idaho Operating Engineers and Employers Health and Security Trust.

Out Of Pocket Expense means Expense which the Covered Person incurs for covered services during the Calendar Year and must pay Out of Pocket:

A. to satisfy the deductible; or
B. as coinsurance (the percentage the Covered Person must pay in accordance with the percentage payable provision.

Paid Work Hours is defined as an hour of work at the negotiated Heavy/Highway rate. Any other rate paid by an employer will be factored up or down in direct ratio to the negotiated Heavy/Highway rate.

Peer-Review Medical Literature means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.

Physical Therapy means treatment by:

A. manual manipulation or other physical means; and
B. hydrotherapy; and
C. heat; and
D. physical agents; and
E. biomechanical and neurophysiological principles and devices; used to:
    1. relieve pain; and
    2. restore maximum bodily function; and
    3. prevent Disability arising from Injury or Sickness.

Physical Therapy shall not include cardiac rehabilitation.

Physician means any of the following licensed practitioners who perform a service payable under the Plan:

A. a doctor of Medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC); or
B. a licensed doctoral clinical psychologist; or
C. a master's level counselor and licensed or certified social worker; or
D. a licensed Physician's assistant (PA); or
E. where required to cover by law, any other licensed practitioner who:
    1. is acting within the scope of his/her license; and
    2. performs a service which is payable under the Plan when performed by an MD.

A Physician does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or a parent of you or your spouse.

Placed for Adoption means assumption and retention by the Covered Person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

Plan means the provisions and benefits described in this booklet.
Plan also means any of the following coverage (including Plan coverage) which provides benefits payments or services to a Covered Person for Hospital, medical, surgical, dental, or prescription drug care

A. group or blanket insurance (except student accident insurance);
B. group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis including HMO's (Health Maintenance Organizations);
C. coverage under a labor-management trust Plan, a union welfare Plan, an employer organization Plan or an Employee Plan;
D. coverage under government programs, other than Medicaid, and any other coverage required or provided by law;
E. other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type Hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds $200 a day.

Preferred Provider means a provider of covered services who:

A. is participating in Our Preferred Provider option; and
B. is shown on Our current list of members in that option.

The payments to Preferred Providers will be based on arrangements with providers who participate in the Preferred Provider option.

Prescription Drug means a Drug requiring a prescription by federal or state law which will be provided when dispensed by a licensed pharmacist to treat a condition covered under the Plan. Any other Drug or medication furnished by the Physician or any Drug not requiring a prescription will NOT be covered.

Prior Group Plan means the group Plan providing similar benefits (whether insured or self-insured, including HMO's and other prepayment Plans provided by the Plan) in effect immediately prior to the effective date of this Plan.

Qualified Medical Child Support Order is defined by Section 609 of ERISA. In general, a Qualified Medical Child Support Order means any judgment, decree or order (including approval of a settlement) issued by a court or state agency of competent jurisdiction which:

A. either:
   1. relates to medical benefits under the Plan and provides for your child's support or health benefit coverage pursuant to a state domestic relations law (including a community property law); or
   2. enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
B. creates or recognizes the existence of your child's right to be enrolled and receive medical benefits under the Plan;
C. states the name and last known mailing address (if any) of you and each child covered by the order;
D. reasonably describes the type of medical insurance to be provided by the Plan to each child, or the manner in which this type of insurance is to be determined;
E. states the period to which the order applies; and
F. does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Sickness means a disease, disorder or condition which requires treatment by a Physician.

For a female Employee and Dependent spouse, Sickness **includes** childbirth or pregnancy. For a Dependent child, Sickness **does not include** Normal Pregnancy or normal childbirth, **but it does include** Complication of Pregnancy.

Normal Pregnancy or Normal Childbirth means pregnancy or childbirth which is free of Complications of Pregnancy.

Complications of Pregnancy means:

A. any condition resulting in Hospital Confinement, the diagnosis of which is distinct from pregnancy, but is adversely affected or caused by pregnancy; or
B. a non-elective cesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia.

False labor, occasional spotting, Physician prescribed rest, morning Sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not Complications of Pregnancy.

Serious Health Condition is defined as stated in the FMLA (Family Medical Leave Act.

Skilled Nursing Facility means an institution which is classified as a skilled nursing care facility under Medicare (Title XVIII of the Social Security Act) and has a transfer agreement in effect with a Hospital under Medicare.

Smoking Cessation Services means treatment received in conjunction with tobacco usage including chewing.

Speech Therapy means treatment for the correction of a speech impairment resulting from an Injury, Sickness or surgery, or such treatment following surgery to correct congenital and developmental anomalies. Speech Therapy is covered only if there is a Physician's recommendation that Speech Therapy is required for a Covered Person. Speech Therapy which is educational in nature, such as for treatment of a learning Disability, is not covered.

Spinal Treatment means detection or correction (by manual or mechanical means) of:

A. structural imbalance; or
B. distortion; or
C. subluxation in the body to remove nerve interference or its effects. The interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Spouse means a person to whom you are legally married and provided there has not been a decree of dissolution or legal separation entered with a court of competent jurisdiction regarding the marriage.

Terminally Ill means

A. determined by a Physician to have a terminal Sickness with no reasonable prospect of cure; and
B. expected by a Physician to have less than six months to live.

Total Disability, Totally Disabled or Disabled means that because of an Injury or Sickness:

A. you are determined by a Physician to be completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit; or
B. Your Dependent is determined by a Physician to be:
    1. either physically or mentally unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health; and
    2. not engaged in any work or occupation for wages or profit.

Trust Administrative Agent means Zenith Administrators, Inc.

Uniformed Service 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 for the Public Health Services, and any other category of persons designated by the President in time of war or emergency.

Union means the International Union of Operating Engineers, Local 370.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings.

Usual and Customary Charge means a charge by a Professional Service Provider for a Covered Service which is no higher than the 90th percentile identified on the Healthcare Charges Database (HCD. When there is, in Our determination, minimal data available from the HCD for a Covered Service, We will determine the Usual and Customary Charge by calculating the unit cost for the applicable service category using HCD, and multiplying that by the relative value of the Covered Service assigned by the Medicare Resource Based Relative Value Scale (supplemented with a commercially available relative value scale selected by us where one is not available from Medicare. In the event of an unusually complex Covered Service, a Covered Service that is a new procedure or a Covered Service that otherwise does not have a relative value that is in Our determination applicable, we will assign one. In no event will the Usual and Customary Charge exceed the amount billed by the Professional Service Provider or the amount for which the Covered Person is responsible. The term "Usual and Customary Charge" may not reflect the actual Charges of the Professional Service Provider, and does not take into account the Professional Service Provider's training, experience or category of licensure.

Women's Health Care Practitioner means a person licensed under state law to provide Women's Health Care Services.

Women's Health Care Service includes, but is not limited to covered Medically Necessary maternity care, reproductive health services, gynecological care, general examination and medically appropriate preventive care, including follow-up visits.

It includes any appropriate care for other health problems, discovered and treated during the course of a visit to a Women's Health Care Practitioner for a Women's Health Care Service which is within the practitioner's scope of practice.

It includes Medically Necessary laboratory, imaging, and diagnostic services, or prescriptions for Covered Drugs or covered medical supplies.

Worker's Compensation means the insurance described herein is not in lieu of, and does not affect any requirement for coverage by, Worker's Compensation insurance or other similar insurance.

ELIGIBILITY

Each Employee (and eligible Dependents, if any) will be covered in accordance with the following eligibility standards:

Eligible Employees

Employees eligible for insurance under this Plan are bargaining unit Employees of Contributing Employers or flat rate Employees of non-bargaining unit employers.

An Employee is eligible for this coverage if he/she is an Employee of a Contributing Employer and has accrued hours as described below. A Covered Employer is an Employer that is signatory to a Collective Bargaining Agreement which requires contributions to the Washington-Idaho Operating Engineers and Employers Health and Security Trust.

If you are employed by more than one Contributing Employer, the amount of your benefits under the Plan will not exceed the amount for which you would have been covered if you were employed by only one such Contributing Employer.

Initial Eligibility

You will initially become eligible for benefits on the first day of the second calendar month following the calendar month in which you accumulate 200 reported and paid hours.

Example: All hours reported on your behalf by Contributing Employers are credited to your "Employee hour bank".
If you work 160 hours in January and 160 hours in February, you will become eligible for benefits beginning the first of April. March is the "Lag Month".

Pro-Rata Hours

One credited hour is determined by the hourly rate paid under the heavy/highway collective bargaining agreement. When an Employer contributes at an hourly rate which is more or less than the heavy/highway negotiated rate, the hours reported to the fund are pro-rated based upon the hourly rate paid by that employer.

Lag Month

In order that there is sufficient time for employer reports to be received and processed by the Trust Administrative Agent, a lag month is used in determining eligibility. For example: Hours worked in January are reported to the Trust in February. The Trust Administrative Agent determines eligibility in February (lag month) for March coverage.

Continuing Eligibility

Once the minimum eligibility requirement has been established, the Employee will continue to be covered as long as he has 200 hours or more in his Hour Bank. For each month of coverage, 130 hours will be deducted from the Employee's Hour Bank. You should also review the Continuing Coverage section addressing COBRA rights, at page 51.

Employee Hour Bank

All hours reported on your behalf by your employer for which contributions are received will be credited to your Hour Bank. The maximum Hour Bank you will be allowed to maintain is 850 hours. This Hour Bank may be used by you during periods when you are unemployed, or you are not working sufficient covered hours to meet the requirement for monthly coverage. The Trust Administrative Agent will deduct hours from your Hour Bank each month, as needed for coverage.

Termination of Eligibility

Coverage will terminate at the end of the calendar month following the calendar month during which the Employee's hour bank accumulation is reduced to less than 200 hours, unless COBRA is elected. If your Hour Bank becomes Inactive (no Paid Work Hours for nine (9) consecutive months following the last recorded payroll-period or last date of eligibility) any balance therein will revert to the Fund.

After your hour bank becomes inactive, you must meet the initial eligibility rules to become covered.

Disability – Termination of Coverage

If the insurance of the Employee or Dependent is terminated while that person is Totally Disabled as defined under the Plan, the benefits will be extended, without premium payment, to cover the care and treatment of such disabling condition, for one year after the date of termination of insurance, provided the Plan is in effect at the time the care and treatment are received.

Dependent Eligibility

The participant must notify the Trust Administrative Agent within 31 days of a change in Dependent status.

An Employee must be eligible for benefits to have their Dependents covered. The coverage for their eligible Dependents shall become effective on the latest of the following dates:

A. on the date the employee's coverage becomes effective, or
B. on the date the employee first acquires an eligible Dependent.

If an Employee covered under the Plan acquires an eligible Dependent, such Dependent shall become covered automatically.

SHOULD YOU ACQUIRE NEW DEPENDENTS

Contact the Trust Administrative Agent immediately for information on enrolling new Dependents.

Eligible Dependents of an eligible Employee or retiree shall include:

A. Their lawful spouse, if not divorced or legally separated;
B. unmarried children under the age of 19, legally Adopted Children or children Placed For Adoption with the Employee or retiree;
C. stepchildren provided such children reside with the Employee or retiree and are primarily dependent on them for support and maintenance;
D. a Foster Child; and
E. a child age 19 and over if, in addition to the above:
    1. The child is less than 23 years of age and is enrolled as a full-time student in an accredited educational institution. The Employee must submit to the Trust Administrative Agent proof of full-time student status twice each year (winter and fall quarters.
    2. As of the date the child would otherwise lose coverage he/she is incapable of self-sustaining employment by reason of mental or physical handicap. Such incapacity must have commenced prior to the child reaching the limiting age (19 or 23 if a full-time student) and the child must be primarily dependent on the Employee or retiree for support. The Plan will continue the coverage for such a child so long as the coverage for the Employee or retiree remains in force and such incapacity continues. Proof of such incapacity must be submitted to the Trust Administrative Agent within 31 days of the date the child's coverage would otherwise terminate and thereafter as We require, but no more than once every two (2) years.

TERMINATION OF DEPENDENT COVERAGE

All Plan coverage will automatically terminate upon the earliest of the following dates:

A. the date of termination of the Plan;
B. the date the Employee and/or Dependent ceases to be eligible for coverage under the Plan. (See Eligibility Rules and Definition of a Dependent on page 7;
C. the date of expiration of the period for which a required COBRA or retiree self-pay premium is paid; or
D. the date the Employee or Dependent begins active duty in the military service of any country or international authority if the period of active duty is to exceed 30 days, subject to USERRA requirements see page 47.

Reinstatement of Eligibility

A previously insured employee will again become eligible following the accumulation in his "bank" of 200 or more paid work hours. This reinstatement is allowed only if an hour bank is not Inactive. Such reinstatement will become effective on the first day of the second calendar month following the month in which this requirement is met.

Example: Your coverage terminated January 31 with an hour bank of 90 hours. You work 120 hours with a Contributing Employer in October. Your eligibility is reinstated as of the first of December.

The Board of Trustees reserves the right to request documentation of proof of dependency at any time.

Qualified Medical Child Support Eligibility

If your eligible child is not covered because you did not enroll your child for Dependent coverage, such child may be enrolled after we:

A. receive a final medical child support order which requires enrollment; and
B. determine that the order is qualified.

In accordance with federal law, the Plan also provides medical/dental/prescription coverage to certain Dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction. Contact the Trust Administrative Agent for details. You and your Dependents may obtain, without charge, a copy of the procedures governing medical child support orders and determination from the Trust Administrative Agent.

When the Trust Administrative Agent receives the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date We receive the enrollment form for coverage. The enrollment application may be submitted to the Trust Administrative Agent by the Employee, the child's custodial parent, or a state agency administering Medicaid.

UTILIZATION MANAGEMENT PROGRAM

Medical Management Program

The Medical Management program requires you, your representative, your doctor and/or hospital to take certain steps when an inpatient confinement is recommended. Before the services or supplies are received, all Hospital confinements must be pre-certified as Medically Necessary. You, not your Physician, are responsible for making sure pre-certification occurs. However, you, your representative or your Physician may initiate the pre-certification.

What does the Medical Management program do for you?

A. It helps you work with your doctor or other health care providers to ensure that your medical services are Medically Necessary under the terms of the Plan.
B. It will monitor your hospitalization to ensure that you receive treatment in the least costly manner.
C. It will assist in your hospital discharge planning and see that you receive appropriate medical support services following your discharge, when necessary.
D. It allows the Plan to manage health care services and cost more efficiently to ensure that your high level of benefits can continue.

