HEALTH & WELFARE PLAN OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 487

Summary Plan Description
October 2017

INTERNATIONAL UNION
OF OPERATING ENGINEERS
LOCAL 487
HEALTH AND WELFARE TRUST FUND

Fund Office:
911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (877) 291-2387
www.associated-admin.com

BOARD OF TRUSTEES

EMPLOYER TRUSTEES	UNION TRUSTEES
Jack Epperson, Jr.	John Mullen
Michael Harrison	Mark Schaunaman
Jonathan Turk	Scott Singer
Frank Villella	Walberto Utreras

FUND COUNSEL

Phillips, Richard & Rind, P.A.

ADMINISTRATIVE MANAGER

Associated Administrators, LLC

CONSULTANT

The Segal Company

This Summary Plan Description replaces and supersedes any previous document, and may be modified without prior notice.

October 2017

Dear Participant:

The Trustees of the International Union of Operating Engineers Local 487 Health and Welfare Fund ("Fund") are pleased to present this Summary Plan Description or "SPD" booklet. The booklet describes your Health and Welfare benefits under the Fund. Please read it carefully to become familiar with its contents and keep it readily available so you will have it when you need to refer to it.

The Fund was established as a result of collective bargaining between your union (Local 487) and your participating Employer. The contribution rate paid by your participating Employer determines the benefits you receive. An equal number of Trustees administer the Fund and serve without compensation. Their authority, established under a trust agreement, includes the right to make rules about your eligibility for benefits and the level of benefits provided. The Trustees may amend the rules and benefit levels at any time. You will be notified of any material modifications (changes) to this booklet – the Summary Plan Description – as required by federal law.

The Trustees delegate authority to professionals who help them manage the Plan.

- **Administrative Manager**: Often referred to as "the Fund Office" or "Administrator," the Administrative Manager receives Employer contributions, keeps eligibility records, and assists Plan participants in getting their benefits. Some benefits are paid directly from the Fund's assets while others are provided by insurance carriers or other providers to whom the Fund pays premiums. Benefits are limited to Plan assets for all Fund-provided benefits. The Fund Office is not an insurance company but is hired by the Trustees to carry out its instructions in administering the Plan in accordance with Fund

rules. The Administrative Manager is Associated Administrators, LLC.

- **Investment Manager**: Investment managers invest the Fund's assets to achieve a reasonable rate of investment return.

- **Investment Advisor:** An Investment Advisor assists the Board of Trustees in selecting Investment Managers and monitors the investment performance of the Trust Fund.

- **Consultant/Actuary:** The Consultant and Actuary assist the Board of Trustees in determining the benefits to be provided under the Plan, help to identify medical and service providers to be used by the Plan, and make actuarial calculations to project future trends and expenses.

- **Fund Counsel**: Fund counsel provides legal advice and services to the Fund.

- **Certified Public Accountant**: An independent accountant audits the Fund each year. Periodic payroll audits are also performed for each participating Employer.

The Trustees are always interested in providing increased benefits for the International Union of Operating Engineers Local 487 and their Dependents, when it is economically sound to do so. In order to protect the interests of all Fund participants and beneficiaries, the Trustees reserve the right to terminate, suspend, amend or modify the Plan in whole or in part at any time. In the event the Plan is terminated, Plan assets will be allocated, and benefit claims paid, in the manner determined by the Trustees.

We encourage you to take full advantage of the benefits provided for you and your dependents. If you have any questions about your benefits after reading this booklet, please contact the Fund Office.

At all times, the Trustees of the Fund have discretion to determine eligibility for benefits and to interpret the terms of the Trust Agreement and this booklet — the Summary Plan Description. The decision of the Board of Trustees shall be final and binding on all parties, including participants, employers, unions, claimants, and beneficiaries.

The Health benefits are provided through the United HealthCare ("UHC") Neighborhood Health Plan Health Maintenance Organization ("NHP HMO"). NHP HMO benefits are available to eligible employees and Dependents who reside within the NHP HMO service area, as defined by UHC. Please call UHC at (844) 651-3833 to get a current list of the Florida counties in which the NHP HMO Plan is offered. Participants in the NHP HMO must designate a participating primary care provider ("PCP") or UHC will assign a PCP to you when you enroll. Eligible employees and Dependents that reside in one of the other counties within the State of Florida may enroll in the UHC Choice Health Maintenance Organization ("UHC HMO"). Eligible Employees and Dependents that reside outside of the State of Florida may enroll in the UHC HMO, unless they reside in a state where the UHC HMO is not available. In that case, eligible participants may enroll in the UHC Choice Plus Point of Service Plan ("UHC POS"). Benefits are described in the NHP HMO, UHC HMO, or UHC POS Schedule of Benefits.

Dental Benefits are provided through the UHC Dental Maintenance Organization ("UHC DMO"). UHC DMO provides dental benefits to eligible employees and Dependents that reside within the State of Florida. Eligible employees and Dependents that reside outside of the State of Florida may enroll in the UHC Dental Preferred Provider Organization ("UHC DPPO"). Dental benefits are described in the UHC DMO or UHC DPPO Schedule of Dental Benefits.

Vision care benefits are provided to all eligible employees and Dependents through the UHC Vision Benefits Program. Vision benefits are described in the UHC Vision Schedule of Benefits.

Life Insurance and Accidental Death & Dismemberment benefits are provided through an insurance carrier. These benefits are described in the carrier's Certificate of Insurance.

If you have any questions about the Plan, please call the Fund Office toll free at (877) 291-2387 or write the Fund Office at 911 Ridgebrook Road, Sparks, Maryland 21152-9451. **You should keep the Fund Office advised of your current mailing address to ensure that you will receive all required communications.**

Se le prestarán servicios de traducción e interpretación:
Este documento trata acerca de beneficios de salud para usted y su familia a travéz del Fondo. Si usted nesecita ayuda con la traducción e interpretación de este documento, favor de llamar a la Oficina del Fondo al (877) 291-2387 y oprima el número 1.

Sincerely,

Board of Trustees

IMPORTANT NOTE REGARDING BENEFITS

At all times, the Trustees of the Fund have discretion to determine eligibility for benefits and to interpret the terms of the Trust Agreement and this Plan of Benefits also known as the Summary Plan Description.

The Summary Plan Description for the International Union of Operating Engineers Local 487 Health & Welfare Fund functions as both the Plan Document and the Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The terms contained herein constitute the terms of the Plan.

TABLE OF CONTENTS

Page

THE PLAN

ELIGIBILITY

CONTINUATION OF COVERAGE

BENEFITS

ADMINISTRATIVE PROCEDURES

FACTS ABOUT THE PLAN

The following information concerning this Plan is being provided in accordance with government regulations. This summary describes the plan in effect as of April 1, 2017.

