OPERATING ENGINEERS LOCAL 139
HEALTH BENEFIT FUND

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SUMMARY OF MATERIAL MODIFICATIONS

Date: April 2018

To: Active and Retired Plan Participants and Their Eligible Dependents Enrolled in the Operating Engineers Local 139 Health Benefit Fund

From: The Board of Trustees

As the Board of Trustees of the Operating Engineers Local 139 Health Benefit Fund, it is our responsibility to ensure that you understand the Plan's eligibility requirements and how to enroll your eligible dependents in the Plan. This Summary of Material Modifications (SMM) provides details about the Plan's eligibility requirements, as of January 1, 2018. Please read it in its entirety.

WHEN YOU BECOME ELIGIBLE FOR PLAN BENEFITS

You become eligible for benefits if the Fund receives (or has received) employer contributions for your hours worked. You must satisfy certain eligibility requirements relating to contributions made on your behalf for hours of work, and you must work (or must have worked) for an employer that has entered into a collective bargaining agreement or a participation agreement with the Fund.

When you first become eligible for benefits from the Plan, you must fill out an Enrollment Form (which you can request from the Fund Office) and provide documentation for yourself and your eligible dependents. No benefits will be processed by the Fund Office without this information. This form also includes your beneficiary designation for the Death Benefit provided by the Fund.

Once your Plan coverage begins, it is also your responsibility to notify the Fund Office of any life-changing events that you experience that may affect your benefits coverage, including any changes in your:

- marital status (if you marry, separate or divorce);
- spouse's employment and/or insurance coverage (including Medicare eligibility);
- dependents (provide the name, Social Security number, and birth date of your newborn or adopted child, or a child placed with you for adoption; also provide copies of adoption papers, if applicable);
- address; or
- beneficiary designation.

If any of the above changes occur, contact the Fund Office for an Enrollment Form.

OUR PLAN'S DEPENDENT ELIGIBILITY REQUIREMENTS

If you elect coverage for yourself, your dependents are also eligible for coverage. In general, your dependents are your legal spouse and your children. Covered dependents **do not** include your grandchildren, unless you are their legal guardian/conservator/custodian or have legally adopted them.

Your dependents become eligible on the later of the day you become eligible for your own medical coverage or the day you acquire a dependent, by either marriage, birth, adoption or placement for adoption, but only if:

- you have completed, signed and returned a written Enrollment Form to the Fund Office; and
- you provide the Plan's required proof of dependent status.

Your dependent children are covered up to the last day of the birth month in which they reach age 26. However, if you have an unmarried disabled child, coverage for the child may be continued beyond his or her 26th birthday if he/she meets the Plan's definition of "Dependent" shown in Attachment A.

Coverage for a dependent for whom you are legal guardian/custodian/ward will end on the earlier of the date indicated in the legal guardianship/custody/conservatorship order signed by a judge or on the last day of the birth month in which the dependent reaches age 26.

HOW TO ENROLL A DEPENDENT FOR PLAN COVERAGE

Remember that you may not enroll a dependent for coverage unless you, the Participant, are also enrolled for coverage.

To obtain coverage for a dependent, you must complete an Enrollment Form for yourself and the dependent within 30 days (60 days for newborn children) after the date on which you and/or your dependent first becomes eligible for enrollment. If you do not notify the Fund Office and submit a completed Enrollment Form and documentation proving dependent status within the required timeframe, enrollment of your dependent will be late. **No claims incurred prior to late enrollment will be paid.** Coverage based on late enrollment begins on the first day of the Eligibility Quarter when the Enrollment Form and documentation proving dependent status are received by the Fund Office.

You should contact the Fund Office for the necessary forms immediately after a child is born, becomes your legal responsibility or adoption proceedings have begun, to assure coverage when needed.

Your Enrollment Form will not be considered complete until you have submitted proof of dependent status. Specific documentation proving dependent status will be required by the Plan, and may include:

- a birth certificate;
- adoption papers;
- marriage certificate;
- guardianship documents;
- paternity order;
- proof of the dependent's age;
- the dependent's Social Security number;
- proof of initial and ongoing disability;
- a valid medical child support order document signed by a judge or a National Medical Support Notice in the case of a legal guardianship/custody/conservatorship order signed by a judge; and
- other documents deemed necessary by the Plan.

Receipt of a valid Qualified Medical Child Support Order ("QMCSO") by the Fund Office will automatically result in the enrollment of the applicable person.

WHEN YOUR SPOUSE IS ELIGIBLE FOR OTHER COVERAGE

If your spouse is employed and eligible for medical and/or prescription drug coverage through his/her employer, your spouse must enroll for that coverage even if there is a charge to do so. If your spouse does not enroll for that coverage, he/she will not be covered under our Plan. Therefore, it is essential that your spouse enroll for such other coverage as soon as possible. Once your spouse is covered under the other plan, he/she will also be covered under our Plan. Your spouse's other plan will be his/her primary plan, which means that plan will pay benefits first. Costs not covered under the other plan may then be submitted to our Plan. That means your spouse may receive more benefits than if he/she were covered under only one plan.

If your spouse's coverage is a high deductible plan with a Health Savings Account (HSA) component, the IRS does not allow our Plan to coordinate benefits and provide secondary coverage. However, your spouse will still be required to take his/her employer's coverage and will not be covered for medical or prescription drug benefits by our Plan. Dental and routine vision benefits will be available for your spouse. This limitation of benefits for a primary insurance plan that is a high deductible plan with a Health Savings Account (HSA) component also applies to dependent children who have other primary insurance coverage.

