ADDITIONAL IMPORTANT INFORMATION ABOUT YOUR HEALTH AND WELFARE BENEFITS FOR 2013

March 2013

Dear Participant:

As Trustees of the Employers and Operating Engineers Local No. 520 Health and Welfare Fund (the "Plan"), we value your service and are proud to offer coverage to help meet the health care needs of you and your family. With a key commitment to keeping you informed and recognizing that healthcare costs continue to increase each year, we want to make you aware of certain additional changes to your benefits, which are highlighted in this letter, along with the effective date of those changes.

Increase in Annual Deductibles and Out-of-Pocket Maximums

The individual and family Deductibles and Out-of-Pocket Maximums that apply to a Coverage Period (June 1 through May 31) have been increased. The following describes the changes being made to your Summary Plan Description and Plan Document (SPD).

- Subsection 1.b., "Deductibles for Each Coverage Period", of the *Medical Benefits* section of the *Schedule of Benefits* on page 3 of the SPD is deleted and replaced as follows:

  b. Deductibles for each Coverage Period

  In-Network ..... $500 per individual/$1,000 per family

  Out-of-Network ..... $750 per individual/$1500 per family

  The In-Network deductible amount always applies to Medicare-eligible Retired Employees and the Medicare-eligible Dependent spouses of Eligible Retired Employees.

- Subsection 1.d., "Out-of-Pocket Maximum for Each Coverage Period", of the *Medical Benefits* section of the *Schedule of Benefits* on page 4 of the SPD is deleted and replaced as follows:

  d. Out-of-Pocket Maximum for Each Coverage Period

  In-Network ..... $2,000 per individual/$4,000 per family

  Out-of-Network ..... $4,000 per individual/$8,000 per family

  The In-Network Out-of-Pocket Maximums always apply to Medicare-eligible Retired Employees and the Medicare-eligible Dependent spouses of Eligible Retired Employees.

Change in Physical Exam and Other Preventive Care Benefits

The Plan's coverage of physical examinations and other preventive care services has been substantially improved. The following describes the changes being made to your SPD.

- Section 2, "Wellness Benefits", of the *Medical Benefits* section of the *Schedule of Benefits* on page 4 of the SPD is deleted and replaced as follows:

  a. Preventive Services as described in the Covered Charges section of the SPD:

In-Network	The Plan pays 100% of covered charges
Out-of-Network	The Plan pays 60% of covered charges after Deductible

  b. Physical Exam Benefit –You may choose to receive either the benefit under i or ii below each Coverage Period (June 1 through May 31). See the *Physical Exam Benefit* section of the SPD for additional details.

  i. <u>Regular Physical Examination Obtained from Any Physician—Participant and Dependent Spouse and Children:</u>

  Covered expenses include: physician's examination; laboratory tests (complete health panel, urinalysis, etc.); chest x-ray; EKG; and optional drug test. Obtain a claim form from the Fund Office before your physical examination and return it to Fund Office after your exam and tests have been performed.

In-Network	The Plan pays 100% of covered charges
Out-of-Network	The Plan pays 60% of covered charges (Deductible does not apply)
Maximum Benefit.....	One exam per Coverage Period

  ii. <u>Comprehensive Physical Examination performed by Health Dynamics—Participant and Dependent Spouse:</u>

  A comprehensive full-day physical examination provided exclusively at Health Dynamics facilities. Covered expenses include: medical evaluation, fitness assessment, orthopedic assessment, nutritional analysis, cancer screening, stress inventory, and an individual consultation/wellness coaching session. You may make an appointment directly with Health Dynamics, or you may contact the Fund Office if you need information about the Health Dynamics physical examination. You do not need to obtain a claim form from the Fund Office before your Health Dynamics examination. Health Dynamics will complete the claim form for you.