Plan Name:
International Union of Operating Engineers Local 487
Health and Welfare Trust Fund

Plan Sponsor:
Trustees of the International Union of Operating Engineers Local 487 Health and Welfare Trust Fund:

911 Ridgebrook Road
Sparks, Maryland 21152-9451

This Plan is maintained pursuant to one or more collective bargaining agreements; a copy of any of the agreements may be obtained by Plan participants or their beneficiaries upon written request to the Fund Office or may be inspected at the Fund Office during normal business hours.

A complete list of Employers sponsoring the Plan may be obtained by Plan participants or their beneficiaries upon written request to the Fund Office or may be inspected at the Fund Office during normal business hours.

Employer Identification Number: 59-6231991

Plan Number: 501

Type of Plan:
Employee Welfare Benefits Plan including:

1. Medical Expense benefits;
2. Death benefits;

3. Accidental Death and Dismemberment benefits;
4. Vision benefits; and
5. Dental benefits.

Type of Administration:
United of Omaha Life Insurance Company insures the group life insurance and accidental death and dismemberment benefits provided by the Plan and administers the payments of life insurance benefits. Their address is:

Mutual of Omaha Plaza
Omaha, Nebraska 68175

United HealthCare ("UHC") insures the NHP HMO, UHC Choice HMO, UHC POS, UHC Vision, UHC DMO, and the UHC DPPO plans.

UHC's Customer Service numbers are:
NHP HMO: (844) 651-3833
UHC Choice HMO: (866) 633-2446
UHC Choice Plus POS: (866) 633-2446
UHC Vision: (800) 638-3120
UHC Dental: (800) 955-4137

UHC's website is www.uhc.com

Administrative Manager:
The day-to-day administration of the Plan is handled by Associated Administrators, LLC, a contract administrator, 911 Ridgebrook Road, Sparks, MD 21152-9451, (877) 291-2387.

Agent for Service of Legal Process:

Phillips, Richard & Rind, P.A.
9360 SW 72 Street, Suite 283
Miami, FL 33173

Service of legal process may also be made upon a Plan Trustee or the Administrative Manager at the address shown herein.

Eligibility and Benefit Provisions:
All types of benefits for which employees and their eligible Dependents are entitled are set forth in the Schedule of Benefits and the Certificate of Insurance.

Contributions:
The amount of Employer contributions is determined by the provisions of their collective bargaining agreements with employee representatives.

Funding:
Benefits are provided from Plan assets, which are held in reserve for payment of premiums for Plan benefits and expenses.

Plan Year:
The year for purposes of maintaining Plan records and reporting to applicable governmental bodies is April 1 through March 31.

BOARD OF TRUSTEES

UNION TRUSTEES

John Mullen
IUOE Local 487
4731 W Atlantic Avenue,
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Chuck's Backhoe Service, Inc.
2301 NW 15 Court
Pompano Beach, FL 33069

Frank Villella
Gold Coast Crane Service, Inc.
4450 N 29th Avenue
Hollywood, FL 33020

NOTICE - NO FUND LIABILITY

Use of the services of any provider rendering health care is the voluntary act of the participant or Dependent, even in cases where the Fund limits coverage to certain providers. Some benefits may only be obtained from providers designated by the Fund. This is not meant to be a recommendation or instruction to use those providers.

You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Fund. Providers are independent contractors, not employees of the Plan. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

SCHEDULE OF BENEFITS

The benefits payable under this Fund for covered medical services and supplies are determined through negotiation by the Board of Trustees and the service provider, currently United HealthCare, through the NHP HMO, UHC HMO, UHC POS, UHC Vision, UHC DHMO, and the UHC DPPO. Included with this Summary Plan Description is a summary of the benefits offered by UHC. This summary sets forth a list of current covered services and supplies and the co-payments which you are required to pay for such services and supplies. The Schedule of Benefits describes the services covered and the co-payments charged to a participant; it also provides the guidelines for selecting primary care physicians (NHP HMO only) and obtaining specialist services and describes the benefits payable for use of out-of-network physicians or facilities.

The Fund provides Life and Accidental Death & Dismemberment coverage through an insurance carrier, currently United of Omaha Life Insurance Company. The Certificate of Insurance from United of Omaha Life Insurance Company sets forth the benefits payable, exclusions for which no benefits will be paid, conversion rights, and rules pertaining to continuation of the Life insurance in the event of total disability.

The Fund provides dental coverage through the UHC DHMO or UHC DPPO plans. Treatment must be performed by participating dentists. You may choose a dentist from the list of participating providers. The DHMO and DPPO schedules of benefits offered by UHC outline the services covered, and the amount of the co-payments you are responsible for paying to the provider.

DEFINITIONS

EMPLOYER

The term "Employer" means any company which has entered into a Collective Bargaining Agreement with the International Union of Operating Engineers Local 487 or is otherwise obligated to make contributions to the Fund. The term "Contributing Employer" means an Employer which makes contributions to the International Union of Operating Engineers Local 487 Health & Welfare Fund by the terms of a participation agreement. The Union and the Trust Fund are considered Employers with respect to its employees for whom it contributes to this Fund.

EMPLOYEE

The term "Employee" means all active employees on whose behalf contributions are required to be made to the Fund by Employers in accordance with a Collective Bargaining Agreement or other written participation agreement by and between Employers and the IUOE Local 487, including non-bargaining unit employees of the Employer, elected officials of the Union and employees of the Trust Fund. In addition, officers of the Employer may be considered employees, provided that sole proprietors, partners and persons owning 100% of the stock of a corporation will not be considered employees and will not be eligible to participate in the Plan.

RETIRED EMPLOYEES

The term "Retired Employee" means employees who have retired from active employment since April 21, 1977, under the IUOE Local 487 Pension Fund or its successor

Fund, and were eligible under the IUOE Local 487 Health and Welfare Fund and/or the IUOE Local 675 Health and Welfare Fund for 36 months immediately prior to retirement. Such employees must be at least age 55 if retiring with 25 years of vested service, or at least age 60 if retiring on Early Retirement.

DEPENDENT

The term "Dependent" means (1) an Employee's spouse who is not legally separated from the employee; (2) the employee's child(ren), from birth to age 26, regardless if the child is married, attending school, living with the participant, employed or financially dependent on the participant.

The term "children" shall include natural children, adopted children (a child(ren) who is adopted or placed for adoption, as defined by the state in which the adoption takes place), foster children (a child(ren) who is placed in compliance with Florida Statute Chapter 63), stepchildren, provided they reside with the employee, and children under legal guardianship if the child depends primarily upon the Employee for support and lives with the Employee in a regular parent and child relationship; and the Employee's Dependent child(ren) who, upon attaining age 26, is mentally or physically handicapped so as to be incapable of self-support, provided such proof is furnished to the Administrative Manager within 30 days of the date benefits would otherwise terminate, and then periodically as requested by the Plan.