When you complete the required Enrollment Form, you must indicate whether your spouse (if applicable) is employed and has health coverage available through his or her employer. The Enrollment Form and any supporting documents must be submitted to the Fund Office within 30 days. Otherwise, the request for enrollment is considered late.

- If your spouse is employed, but does not have health plan coverage available from his or her employer, you must include a letter from your spouse's employer stating that no other coverage is available.
- If your spouse is not employed, complete and return an Enrollment Form, signed by both of you, stating that your spouse is not employed.

If the Fund Office learns that your spouse is eligible for other coverage but has refused it, your spouse's coverage under the Plan will be terminated immediately. Written notice will be sent to you if and when the coverage under our Plan ends. The Fund reserves the right to recoup from you and/or your spouse all claims paid during the period of time when your spouse was eligible for other coverage.

Important: Your coverage and your other dependent's coverage is not affected by your spouse's other health plan coverage, regardless of whether or not you are covered under your spouse's plan. However, if you or your dependent children are also covered under your spouse's plan, benefits will be coordinated in accordance with the Plan's Coordination of Benefits provisions (refer to your Summary Plan Description(SPD)/Plan Document for details).

YOUR SPECIAL ENROLLMENT RIGHTS

Federal law requires you also be eligible to enroll if:

- you and/or your dependent(s) decline coverage under our Plan because you have other health coverage and then you and/or your dependents later lose the other health coverage;
- you and/or your dependent(s) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you and/or your dependent(s) lose eligibility for that coverage or become eligible for premium assistance through Medicaid or CHIP; and
- you acquire a dependent through marriage, birth, legal guardianship/custody/conservatorship, adoption or placement for adoption.

For enrollment due to loss of other coverage, you or your dependent must:

- otherwise be eligible for Plan coverage; and
- have been covered under another group health plan or other health insurance when coverage under this Plan was declined, and enrollment must have been declined due to such other coverage.

However, you may **not** avail yourself of this opportunity for Special Enrollment for yourself or any dependent(s) unless, when coverage under this Plan was previously offered, you indicated that the reason you, your spouse and/or your dependent children declined coverage was because you or they had coverage under another health insurance policy or plan.

If the other health coverage is COBRA continuation coverage, a special enrollment opportunity is only available after the COBRA continuation coverage has been exhausted. COBRA continuation coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA continuation coverage). Refer to your Summary Plan Description (SPD)/Plan Document for further information about coverage available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (or "COBRA").

For a loss of coverage, coverage will become effective on the date you and/or your dependent(s) lose the other health coverage **but only if** you (or your dependent(s)) submit a completed Enrollment Form and documentation proving dependent status within 30 days of loss of the other coverage. If you fail to submit a completed Enrollment Form and documentation proving dependent status within 30 days of loss of coverage, enrollment will be late.

If you or your dependent becomes eligible for premium assistance through Medicaid, coverage will become effective on the date you and/or your dependent(s) become eligible for premium assistance **but only if** you (or your dependent(s)) submit a completed Enrollment Form and documentation proving dependent status within 60 days you and/or your dependent(s) become eligible for premium assistance. If you fail to submit a completed Enrollment Form, proof of eligibility for premium assistance and documentation proving dependent status within 60 days, enrollment will be late.

Special Enrollment is not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation.

STATEMENT OF THE PLAN'S GRANDFATHERED STATUS

The Operating Engineers Local 139 Health Benefit Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at (262) 549-9190 or (800) 242-7018. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or via http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

FINAL NOTES

Please share this SMM with your family members and store it with your Summary Plan Description (SPD)/Plan Document booklet for easy reference.

If you have any questions regarding this SMM or your Plan of benefits, do not hesitate to contact the Fund Office at (262) 549-9190 or (800) 242-7018.

This Summary of Material Modifications provides only highlights of recent changes to the Operating Engineers Local 139 Health Benefit Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

ATTACHMENT A

A **"dependent"** is an individual, as defined below, who is eligible for certain benefits from the Fund. In general, covered dependents include your:

- legal spouse in accordance with federal law;
- child, who is your natural-born child, adopted child, a child placed with you for adoption or your stepchild, until the end of the month in which the child turns age 26;
- unmarried child for whom you have been appointed legal guardian, provided the child: (i) maintains a principal place of residence in your home and is a member of your household for the entire Calendar Year, (ii) is dependent on you for more than one-half of his or her support, (iii) is one for whom you have received a court decree or order of legal guardianship, and (iv) is not claimed as any other person's dependent child during the Calendar Year;
- unmarried child age 26 or older, who is: (i) dependent on you for more than one-half of his or her support for the Calendar Year, (ii) resides with you for more than one-half of the Calendar Year, and (iii) is permanently and totally Disabled according to the terms of Internal Revenue Code section 22(e)(3), and (iv) the permanent and total Disability existed prior to the date the child attained age 26. Proof of total and permanent Disability must be submitted to the Trustees within 31 days of the date the child's coverage would otherwise end or within 31 days after he or she initially becomes eligible for benefits from the Fund; and
- your dependent child who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Board of Trustees.

If your unmarried child for whom you have been appointed legal guardian or your unmarried disabled child age 26 or older does not live with you, he or she will be considered an eligible dependent child, provided that:

- the child's parents: (i) are divorced or legally separated under a decree of divorce or separate maintenance; (ii) are separated under a written separation agreement; or (iii) live apart at all times during the last six months of the Calendar Year;
- the child's parents provide over one-half of the child's support;
- the child is in the custody of one or both of his or her parents for more than one-half of the Calendar Year; and
- the child is not the qualifying child or qualifying relative of any other person.

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