Hospital Pre-certification

All inpatient hospitalization except for emergency care and childbirth (unless the stay is for greater than 48 hours for normal delivery or 96 hours for caesarean delivery) require pre-certification. To pre-certify, you must call First Choice Health Network at 1-800-467-5281 as soon as you know you are going to be hospitalized. If an emergency admittance, you, your representative or the hospital must call within two (2) business days following the admittance or as soon as reasonably possible.

Pre-certification of a Hospital confinement as Medically Necessary through the utilization review process does not necessarily mean that benefits are payable. A determination will be made regarding the Medical Necessity of your inpatient treatment and you will receive a letter indicating the number of hospital days certified.

Also, unless you have a medical emergency, you should make the call yourself and not rely on your doctor or the hospital to pre-certify your hospital stay for you.

Medical Review While Hospitalized

During an approved hospitalization, the Plan will monitor the confinement to assure that continued general hospital care is medically necessary and that the services being provided are appropriate to the condition being treated. Your doctor will be advised of alternatives to hospitalization, such as home care services, which may promote an earlier discharge and recovery at home.

If you Have Questions Regarding the Care Management Program

If you have questions regarding the Case Management Program, your doctor or hospital should call First Choice Health Network. If you have questions regarding the Plan, you should call the Trust Administrative Agent. When calling please identify yourself as a participant in The Washington-Idaho Operating Engineers and Employers Health and Security Trust Fund.

Trust Administrative Agent
(509) 624-3257 or (800-351-6480) or
Care Management Program First Choice Health Network
1-800-457-5281

Request For An Appeal Of The Utilization Review Decision

You, your representative, or your health care provider have the right to request an appeal regarding the Utilization Review decision. The request should be submitted in writing and should include any additional information that may have been omitted from the review or that should be considered by us.

The request should be sent to:

Care Management Program

First Choice Health Network

The Washington-Idaho Operating Engineers and Employers Health and Security Trust Fund.

c/o Zenith Administrators, Inc.

111 W. Cataldo, Suite 220

Spokane, WA 99201

You may also call the Care Management Program's toll free phone number listed on your insurance identification card for additional information regarding the appeal.

If you are not satisfied with the determination to pre-certification requirement you can appeal thru the Plan appeal procedures on page 55.

Exceptions

A. Pre-certification is not required when the Insured Person is a retiree or a dependent of a retiree and/or has Medicare coverage which has primary responsibility for the Insured Person's claims and which must pay its full benefits before Plan benefits are paid in accordance with the Coordination of Benefits provision.

B. Pre-certification is not required when an Insured Person has other group medical coverage which has primary responsibility for the Insured Person's claims and which must pay its full benefits before Plan benefits are paid in accordance with the Coordination of Benefits provision.

C. Pre-certification is not required when the Insured Person receives services or supplies outside of the United States, Mexico, Canada, or any state, district, province, territory or possession thereof.

LIFE INSURANCE BENEFIT FOR EMPLOYEES ONLY

This section is only a summary of the coverage provided under the Symetra policy. For details as to eligibility and requirements of coverage, please contact the Trust Administrative Agent at (800) 566-4455 or (509) 534-0265 for a complete copy of the Symetra Life Insurance Company Group Policy.

The Trust provides a life insurance benefit for eligible participants as described in this section, thru Symetra Life Insurance Company. This benefit has a maximum life insurance benefit of $5,000. In addition to the life insurance benefit, the policy offers an accelerated benefit for a qualifying terminally ill person, seatbelt and airbag coverage, repatriation benefit, child education benefit, day care benefit, rehabilitation benefit, spouse education benefit and adaptive home and vehicle benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR EMPLOYEES ONLY

The Trust provides an Accidental Death and Dismemberment benefit for eligible participants as described in this section, thru Symetra Life Insurance Company. Persons eligible for this coverage are Active Employees covered under this Plan, who complete 200 hours of covered employment and maintain 200 hours in their hour bank and who are citizens or legal residents of the United States, its territories and protectorates, excluding temporary, leased or seasonal employees.

SCHEDULES OF INDEMNITIES PRINCIPAL SUM $5,000:

Life	$5,000
Both Hands or Both Feet or Sight of Both Eyes	$5,000
One Hand and One Foot	$5,000
One Foot and Sight of One Eye	$5,000
For loss of:	
One Hand and Sight of One Eye	$5,000
One Hand or One Foot	$2,500
Sight of One Eye	$2,500
Thumb or Fingers of either Hand, Toe (maximum 2 per accident)	$1,250

Loss with reference to Hand or Hands means complete severance through or above the wrist joint so that no part of the Hand remains.

Loss with reference to Foot or Feet means complete severance through or above the ankle joint so that no part of the Foot remains.

Loss with reference to Eye or Eyes means the irrecoverable loss of the entire sight thereof.

Loss with reference to Thumb or Fingers means complete severance of the Thumb or Fingers to the first joint.

No more than the principal sum shall be paid for all losses resulting from any one accident.

No indemnity will be paid under any circumstances for any loss not enumerated in the above Schedule.

Benefits for loss of life of an Employee shall be paid to the beneficiary designated by such Employee, if living; otherwise to the estate of such Employee. All other benefits payable hereunder shall be paid to the Employee.

The coverage with respect to accidental Death and Dismemberment Benefits does not cover loss caused or contributed to by:

A. Bodily or mental infirmity, hernia, ptomains, bacterial infections (except pyogenic infections which shall occur with and through an accidental cut or wound) or by any other kind of disease;
B. Suicide or intentionally self-inflicted Injury, while sane or insane,
C. Accidental bodily Injury sustained while operating or riding in or on any kind of aircraft, or falling there with or there from or in any other manner descending there from while such aircraft is in flight or in motion, except where the Employee is a fare paying passenger of a commercial airline flying on a regular scheduled route between definitely established airports; or
D. Participation in a riot.

This coverage may not be converted to an Individual Policy.

WEEKLY TIME LOSS BENEFIT
FOR EMPLOYEES ONLY

Benefits

If an Employee while covered as an active participant (excluding COBRA or self-pay coverage) becomes Totally Disabled as defined under the Plan as a result of Injury or Sickness that occurs while covered as an active participant (excluding COBRA or self-pay coverage) and is prevented thereby from engaging in any occupation or employment for wage or profit, the Plan will pay a weekly time loss benefit. The amount of this benefit, the day on which benefits begin, and the maximum period for which benefits are payable are specified below. The Employee is entitled to benefits during each separate period of Disability. Benefits for partial weeks of Disability are paid on a pro rata basis.

Successive periods of Disability separated by less than 14 days of continuous, active employment or availability for work shall be considered as one continuous period of Disability unless they arise from different and unrelated causes.

Weekly Loss of Time Payments $250.00
Benefits begin: 1st day, accident
8th day, illness
1st day illness, if Hospitalized

Maximum number of weeks payable - 26 weeks

Exclusions:

No benefits are payable for any period of Disability:

A. During which the Employee is not regularly attended by a Physician;
B. resulting from accidental bodily Injury sustained or Sickness contracted in the course of any occupation or employment for wage or profit;
C. caused by an intentionally self-inflicted Injury or Sickness;
D. caused by any act of war, declared or undeclared, if such act occurs while the Employee is covered under the Plan, or by participation in a riot; or
E. caused by the participant's criminal activity.

COMPREHENSIVE MAJOR MEDICAL COVERAGE
For You and Your Dependents

The Washington-Idaho Operating Engineers and Employers Health and Security Trust has implemented a Preferred Provider Plan through First Choice Health Network for Hospital and Physician services. You will be provided with an identification card which will identify you as being covered through the Preferred Provider Plan.

NOT ALL PROVIDERS LISTED IN THE DIRECTORY ARE COVERED BY THE PLAN AND SOME MAY BE COVERED ONLY UNDER CERTAIN BENEFITS OR CERTAIN CIRCUMSTANCES. THE PLAN DOES NOT SUPERVISE, CONTROL OR GUARANTEE THE HEALTH CARE SERVICES OF ANY PROVIDER.

Refer to First Choice Health Network (FCHN) www.fchn.com or 1-800-231-6935 to see if your provider is participating with FCHN.

BENEFITS

If you or your Dependent incurs Expense for Covered Services because of an Injury or Sickness, We will pay a percentage of that Expense after the deductible is satisfied. We will pay up to the Maximum for each Covered Person. The Percentage Payable, Deductible and Maximum are shown in the Schedule of Benefits on page 5.

INPATIENT HOSPITAL SERVICES

We will pay Expenses for:

A. Hospital room and board, up to the semi private room rate; or
B. Hospital services and supplies used when benefits are payable under (a) above.

Hospital Charges for the services of a Physician, private duty nurse or other practitioner are not covered under (a) or (b) above.

EMERGENCY ROOM TREATMENT

Emergency room treatment is subject to a $75 Co-Payment unless:

A. the Covered Person is admitted directly to the Hospital from the emergency room, or
B. the Emergency Room visit is a result of an accident or life threatening illness.

SURGICAL SERVICES

We will pay Expenses for:

A. Physician's services for an operation, or the repair of a dislocation or fracture; and
B. administration of anesthesia by persons not employed by the Hospital.

DENTAL CARE

Dental services required for Injury to sound, natural teeth only, which are furnished within 180 days after the date of Injury which occurred while the Covered Person was covered under the Plan including the setting of a jaw fractured or dislocated in an accident.

Also covered are Physician's Charges for extraction of bony impacted wisdom teeth. This benefit is paid at a maximum benefit of $55 per bony impacted tooth subject to deductible and co-insurance. This benefit is for services not covered by a Dental Plan.

SKILLED NURSING CARE (facility services)

The Plan will pay for covered Charges made in connection with confinement in a Skilled Nursing Care Facility provided:

A. such confinement commences within 14 days after at least five continuous days of confinement in such Hospital;
B. covered Charges will be payable up to $20 per day; and
C. in no event will benefits be payable beyond a maximum of 180 days during any one period of Skilled Nursing care confinement. Successive periods of confinement shall be considered one period of confinement unless they are separated by an interval of at least 60 days during which the Covered Person has not been confined as a result of the same accidental bodily Injury or the same or related Sickness, in either a Hospital or a Skilled Nursing Care Facility. Skilled Nursing Care Facility, as used herein, means an institute which is classified as a Skilled Nursing Care Facility under Medicare (Title XVIII of the Social Security Act) and has a transfer agreement in effect with a Hospital under Medicare.

HOME HEALTH CARE SERVICES

We will pay Expenses for:

A. skilled nursing care provided on a part-time basis (no more than an eight hour shift) by:
    1. A registered nurse (RN); or
    2. A licensed practical nurse (LPN);
B. Physical Therapy, occupational therapy, inhalation therapy or Speech Therapy provided by a licensed therapist;
C. a home health aide services provided on a part-time basis (less than an eight-hour shift) which:
    1. Are performed by a home health aide under the supervision of a registered nurse (RN) or a licensed therapist;
    2. consists mainly of medical care and therapy for the Covered Person;
    3. may include helping the Covered Person with:
        a. personal care;
        b. taking medications;
        c. movement of exercise;
        d. making reports on the Covered Person's condition.
D. medical social services provided by a licensed social worker with a master's degree in social work;
E. ambulance service which is:
    1. certified by a Physician to be necessary because of the Covered Person's medical condition; or
    2. required because of a Medical Emergency;
F. the following equipment and supplies, which are ordered or prescribed by a Physician and would be covered as a Hospital Inpatient Expense:
    1. Drugs and medicines requiring a Physician's written prescription (and insulin);
    2. medical supplies such as oxygen, catheters, syringes, dressings, antiseptics, irrigation solutions and intravenous fluids;
    3. prosthetic devices, casts, splints, trusses, crutches and braces; and
    4. rental (up to the purchase price) of a wheelchair, Hospital bed for patient care or other Durable Medical Equipment.

Benefits for such equipment and supplies will be paid in the same manner as when they are provided while the Covered Person is confined to a Hospital.

HOSPICE CARE

If you or your Dependent incurs Expenses for Hospice Care services because of a terminal Sickness, we will pay major Medical benefits at 80%, but not to exceed 6 months of Inpatient and outpatient Hospice Care services combined while covered under the Plan.

Payment of Hospice care benefits is not in lieu of Hospital or medical benefits under the Plan; but we will not pay duplicate benefits for the same services and supplies or the same days of confinement.

Exceptions for Home Health Care and Hospice Care

We will not pay for:

A. services and supplies which are not covered under this Home Health Care benefit and Hospice care benefit;

B. services by a person who lives in your home or is a member of your family;
C. services which consist mainly of housekeeping, companionship or sitting;
D. services which are not directly related to the Covered Person's medical condition, including (but not limited to):
    1. estate planning, drafting of wills or other legal services;
    2. pastoral counseling or funeral arrangements or services;
    3. nutritional guidance or food services such as "meals on wheels";
    4. transportation services (except as provided above); or
E. Expense for which benefits are paid under any other provision of the Plan.

MENTAL HEALTH DISORDERS

Benefits provided under the Plan for the treatment of a Mental Disorder will include treatment by:

A. a Physician;
B. a licensed psychologist;
C. a community mental health agency; or
D. a state Hospital;

Subject to such provisions being licensed by the proper authority of the state in which they are located. Outpatient and Inpatient Charges are not subject to the deductible. Inpatient and Outpatient Out of Pocket Expenses incurred for this type of treatment do not accumulate toward the Plan Out Of Pocket maximums.

Outpatient Benefits

The Trust will pay 50% of Charges for eligible Charges incurred for up to 20 office visits per year by an approved provider. The amount of the benefits paid is subject to UCR (usual, customary and reasonable) as defined by the Plan.

Inpatient Benefits

The Plan will pay 80% of eligible Charges incurred, up to 20 days as an Inpatient in an approved facility in a Calendar Year and with a maximum of 20 Inpatient visits by an approved medical provider. The amount of the benefits paid is subject to UCR (usual, customary and reasonable) as defined by the Plan.

ALCOHOLISM AND DRUG ABUSE

If, while covered under the Plan, an Employee or Dependent is treated for alcoholism or Drug abuse, the Plan will pay, after deductible, 80% of incurred Charges for Inpatient or Outpatient services in a qualified treatment facility. However, the maximum shall not exceed $5,000 in a Calendar Year up to a lifetime maximum of $10,000 for each Covered Person.

COSMETIC SURGERY

Cosmetic Surgery is covered, only if it is not elective and only if it relates to and begins within 90 days after the date of an Injury. Also covered is the initial reconstruction of a breast after a Mastectomy, pursuant to the Women's Health and Cancer Rights Act of 1998. This Plan will cover breast reductions, only when such treatment is deemed Medically Necessary by a Physician.