It is a further requirement for Dependent eligibility that a valid Social Security Number be provided to the Fund Office for each Dependent.

The covered Employee, at his or her option, may extend coverage to an eligible Dependent child until the end of the calendar year in which the child reaches the age of 30 if the child (1) is unmarried and does not have a Dependent of his or her own; (2) is a resident of the State of Florida or is a full-time or part-time student; and (3) is not named a subscriber, insured, enrollee, or covered person under any other health insurance policy, or is entitled to benefits under Title XVIII of the Social Security Act (Medicare). An eligible Dependent child who was provided coverage under the Covered Employee's policy after the end of the calendar year in which the eligible Dependent child reaches age 26 whose coverage was subsequently terminated is not eligible for coverage under this section unless the eligible Dependent child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days. All applicable premiums shall apply.

A Dependent full-time student at an accredited school who takes a "medically necessary leave of absence" will not lose health plan coverage for up to one year. (See "medically necessary leave of absence").

DISABILITY

The term "Disability" or disabled for purposes of this Plan means unable to work within the

trade jurisdiction of the union, medically substantiated in a form approved by the Plan Administrator, who shall have the sole discretion to approve the form of proof of disability.

FUND OFFICE

The Administrative Manager of the Fund is also referred to as "the Fund Office." Associated Administrators, LLC, the Third Party Administrator hired by the Fund, is the Administrative Manager of the Plan and acts as the Fund Office.

MEDICALLY NECESSARY LEAVE OF ABSENCE

A "medically necessary leave of absence" for purposes of this Plan occurs when the student starts a leave of absence from an accredited school that 1) starts while the student is suffering from a serious illness or injury; 2) is medically necessary; and 3) would ordinarily cause the student to lose full-time student status for purposes of coverage under the terms of the Plan.

A Dependent on a medically necessary leave of absence will be treated as meeting the full-time student requirement for up to a year from the date of leave or until the date the child attains age 26, whichever is earlier.

To obtain this continuing coverage, the Plan must be provided a certification from the student's treating physician that the student is suffering from a serious illness or injury, and that the leave of absence is medically necessary.

OWNER OPERATOR	An "owner-operator" is an employee of a corporation in which he or his spouse has an ownership interest, and whose participation has been approved by the Board of Trustees of the International Union of Operating Engineers Local 487 Health and Welfare Fund.
QUALIFIED MEDICAL CHILD SUPPORT ORDERS OR "QMCSOs"	Qualified Medical Child Support Orders (including National Medical Child Support Orders) or "QMCSOs". A medical child support court order which requires a child to be covered under a Plan, which permits the child to receive benefits from the Plan and which complies with the requirements for a QMCSO under ERISA.

NOTE: ANY REFERENCE TO MALE GENDER ALSO INCLUDES FEMALE GENDER, WHERE APPLICABLE.

EMPLOYEES AND RETIRED EMPLOYEES
ELIGIBILITY AND TERMINATION RULES

BARGAINING UNIT EMPLOYEES

INITIAL ELIGIBILITY

A new Employee will become eligible for benefits on the first day of the month following receipt of 400 hours of contributions on his behalf by Contributing Employers, provided that the 400 hours were contributed within a period of no greater than three consecutive months. If the above requirement is not met, an Employee will become eligible on the first day of the month following a period of six consecutive months or less, in which at least 500 hours have been contributed on his behalf by Contributing Employers. Upon meeting the requirements for Initial Eligibility, the Employee will remain eligible for three months.

The following chart shows how this requirement can be met.

Initial Eligibility	
400 Hours In	**Gives Coverage For**
January-February-March	April-May-June
February-March-April	May-June-July
March-April-May	June-July-August
April-May-June	July-August-September
May-June-July	August-September-October
June-July-August	September-October-November
July-August-September	October-November-December
August-September-October	November-December-January
September-October-November	December-January-February
October-November-December	January-February-March
November-December-January	February-March-April
December-January-February	March-April-May

Notification Requirements – Participant's Responsibilities

Once you become eligible for benefits, it is important that you keep the Fund Office updated on any changes in your status. You must notify the Fund Office of:

- Any changes in marital status;
- The names and birth dates of newborn children, stepchildren, adopted children or children placed for adoption;
- Any change of address; and
- Any change in beneficiary.

You must notify the Fund Office when any of the foregoing information changes.

ADDING NEW DEPENDENTS

To add a **newly eligible** Dependent, contact the Fund Office for an enrollment form. Your spouse and eligible stepchildren can be added for coverage on the first of the month following the date of marriage. Biological children can be added effective on the date of their birth, and legally adopted children and children placed for adoption may be added effective the date of adoption or placement for adoption**. In order for a new Dependent to be covered, a valid Social Security Number must be provided to the Fund Office.**

NOTE: Only those eligible Dependents listed on your most recent enrollment form and for whom a valid Social Security Number is provided will receive Dependent coverage.

In order for a new Dependent's coverage--including a newborn's coverage--to begin on the earliest date of eligibility, you must inform the Fund Office within 30 days from the date he or she first became your Dependent. Otherwise, coverage will begin on the first of the month following the date the Fund Office receives the required information.

CONTINUED ELIGIBILITY

The employment records of all eligible Employees will be reviewed monthly to determine whether an Employee is eligible for continued benefits. Eligibility Months are the months which are used to determine if Employees have worked the minimum number of hours required under the Plan. Benefit Months are the months in which the Employees are covered for benefits under the Plan. The chart in this section on page 24 shows the Eligibility Months and the corresponding Benefit Months.

Eligibility may be continued through one of the following methods:

1. Active Work Employees who work a minimum of 100 hours during an Eligibility Month will be covered for benefits during the corresponding Benefit Month.

2. Rollback Rule Employees who fail to work at least 100 credited hours during an Eligibility Month may still continue to be eligible for coverage. The Fund Office will look at the Eligibility Month and the five previous Eligibility Months and determine if the Employee has worked the required number of hours, as shown in the chart on page 24. If the hours requirement is met, the Employee will be covered for the next Benefit Month.

   Eligibility may be determined using this method only if the Employee has been covered in the preceding Benefit Months; this rule will not be used to determine if an Employee can reinstate his eligibility after losing it, or to regain eligibility after making COBRA self-payments.

3. Continuing Eligibility Through Disability Credits. For the purposes of maintaining eligibility, a month of proven disability will not count as a month of unemployment. A month of proven disability is defined as any calendar month in which an Employee can medically substantiate that he has been disabled for a minimum of 20 consecutive days

during the month. During such periods of disability, the Employee will be automatically credited with up to a maximum of 100 hours for each calendar month of proven disability. The maximum credit for disability will be limited to six calendar months within any two-year period.