Maximum Benefit.....	One Exam per Coverage Period

  If you obtain a Health Dynamics comprehensive physical examination, you will receive an incentive credit of $100 to be used toward your deductible or co-payments in the current Plan Year or the immediately following Plan Year.

- The *Covered Charges* section beginning on page 60 of the SPD in the *Comprehensive Major Medical Benefit* section is amended by adding the following new subsection at the end of the *Covered Charges* section:

4. Preventive Services, as follows:

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 ("ACA"). Preventive Services are paid for based on the Plan's payment schedules for the individual services. Coverage is provided on an In-Network basis with no cost-sharing (for example, no deductibles, co-insurance, or co-payments), and on an Out-of-Network basis with cost sharing as reflected in the Schedule of Benefits. The Preventive Services covered by the Plan include the following:

a. Items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), for example, aspirin to prevent heart attacks, folic acid supplementation for women, and screenings for blood pressure and cholesterol abnormalities and obesity;

b. Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, for example, hepatitis, influenza, tetanus, measles, mumps and rubella;

c. Preventive care and screenings for newborns, infants and children as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including the American Academy of Pediatrics Bright Futures guidelines, for example, screenings for autism and depression and counseling and alcohol and drug use assessments; and

d. Preventive care and screenings as provided for women supported by the Health Resources and Services Administration, for example, contraceptives, breastfeeding counseling and supplies, and screenings for certain sexually transmitted infections.

In-Network Preventive Services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent for In-Network services. This means that the service will be covered at 100% of the Plan's Usual, Reasonable and Customary Charge, with no co-insurance, co-payment or deductible when you use In-Network providers.

If Preventive Services are received from an Out-of-Network provider, they will be eligible for coverage under this Preventive Services benefit, but will be subject to the cost-sharing noted in the Schedule of Benefits.

Change in Out-of-Network Emergency Room Co-Payment

The Out-of-Network Emergency Room benefit has been improved by making the Co-payment the same for the In-Network and Out-of-Network Emergency Room benefit, as described below.

- Section 5, "Emergency Room Benefits", of the *Medical Benefits* section of the *Schedule of Benefits* on page 6 of the SPD is deleted and replaced as follows:

5. Emergency Room Benefits

Subject to Medical Necessity and normal Deductibles, the Plan will cover emergency room expenses as follows:

Covered Person's Emergency Room Co-Payment.....$100

In-Network and Out-of-Network Co-Payment
after Deductible and $100 Emergency Room Co-Payment.....90%

There is no Emergency Room Co-Payment for Medicare-eligible Retired Employees and the Medicare-eligible Dependent spouses of Eligible Retired Employees.

The Emergency Room Co-Payment is waived if the covered person is admitted to the hospital from the emergency room.

Change in Dependent Child Eligibility

An adult child under age 26 who otherwise meet the definition of Dependent child under the Plan and who is eligible to enroll in coverage under an employer-sponsored health plan will no longer be excluded from Plan coverage, as described below.

- The last paragraph of the definition of *Dependent* on pages 13-16 of the SPD (that was added to the Plan by item 4 of Amendment 4 in 2011) is deleted.

Changes to the Plan's Claims and Appeal Procedures

The Plan's Claims and Appeal Procedures have been expanded to provide you with more information in connection with the denial of a claim either at the initial decision or on appeal, and to give you the opportunity to request external review of your claim by an independent review organization (IRO) if your claim is denied on appeal, as described below.