GASTRIC BYPASS/GASTRIC BANDING FOR TREATMENT OF MORBID OBESITY

Gastric Bypass/Gastric banding for treatment of morbid obesity is covered, based on specific criteria listed below. All Gastric Bypass and Gastric Banding have to be pre-authorized prior to surgery.

I. Roux-en-Y Gastric Bypass (RYGB), Laparoscopic Adjustable Silicone Gastric Banding (LASGB), Biliopancreatic Diversion (BPD) and Duodenal Switch (DS) Procedures:

The Washington-Idaho Operating Engineers and Employers Health & Security Trust Fund considers open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) medically necessary when the selection criteria listed below are met.

Selection criteria:

A. Presence of severe obesity that has persisted for at least the last 2 years, defined as any of the following:
   1. Body mass index (BMI)* exceeding 40; or
   2. BMI* greater than 35 in conjunction with any of the following severe co-morbidities:
      a. Coronary heart disease; or
      b. Type 2 diabetes mellitus; or
      c. Clinically significant obstructive sleep apnea; or
      d. Medically refractory hypertension (blood pressure greater than 140 mmHG systolic and/or 90mmHG diastolic despite optimal medical management);

And

B. Member has completed growth (18 years of age or documentation of completion of bone growth); and
C. Member has attempted weight loss in the past without successful long-term weight reduction; and
D. Member must meet either criterion 1 (physician-supervised nutrition and exercise program) or criterion 2 (multidisciplinary surgical preparatory regimen):
   1. Physician-supervised nutrition and exercise program: Member has participated in physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. This physician-supervised nutrition and exercise program must meet all of the following criteria:

      a. Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; and
      b. Nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within 2 years prior to surgery, with participation in one program of at least three consecutive months. (Precertification may be made prior to completion of nutrition and exercise program as long as a cumulative of six months participation in nutrition and exercise program(s) will be completed prior to the date of surgery.); and
      c. Member's participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the member's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. Note: A physician's summary letter is not sufficient documentation. Documentation should include medical records of physician's contemporaneous assessment of patient's progress throughout the course of the nutrition and exercise program.

   Or

   2. Multidisciplinary surgical preparatory regimen: Proximate to the time of surgery, member must participate in organized multidisciplinary surgical preparatory regimen of at least three months duration meeting all of the following criteria, in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the member's ability to comply with post-operative medical care and dietary restrictions:

      a. Consultation with a dietician or nutritionist: and
      b. Reduced-calorie diet program supervised by dietician or nutritionist: and
      c. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or other qualified professional; and
      d. Behavior modification program supervised by qualified professional: and
      e. Documentation in the medical record of the member's participation in the multidisciplinary surgical preparatory regimen at each visit. (A physician's summary letter, without evidence of contemporaneous oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the member, and the physician's assessment of the member's progress at the completion of the multidisciplinary surgical preparatory regimen.)

And

E. For members who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, pre-operative psychological clearance is necessary in order to exclude members who are unable to comply with the pre- and postoperative regimen. Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery.

II. Vertical Banded Gastroplasty (VBG):

The Washington-Idaho Operating Engineers and Employers Health & Security Trust Fund considers open or laparoscopic vertical banded gastroplasty (VBG) medically necessary for members who meet the selection criteria for obesity surgery and who are at increased risk of adverse consequences of a RYGB due to the presence of any of the following comorbid medical conditions:

A. Hepatic cirrhosis with elevated liver function tests; or
B. Inflammatory bowel disease (Crohn's disease or ulcerative colitis); or
C. Radiation enteritis; or
D. Demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma; or
E. Poorly controlled systemic disease.

The Washington-Idaho Operating Engineers and Employers Health & Security Trust Fund considers VBG experimental and investigational when medical necessity criteria are not met.

III. Repeat Bariatric Surgery:

The Washington-Idaho Operating Engineers and Employers Health & Security Trust Fund considers medically necessary surgery to correct complications from bariatric surgery, such as obstruction or stricture.

The Washington-Idaho Operating Engineers and Employers Health & Security Trust Fund considers repeat bariatric surgery medically necessary for members whose initial bariatric surgery was medically necessary (i.e., who met medical necessity criteria for their initial bariatric surgery), and who meet either of the following medical necessity criteria:

A. Conversion to RYGB or BPD/DS may be considered medically necessary for members who have not had adequate success (defined as loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure and the member has been compliant with a prescribed nutrition and exercise program following the procedure; or
B. Revision of a primary bariatric surgery procedure that has failed due to dilation of the gastric pouch is considered medically necessary if the primary procedure was successful in inducing weight loss prior to the pouch dilation, and the member has been compliant with a prescribed nutrition and exercise program following the procedure.

IV. Experimental and Investigational Bariatric Surgical Procedures:

The Washington-Idaho Operating Engineers and Employers Health & Security Trust Fund considers each of the following procedures experimental and investigational because the peer reviewed medical literature shows them to be either unsafe or inadequately studied:

- Loop gastric bypass
- Gastroplasty, more commonly known as "stomach stapling" (see below for clarification from vertical band gastroplasty)
- Sleeve gastrectomy
- Mini gastric bypass
- Silastic ring vertical gastric bypass (Fobi pouch)
- Intragastric balloon
- VBG, except in limited circumstances noted above.
- LASGB, RYGB and BPD/DS procedures not meeting the medical necessity criteria above.

Cholecystectomy:

As a high incidence of gallbladder disease (28%) has been documented after surgery for morbid obesity, The Washington-Idaho Operating Engineers and Employers Health & Security Trust Fund considers routine cholecystectomy medically necessary when performed in concert with elective bariatric procedures.
Notes:

Calculation of BMI:
* BMI is calculated by dividing the patient's weight (in kilograms) by height (in meters) squared:
  BMI = weight (kg) * [height (m)]^2
  Note: To convert pounds to kilograms, multiply pounds by 0.45.

  To convert inches to meters, multiply inches by 0.0254.

CHELATION THERAPY

Medical problems in which chelating agents are considered include:

A. Ventricular arrhythmias (irregular heartbeats) caused by digoxin toxicity;
B. hypercalcemia (too much calcium);
C. mental toxemia, i.e. thalassemia hemosiderosis;
D. Wilson's disease (halatolenticular degeneration); and
E. lead poisoning.

The Plan will not cover Chelation treatment related to arteriosclarotic vascular disease or peripheral vascular disease.

TMJ SYNDROME

We will pay limited benefits for surgical and non-surgical treatment by a Physician or Dentist for:

A. temporomandibular joint dysfunction (TMJ);
B. myofascial pain dysfunction (MPD); and
C. jaw surgeries of any nature; including skeletal deformities, except treatments relating to tumors or malignancies.

Coverage includes:

A. diagnosis;
B. x-rays;
C. Hospitalization;
D. surgery;
E. physical Therapy;
F. splints; and
G. guards.

We will pay benefits in the same manner as any other Sickness at 80% for covered Charges up to a lifetime maximum of $500 subject to deductibles and co-insurance. *Charges in excess of these benefits do not apply to the annual Out Of Pocket maximum.*

SPINAL TREATMENT

Chiropractic benefits will be paid at 80% with no deductible. The maximum benefit per Calendar Year is $1200 per family. X-rays will be subject to the deductible and Out of Pocket maximums. *Expenses related to Spinal Treatment will not accumulate toward the Plan Out Of Pocket Maximums.*

OUTPATIENT PHYSICAL THERAPY

Outpatient Physical Therapy benefits will be paid at 80% with no deductible. The maximum benefit per Calendar Year is 15 visits per family.

OUTPATIENT REHABILITATION FACILITY

Outpatient Rehab is paid at 80% subject to deductible and co-insurance unlimited for the first 100 days after stroke, accident or surgery.

HEARING AID BENEFIT

If you or your Dependent incurs Expenses by a Physician or a certified or licensed audiologist for covered hearing aid services, We will pay for the Expense incurred up to the hearing aid benefit maximum shown in the schedule.

We will pay Expenses for the following up to $700 per ear once every 36 months:

A. an otologic examination made by a Physician;
B. an audiologic examination made by a certified or licensed audiologist and the Expense for one follow-up visit; and
C. the purchase of a hearing aid device (monaural or binaural) prescribed as a result of such examinations, but only if the examining Physician or audiologist certifies that the Covered Person has a hearing loss that may be lessened by the use of a hearing aid device. These Charges include the Expense for:
    1. the actual hearing aid device;
    2. ear mold(s);
    3. the initial batteries, cords and other necessary ancillary equipment;
    4. a warranty; and
    5. a follow-up visit within 30 days after the delivery of the hearing aid device.

Exceptions

We will not pay for:

A. replacement of a hearing aid more than once during any period of 36 consecutive calendar months, regardless of the reason;
B. batteries or other ancillary equipment, except those purchased with the hearing aid device;
C. repairs, servicing or alterations of hearing aid equipment;
D. a hearing aid device that exceeds the specification of the prescription;
E. service or supply that is not necessary or that does not meet professionally recognized standards; or
F. anything excluded under the General Exclusions and Limitations.

NOTE: Most providers of hearing aids allow for a 90-day trial use. It is best not to submit the bill for payment until you are satisfied with your hearing aid.

ORTHOTICS

If while covered under the plan, an Employee or Dependent incurs Expenses for the orthotic devices, the Plan will pay a maximum of $250 annually, subject to deductible and co- insurance.

ROUTINE PHYSICAL EXAMINATION (FOR EMPLOYEE ONLY)

If while covered under the Plan an Employee should incur Expense for a routine physical examination and if such examination is performed by a Physician licensed to practice medicine, the Plan will pay up to 80%, not to exceed $100 each Calendar Year.

WELLNESS EXAM (FOR ALL PARTICIPANTS)

The Plan will pay 80% of the office visit related to the following, along with the related tests for wellness exams.

We will pay for:

A. one routine physical examination per year (male or female member);
B. one mammogram per year (female member);
C. one pap smear per year (female member); and
D. one prostate test per year (male member.

WELL CHILD CARE

The Plan will cover an annual maximum of $300 for Well Child visits to a Physician and immunizations, up to age 5.

MATERNITY

If a Covered Person is confined to a Hospital as a resident Inpatient for childbirth, including any post delivery follow-up

care. We will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service. Benefits will be in accordance with accepted medical practice as recommended by the attending Physician (including a licensed nurse midwife, a licensed Physician's assistant, or a licensed advanced registered nurse-practitioner), in consultation with the mother.

Post delivery follow-up care includes, but is not limited to, visits by a licensed home health agency or by a licensed registered nurse.

The newborn child will be covered automatically for thirty (30) days following birth, even if the newborn child is admitted separately to the Hospital. Following such thirty day period, the participant must enroll the newborn child, the newborn child will then be covered in accordance with the Dependent eligibility provisions of the Plan.

DIABETES BENEFITS

If you or your Dependent is a Covered Person with diabetes and incurs Expense for the following diabetes equipment and supplies for the treatment of diabetes, benefits will be paid in the same manner and subject to the same conditions and limitations as any other covered service.

Diabetes equipment and supplies include, but are not limited to, and are paid under Major Medical:

A. blood glucose monitors;
B. test strips for blood glucose monitors, visual reading and urine test strips;
C. injection aids;
D. syringes, prefilled syringes;
E. insulin pumps and accessories to the pumps;
F. insulin infusion devices;
G. foot care appliances for prevention of complications associated with diabetes;
H. glucagon emergency kits; and
I. insulin.

If you or your Dependent incurs Expenses for diabetes outpatient self-management training and education, including medical nutrition therapy, benefits will be paid in the same manner and subject to the same conditions and limitations as any other covered service up to 3 sessions per lifetime maximum.

ARTIFICIAL INSEMINATION AND IN VITRO FERTILIZATION

If while covered under the Plan an Employee or Dependent spouse incurs Expenses for artificial insemination or In Vitro Fertilization, the Plan will pay at 80% up to a maximum lifetime benefit of $2,500, subject to deductibles and co-insurance.

NOTE: Expenses related to Artificial Insemination and In Vitro Fertilization will not accumulate toward the Plan Out of Pocket maximums.

INFERTILITY

If while covered under the policy an Employee or Dependent spouse incurs Expenses for diagnosis of infertility, the Plan will pay for each exam and each diagnostic procedure at 80% up to a maximum lifetime benefit of $2,500, subject to deductibles and co-insurance.

NOTE: Expenses related to Infertility will not accumulate toward the Plan Out of Pocket maximums.

ACUPUNCTURE

If while covered under the Plan a participant incurs Expenses for Acupuncture, the Plan will pay benefits at 80% after the deductible is met if the procedure is medically necessary and is administered by a licensed provider or Physician as defined by the Plan. *Acupuncture treatment for a diagnosis of obesity or cessation of smoking is not covered.*

NOTE: Expenses related to Acupuncture will not accumulate toward the Plan Out of Pocket maximums.

SPEECH THERAPY

If while covered under the Plan a participant incurs Expenses for Speech Therapy, the Plan will pay benefits at 80% up to a maximum of $1200 per Calendar Year, subject to deductible and only if Medical Necessity (i.e. for restoration of lost speech ability due to stroke or congenital defect) has been established.

DURABLE MEDICAL EQUIPMENT RENTAL

The Plan will cover Expenses for rental of Durable Medical Equipment at 80% subject to the deductible. A written prescription from the attending Physician is required. The maximum benefit allowed will not exceed the equivalent purchase price of the equipment.

OTHER COVERED SERVICES (if not included above)

We will pay Expenses for:

A. Hospital outpatient services;
B. active services of an assisting surgeon;
C. services of a registered graduate nurse (RN) for private duty nursing care, or of a licensed physiotherapist (RPT);
D. Charges for local professional ambulance service, and if the Injury or illness requires special and unique Hospital treatment, transportation within the United States or Canada to the nearest Hospital equipped to furnish the treatment not available in a local Hospital, by professional ambulance, railroad or commercial airline on a regularly scheduled flight.
E. the following services and supplies:
    1. Formulas necessary for the treatment of phenylketonuria (PKU) (Benefits payable for PKU are not subject to any Preexisting Condition exclusion or limitation);
    2. diagnostic x-ray and laboratory service;
    3. Women's Health Care Services because of an Injury or Sickness;
    4. oxygen and the rental of equipment for its administration;
    5. blood or blood plasma and its administration;
    6. x-rays;
    7. casts, splints, braces, trusses and crutches;
    8. artificial limbs and eyes to replace natural limbs and eyes;
    9. initial placement of contact lenses required because of cataract surgery;
    10. sterilization procedures and elective abortions for Employees and spouses;
    11. Prescription Drugs for which a Physician's written prescription is required; and
    12. Compression stockings limited to 4 pair per year.