4. Continuing Eligibility Through Self-Payments; Crediting of Hours Worked (For Bargaining Unit Employees). If a bargaining unit Employee's coverage terminates, but he remains available for work, he will be given the opportunity to continue coverage by making self-contributions.

   (a) The Fund Office will send the Employee a notice informing him when his coverage will terminate and of his right to self-pay and the amount of the self-payment required to maintain eligibility.

   (b) If the Employee fails to make the self-payment by the due date, his coverage will be terminated, unless he is eligible for and elects COBRA continuation of coverage, as described on page 32.

   (c) If the Employee is making self-payments to continue coverage and has worked some hours in the month for which self-payments are due, the Fund will reimburse him for the amount of the contributions made for the hours of work or will credit the contributions to his next payment.

   (d) Self-payment may not be used by a Dependent who is no longer an eligible Dependent (as defined on page 15); however, a Dependent may be eligible for COBRA continuation of coverage, as described on 32.

(e) If an Employee makes a self-payment for coverage and then terminates employment with an Employer or becomes unavailable for full-time work with an Employer, his coverage will terminate at the end of the Benefit Month for which he last made a self-payment. At that point, the Employee may be eligible for COBRA continuation of coverage, as described on page 32.

Eligibility Months						
Benefit Month	**100 Hours In**	**200 Hours In**	**300 Hours In**	**400 Hours In**	**500 Hours In**	**600 Hours In**
April	Jan	Dec-Jan	Nov-Jan	Oct-Jan	Sept-Jan	Aug-Jan
May	Feb	Jan-Feb	Dec-Feb	Nov-Feb	Oct-Feb	Sept-Feb
June	Mar	Feb-Mar	Jan-Mar	Dec-Mar	Nov-Mar	Oct-Mar
July	Apr	Mar-Apr	Feb-Apr	Jan-Apr	Dec-Apr	Nov-Apr
August	May	Apr-May	Mar-May	Feb-May	Jan-May	Dec-May
September	Jun	May-Jun	Apr-Jun	Mar-Jun	Feb-Jun	Jan-Jun
October	Jul	Jun-Jul	May-Jul	Apr-Jul	Mar-Jul	Feb-Jul
November	Aug	Jul-Aug	Jun-Aug	May-Aug	Apr-Aug	Mar-Aug
December	Sep	Aug-Sept	Jul-Sept	Jun-Sept	May-Sept	Apr-Sept
January	Oct	Sept-Oct	Aug-Oct	Jul-Oct	Jun-Oct	May-Oct
February	Nov	Oct-Nov	Sept-Nov	Aug-Nov	Jul-Nov	Jun-Nov
March	Dec	Nov-Dec	Oct-Dec	Sept-Dec	Aug-Dec	Jul-Dec

REINSTATEMENT

If an Employee's eligibility has terminated, he will be reinstated for eligibility if and when he meets the Initial Eligibility requirements. However, if at least some hours were worked in the 12-month period preceding reinstatement, coverage will be reinstated on the first day of the calendar month immediately following the date he has worked 300 hours in the preceding three months or 500 hours in the preceding six months. Upon meeting the requirements for reinstatement, he will remain eligible for the next three consecutive months.

TERMINATION

Eligibility for benefits will terminate on the earliest of the following dates:

(a) the first day of the month following the month in which the Employee has not accumulated 100 hours, or the required number of hours during the rolling eligibility period;

(b) the date the Employee enters full time military, naval or air service, provided that if the Employee is a reservist called up to active duty, he may be entitled to make COBRA payments regardless of any coverage provided by the military;

(c) the date the Employee ceases to be in an eligible status;

(d) the date the Employee's Employer is no longer a contributing Employer to the Fund;

(e) the last day of the third month after which the participant has ceased employment with a contributing Employer, and who is unavailable for work in covered employment, except for unavailability due to disability or retirement;

(f) the date of the Employee's death; or

(g) the date the Plan terminates.

The Fund will not retroactively cancel coverage except when contributions, if any, are not timely paid or in cases of fraud or intentional misrepresentation of material fact, as required under the Patient Protection and Affordable Care Act.

DEPENDENTS OF DECEASED EMPLOYEES

Benefits for Dependents of a deceased Employee who is eligible for coverage at the time of his death will be continued at no cost for six months from the date of the death of the Employee. At the end of the six-month period, Dependents are eligible to contribute for coverage as provided under COBRA Continuation of Coverage (see page 32).

EXCEPTION TO ELIGIBILITY RULES

ELIGIBILITY OF EMPLOYEES OF A NEW EMPLOYER

Active, full-time Employees working in covered employment of new Employers as of the operative date of that Employer's bargaining agreement shall be eligible for immediate benefits under this Plan if they meet the following requirements:

(a) The Employer has maintained other comprehensive medical coverage for Employees working in covered employment directly before the operative date of the Employer's bargaining agreement providing for contribution to this Plan on behalf of such Employees; and

(b) The New Employer submits a list of full-time Employees to be covered to the Fund Office.

Initial eligibility for benefits shall begin the first day of the month subsequent to the month the Employer is first required to make contributions on such Employee's behalf to this Plan.

Once eligible for benefits, Employees must work a minimum of 100 hours a month to maintain eligibility under this Plan. Rules regarding rolling eligibility periods and reinstatement shall not apply to Employees who qualify for coverage under these rules.

The eligibility of any Employee will terminate on whichever of the following dates occurs first:

(a) The last day of the calendar month following receipt of a report in which the Employee works less than 100 hours; provided that the Fund Office will send the Employee a notice informing him when his coverage terminates and of his right to self-pay and the amount of the self-payment required to maintain eligibility. The Employee will be eligible for reinstatement of coverage in the month following the Fund Office's receipt of a report from the

Employer in which the Employee works 100 hours or more;

(b) The last day of the calendar month for which the Employer submits contributions for coverage on behalf of the Employee;

(c) The last day of the calendar month for which the Employer is obligated, pursuant to the collective bargaining agreement, to contribute to this Plan; or

(d) The date this Plan is terminated.

If an Employee's eligibility terminates, such Employee may not re-qualify for coverage under these rules and must instead meet the initial eligibility rules of this Plan.

NON-BARGAINING UNIT EMPLOYEES

ELIGIBLE EMPLOYERS

An Employer may have its non-bargaining unit Employees (including Owner-Operators) participate in the Fund if the Employer is signatory to a collective bargaining agreement on behalf of its bargaining unit Employees and it signs a participation agreement with the Fund. The Employer must specifically name the Employees to be covered under this Fund, in the participation agreement. Contributions must be made to the Fund on the basis of 40 hours per week, 52 weeks per year, at the hourly rate set forth in the participation agreement.

Non-bargaining unit Employees are subject to the same rules for initial eligibility and continued eligibility as any other Employee.

Coverage will be terminated at the earliest of the following:

(a) the earliest date set forth in the Termination Section on page 25;

(b) the last day of the month for which contributions were made on a timely basis;

(c) the last day of the month in which the Employee's employment terminates; or

(d) the last day of the month for which there is not a valid participation agreement.

DEPENDENT ELIGIBILITY AND TERMINATION

DEPENDENTS' ELIGIBILITY DATE

An Employee will become eligible for Dependent Coverage on the latest of (1) his own eligibility date, (2) the date he acquires his first Dependent, or (3) the date Dependent Coverage is made available under the Plan. The term "Dependent" will not include any person who is eligible as an Employee or any person who is in full-time military service. If both parents are eligible as Employees under the Plan, a child may be included as a Dependent of either parent, but not of both.

NEWBORN, FOSTER OR ADOPTED CHILDREN

Foster and adopted children, as well as natural children, and children defined herein as “Dependents” may be enrolled upon timely submission of enrollment forms and legal documents, if applicable. Required documents must be submitted within 30 days of the adoption or effective date of legal custody or placement. Natural newborn children should be pre-enrolled at least 30 days prior to the scheduled delivery date.

NEW SPOUSE

An Employee may enroll a new spouse within 30 days of the date of marriage, upon submission of enrollment forms and a copy of the marriage certificate.

TERMINATION OF DEPENDENT BENEFITS

Dependent benefits will automatically terminate on the date the Employee's benefits terminate.

In addition, the benefits for any person eligible as a Dependent will automatically terminate on the date he or she ceases to qualify as a Dependent.

If the Employee should die while covered under the Plan, the medical expense benefits for his Dependents who were covered

under the Plan on the date of the Employee's death will remain in force, to the same extent as if death had not occurred, until the earlier of (1) the end of a period of six months from the date of the Employee's death, or (2) the date the Plan terminates.

Dependents are eligible to continue coverage beyond the six-month period by making self-contributions as provided under COBRA Continuation of Coverage on page 32.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When an Employee's medical coverage ends, he and/or his eligible Dependents may request a “Certificate of Coverage” that indicates the period of time he and/or his eligible Dependents were covered under this Plan. Such request must be received by the Fund Office within two years after the date coverage ended.

CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

Federal law mandates that Employer-sponsored group plans provide individuals with the option of continuing their health coverage through self-payment of contributions when their coverage terminates under the group plan.

This Plan provides eligible individuals with the option of continuing health and in some instances, death benefits, when coverage terminates under the Plan. Provisions relative to continuation coverage are discussed below. It is important that all family members be aware of these provisions in the event coverage terminates.

1. Qualifying Events

   An Employee and his or her eligible Dependents have the right to continue group health coverage (and an Employee may additionally continue Death Benefits) if it terminates for certain reasons, provided the Employee or Dependents make the required self-payment of premiums. The continuation coverage is available in the event coverage terminates due to:

   a. Termination of the Employee's employment for any reason, except gross misconduct;

   b. A reduction in hours worked by the Employee;

   c. Death of the Employee;

   d. Divorce or legal separation of the Employee and spouse;

   e. A Dependent child ceasing to be a Dependent, as defined on pages 15-16; or

f. A Dependent ceasing to be eligible due to the Employee becoming entitled to Medicare.

2. Notice Requirements

If one of the Employee's Dependents would lose coverage due to d. or e. above, the Employee or the Dependent must notify the Plan in writing within 60 days of the event so that the Fund Office can provide the Employee and his covered Dependents with appropriate notice of COBRA continuation coverage rights and the terms which apply to the continuation coverage. Notice must be sent to the Administrative Manager, Fund Office, 911 Ridgebrook Road, Sparks, MD 21152-9451. If events in items a., b., c. or f. above occur, the Employee or his Dependents should notify the Fund Office as well. The Employee or Dependent should try to give notification within 30 days of the qualifying event to assure there is no break in coverage.

3. Election Requirements

The Employee and/or Dependent must elect to make self-payment of contributions within the later of 60 days after his eligibility terminates or within 60 days from the date he is notified by the Fund Office of his right to maintain eligibility through self-payment. If an election is not made and postmarked within the time periods stated in the notice, he cannot continue coverage under this Plan.

4. Self-Payment of COBRA Contributions

Self-payment, if elected, must be made from the date of termination. No lapse in coverage is permitted.

a. If an Employee or Dependent elects to continue coverage within 60 days after his or her eligibility terminates, the initial premiums due for continuation

coverage must be postmarked and sent to the Plan Office within 45 days after the election. This includes premiums required for months of continuation coverage between the termination date of regular coverage and the date the initial premium is due.

b. After the initial election and payment of contributions, subsequent payments must be postmarked and sent to the Fund Office before the last day of the month for which coverage is to be provided.

c. The contribution rate for continuation coverage will be determined according to federal law and is subject to change in the event the Plan's cost changes.

d. Self-contributors will be notified of any change in contribution rates which they are required to pay.

e. If benefits provided to active Employees and/or their Dependents change, your continuation of coverage will also change.

5. Maximum Period Allowed Under Continuation Coverage

a. 18 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for an Employee, spouse or Dependent because the Employee ceased covered employment, including retirement or had a reduction in hours of employment for any reason, other than gross misconduct; or

b. 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for a spouse or Dependent for reasons other than those referred to in 5.a. above.

c. If a qualified beneficiary is determined to have been disabled at the time of a Qualifying Event as described in 1.a. or 1.b. or becomes disabled during the initial 18-month period, the period of coverage may be extended from 18 to 29 months, provided the Qualified Beneficiary notifies the Administrative Office by submitting documentation of such determination within 60 days of the date he receives notice from the Social Security Administration that he is entitled to disability benefits, and within 18 months of the qualifying event. A person who has been determined to be disabled by the Social Security Administration must notify the Plan Office not later than 30 days after the date of any determination by the Social Security Administration that he is no longer disabled.

If extended coverage is elected under this paragraph, the cost of coverage for the period beyond the first 18 months may be higher, at a rate determined by the Board of Trustees.

This coverage may be extended for the disabled person and any other qualified beneficiaries covered under COBRA at the end of the first 18-month period.

d. Multiple Qualifying Event - A spouse or a Dependent child who has a subsequent qualifying event while covered under this continuation coverage may elect to continue coverage for the balance of the 36-month period from the initial date of eligibility for continuation coverage. However, if an Employee has a qualifying event (as described in 1. a. or b.) after he has become entitled to Medicare, his eligible spouse and dependent children may elect to continue coverage for a maximum of 36 months from the date the Employee became entitled to Medicare.

6. Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the earliest of:

a. The first day of the month for which premium is not paid on time;

b. The date the individual becomes covered under another Employer sponsored group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition;

c. The date the individual becomes entitled to Medicare; or

d. The date the plan terminates.

If an Employee and/or Dependent does not elect and pay premiums for COBRA continuation coverage on a timely basis, he will no longer be covered under the Plan and any claims filed during the election period or following termination for non-payment of contributions will not be paid by the Plan. Reinstatement of coverage is not permitted.