NOTE: All Major Medical Benefits are payable for non-occupational accident and Sickness only.

PRESCRIPTION DRUG COVERAGE

For Covered Drugs

Each Covered Person will have a $50 annual deductible and maximum Out Of Pocket of $1,000 before the Plan will pay 100%.

Retail Pharmacy

The Covered Person's co-pay responsibility is:

20% for Generic Drugs

30% for Name Brand Drugs

You may receive up to a 90-day supply for each prescription.

Mail Order

The Covered Person's co-pay responsibility is:

20% for Generic Drugs

30% for Name Brand Drugs

You may receive up to a 90-day supply for each prescription.

PREFERRED PRESCRIPTION DRUG PROVIDER OPTION

When you or your Dependents require Covered Drugs, the Covered Person may choose any pharmacist he or she wishes. However, if the Covered Person uses the services of a preferred prescription drug provider, benefits may be subject to a more favorable Co-Payment or percentage payable (as shown below. Regardless of the provider chosen, benefits will be subject to all other terms, conditions and limitations of the Plan.

We will publish an updated list of Preferred Provider pharmacies periodically. For the current list, contact the Trust Administrative Agent. We will also provide the Covered Person with a Prescription Drug card.

We do not supervise, control or guarantee the services of any preferred Prescription Drug provider or other provider.

Under your prescription benefit program, you can get your prescriptions filled with a preferred prescription drug provider or through the Caremark Mail Service Program.

Getting Your Prescription Filled at a Retail Pharmacy

Refill Limit

The Plan does not limit the number of refills you may obtain at a retail pharmacy for maintenance or long-term medicines. Please note, you are allowed up to a 90 day supply or 100 tablets per script (whichever is greater. However, if you use the Caremark Mail Service Pharmacies for medicine you will be taking for a long time, you may save money.

Caremark Participating Retail Pharmacies

The Caremark Retail program includes more than 62,000 participating pharmacies nationwide, including over 20,000 independent community pharmacies. For a full listing, visit www.caremark.com or call 1-888-739-7985.

Using the participating retail pharmacy is generally more convenient and less expensive. Participating pharmacies can easily access information about your prescription benefit program and the appropriate payment. You will not need to file any additional paperwork when you use a Caremark participating retail pharmacy.

Non-Participating Retail Pharmacies

In most cases, you will pay more for your prescription if you use a pharmacy outside the Caremark network. You will be asked to pay 100 percent of the prescription price at the pharmacy. Then, you will need to submit the paper claim form included in the separate book from Caremark for reimbursement of covered Expenses.

Getting Your Prescription Filled through the Caremark Mail Service Program

Caremark operates seven mail service pharmacies across the United States to provide quick service to Covered Persons wherever they live. To ensure your safety, Caremark mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacists, Caremark pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medicines you may be prescribed.

Convenient Home Delivery

You can expect your medicine to arrive 10 to 14 calendar days after Caremark receives your prescription. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medicine that you would receive for a retail pharmacy.

Note: Injectible drugs, diabetic supplies and insulin are paid at Major Medical Plan benefits.

Exclusion

We will not pay Prescription Drug benefits for Drugs that have been determined under the internal standards of the Food and Drug Administration to be "less-than-effective" in accordance with the Drug Efficacy Study Implementation (DESI) or where the same Prescription Drug item is also available over-the-counter.

Coordination of Benefits

This Prescription Drug Plan does not coordinate benefits.

NOTE: The Co-Payment amount does not apply to the Medical Plan deductible or Out Of Pocket maximum amounts and will not be reimbursed under the medical Plan.

RETIRED AND DISABLED MEMBERS COVERAGE
RETIREE AND DISABLED MEMBERS
HOSPITAL – SURGICAL – MEDICAL EXPENSE COVERAGE

For Employees who were permanently and totally Disabled, or who were retired on or after September 1, 1983, and at and after that time eligible for the existing retiree health and welfare Plan under the eligibility rules, certain benefits are available to those eligible Employees and their eligible Dependents.

The Trust Fund, therefore, will provide for the same Hospital – surgical – medical insurance coverage as outlined in this booklet as provided for the Actively Working Employee. However, the following benefits are NOT provided for these permanently and totally Disabled Employees and retired Employees.

A. Accidental Death and Dismemberment Benefits
B. Accident and Sickness Weekly Indemnity
C. Routine Physical Examinations

Benefits outlined in the portion of this booklet referred to as Comprehensive Major Medical coverage apply to this category of membership.

The Board of Trustees has Adopted the following rules to be eligible for Retiree Medical effective September 1, 1983.

RULES OF ELIGIBILITY Retirement and Disability

A. The retiring Employee must be age 55 or older, and have earned ten credits, or 15,000 future service hours, of which 3,000 future service hours has been accumulated in this Trust Fund within the five years immediately preceding the date benefits commence from the Engineers-AGC Retirement Trust Fund of the Inland Empire or the Idaho Operating Engineers-Employers Pension Trust Fund.
B. The majority of credits earned must be earned in Engineers-A.G.C. Retirement Trust of the Inland Empire or the Idaho Operating Engineers-Employers Pension Trust Fund
C. Supplemental benefits only will be available if the Employee or spouse is eligible for medical benefits in any other group insurance Plan. This Plan will always be secondary.
D. Any premium payable for medical coverage as determined by the Board of Trustees must be paid each continuous month. Failure to make such payment will forfeit all Medical coverage commencing on the first day of the month the premium is due.
E. Disability benefits are considered when the Employee submits evidence of Total and Permanent Disability to the Board of Trustees. The Trustees may grant Disability coverage based on the statement of a medical doctor, Social Security award, and/or any other evidence deemed acceptable by the Board of Trustees.
F. The Employee is required to apply for Medicare Coverage on a timely basis as allowed under the rules of the Social Security program. This includes Part A and Part B of Medicare.
G. An Employee may qualify for Disability Coverage at any age provided the foregoing requirements for eligibility are met.
H. The rules for retiree or Disability coverage do not constitute a vested benefit. Benefits for retirees and Disabled individuals will be available as long as it is economically feasible as determined by the Board of Trustees.

COVERED PERSON PRIOR TO MEDICARE

In a Calendar Year, after the Retiree or eligible Dependent has met a deductible of $300 or $600 for family coverage, the Retiree Plan will pay 80% of the first $2,500 of all eligible Charges, or $5,000 for family coverage, then the Plan will pay benefits at 100% of charges for the remaining of the year .

If the Retiree or eligible Dependent has other group coverage to which this Plan's benefits are secondary, then benefits provided by the other group coverage will be deducted from the eligible Charges before determination is made as to whether the remaining amount of eligible Charges is to be applied toward the deductible, paid at 80% or at 100%.

The maximum lifetime benefit is $1,000,000. Hospital room and board is limited to the semi-private room rate.

COVERED PERSON WITH MEDICARE

Covered Persons eligible for Medicare benefits will not be subject to the deductible before benefits are paid. Benefits will be calculated at a rate of 80% of eligible Charges not paid by Medicare.

For those retirees and Dependents covered under Medicare, the Plan will use the Medicare allowed benefits as the basis on which all claims will be paid. After deducting the amount paid by Medicare, the Plan will pay the remaining amounts subject to Coordination of Benefit rules.

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Part A and Part B, regardless of whether or not the person was enrolled under both of these parts. This includes Charges incurred in Veterans' Affairs facilities.

Note: Medicare may affect Plan benefits; therefore, you may want to contact your local Social Security Office for information about Medicare. This should be done before you or your spouse's 65th birthday. A penalty may be imposed should you delay your enrollment with Medicare and your premium will be increased when you do elect your Medicare coverage.

RETIREES HEALTH COVERAGE

The Board of Trustees decided on October 10, 2007, the Plan will no longer allow retroactive health coverage for retirees. The Plan will allow health coverage for retirees to commence on the 1st day of the month following the month in which the Application for Retirement is received by the Pension Plan, or the retiree is placed into pay status, whichever is later, and provided that the premium for health coverage is made timely.

The Board of Trustees decided on October 10, 2007, the Plan will now allow deferred enrollment. If a Retiree or Dependent has other group coverage including COBRA or Dependent coverage under a spouse's Group Health Plan, participation in the Retiree Plan may be deferred until other medical coverage ends. However, the Retiree must still make timely application to the Trust Administrative Agent and indicate the request for delayed participation, and at that time you must provide proof of other coverage. Timely application means the Retiree must notify the Trust Administrative Agent in writing within 30 days after the other medical coverage has ended, in order to elect coverage under this Plan. Coverage under the other medical Plan must be continuous. Once enrolled in this Plan, enrollment must be continued with no break. If the Retiree or Dependent terminates from the Plan, re-enrollment will not be permitted.

BENEFITS NOT COVERED UNDER RETIREE MEDICAL

A. Accidental Death and dismemberment
B. Accident and Sickness weekly time loss
C. Dental care benefits
D. Physical examination benefits

COVERAGE FOR SPOUSE OF DECEASED RETIREE

Effective July 1, 1978, Retiree Medical coverage became available to the spouse of a deceased retiree. Based upon current Plan provisions, this coverage will be available for the lifetime of the spouse. Coverage would also be provided for Dependent children covered at the time the spouse coverage became effective. No coverage would be provided to Dependents acquired after the spouse coverage begins.

To be eligible for this benefit, the Employee must be eligible for Retiree Medical Coverage on or after July 1, 1978, and must pay the monthly premiums due as determined by the Board of Trustees.

The spouse of a deceased retiree is required to pay a monthly premium as determined by the Board of Trustees.

Note: Cost and availability of this Plan is dependent upon Trustee determination and economic conditions involving the Trust Fund.

Dependent Eligibility

The participant must notify the Trust Administrative Agent within 31 days of a change in Dependent status.

A Retiree must be eligible for benefits to have their Dependents covered. The coverage for their eligible Dependents shall become effective on the latest of the following dates:

A. On the date the Retiree's coverage becomes effective, or
B. On the date the Covered Retiree first acquires an eligible Dependent.

If an Employee or retiree covered under the Plan acquires an eligible Dependent, such Dependent shall become covered automatically.

PRESCRIPTION DRUG PROGRAM FOR RETIREES

The Prescription Drug Program for retirees is the same program as that of an active member with the exception that the maximum benefit per year is $1,000 per family. Reimbursement will be based upon the same deductible and the same co-pay as the active participant.

When you or your Dependents require Covered Drugs, the Covered Person may choose any pharmacist he or she wishes. However, if the Covered Person uses the services of a preferred Prescription Drug provider, benefits may be subject to a more favorable Co-Payment or percentage payable (as shown under the Active Employee Prescription Drug program portion of this Plan book. Regardless of the provider chosen, benefits will be subject to all other terms, conditions and limitations of the Plan.

We will publish an updated list of preferred/network providers periodically. For the current list of providers, contact the Trust Administrative Agent. We will also provide the Covered Person with a Prescription Drug card.

We do not supervise, control or guarantee the services of any preferred Prescription Drug provider or other provider.

SUMMARY OF DENTAL BENEFITS

Active Employees
And their covered Dependents only

NEW EMPLOYEE ENROLLMENT

If you are a new Employee in the Plan or have not been eligible within the last year (12 months), you may enroll in Dental Plan A or B by filling out the enrollment form which is enclosed in this booklet and submitting it to the Trust Office within 90 days of you first becoming eligible for benefits. The enrollment form requires you to make a selection between Dental Plan B,(the scheduled Benefit Plan) or Dental Plan A, (the Willamette Dental Plan of Washington and Oregon. If you do not enroll in a Dental Plan within 90 days you will automatically be enrolled in Dental Plan B and will not be allowed to change dental plans until the next open enrollment period.

OPEN ENROLLMENT

Each year the Trust will hold an open enrollment period during which time you may select a new dental plan option. If you wish to change your dental plan option, you may do so by filling out the new enrollment card supplied with this booklet and submitting it to the Trust Office at the address on the enrollment card. **Your next opportunity to change dental plans will not be until the next open enrollment period.**

IMPORTANT

You only need to complete an enrollment card if:

A. You have never submitted an enrollment form to the Trust Office; or
B. You wish to switch dental plans; or
C. Your address has changed; or
D. Your dependent information and / or beneficiary designation has changed.

CHANGING PLANS

Changes to your dental plan option may only be made on an annual basis.

QUESTIONS

For questions regarding the Scheduled Benefit Dental Plan B contact the Trust Office at:

Zenith Administrators
111 W. Cataldo, Suite 220
Spokane, WA 99201
(509) 624-3257
(800) 351-6480

PLAN A
WILLAMETTE DENTAL OF WASHINGTON INC. (WDWI)
PREFERRED PROVIDER DENTAL PLAN

For questions regarding the Preferred Dental Plan A contact:

Willamette Dental of Washington, Inc.

Call the customer service number listed for each area.

Appointments or Emergencies (800) 359-6019
Appointment Center Hours
Monday – Thursday ……7:00 a.m. – 8:00 p.m. PST
Friday……...7:00 a.m. – 6:00 p.m. PST
Saturday……...7:00 a.m. – 6:00 p.m. PST

Patient Relations (Customer Service) (800) 360-1909
Patient Relations Hours
Monday – Friday…….8:00 a.m. – 5:00 p.m. PST
Email:……....relations@willamettedental.com
Website:..……..…..www.WillametteDental.com

PLAN A SCHEDULE OF BENEFITS

Group Name:				Operating Engineers	
Group Number:	Z1100	Plan ID:	OPERA	Effective Date:	January 1, 2005
BENEFIT				**CO-PAYMENT**	
Annual Maximum				No Annual maximum **	
Deductible – applies to all services				$50	
Office Visit co-payment				No Office Visit co-payment	
DIAGNOSTIC AND PREVENTIVE SERVICES					
Routine and Emergency Exams				Covered at 100%	
Intraoral – Complete Series X-ray				$20	
Panoramic X-ray				$50	
Teeth Cleaning				$45	
Fluoride Treatment				$15	
Sealants				$20	
Head and Neck Cancer Screening				Covered at 100%	
Oral Hygiene Instruction				Covered at 100%	
Periodontal Screening				Covered at 100%	
Periodontal Evaluation				Covered at 100%	
RESTORATIVE DENTISTRY AND PROSTHETICS					
Fillings – One Surface				$60	
Fillings – Two Surface				$80	
Fillings – Three Surface				$100	
Fillings – Four Surface				$120	
Permanent Crowns				$475	
Complete Upper or Lower Denture				$585	
Bridge – per tooth				$475	
All lab fees				Covered at 100%	
ENDODONTICS AND PERIODONTICS					
Root Canal Therapy – anterior				$250	
Root Canal Therapy – bicuspid				$350	
Root Canal Therapy – molar				$400	
Osseous Surgery – per quadrant				$155	
Root Planing – per quadrant				$90	
ORAL SURGERY					
Routine Extraction – Single tooth				Covered at 100%	
Surgical Extraction				$105	
ORTHODONTIA					
Pre-Orthodontic Service				$150*	
Comprehensive Orthodontia				$2,500	

MISCELLANEOUS	
Local Anesthesia (Novocain)	Covered at 100%
Nitrous Oxide (per visit)	$20
After Hours Emergency Care	$20
Out of Area Emergency Care Reimbursement up to:	$100
TMJ**	$1,000 annual maximum $5,000 Lifetime maximum

* Fee credited towards comprehensive orthodontic co-payment if patient accepts treatment plan.
** Services for temporomandibular joint disorders (TMJ) has a maximum benefit.
This is a summary of your benefits. Contact your Plan Administrative Agent for additional questions.