Full details of COBRA continuation coverage will be furnished to the Employee and/or his Dependents when the Fund Office receives notice that one of the qualifying events described in item 1 above has occurred. Therefore, the Board of Trustees urges Employees and Dependents to contact the Fund Office as soon as possible after the occurrence of one of those events.

7. Self-Payment after Termination of COBRA Continuation Coverage

After the maximum period of COBRA Continuation Coverage has been reached, an Employee and/or Dependents may continue to make self-payments to continue coverage under the Plan. This eligibility to self-pay is only available under the following circumstances:

a. The Employee is retired under the International Union of Operating Engineers Local 487 Pension Plan or its successor plan or was an Employee covered under the IUOE Local 675 agreement and retired under the International Union of Operating Engineers Central Pension Fund and neither the Employee nor the eligible Dependents are eligible for Medicare or Medicaid. Retired Employees who are working in the trade jurisdiction of Local 487 for a non-signatory Employer are not eligible for this coverage.

b. The spouse and eligible dependent children of a deceased Employee who are not eligible for Medicare or Medicaid are Dependents.

c. The Employee is not currently working for an Employer who is obligated to make contributions to the Plan, but the Employee is currently listed on the IUOE Local 487 out-of-work list.

d. The Employee is currently covered under the IUOE Local 487 collective bargaining agreement and is unable to work within the trade jurisdiction of the Union, due to a disability.

Coverage will continue until the earliest of the following events:

1. The last day of the month for which self-payment has been made on a timely basis to the Fund Office;

2. The death of the Employee (for the Employee's coverage) or the death of Dependent (for the Dependent's coverage);

3. The last day of the month prior to the month in which an Employee turns age 65 and becomes Medicare eligible;

4. The date a Dependent is no longer an eligible Dependent (as defined on pages 15-16);

5. The date the Board of Trustees eliminates this coverage;

6. The date the Plan is terminated.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description you should contact the Fund Office, Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, MD 21152-9451, Telephone: 1 (877) 291-2387.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Keep Your Plan Informed of Address Changes

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

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Family and Medical Leave Act ("FMLA") is federal legislation enacted to provide job protection for up to 12 weeks an entitlement year to an Employee, or for an Employee to care for his or her parent, spouse, or child who has a serious health condition determined to be FMLA-qualifying by the patient's physician, or when an Employee must be absent due to becoming a parent. Employers must approve leave for events that qualify under the FMLA. The National Defense Authorization Act for Fiscal Year 2008 ("NDAA") amended the FMLA to allow eligible Employees to take up to 12 workweeks of job-protected leave in the applicable 12-month period for any "qualifying exigency" arising out of the active duty or call to active duty status of a spouse, son, daughter, or parent. The 2008 NDAA also amended the FMLA to allow eligible Employees to take up to 26 workweeks of job-protected leave in a "single 12-month period" to care for a covered service member with a serious injury or illness.

CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 ("USERRA")

As required under the Uniformed Services Employment and Re-Employment Rights Act ("USERRA") the Fund provides you with the right to elect continuous health coverage for you and your eligible Dependent(s) for up to 24 months, beginning on the date your absence from employment begins due to military service, including Reserve and National Guard Duty, as described below. Contact the Fund Office for more information if this may apply to you.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible Dependent(s) under the provisions of USERRA. The period of coverage for you and your eligible Dependent ends on the earlier of:

1. The end of the 24-month period beginning on the date on which your absence begins; or

2. The day after the date on which you are required but fail to apply under USERRA for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

Cost

After 31 days, you must pay the cost of coverage unless your participating Employer elects to pay for your coverage pursuant to the Plan provision described below or your participating Employer elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of USERRA by the same method the Fund uses to determine the cost of COBRA continuation coverage.

If your military service is considered an approved Leave of Absence, your participating Employer must pay the cost of the coverage for the first 12 months that you are eligible for coverage. After the first 12 months, you must begin paying for the cost of your coverage.

You must notify your participating Employer or the Fund Office that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact the Fund Office and elect continuation coverage for yourself or your eligible Dependent(s) under the provisions of USERRA within 60 days from the date your military

service begins. Payment of the USERRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of the election of your USERRA coverage. If your participating Employer is obligated to pay but does not, or ceases making voluntary payment for the cost of the coverage, the Fund Office may require you to pay the required premiums.

Ongoing payments must be made by the last day of the month for which coverage is to be provided. You will not be billed; it is your responsibility to send payments to the Fund Office. Late payments can result in termination of coverage. You are responsible for payment of the required premiums.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under USERRA.

Death Benefits under USERRA

If you elect USERRA continuation coverage under the provisions of this Plan, your death benefit will not be continued for the duration of your USERRA continuation coverage.

Reinstatement after Discharge

If you become employed by a Contributing Employer based upon an application for employment made in accordance with the timelines established under USERRA, you and your eligible Dependents will continue to be fully eligible subject to the regular eligibility rules set forth in this booklet. In the event you are not employed by a Contributing Employer based upon an application for employment made in accordance with the timelines established under USERRA, your eligibility will be terminated and will be reinstated only upon your completion of the normal eligibility requirements.

The timelines established under USERRA are:

- Service of 1 to 30 days: You must report to work by the first regularly scheduled work period on the first full calendar day that falls eight (8) hours after the completion of military duty leave.

- Service of 31 to 180 days: You must submit an application for reemployment no later than fourteen (14) days after the completion of service.

- Service of 181 days or more: You must submit an application for reemployment not later than ninety (90) days after the completion of service.

DEATH BENEFITS
RETIRED EMPLOYEES

ELIGIBILITY

A Retired Employee will be eligible for Death Benefits if he:

1. Is retired under the IUOE Local 487 Pension Plan or its successor plan in any of the following forms of retirement:

   a) Is at least 55 years of age and retiring with 25 years of vested service, or
   b) Is at least 60 years of age and retired on an Early Retirement, or
   c) Retires at Normal Retirement Age, or
   d) Retirees, on a Disability Retirement;

2. Is retired from active employment on or after April 21, 1977; and

3. Was eligible for health and death benefits from the IUOE Local 487 Health and Welfare Fund for a period of 36 months immediately prior to his retirement.

This benefit shall be available without premium payment by the retiree. A Retired Employee who does not meet these eligibility provisions may still be eligible for a benefit if he complies with the self-pay rules for continuation of coverage. However, in the event a Retired Employee returns to work in the trade jurisdiction of Local 487 for a nonsignatory Employer, he will immediately and permanently forfeit his eligibility for continued death benefits under this provision and any other provision of the Plan.

Special Rule for Members of Local 675 Plan - Members of Local 675 who were retired on or before July of 1999, the date of the merger of IUOE Local 675 Health and Welfare Fund into the IUOE Local 487

Health and Welfare Fund may continue their death benefits through the IUOE 487 Local Health and Welfare Fund. Eligible retired members of Local 675 shall have submitted a completed election form, as provided by the Fund Office, to the Fund Office and to self-pay the premium cost for the death benefit to be continued. Coverage on a self-pay basis for retired members of Local 675 will continue until the earliest of the following events:

(a) The last day of the calendar year quarter for which self-payment has been made on a timely basis to the Fund Office;
(b) The date the Board of Trustees eliminates this or
(c) The date the Plan is terminated.

When your life insurance coverage ends as a participant of the Plan, you may apply for an individual life insurance policy without evidence of good health. You must apply within 31 days after your group insurance ends. You would be responsible for paying the premium for the coverage. For information and premium rates on conversion coverage, please write or call:

United of Omaha Life Insurance Company
Attention: 11th Floor, Group Conversion
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Telephone: (800) 826-8054

COORDINATION OF BENEFITS

If a covered person has coverage under another plan, this Plan will coordinate its benefits with those of the other plan to prevent situations where benefits paid total more than 100% of the charges. Coordination of benefits requires the determination of which plan is primary (the plan which pays first) and which is secondary (the plan which pays second). If this Plan is primary, it will pay its full benefits. If it is secondary, the benefits it would have paid will be reduced to account for the benefits paid by the primary plan. In no event will more than 100% of the total reasonable and customary charges be paid.

The Plan Administrator will determine the primary/secondary plan in the following order:

1. The Plan that does not have a coordination of benefits clause will be primary.

2. If both plans have a coordination of benefits clause, the following rules apply:
    a. The benefits of a plan that covers the patient as an Employee are determined before the benefits of a plan that covers the Employee as a Dependent.

    b. When two or more plans cover the same Dependent:
        i. The benefits of the plan of the parent whose birthday falls earlier in the year are determined first.

        ii. If both parents have the same birthday, the benefits of the plan that covered the parent for a longer period of time are determined first.

iii. Where the Dependent is a child of divorced or separated parents, the benefits of the plan that covers the child as a Dependent of the custodial parent shall apply first unless there is a court decree that states otherwise.

Medicare coverage will be considered to be primary when determining retiree benefits, except for the first 30 months of Medicare entitlement because of renal dialysis due to end-stage renal disease. The Plan will be primary for a covered Dependent entitled to Medicare because of total disability qualifying for social security benefits. (See Health Coverage for Employees and their Spouses, Age 65 and Older).

The Plan Administrator has the right to exchange claims information with any other organization for the sole purpose of coordinating benefits.

SUBROGATION

Upon the delivery of health services or payment for such services pursuant to this Plan, the Plan shall be subrogated to any Employee's or Dependent's rights against an Employer or other third party alleged to be legally responsible for bodily injury or illness to such member, to the extent of the reasonable value on a fee for service basis of the health services or payments provided and to the extent that compensation or damages are recovered. Any such right of subrogation provided to the Plan under this paragraph shall not apply or shall be limited to the extent Florida Statutes or the courts of Florida eliminate or restrict such right.

The Plan may, at its option, take such action as may be necessary and appropriate to preserve its rights to recover such compensation or damages, including the right to bring suit in the name of the Employee or Dependent. Such Employee or Dependent shall cooperate fully with the Plan in protecting its legal rights under this provision, including cooperating in obtaining information about the injury or illness and its cause.

To the extent not prohibited by applicable law, the Plan shall be entitled to be repaid first from, and have a lien against, the proceeds of any settlement or judgment which the Employee or Dependent may recover against any Employer or third party legally responsible for any bodily injury or illness for 100% of the reasonable value on a fee for service basis of health services provided by the Plan. The Employee or Dependent shall hold such proceeds in trust for the benefit of the Plan and pay them over to the Plan upon demand if paid directly to the Employee or Dependent.

The Employee or Dependent shall execute any documents and aid the Plan in any way required or requested by the Plan to secure a recovery.

HEALTH COVERAGE FOR EMPLOYEES AND THEIR SPOUSES, AGE 65 OR OLDER

Federal law provides that active Employees age 65 or older who are eligible for Medicare because of age may be provided the choice of either their Employer-sponsored Plan or Medicare.

At this time, the IUOE Local 487 Health & Welfare Fund has agreed to provide group coverage for those working Employees and/or their spouses, age 65 or older, who elected this group health Plan as primary payor of their health claims.

This Plan will pay first, subject to any applicable deductibles and co-payments specified in the UHC Summary of Benefits. Medicare benefits, if applicable, would be secondary. It is possible that the payment paid by this Plan, plus the payment made by Medicare, may not equal the actual charge. However, the combined benefits will in no event exceed 100% of the allowable charges. The primary and secondary payor rules as of the Effective Date of this Plan are as follows:

If the person is age 65 or older and employed:	The primary payor is the IUOE Local 487 Plan
If the person is age 65 or older and only the spouse is employed:	The primary payor is the spouse's group health plan
If the person is under 65 and Medicare-eligible solely because of End Stage Renal Disease:	The primary payor is the group health plan of the current or former Employer of the Employee or family member for the first 30 months of Medicare eligibility; thereafter, Medicare is primary

If the person is under 65 and Medicare-eligible solely because of disability, or if the spouse is under 65 and Medicare-eligible solely because of disability:	The primary payor is the IUOE Local 487 Plan
If the person is age 65 or older, retired, and the spouse, if any, is not the Employee, or the spouse is employed but does not have group health coverage:	The primary payor is Medicare

Most workers age 65 and over do not have to pay for Medicare Part A (basic hospital insurance). Part B (supplementary medical insurance) may be purchased for a low monthly premium. This Plan will coordinate with Medicare, Parts A and B, as if both were in effect.

WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA")

If you or your insured Dependent is receiving benefits in connection with a mastectomy and you or your insured Dependent, in consultation with the attending physician, elects breast reconstruction, coverage will be provided for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis; and
- treatment of physical complications of all stages of mastectomy, including lymph edemas.

Reconstruction benefits are subject to the same provisions as any other benefit provided under the Plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). The Plan will not require precertification for hospital stays within these time frames.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

The Fund will provide Dependent coverage to a child if it is required to do so under the terms of a QMCSO. The Fund will provide coverage to a child under a QMCSO even if the child does not meet restrictions which otherwise may exist for Dependent coverage. If the Fund receives a QMCSO and the participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the Fund Office, free of charge.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP, you can contact the Florida State Medicaid or CHIP office to find out if premium assistance is available by calling (877) 357-3268 or at http://www.fdhc.state.fl.us/Medicaid/index.shtml.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your Dependents to enroll in the plan – as long as you and your Dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

CLAIMS APPEAL PROCEDURE

Any covered person or beneficiary who applies for benefits under the Plan and is ruled ineligible or not qualified for such benefits in whole or in part, or believes he did not receive the full amount of benefits to which he is entitled, or is otherwise adversely affected by any action of the Trustees acting through the Fund Office, shall have the right to request the Board of Trustees to review the matter. The covered person or his duly authorized representative must make such a request in writing, within one hundred eighty (180) days after being apprised in writing of such adverse action. Furthermore, upon written request to the Fund Office during the one hundred eighty (180) day period, the covered person (or duly authorized representative) will be extended an opportunity to review pertinent documents relating to the denial and may submit any additional relevant information and/or comments in writing to the Fund Office.