PLAN A
WILLAMETTE DENTAL OF WASHINGTON INC. (WDWI)
PREFERRED PROVIDER DENTAL PLAN

If you choose Dental Plan A for your dental benefits, you must receive your care from any of the Willamette Dental of Washington, Oregon or Idaho offices listed below.

Washington

(800) 359-6019 – Appointments – (800) 360-1909 – Customer Service

Bellingham
Pacific Meridian Plaza
4164 Meridian Street
Bellingham, WA 98226

Everett
4310 Colby Ave., Suite 300
Everett, WA 98203

Silverdale
3505 NW Anderson Hill Road
Silverdale, WA 98383

Lynnwood
Scriber Flake Office Center
6101 – 200th St. SW, Suite 201
Lynnwood, WA 98036

Bellevue
Park 120 Office Complex
626 – 120th Ave. NE, Suite B210
Bellevue, WA 98005

Federal Way
181 S. 333rd St., Suite C-100
Federal Way, WA 98003

Puyallup
702 South Hill Park Dr., Suite 201
Puyallup, WA 98373

Lakewood
9307 Bridgeport Way SW
Tacoma, WA 98499

Pullman
Wheatland Shopping Center
1646 S. Grand Ave.
Pullman, WA 99163

Kent
24722 104th Avenue SE
Kent, WA 98031

Olympia
Columbia Commons
3773-C Martin Way, Suite 105
Olympia, WA 98506

East Vancouver
1201 SE Tech. Center Dr., # 150
Vancouver, WA 98683

Yakima
1200 Chesterly Dr., Suite 230
Yakima, WA 98908

Spokane
Fidelity Associates Building
501 S. Bernard, Suite 203
Spokane, WA 99204

Northgate
2111 N. Northgate Way, Suite 100
Seattle, WA 98133

Tumwater
6120 Capital Blvd. S.
Tumwater, WA 98501

Downtown Seattle (free parking)
133 Dexter Ave. N
Seattle, WA 98109

Vancouver
9609 Mill Plain Blvd.
Vancouver, WA 98664

Wenatchee
Mission Plaza Prof Center
317 N. Mission St., Suite 200
Wenatchee, WA 98801

Renton
Black River Corporate Park
1000 Oakesdale Ave., SW, Suite 100
Renton, WA 98055

Longview
1461 Broadway St., Suite A
Longview, WA 98632-3713

Northpointe (Spokane)
9717 N. Nevada
Spokane, WA 99218

West Tacoma
Sixth Ave. Plaza Shopping Ctr
5401 Sixth Avenue
Tacoma, WA 98406

Kennewick
Westhaven Professional Park
602 N. Colorado
Kennewick, WA 99336

Richland
104 Columbia Point Drive
Richland, WA 99352

Vancouver
Hazel Dell
910 NE 82nd Street
Vancouver, WA 98665

WILLAMETTE DENTAL
OREGON

Appointments

Portland Area – (503) 644-3200 – Outside Portland – (800) 4607644

Customer Service
Portland Area – (503) 644-6444 – Outside Portland – (800) 461-8994

SW Jefferson (DT Portland)
1933 SW Jefferson St.
Portland, OR 97201

Salem- Liberty
4755 Liberty Rd. S
Salem, OR 97302

Tigard
11415 SW Scholls Ferry Rd.
Beaverton, OR 97008

Beaverton
14425 SW Allen Blvd.
Beaverton, OR 97005

Albany
2225 Pacific Blvd. SE, Suite 201
Albany, OR 97321

Tillamook
800 Main Ave., Suite B
Tillamook, OR 97141

Corvallis
2420 NW Professional Dr., #150
Corvallis, OR 97330

Portland – Weidler St.
220 NE Weidler St.
Portland, OR 97232

Gateway Specialty
1320NE 106th
Portland, OR 97123

Eugene
2703 Delta Oak Dr.
Eugene, OR 97408

Hillsboro
5935 SE Alexander St.
Hillsboro, OR 97123

Lincoln City
1105 SE Jetty, Suite B
Lincoln City, OR 97367

Tuallatin
17130 SWE Upper Boones Ferry
Durham, OR 97224

North Bend
2085 Inland Drive, Suite A
North Bend, OR 97459

Springfield
2510 Game Farm Rd.
Springfield, OR 97477

Stark Street
13255 SE Stark St.
Portland, OR 97233

Stark Specialty
405 SE 133rd
Portland, OR 97233

Bend
Apple Tree Office Park Building D
62969 OB Riley Rd.
Bend, OR 97701

Gresham
1107 NE Burnside
Gresham, OR 97030

Roseburg
2365 NW Stewart Parkway
Roseburg, OR 97470

Milwaukee
6902 SE Lake Rd., Suite 200
Millwaukee, OR 97267

Grants Pass
2166 NW Vine St., Suite H
Grants Pass, OR 97526

Eastport
4104 SE 82nd Ave., Suite 450
Portland, OR 97266

Medford
773 Golf View Drive
Medford, OR 97504

Salem-Lancaster
3490 Lancaster Dr. NE
Salem, OR 97305

WILLAMETTE DENTAL
IDAHO

Boise
8950 W. Emerald St., Suite 108
Boise, ID 83704

Nampa
222 W. Iowa Ave., Suite 200
Nampa, ID 83686

Idaho Falls
3411 Merlin Drive
Idaho Falls, ID 83404

Pocatello
1525 Baldy Avenue
Pocatello, ID 93201

Coeur d'Alene
943 W. Ironwood Dr., Suite 200
Coeur d'Alene, ID 83814-4925

Twin Falls
Locust Business Park
1411 Falles Ave. E., Suite 1200
Twin Falls, ID 83301-3455

Meridian
Midvalley Professional Bldg
2365 Gala St., Suite 1
Meridian, ID 83642

WASHINGTON-IDAHO OPERATING ENGINEERS
AND EMPLOYERS HEALTH AND SECURITY TRUST
DENTAL PLAN B

Annual Deductible $50.00 per member
Annual Deductible $150 per family
Calendar Year Maximum $750.00 per family member
Orthodontia is not covered

Dental Fee Schedule Plan B

ADA CODE	PROCEDURE	MAXIMUM BENEFIT	LIMITS
DIAGNOSTIC			
	Examinations		
0120	Periodic oral exam	28.50	2/year
0140	Limited exam – problem	41.50	
0150	Comprehensive exam	43.50	
	Radiographs (X-rays)		
0210	Full mouth x-rays	78.00	
0220	Intraoral single x-ray	13.00	
0230	Intraoral add'l x-ray	11.00	
0240	Intraoral occl x-ray	25.50	
0270	Bitewing – 1st x-ray	13.00	Once each calendar year
0272	Bitewings – 2 films	24.00	Once each calendar year
0274	Bitewings – 4 films	32.50	Once each calendar year
0330	Panoramic single x-ray	49.50	
PREVENTIVE			
	Prophylaxis		
1110	Prophylaxis adults	62.00	14 and over 2/year
1120	Prophylaxis children	39.00	To age 14 2/year
	Fluoride Treatment		
1201	Prophy w/fluoride child	86.00	14 and over 2/year
1203	Fluoride	24.00	To age 19 1/year
1204	Fluoride adult	28.00	1/year
	Sealants		
1351	Sealant per tooth	27.00	To age 19
	Space Maintainers		
1510	Space maintainer	190.00	
1515	Space maintainer	268.00	
MINOR RESORATIONS			
	Amalgam Restorations		
2140	Amalgam - 1 surface	72.00	
2150	Amalgam - 2 surface	84.50	
2160	Amalgam – 3 surface	104.00	
2161	Amalgam – 4 + surface	128.00	
2951	Pin retention per tooth	21.50	
	Other Minor Restorations		
2330	Composite resin – 1 surface	72.00	
2331	Composite resin – 2 surface	89.50	
2332	Composite resin – 3 surface	132.00	
2335	Composite resin	170.00	
MAJOR RESTORATIONS			
	Inlays and Onlays		
2510	Inlay 1 surface-gold	376.00	
2520	Inlay 2 surface-gold	422.00	
2530	Inlay 3 surface-gold	453.00	
2542	Onlay - metallic -2 surfaces	347.00	
2910	Recement inlays	37.00	
	Crowns		
2740	Porcelain crown	428.00	
2750	Porcelain/metal crown	414.00	
2751	Porcelain/metal crown	414.00	
2752	Porcelain/metal crown	414.00	

ADA CODE	PROCEDURE	MAXIMUM BENEFIT	LIMITS
2780	¾ cast crown	418.00	
2790	Gold full cast crown	410.50	
2792	Semi-precious metal crown	110.50	
2930	Prefab stainless crown	72.00	
2931	Prefab stainless crown	72.00	
2940	Sedative fillings	38.50	
2950	Crown build-ups	100.50	
2920	Recement crowns	54.00	
ENDODONTICS			
3110	Pulp cap direct	25.50	
3120	Pulp cap indirect	36.00	
3220	Vital pulpotomy	54.00	
	Root Canal Therapy (includes treatment plan, clinical procedures and follow-up care, excludes final restoration)		
3310	Root canal – 1 canal	256.00	
3320	Root canal – 2 canals	349.50	
3330	Root canal – 3 canals	436.50	
3346	Retreatment root canal – ant	427.00	
3410	Apicoectomy	342.00	
3430	Retrograde Filling	95.50	
PERIODONTICS			
	Non-Surgical Services		
4910	Periodontal prophy	65.00	1 every 3 months
4341	Periodontal scaling – quadrant	78.50	
	Surgical Services		
4210	Gingivectomy/quadrant	185.00	
4260	Osseous surgery/quad	500.00	
4270	Pedicle grafts – soft	521.00	
4271	Free soft tissue grafts	324.00	By report
4320	Splint – intracoronal	169.00	
4321	Splint – extracoronal	128.00	
PROSTHODONTICS			
	Dentures (includes six months post-delivery care)		
5110	Denture complete upper	400.00	Every 4 years
5120	Complete lower denture	400.00	Every 4 years
5211	Partial upper denture	350.00	
5212	Partial lower denture	350.00	
5213	Partial upper denture	350.00	
5214	Partial lower denture	350.00	
	Related Denture Services		
5610	Repair denture	59.00	
5640	Replace denture tooth – ea add'l	54.00	
5650	Add tooth partial/denture	74.00	
	Bridgework		
6210	Cast gold pontic	403.50	
6240	Porcelain/metal pontic	419.50	
6241	Porcelain/metal pontic	360.00	
6242	Porcelain/metal pontic	376.00	
6750	Porcelain/metal abutment	410.00	
6751	Porcelain/metal abutment	360.00	
6752	Porcelain/metal abutment	382.00	
6930	Recement bridge	54.00	
ORAL SURGERY			
	Extractions (includes local anesthesia and routine postoperative care)		
7140	Extraction – erupted tooth	50.50	
7210	Extract tooth erupted	112.50	
7220	Extract soft impaction	122.00	
7230	Extract partial impaction	162.00	
7240	Extract total impaction	204.50	
7250	Surgical root recovery	121.00	
	Related Oral Surgical Procedures		
7286	Biopsy of soft tissue	150.50	
7310	Alveoloplasty/quad	84.50	
7510	I & D of abscess	90.00	
7960	Frenectomy	225.00	

ADA CODE	PROCEDURE	MAXIMUM BENEFIT	LIMITS
9220	General anesthesia	164.00	
9221	General anesthesia each 15 min	59.50	
9241	IV sedation/analg 1st 30 min	160.00	

DENTAL PLAN B

HOW TO SUBMIT A DENTAL CLAIM

If you and your Dependents are covered under Dental Plan B – Scheduled Benefit Plan you will be required to file claims for all covered services with the Trust Office.

A. Obtain a claim form from the Local Union office, the office of the Trust Administrative Agent, or go to the Zenith website www.zenithadmin.com; and
B. complete the Employee portion of the form. A claim form need not be completed each time a bill is submitted; and
C. have the dentist complete his portion of the form or attach an itemized bill. If there is need for continued treatment, the dentist should forward subsequent bills to the Trust Administrative Agent; and
D. For dental services in connection with crowns or periodontal treatment, a "dental Treatment Plan" must be submitted to the Trust Administrative Agent for pre-determination of benefits. Please refer to paragraph below for further explanation.
E. mail the completed claim form and the itemized bills covering Dental to the Trust Administrative Agent.

In the case of an accidental death, your beneficiary must notify the office of the Trust Administrative Agent immediately. A claim form and instructions for its submission will be furnished.

NOTE: *First notice of claim should be given to the Trust Administrative Agent within 20 days after the date of first treatment. It is the responsibility of the Covered Person to see that properly completed claim forms are submitted to the Trust Administrative Agent.*

NOTE: *The Trust Fund does issue identification cards for eligibility purposes. It is recommended that the Employee not use their Union Card for identification at a dental provider as that office will use the Union office address for mailing purposes. This will delay claims processing from one to two days.*

NOTE: *Incomplete forms and bills that are not itemized may delay payment of your claim.* ***No claim will be accepted unless filed within twelve months from the date dental treatment was performed.***

DENTAL PRE-DETERMINATION OF BENEFITS

Pre-determination of benefits helps you determine your out-of-pocket expenses prior to authorizing your dentist to complete a recommended treatment plan. If treatment begins prior to pre-determination of benefits, you may experience unanticipated out-of-pocket expenses.