The written request for review must be addressed to the Board of Trustees in care of the Fund Office and must state (1) the Employee's name and address, (2) the fact that the covered person is appealing from a decision of the Fund Office of (the date of the decision appealed from), and (3) the basis of the appeal, i.e., the reason or reasons why the claim should not be denied.

The Board of Trustees will issue a written decision affirming, modifying, or setting aside the decision appealed from within sixty (60) days of the receipt by the Fund Office of the request for review.

The decision by the Board of Trustees on review will be in writing and will include specific reasons for the decision, as well as specific references to the pertinent plan provisions on which the decision is based. Such a decision by the Board of Trustees will be final and binding. The term "Board of Trustees" means the Board of Trustees of the Plan or a duly authorized committee acting on behalf of the Board of Trustees.

Regulations from the Department of Labor's Employee Benefits Security Administration establish several categories of medical claims, including urgent care claims, pre-service claims, and post-service claims. **If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law.** All claims and appeals relating to your benefits with UHC are subject to the claims and appeals procedures of UHC. Procedures for expedited review of urgent care claims are set forth in the UHC Certificate of Coverage. The Certificate of Insurance/Certificate of Coverage or "Certificate" can be obtained through (1) UHC's website at www.uhc.com, (2) by calling the Customer Service Department for UHC and requesting a hard copy of the Certificate be mailed to you via U.S. Regular mail (see phone numbers listed below), or (3) by contacting the Fund Office at (877) 291-2387.

Customer Service numbers for UnitedHealthCare are:
NHP HMO: (844) 651-3833
UHC Choice HMO: (866) 633-2446
UHC Choice Plus POS: (866) 633-2446

No lawsuit may be brought to contest a denial, suspension or termination of benefits until the above claims appeal procedures are complied with. In no case shall any action be brought unless instituted within one year from the time the claimant received the Notice of denial, suspension or termination.

NOTICE OF PRIVACY PRACTICES

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

THE PLAN'S COMMITMENT TO PRIVACY

The International Union of Operating Engineers Local 487 Health and Welfare Fund (the "Plan") is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to participants and Dependents who are eligible for benefits under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal

and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers or other Employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, Social Security number, employment information, and medical and health claims information.

SUMMARY OF THE PLAN'S PRIVACY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health

information;

- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- File a complaint with the Fund Office or the Secretary of the Department of Health and Human Services if you believe that your that privacy rights have been violated;
- Receive a paper copy of this Notice; and
- Be notified if your health information is improperly accessed or disclosed.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan's privacy practices, please contact:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(877) 291-2387

DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES

THE PLAN'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** While the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.

2. **For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with its third party administrator Associated Administrators, LLC ("Associated") so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered under the Plan. Associated also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, Associated may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. **For Health Care Operations**. The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan, may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its "business associates," which are third parties that assist the Plan in its operations. The Plan discloses information, without your

authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with Associated so that it may process your claims. The Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Plan may disclose your health information to a translator; and Associated may provide names and address information to mailing services.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected. Similarly, Associated contracts with the subcontractors it uses to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information to the Plan Sponsor, which is the Plan's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan, without your authorization. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Plan that it will protect your health information and that it has amended the Plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan, may make without your authorization.

1. **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:

- For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
- To report information related to victims of abuse, neglect, or domestic violence.
- To assist law enforcement officials in their law enforcement duties.

2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

4. **Active Members of the Military and Veterans**. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

6. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

7. **Others Involved In Your Care**. Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, Associated may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. **Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

9. **Treatment and Health-Related Benefits Information**. The Plan and its business associates, including Associated, may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.

10. **Research**. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

11. **Organ, Eye and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

12. **Deceased Individuals**. The health information of a

deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan and its business associates, including Associated, do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

When the Plan Must Provide You a Breach Notification

If your protected health information is used, accessed, or disclosed in a manner not described in this Notice of Privacy Practices, we will investigate the "breach" and take available steps to mitigate the harm. In addition, if we determine that the breach poses a significant risk of financial, reputational, or other harm, we will send you a "breach notification" to you and any other affected individual within 60 days of the breach. The breach notification notice will: (1) briefly describe the breach; (2) describe the types of protected health information that were disclosed; (3) describe the steps to take to protect yourself from potential harm caused by the breach; (4) described what we are doing to investigate and mitigate the breach and to protect future breaches; and (5) instruct you to contact us.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(877) 291-2387

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Plan will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a two year period, state that in your written request, and that request will be accommodated. If you request a copy of your underlying health record or a portion of your health record, the Plan will charge you a fee of $.25 per page for the cost of copying and mailing the response to your request.

In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will

inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Plan, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan, including disclosures by Associated, to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request, except, in accordance with applicable law, the accounting will not include disclosures made before April 14, 2003. If you want an accounting

that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but Associated will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that Associated discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with

access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan and to the Department of Health and Human Services if you believe your privacy rights (including your breach notification rights) have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice at Associated Administrators' website, www.associated-admin.com.

CHANGES IN THE PLAN'S PRIVACY POLICIES

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be posted for review near the front lobby of Associated Administrators' office in Sparks, Maryland. Any revised notice will also be available at Associated's website, www.associated-admin.com.

YOUR RIGHTS UNDER ERISA

As a participant of the International Union of Operating Engineers Local 487 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Board of Trustees complies fully with this law and encourages you to first seek assistance from the Fund Office when you have questions or problems that involve the plan.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
This Plan is maintained pursuant to Collective Bargaining Agreements. A copy of these documents may be obtained by participants and beneficiaries upon written request to the Fund Office. The documents are also available for examination by participants and Dependents.

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

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

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

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of your and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security

Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND/OR TERMINATION

The Board of Trustees has the right to amend and/or terminate the Plan. Circumstances under which the Plan may be terminated include, but are not limited to:

(a) When there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan' s benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligation to maintain the maximum possible benefits within the limits of the Plan's resources;

(b) When there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement;

(c) When the last surviving participant or beneficiary entitled to receive benefits has died;

(d) With respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement or when that Employer is declared by the Board of Trustees to be in default; or

(e) With respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

If the Plan were to terminate, the Board of Trustees will, within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the Plan was established.