For all dental services in connection with crowns and periodontal treatment, a Dental Treatment Plan must be submitted to the Trust Office for pre-determination of benefits. If the Trust determines that alternate procedures, services or courses of treatment may be performed to correct a dental condition, the maximum amount that Scheduled Benefits Plan B will cover is payment for the least expensive procedure which will produce a professionally satisfactory result as determined by the Trust.

Services are authorized for 60 days (if pre-determination is completed) even if you become ineligible.

COVERED EXPENSES

Expenses for procedures not listed in the Dental Schedule will be determined by the Plan. No expenses in excess of the allowances shown in the Dental Schedule will be considered Covered Expenses.

LIMITATIONS AND EXCLUSIONS

A. Services, supplies or treatment which are unnecessary or not prescribed by a legally qualified dentist, or legally qualified denturist.
B. Services and supplies furnished solely for cosmetic purposes.
C. A prosthetic device will not be provided more than once in every 4 year period. Said 4 year period will be measured from the date on which the existing appliance was last supplied, whether under the current dental agreement or under any prior dental agreement. Services which are necessary to make an appliance satisfactory will be provided in accordance with the agreement. The term "existing" as used in this paragraph is intended to include and appliance that was placed in the inception of the aforementioned 4 year period, but, for whatever reason, is no longer in the possession of the patient.
D. Expenses incurred after termination of eligibility from Plan B except for the following:
    1. Prosthetic devices which are fitted, ordered and pre-certified by the Trust Office prior to termination but were delivered to the Covered Person within thirty (30) days after the date of termination.
    2. Treatment that was pre-authorized prior to termination is covered up to sixty (60) days.
E. Care and treatment for which there would not have been a charge if no coverage had been in force.
F. Prosthetic services or devices (including bridges and crowns) started or under way prior to the date the insured employee or dependent became eligible for benefits under the plan.
G. Any injury or sickness for which the person on whom a claim is presented has received, or is entitled to receive, compensation for that particular injury or sickness under any workman's compensation or occupational disease law.
H. Charges made for services or supplies furnished while the Employee or Dependent is confined in a Hospital unless such confinement is deemed to be Medically Necessary and dental treatment in a dental office will cause significant risk to the patient's health.
I. Any loss caused by war or act of war
J. Care, treatment or supplies furnished by a program or agency funded by any government.
K. Replacement of lost or stolen prosthesis,
L. Orthodontia
M. Treatment of TMJ syndrome (examination, equilibration and x-rays are not covered)
N. Dental services for surgery involving tumor and cysts.
O. The cost of Prescription Drugs or medicines in conjunction with dental services.

SUMMARY OF VISION CARE BENEFITS

Active Employees
And their covered Dependents only

Covered Vision Expenses

Covered vision expenses include eye exams and any of the eyewear listed below. Eye exams or professional services must be performed and the eyewear prescribed by a person licensed to practice as a doctor of medicine, ophthalmology or optometry.

Benefit Limitations

Exam	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 12 months
Contacts	Once every 12 months (in lieu of lenses and frames)

Co-payments

Exams	$25.00
Eyewear	$25.00

Payment Rates

	Services from a VSP Doctor (after co-payment)	**Services from an Out-of-Network Provider (Maximum amount payable)**
Exam	Covered in full	Reimbursed up to $45 allowance
Single Vision Lenses	Covered in full	Reimbursed up to $45 allowance
Bifocal Lenses	Covered in full	Reimbursed up to $65 allowance
Trifocal Lenses	Covered in full	Reimbursed up to $85 allowance
Lenticular Lenses	Covered in full	Reimbursed up to $125 allowance
Frames	Your allowance is $130. There is a 20% discount off the amount over your allowance.	Reimbursed up to $47 allowance
Contact Lenses (instead of spectacle lenses and frames) and the contact lens exam [fitting and evaluation]	$130 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts	Reimbursed up to $105.00 allowance

How the Plan works

When you want to obtain vision care services, call a VSP doctor to make an appointment. For details on how you locate a VSP doctor, contract your benefits representative, call VSP at (800) 877-7195 to request a doctor listing, or visit VSP's web site at www.vsp.com . When you make the appointment, make sure you identify yourself as a VSP member, and be prepared to provide the member's Social Security number.

The VSP doctor will contact VSP to verify your eligibility and Plan coverage, and will also obtain authorization for services and eyewear. If you are not currently eligible for services, the VSP doctor is responsible for communicating this information to you . VSP will pay the doctor directly for covered services and eyewear.

Services and eyewear obtained from an out-of-network provider will be reimbursed up to amounts on the above schedule. If you receive an exam and /or eyewear from an out-of-network provider, you are responsible for paying the provider in full, and submitting itemized receipts to VSP for reimbursement at:

VSP
PO Box 997105
Sacramento, CA 95899-7105

It is important to note that the reimbursement schedule does not guarantee full payment.

When an exam and/or eyewear are received from a VSP doctor, you will receive a higher benefit than with an out-of-network provider.

However, you will be responsible for paying for optional items which include, but not limited to, oversized lenses (61mm or larger), coated lenses, no-line multifocal lenses, treatments for cosmetic reasons or a frame that exceeds the retail allowance.

NOTE: This Plan will pay benefits for your contact lenses or glasses (lenses and frames), but not both. Once benefits for contact lenses have been paid, you must wait 24 months from the time you obtain the contacts before you are eligible for frames.

Vision Exclusions

The following expenses and procedures are not covered by this Plan although discounts may be available on some of them (see the value added discounts section) by going to the website www.vsp.com or calling (800) 877-7195:

A. More than one eye exam during any 12 consecutive months.
B. More than one pair of lenses or contact lenses during any 12 consecutive months.
C. More than one pair of frames during any 12 consecutive months.
D. Any material furnished as the result of an exam which began before the date the person became eligible for benefits.
E. Photorefractive keratectomy (PRK), LASIK surgery, or other procedures for surgical correction of myopia and/or other refractive errors.
F. Supplies or services for which no charge is made or for which you are not required to pay.
G. Expense for service or supplies that are for educational, experimental, or research purposes.
H. Sunglasses, plain or prescription, or safety lenses or goggles.
I. Orthoptics, vision training and/or transition lenses.
J. Replacement of lenses or frames which have been lost, stolen or broken.
K. Medical or surgical treatment of the eyes (including refractive surgery.
L. Expenses for which you have a right to payment under workers' compensation or similar law.

FAMILY AND MEDICAL LEAVE
as Federally Mandated

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act), your benefits may be continued on the same basis as if you were an Actively-At-Work Employee, for up to 12 weeks, 26 weeks if due to military duty, during the 12-month period, as defined by your employer, for any of the following reasons:

A. to care for your child after the birth or placement of a child with you for adoption or foster care, so long as such leave is completed within 12 months after the birth or placement of the child;
B. to care for your spouse, child, Foster Child, Adopted Child, stepchild or parent who has Serious Health Condition; or
C. for your own Serious Health Condition.

In the event you or your spouse are both covered as Employees of the Plan, the continued coverage under (a) may not exceed a combined total of 12 weeks, 26 weeks if due to military duty. In addition, if the leave is taken to care for a parent with a Serious Health Condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions

A. If, on the day your coverage is to begin, you are already on an FMLA leave of absence, you will be considered Actively-At-Work. Coverage for you and any eligible Dependents will begin in accordance with the terms of the Plan. However, if your leave of absence is due to your own or any eligible Dependent's Serious Health Condition, benefits for that condition will not be payable to the extent benefits are payable under any Prior Group Plan.
B. You are eligible to continue coverage under FMLA if:
    1. You have worked for your employer for at least one year;
    2. You have worked at least 1,250 hours over the previous 12 months;
    3. Your employer employs at least 50 Employees within 75 miles from your worksite; and
    4. You continue to pay any required premium for yourself and any eligible Dependents in a manner determined by your employer.

C. In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to meeting eligibility requirements and subject to any changes that may have occurred in the Plan during the time you were not covered. You and any covered Dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
D. You and your Dependents are subject to all conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
E. If requested by Us, you or your employer must submit proof acceptable to Us that your leave is in accordance with FMLA.
F. This FMLA continuation is concurrent with any other continuation option except for COBRA if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day your FMLA continuation ends.
G. FMLA continuation ends on the earliest of
    1. the day you return to work;
    2. the day you notify your employer that you are not returning to work;
    3. the day your coverage would otherwise end under the Plan; or
    4. the day coverage has been continued for 12 weeks, 26 weeks if due to military duty.

Important Notice

Contact your employer for additional information regarding FMLA.

Military Service under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

As Federally Mandated

If you leave covered employment to perform certain United States military service, you and your enrolled Dependents may have the right to continue your medical and dental coverage:

If you serve:

A. Less than 31 days of military service (e.g. active duty for training) - the Plan continues to cover you and your Dependents.
B. 31 days of military service or longer - you and your Dependents are eligible to continue coverage up to 24 months through COBRA. See COBRA Coverage, at page 51.

When you return to covered employment, your regular coverage begins immediately, provided you meet the requirements summarized below.

Under USERRA, you must notify your employer before taking leave (unless prevented from doing so by military necessity or other reasonable cause) and you should tell your employer how long you expect to be absent due to military service. When you are released from military duty, you must apply for reemployment:

A. Less than 31 day of military service - apply immediately upon release, taking into account safe transportation and an eight-hour rest period.
B. 31 to 180 days of military service - apply within 14 days of release.
C. More than 180 days of military service - apply within 90 days of release.

If you are Hospitalized or convalescing, the above reemployment deadlines are extended while you recover (but will not be longer than two years.

Note: *These rules also apply to Uniformed Service in the commissioned corps of the Public Health Service.*

To ensure proper crediting of service under USERRA, be sure to let the Trust Administrative Agent know how long you expect to be gone and notify them when you apply for reemployment after your leave. If you have an hour bank at the time you deploy, your hour bank will be frozen, unless you elect to continue Dependent coverage by using your hour bank. Please call the Trust Administrative Agent for more details about coverage under USERRA.

COORDINATION OF BENEFITS (COB)

If the covered Employee or an eligible Dependent is entitled to benefits under any other Group Plan which will pay part or all of the Expenses incurred for necessary, reasonable and customary Charges, the amount payable under this Plan and any other Group Plan will be coordinated so that the aggregate amount paid will not exceed 100% of the Expense incurred. In no event will the Plan pay more than the amount that would have been paid if no other Plan were involved.

Primary coverage under this Plan means that this Plan will pay benefits first for covered medical Expenses. If you are eligible, Medicare will then pay benefits for Medicare-covered Expenses if the amounts paid under the Plan are less than the actual charge. As a result, up to 100 percent of covered Expenses may be paid.

If the claimant is covered by another Plan or Plans, the benefits under the Plan and the other Plan (s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan (s) pay (S.

A. The primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

B. The secondary Plan (which is the Plan that pays benefits after the primary Plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the primary Plan will not exceed 100% of total Covered Expense exclusive of Co-Payments, deductibles and other cost-sharing arrangements.

Order of Benefit Determination

The order of Benefit determination paragraph below explains the order in which Plans must pay.

If another Plan **does not** have a COB provision, that Plan must determine benefits first.

When another Plan does have a COB provision, the first of the following rules which applies govern:

A. if a Plan covers the claimant as an Employee, member or non-dependent, then that Plan will pay its benefits first;
B. if the claimant is a Dependent child whose parents are not divorced or separated then the Plan of the parent whose birthday anniversary is earlier in the Calendar Year will pay first; except:
    1. if both parents' birthdays are on the same day, the Plan that has had coverage the longest would be prime; or
    2. if another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.
C. if the claimant is a Dependent child whose parents are divorced or separated, the following rules apply;
    1. a Plan which covers a child as a Dependent of a parent who by court decree must provide health coverage will pay first; and
    2. when there is no court decree which requires a parent to provide health coverage to a Dependent child, the following rules will apply:
        a. when the parent who has custody of the child has not remarried, that parent's Plan will pay first; or
        b. when the parent who has custody of the child has remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second and by the Plan of the parent without custody third; and
        c. if none of the above rules apply, the Plan will apply the birthday rule.

Dual Coverage: In the event a family has dual coverage through the Plan, i.e. when spouses are each covered under the Plan as Employees, the resulting dual coverage may allow for up to 100% coverage on claims subject to deductibles and copays.

If the Employee and/or qualified Beneficiary is covered under the COBRA self-pay Plan and eligible for benefits under another Group Plan, that Group Plan will be the primary payer and the COBRA coverage will pay secondary.

Important information about Medicare

Medicare may affect Plan benefits; therefore, you may want to contact your local social security office for information about Medicare. This should be done before you or your spouse's 65th birthday. A penalty may be imposed should you delay your enrollment with Medicare and your premium will be increased when you do elect your Medicare coverage.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. This includes Charges incurred in Veterans Affairs facilities.

MEDICARE FOR AN ACTIVE PARTICIPANT

When an Employee reaches age 65 you may qualify for Medicare Benefits, although you are eligible as an active participant.

If your primary medical coverage is under this Plan, you will receive the same type and level of coverage as those people under age 65.

Your primary coverage will continue to be provided under this Plan.

Medicare Order of Benefit Determination

This section is subject to changes by Medicare and federal legislation. In the event federal rules differ from these rules, federal rules will apply.

For You. We have primary responsibility for your claims if:

A. You are covered under the Plan because of your current active employment status with an ADEA (small group plan) employer, and you are eligible for Medicare benefits because of age; or
B. the Plan is part of a Large Group Plan, and you are covered under the Plan because of your active employment status, and you are eligible for Medicare benefits because of Disability.

We have secondary responsibility for your claims if you are eligible for Medicare benefits and the above conditions do not apply.

For Your Dependent. We have primary responsibility for your Dependent's claims if:

A. You are covered under the Plan because of your current active employment status with an ADEA (small group plan) employer, and your Dependent spouse is eligible for Medicare because of age; or
B. the Plan is part of a Large Group Plan, and you are covered under the Plan because of your current active employment status, and your Dependent is eligible for Medicare benefits because of Disability.

We have secondary responsibility for your Dependent's claims if your Dependent is eligible for Medicare benefits and the above conditions do not apply.

Exception for End Stage Renal Disease. If Medicare does not already have primary responsibility when you or your Dependent becomes eligible for Medicare benefits because of end stage renal disease:

A. We have primary responsibility for you or your Dependent's claims for up to 30 months beginning with the month in which you or your Dependent is first eligible for Medicare benefits because of end stage renal disease; and
B. We have secondary responsibility after the end of this 30-month period.

RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

RIGHT OF RECOVERY

If this Plan pays more for a covered Expense than is required by this provision, the excess payment may be recovered from:

A. the claimant;
B. any person to whom the payment was made; or
C. any insurance company, service Plan or any other organization which should have made payment.

SUBROGATION

If you or your eligible Dependents are entitled to receive benefits from the Plan for injuries caused by a third party or as a result of any accident (for example, an auto accident), or if you or your eligible Dependents receive an overpayment of benefits from the Plan, the Plan has the right in equity, and a right in contract, to obtain full restitution of the benefits paid by the Plan from:

A. Any full or partial payment which your insurance carrier makes (or is obligated or liable to make) to you or your eligible Dependents; and
B. You or your eligible Dependents, if any full or partial payments are made to you or your eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, your, your Dependent's or a third party's:
    1. Automobile liability coverage;
    2. Uninsured motorist coverage;
    3. Homeowner's coverage; or
    4. Other insurance coverage

This means that, with respect to benefits which the Plan pays in connection with an Injury or accident, the Plan has the right to full restitution from any payment received by you or your eligible Dependents from any third party, whether or not the payment separately allocates an amount to the restitution of the Expenses or types of Expenses covered by the Plan or the benefits provided under the Plan. Any payment received by you, or your representative, from a third party is subject to a constructive trust.

Any third party payment received by you must be used first to provide restitution to the Plan to the full extent of the benefits paid by or payable under the Plan. The balance of any third party payment must first be applied to reduce the amount of benefits which are paid by the Plan for benefits after the payment and secondly, be retained by you or your eligible Dependents. The Health Plan does not recognize the Make-Whole Doctrine.

You and your eligible Dependents are responsible for all Expenses incurred to obtain payment from third parties, including attorneys' fees, which amounts will not reduce the amount due to the Health Plan as restitution. The Plan expressly rejects the Common Fund Doctrine with respect to payment of attorneys' fees.

The Plan is entitled to obtain restitution of any amounts owed to it either from third party funds received by you or your eligible Dependents, regardless of whether you or your eligible Dependents have been fully indemnified for losses sustained at the hands of the third party. The Plan may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable and/or contractual right to obtain full restitution.

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable (or other) rights to full restitution. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Trust Administrative Agent, including the signing of any documents or agreements necessary for the Plan to obtain full restitution.

You and your eligible Dependents are also required to:

A. Notify the Trust Administrative Agent as soon as possible and in writing that the Plan may have an equitable (or other) right to obtain restitution of any and all benefits paid by the Plan;
B. Inform the Trust Administrative Agent in advance of any settlement proposals advanced or agreed to by a third party or a third party's insurer;
C. Provide the Trust Administrative Agent all information requested by the Health Trust Administrative Agent regarding an action against a third party, including an insurance carrier;
D. Fully cooperate with the Trust Administrative Agent in all respects in the Plan's enforcement of its equitable (or other) rights to restitution;
E. Not settle, without the prior written consent of the Trust Administrative Agent, any claim that you or your eligible Dependents may have against a third party, including an insurance carrier; and
F. Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny benefits to you or your eligible Dependents or take such other action as the Plan deems appropriate. The Plan has the right to reduce future payments due to you or your eligible Dependents by the amount of benefits paid by the Plan. This right of offset shall not limit the equitable and/or contractual rights of the Plan to recover such moneys in any other manner.

CONTINUING COVERAGE UNDER COBRA - CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

Under certain defined circumstances, eligible Employees, retirees and their Dependents may be able to continue coverage under this Plan beyond the time coverage would ordinarily end. The right to continued coverage may come from the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or in certain situations from the Trust's own self-pay program.

To obtain continuation coverage a participant must have a Qualifying Event, make a timely Election to continue coverage, and make timely Self-Payments. These terms are defined below.

Qualifying Events

To be eligible for continuation coverage, a Participant's coverage must have ended because of the following qualifying events:

For Employees:

A. Termination of your employment for any reason (this includes retirement and voluntary quitting) other than gross misconduct; or
B. Reduction of your hours of employment.

For Spouses:

A. Termination of your spouse's employment for any reason (this includes retirement and voluntary quitting) other than gross misconduct;
B. Reduction of your spouse's hours of employment;
C. Death of your spouse; or
D. Divorce or legal separation from your spouse.

For Dependent Children:

A. Termination of the Employee parent's employment for any reason (this includes retirement or voluntary quitting) other than gross misconduct;
B. Reduction in the Employee parent's hours of employment;
C. Death of the Employee parent;
D. Parent's divorce or legal separation; or
E. Ceasing to meet the definition of an Eligible Dependent.

COBRA Notification Responsibilities

The Employee or Dependent must notify the Trust Administrative Agent within 60 days of a death, divorce, legal separation, or child losing Dependent status. The Employer has the responsibility to notify the Trust Administrative Agent of the Employee's termination of employment, reduction of hours, or the Employer's filing of a Chapter 11 bankruptcy.

Election of Coverage

Upon receiving notification that a qualifying event may have occurred, the Trust Administrative Agent will notify you, your lawful spouse and each of your covered Dependents of their right to elect continuation coverage. The participants must then select continuation coverage by the later of:

A. 60 days after the participant's coverage ends; or
B. 60 days after the participant receives notification of the continuation rights from the Trust Administrative Agent.

Failure to elect continuation coverage within this 60 day period will result in the loss of the right to elect COBRA continuation coverage.

Newly Acquired Dependents

If you acquire an eligible Dependent while eligible for COBRA continuation coverage you may elect to enroll the Dependent for continuation coverage in accordance with the Plan's enrollment rules.

Types of Coverage Available

If you choose continuation coverage, you are entitled to the same benefits you had in the month immediately before you lost coverage. The following benefit options are available under COBRA:

A. Medical only
B. Medical and Dental.

Continuation coverage is not available for weekly income benefits.

Continuous Coverage Required

Your coverage under COBRA must be continuous from the date Plan coverage would have ended if monthly Self-Payments were not made.

Monthly Self-Payments Required

You and your covered Dependents are responsible for the full cost of continuation coverage. The payments must be made to the Trust Administrative Agent within 30 days of the premium due date.

The only exception is that the initial self-payment for the period preceding the election of continuation coverage may be made up to 45 days after the date of election. Failure to make timely payments will result in the permanent loss of continuation coverage. Eligibility will not be granted until payment has been received.

Continuation will end on the earliest of the following dates:

A. 18 months from the date continuation began for individuals whose coverage ended because of a reduction of hours or termination of employment;
B. continuation may extend up to a total of 29 months if the individual is Disabled as of the time his/her eligibility ended, or within 60 days thereafter, and he/she provides proof of the Social Security Administration's Disability determination within 60 days of the Participant's receipt of it from Social Security Administration and during the initial 18 month continuation period;
C. 36 months from the date continuation began for individuals whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, the Dependent ceasing to meet the definition of an Eligible Dependent, or the Employee's entitlement to Medicare;
D. the end of the period for which self-payments have already been made if the individual fails to make a self-payment on the date specified by the Plan;
E. the date the individual becomes covered under any other group health Plan (except to the extent the other group health Plan limits benefits for preexisting conditions that affects the individual's coverage);
F. the date the individual becomes entitled to Medicare; or
G. the date this Plan ends.

LIMITATIONS /EXCLUSIONS

No Benefits will be paid for the following care or services:

A. Any Expense or charge for services or supplies which are provided or paid for by the federal government or its agencies; except for:
   1. the Veterans Administration, when services are provided to a veteran for a Disability which is non-service connected.
   2. a military Hospital or facility, when services are provided to a retiree (or Dependent of a retiree) from the armed services; or
   3. a group health Plan established by the government for its own civilian Employees and their Dependents.

B. For treatment for Injury sustained or Sickness incurred, as the result of war or any act of war, declared or undeclared, or any unfriendly act of one nation against another or any act of armed aggression.

C. Eye refractions or the fitting or cost of visual aids or surgery to correct visual acuity including Charges incurred in connection with radial keratotomy, except as covered under the Accidental Death & Dismemberment coverage.

D. Any Injury or Sickness which arises out of or in the course of any employment with any employer or for which the Covered Person is entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from a workers' compensation carrier.

E. For treatment by a Physician employed by or a Hospital owned or operated by the United States Government or any Agency thereof unless,
   1. the treatment is of an emergency nature; or
   2. the Employee or Dependent is not entitled to such treatment by reason of status as a veteran or otherwise; and.
   3. the Employee is required to pay for benefits due to non-service related medical treatment.

F. During confinement in a Hospital owned or operated by a state, province or political subdivision unless there is an unconditional requirement to pay such Charges without regard to any rights, against others, contractual or otherwise including, rights under the Plan.

G. For treatment on or to the teeth or gums, nor for any Sickness or disease caused by or directly related to a condition of the teeth or gums.

H. Prescription Drugs or medicines except as specifically provided.

I. Alcoholism or Drug abuse except as provided under Alcoholism and Drug Abuse, see page 23.

J. For more than one visit to a Physician or surgeon each day for a Spinal Treatment.

K. For Charges incurred for Audio Care prior to being examined by a Physician. Including:
   1. any examination without a hearing aid being obtained;
   2. replacement of a hearing aid for any reason more than once in a three-year period;
   3. batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid;
   4. repairs, servicing or alterations of hearing aid equipment; and
   5. a hearing aid that exceeds the specifications prescribed for correction of hearing loss.

L. For Expenses incurred after termination of coverage under the Plan except as otherwise provided under the Plan.

M. Any loss, Expense or charge resulting from the Covered Person's participation in a riot or in the commission of a felony.

N. For any Expense which the Employee or Dependent is not required to pay.

O. For any Charges incurred in excess of Usual, Customary and Charges.

P. For Charges incurred for naturopathic medicine.

Q. Charges incurred for reverse sterilization.

R. Marriage or family counseling

S. Dental services, except as expressly covered.

T. Charges for services or supplies not Medically Necessary.

U. Any Expense which is not the result of an Injury or Sickness as defined in the definitions section of the Plan, except as otherwise specifically covered under the Plan.

V. Any treatment, service or supply unless it is shown as a Covered Service.

W. Mental Sicknesses, except as provided under the Mental Health Disorders section of the Plan, see page 23.

X. Any Expense or charge for preventive shots, vaccinations and inoculations, except as specifically provided.

Y. Any Expense or charge for routine physical exams or checkup exams, except as specifically provided.

Z. Any Expense or charge for failure to appear for an appointment as scheduled, or for completion of a claim form or for additional information as requested for claims processing.

AA. Any Expense or charge for medicine, vitamins or any other supplements not prescribed for an illness except as otherwise specifically provided.

BB. Any Expense or charge which is older than 12 months from the date of services to date received by the Trust Administrative Agent.

CC. Services or supplies by a provider who normally resides in your home or is related to you by blood or marriage.

DD. Any Expense or charge for Custodial Care or Developmental Care.

EE. Any Expense which results from Reconstructive Surgery, except:
1. for an Injury;
2. for repair of defects which result from surgery;
3. for the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction.

FF. Any Expense which results from Cosmetic Surgery unless otherwise specifically provided.

GG. Any loss, Expense or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by Us, and present significant symptomatic medical problems) or any treatment of obesity. Refer to page 23 regarding surgery to treat morbid obesity.

HH. Any Expense or charge in connection with dental work, dental surgery or oral surgery (unless otherwise specifically provided or except as required by law), including:
1. treatment or replacement of any tooth or tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
2. surgery or splinting to adjust dental occlusion.

II. Any Expense or charge for treatment of Jaw Joint Disorder unless specifically provided.

JJ. Any loss, Expense or charge related to Mental Health Sickness which are classified as sexual deviations or disorders.

KK. Any loss, Expense or charge for sex transformation.

LL. Any Expense or charge for services or supplies which are not provided in accordance with generally accepted professional standards on a national basis.

MM. Any Expense or charge for services or supplies which:
1. are considered Experimental or investigational Drugs, devices, treatments or procedures; or
2. result from or relate to the application of such experimental or investigational Drugs, devices, treatments or procedures.

NN. Any Expense or charge which is primarily for the Covered Person's convenience or comfort or that of the Covered Person's education, training or development of skills needed to cope with an Injury or Sickness, unless specifically provided in the Plan.

OO. Any Expense or charge which is primarily for the Covered Person's convenience or comfort or that of the Covered Person's family, caretaker, Physician or other medical provider.

PP. Any Expense or charge for telephone calls to or from a Physician, Hospital or other medical provider.

QQ. Any loss, Expense or charge which results from services from developmental Disability, when We, Our medical staff or a qualified party or entity selected by Us determine that a confinement or visit is mainly for developmental Disability, some services such as Prescription Drugs, x-rays and lab tests may still be covered if Medically Necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration.

PAYMENT OF CLAIMS

HOW TO SUBMIT A CLAIM

A. Obtain a claim form from the Local Union office, the office of the Trust Administrative Agent, or go to the Zenith website www.zenithadmin.com; and

B. Complete the Employee portion of the form. A claim form need not be completed each time a bill is submitted; and

C. Have the doctor complete his portion of the form or attach an itemized bill; and

D. Mail the completed claim form and the itemized bills covering Hospital and other Expenses to the Trust Administrative Agent.

In the case of an accidental death, your beneficiary must notify the office of the Trust Administrative Agent immediately. A claim form and instructions for its submission will be furnished.

NOTE: First notice of claim should be given to the Trust Administrative Agent within 20 days after the date of first treatment for Injury or Sickness. It is the responsibility of the Covered Person to see that properly completed claim forms are submitted to the Trust Administrative Agent.

NOTE: The Trust Fund does issue identification cards for eligibility purposes. It is recommended that the Employee not use their Union Card for identification at a medical provider as that office will use the Union office address for mailing purposes. This will delay claims processing from one to two days.

HOW BENEFITS ARE PAID

Benefits will be paid in accordance with one of the following methods:

A. Accidental Death and Dismemberment benefits will be paid in accordance with the summary of coverage on page 19; and

B. Accident and Sickness Weekly Indemnity benefits will be paid to the Employee weekly upon the submission of proper proof of loss of time resulting from non-occupational Injury or Sickness; and

C. Major Medical Coverage will be paid in accordance with the Schedule of Benefits on page 5; and

D. When assignment is made, benefit drafts are made payable to the doctor or hospital performing the service, unless an identifying receipt accompanies the claim when submitted to the Trust Administrative Agent. The receipt becomes a part of the claim and cannot be returned.

WHEN BENEFITS ARE PAID

An Employee or Dependent must be eligible for benefits on the date the medical care or services are received, before a claim can be considered for payment. Please read carefully the Eligibility Rules instructions to determine the minimum eligibility requirement for the particular month during which such medical care or service is provided.

CLAIMS AND APPEAL PROCEDURE:

The Board of Trustees has adopted the following procedures to process claims and to review benefit claim denials and appeals. The appeal procedures below are the exclusive procedures available to a participant who is dissatisfied with an eligibility determination, benefit award or is otherwise adversely affected by an action of the Trust or its authorized claims payers. These procedures must be exhausted before a claimant may file suit under ERISA Section 502 (A.

Procedures to be followed in presenting claims for benefits are outlined below:

Initial Processing

A. Urgent Claims:

For benefit claim applications for urgent care filed on or after January 1, 2003, a claimant will be notified in writing as soon as possible, but no later than seventy-two (72) hours from receipt of initial claim, of the benefit determination.

The Plan will notify the claimant of the need for additional information within twenty-four (24) hours of

receipt of the claim, and the claimant will be allowed at least forty-eight (48) hours to respond. The deadline for the initial determination is then suspended for forty-eight (48) hours or until information is received.

B. Pre-Service (Pre-Authorization) Claims:

For benefit applications for pre-service, or pre-authorization of claims filed on or after January 1, 2003, a claimant will be notified in writing within fifteen (15) days of receipt of the initial claim of the benefit determination.

The Trust Administrative Agent may extend the determination deadline by up to fifteen (15) days, in the event the Trust Administrative Agent determines it is necessary due to matters beyond control of the Plan, and will notify the claimant within the initial determination period. If the extension is necessary because the claimant failed to provide necessary information, the notice of extension will specify the information needed. The claimant will be allowed forty-five (45) days to respond. The Plan will issue a determination within fifteen days of receiving the needed information.

C. Post-Service Claims:

For post-service benefit claim applications filed on or after January 1, 2003, a claimant will be notified in writing of the benefit determination within thirty (30) days after receipt of the application. An extension of up to thirty (30) days is permitted in the event the Trust Administrative Agent determines that such an extension is necessary for reasons beyond the control of the Plan, and provided the Trust Administrative Agent files an extension notice with the claimant. If an extension is needed to obtain further information from the claimant, the claimant will be allowed at least forty-five (45) days to provide the requested information. The benefit determination will then be made within fifteen (15) days from the last date of the extension period.

Adverse Determination

If the benefit determination adversely affects the participant, the notice given to the claimant will include: the specific reason(s) for the determination; reference to the Plan provision(s) on which the determination is based; a description of any additional information, or material necessary for the proper processing of the claim and an explanation of the reason it is needed; a copy of the Plan's review procedures and time periods that the claimant needs to follow in order to appeal the claim; a statement that the claimant is entitled to be represented by an attorney or other individual; and a statement that the claimant can bring suit under ERISA.

Appeal of Adverse Determination

The claimant has up to one hundred eighty (180) days from the date of adverse determination to appeal the decision, except Life and AD & D denials which must be received within 60 days. The appeal must be in writing and filed with the Trust Administrative Agent. A failure to file a claim appeal within 180 days of the denial (or 60 days for life and AD & D denials) will serve as a bar to any claim for benefits or for other relief from the Trust.

In the event a claimant appeals an adverse benefit decision, the Board of Trustees will review the appeal at the next quarterly meeting of the Board (or next meeting of the Appeal Committee designated by the Board) following receipt of appeal, if the appeal is filed more than thirty (30) days prior to the next quarterly meeting, or at the second quarterly meeting of the Board following receipt of the appeal if the appeal is filed less than thirty (30) days before the next quarterly meeting.

At the Claimant's option, the claimant or his or her representative will be allowed to appear before the Appeal Committee and present evidence and witnesses. A copy of the administrative file will be mailed to the participant. The hearing will be based on the administrative file and the comments of any witnesses consulted.

The Board will render a written decision on the appeal and the claimant will be notified in writing of the decision within five (5) calendar days of the meeting. If a decision cannot be reached at the initial meeting at which an appeal is heard, the Appeal Committee may defer a decision on an appeal until the next quarterly scheduled appeal meeting provided that written notice is provided to the claimant.

Appeal of Board's Decision

If the claimant is dissatisfied with the written decision of the Board of Trustees, he or she shall have the right to pursue his or her claim through civil litigation pursuant to section 502(a) of ERISA. The standard of review on appeal shall be whether, in the particular instance, the Trustees 1) were in error upon an issue of law; 2) acted arbitrarily or capriciously in the exercise of their discretion; or 3) whether their findings of fact were supported by substantial evidence.

SUMMARY PLAN DESCRIPTION
for
Washington-Idaho Operating Engineers and Employers Health and Security Fund

NAME OF PLAN

This Plan is known as the Washington-Idaho Operating Engineers and Employers Health and Security Fund.

NAME AND ADDRESS OF PLAN SPONSOR AND TRUST ADMINISTRATIVE AGENT

Washington-Idaho Operating Engineers and Employers Health and Security Fund
c/o Zenith Administrators, Inc
111 W. Cataldo, Suite 220
Spokane, WA 99201

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim is paid, contact:
Washington-Idaho Operating Engineers and Employers Health and Security Fund
c/o Zenith Administrators, Inc
111 W. Cataldo, Suite 220
Spokane, WA 99201
Phone (509) 624-3257 or (800) 351-6480
Fax: (509) 328-8623

EMPLOYER IDENTIFICATION NUMBER

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-1350182, and the Plan Number is 501.

TYPE OF PLAN

This Plan can be described as a self-funded Plan providing medical, dental, life, accidental death and dismemberment, weekly time loss and prescription drug coverage.

TYPE OF ADMINISTRATION

This Plan is administered by a joint Labor-Management Board of Trustees. Local 370, International Union of Operating Engineers is responsible for selecting Employee Trustees, and the Inland Northwest Associated General Contractors of America, Inc., is responsible for selecting Employer Trustees. The Board of Trustees is responsible for establishing and administering this Plan solely for the purpose of providing benefits to Employees, their families and Dependents.

Effective September 1, 2007, the Board of Trustees has engaged Zenith Administrators, Inc., a Third Party Administrator, to assist in administration.

The Board of Trustees has the authority to modify and/or terminate the terms and benefits under this Plan, at any time.

NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS

Zenith Administrators, Inc., 111 W. Cataldo, Suite 220, Spokane, WA 99201, is designated as agent for purposes of accepting service of legal process on behalf of the Plan. Each member of the Board of Trustees is also authorized to accept service of legal process on behalf of the Plan. The names and addresses of the Trustees are set forth in the following paragraph.

Management Trustees	Labor Trustees
Gary Hite, Secretary Hite Crane & Rigging 4323 E. Broadway Spokane Valley, WA 99212	Curt Koegen, Chairman Local #370 510 S. Elm Spokane, WA 99204
Ken Gibson Inland Asphalt 5111 E. Broadway Spokane, WA 99212	Jerry Stephenson 15220 W. Euclid Road Spokane, WA 99204
	Mike Mitchell Local #370 2011 W. Yakima Pasco, WA 99301

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

Employers make contributions to the Plan in the amount required by collective bargaining agreements in the construction or closely related industry between Local 370 and any individual employer. The amount of the contribution is outlined under the section referring to Fringe Benefits in the current collective bargaining agreement. A copy of any applicable collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Trust Administrative Agent and is available for examination by participants and beneficiaries. The names of specific employers sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Trust Administrative Agent and are available for examination by participants and beneficiaries.

SOURCE OF CONTRIBUTIONS

The Plan is supported by employer contributions, the amount of which is determined through the collective bargaining agreements between the Contributing Employers and Local 370 of the IUOE. Self-payments (including COBRA) by Employees and Dependents are permitted as described on page 51 for continuation coverage, and page 32 for retiree benefits. The amount of self-payments is fixed from time to time by the Board of Trustees.

ELIGIBILITY

Employees are entitled to participate in this Plan if they work under the collective bargaining agreements described above, and provided their Employer makes required contributions on their behalf. Employees and their Dependents must meet certain eligibility requirements.

The eligibility rules which determine who is entitled to benefits are set forth beginning at page 14. The Trustees retain the right and authority to determine eligibility and to interpret the terms of the Plan sponsored by the Trust.

TERMINATION OF ELIGIBILITY

Circumstances that may result in termination of eligibility are set forth beginning at page 14.

The Board of Trustees has the authority to terminate the Trust Fund and the Plan. The Trust Fund and the Plan will also terminate upon the expiration of all of the collective bargaining agreements requiring contributions to the Trust.

In the event of termination of the Trust Fund, any and all assets remaining in the Trust after payment of Expenses shall be used for the continuance of the benefits provided by the then existing benefit Plan until such assets have been exhausted.

ENTITIES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS

The life insurance and accidental death and dismemberment benefits provided by the Plan are fully insured by Symetra Financial Company.

The Trustees retain the right and the authority to change any of the coverage, policies or providers named in this section, at any time.

END OF PLAN YEAR

This Plan is on a Calendar Year basis. Each 12 month period ending on December 31 consists of an entire Plan year for the purpose of accounting and all other reports to the U.S. Department of Labor and other appropriate regulatory bodies.

FILING OF CLAIMS

If you or one of your Dependents become Disabled or incur covered medical Expense, you should immediately obtain the necessary claim form to be completed by you. Forms are available from the Trust Fund office, your Local Union office, or from your Employer. Charges for all services must be itemized.

PROPERLY COMPLETED CLAIMS FORMS TOGETHER WITH ALL ITEMIZED BILLS AND/OR OTHER REQUIRED PAPERS NECESSARY TO PROVE THE LOSS OR DISABILITY MUST BE RETURNED TO ZENITH ADMINISTRATORS, P.O. BOX 68, SPOKANE, WA 99210:

Claims must be filed within 1 year of (1) the date covered Expense is first incurred, or (2) the first date of any Disability for which loss of time benefits are payable under the Plan.

The Employee Retirement Income Security Act of 1974 requires that certain information be furnished to each participant (or eligible participant) in an Employee Benefit Plan. The following pages contain information regarding the Plan as it applies to participating Employees as of the date of this booklet. Supplements to this booklet may be provided in the future to indicate changes in the Plan.

STATEMENT OF EMPLOYEE RIGHTS UNDER ERISA

As a participant in the Washington-Idaho Operating Engineers and Employers Health and Security Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA. ERISA provides that all Plan participants shall be entitled to:

A. Examine without charge, at the Trust Administrative Agent and at other specified locations (such as work sites and union halls), all Plan documents, including but not limited to insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the United States Department of Labor.

B. Obtain copies of all documents governing operation of the Plan, upon written request to the Plan Administrative Agent. The Trust Administrative Agent may make a reasonable charge for the copies.

C. Receive a summary of the Employee welfare benefit Plan's annual financial report. The Plan Administrative Agent is required by law to furnish each participant with a copy of this summary.

D. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan, for the rules governing your COBRA continuation coverage rights.

E. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another Plan. Without evidence of creditable coverage, you may be subject to preexisting condition exclusions for twelve months (eighteen months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee welfare benefit Plan, called "fiduciaries." The fiduciaries have a duty to operate your

Employee welfare benefit Plan prudently and in the interest of all Plan participants and beneficiaries.

No one, including your employer, your union, or anyone else, 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. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Employee welfare benefit 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 Administrative Agent 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 Trust Administrative Agent. 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. If it should happen that Plan fiduciaries misuse the Employee welfare benefit 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 sued to pay these costs and fees. However, if you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

If you have any questions about your Employee welfare benefit Plan, you should contact the Plan Administrative Agent. 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 Administrative Agent, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at (866)444-3272.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal law, group health Plans and Health Insurance issuers offering group Health coverage that includes medical and surgical benefits with respect to a Mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a Mastectomy procedure. Breast reconstructive surgery in connection with a Mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the Mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of Mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and coinsurance.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

HIPAA PRIVACY STATEMENT

This section is intended to comply with the Health Insurance and Accountability Act of 1996 (HIPAA), and 45 CFR 164.504(f).

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

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

A. To make or obtain payment for care received by Covered Persons.

B. To facilitate treatment which involves the provision, coordination or management of health care or related services.

C. To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to Covered Persons.

D. In connection with judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.

E. If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.

F. To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other Plan administrative functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.

G. For authorized activities by health oversight agencies, including audits, civil, administrative or criminal investigations, licensure or disciplinary action.

H. To prevent or lessen a serious and imminent threat to a Covered Person's health or safety, or the health or safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.

I. For specified government functions under 45 CFR Part 164.

J. To the extent necessary to comply with laws related to workers' compensation or similar programs.

Trust Use of PHI. The Board of Trustees agrees to the following:

A. The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this section or required by law.

B. The Trustees will ensure that any of their service providers, subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.

C. The Trustees will not use or disclose PHI for employment-related actions.

D. The Trustees will report to the Board any known impermissible or improper use or disclosure of PHI not authorized by this section of which they become aware.

E. The Board will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.

F. When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

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

Trustee Certification as to Participant Rights. The Board of Trustees also certifies it will observe the following in regard to Plan participants and their PHI:

A. The Board of Trustees, through the Trust Administrative Agent, will make PHI available to the Plan to permit participants to inspect and copy their PHI contained in a designated records set.

B. The Board of Trustees, through the Trust Administrative Agent, will make a participant's PHI available to the participant to permit participants to amend or correct PHI contained in a designated record set that is inaccurate or incomplete.

C. The Board of Trustees, through the Trust Administrative Agent, will make a participant's PHI available to permit the Plan to provide an accounting of disclosures.

D. The Trustees represent that PHI will be used only for Plan administration. The Board certifies that it has no Employees, or other persons under its control other than business associates, that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance. The Trustees certify that any individual or entity who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

RECIPROCITY

The Trustees of this Plan have entered into reciprocity agreements with certain other health and welfare trusts. Contributions paid to this Trust, for Employees from outside this area, who are working temporarily in this area, may be transferred to their home trust, and vice versa. Check with IUOE Local 370 to determine which reciprocity agreements exist. Contact the Trust Administrative Agent to obtain an authorization form to transfer funds back to the Employee's home Trust**. PLEASE NOTE THAT THE EMPLOYEE IS RESPONSIBLE FOR CONTACTING THE LOCAL UNION REGARDING RECIPROCITY AGREEMENTS.**