- The following new section is added before the *Appeals from Denials of Claims* section that begins on page 93 of the SPD:

Claim Denial or Adverse Benefit Determination

If for any reason, your claim is denied in whole or in part, this means that you have received an adverse benefit determination. For the purpose of the initial and appeal claims processes outlined in this section, a claim denial or adverse benefit determination is defined as:

1. A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit;

2. A reduction in a benefit resulting from the application of any utilization review decision, pre-existing condition exclusion, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate; or

3. A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

The Claims Administrator will send you a written notice of the claim denial or adverse benefit determination. The notice will include:

1. Identification of the claim involved (e.g., date of service, health care provider, claim amount, if applicable);

2. A statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;

3. The specific reason or reasons your claim was denied, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

4. A reference to the specific Plan provisions on which the denial was based;

5. If an internal rule, protocol or guideline was relied on in making the denial, you will receive a copy of the rule or a statement that it is available upon request at no charge;

6. If the determination was based on medical necessity, Experimental/Investigative exclusion or similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms to your claim, or a statement that it is available upon request at no charge;

7. A description of any additional information you need to submit to support your claim;

8. An explanation of why the additional information is needed;

9. An explanation of the Plan's internal claim appeal procedures, external review processes, and applicable time limits, and information on how to initiate an appeal;

10 A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal; and

11. Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

- The last two paragraphs of the *Appeals from Denials of Claims* section beginning at the top of page 95 of the SPD are deleted and replaced with the following:

The decision on any review of your claim will be provided to you in writing. The notice of a denial of a claim on review will state:

1. Information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

2. The specific reason(s) for the determination, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

3. Reference to the specific Plan provision(s) on which the determination is based;

4. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

5. The statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a second level of appeal or external review;

6. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

7. An explanation of the Plan's internal claims process and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

8. If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

9. If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

10. The statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

11. Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

External Review of Claims

This external review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and your or your covered dependent(s)' authorized representatives, and references to "Plan" include the Plan and its designee(s).

You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within one or both of the following parameters:

1. The denial involves medical judgments, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is Experimental or Investigative. The IRO will determine whether a denial involves a medical judgment; or

2. The denial is due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this external review process does not pertain to claims for Life Insurance benefits, Death Benefits, or Accidental Death and Dismemberment Benefits.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described previously. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

External Review of Standard (Non-Urgent) Claims

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an Appeal Decision or Adverse Benefit Appeal Determination. If there is no corresponding date four (4) months after the date of receipt of the notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the filing deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

For convenience, an Appeal Decision and Averse Benefit Appeal Determination will be referred to below as an "Adverse Determination," unless it is necessary to address either of them separately.

An external review request on a standard claim should be made to the following applicable Plan designee:

Employers and Operating Engineers Local 520 Health and Welfare Fund
Eight Executive Woods Court
Swansea, Illinois 62226
Phone: (618) 233-7978
Fax: (618) 233-7716

Preliminary Review of Standard Claims

Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

1. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

2. The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan;

3. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

4. You have provided all of the information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

1. If your request is complete and eligible for external review; or

2. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review of Standard Claims by an Independent Review Organization (IRO)

If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

2. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

3. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

5. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

1. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will provide coverage or payment for the reviewed claim as soon as possible. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision. The Plan will provide benefits (including making payment on the claim) without delay

pursuant to a final external review decision in your favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

2. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

The assigned IRO's decision notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

2. The date that the IRO received the request to conduct the external review and the date of the IRO decision;

3. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

5. A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

6. A statement that judicial review may be available to you; and

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

External Review of Expedited Urgent Claims

You may request an expedited external review if:

1. You receive an adverse Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2. You receive an adverse Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Your request for an expedited external review of a non-standard claim should be made to the following:

Employers and Operating Engineers Local 520 Health and Welfare Fund
Eight Executive Woods Court

Swansea, Illinois 62226
Phone: (618) 233-7978
Fax: (618) 233-7716

Preliminary Review for an Expedited Urgent Claim

As soon as possible upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard Claims above). The Plan will notify you as soon as possible (e.g., meaning via telephone, fax, etc.) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

Review of Expedited Urgent Claim by an Independent Review Organization (IRO)

Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g., meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of its final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

1. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will provide coverage or payment for the reviewed claim as soon as possible. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision. The Plan will provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in your favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

2. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

IRO Maintenance of External Review Records

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six (6) years. An IRO will make such records available for examination by you, the Plan, or state or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

NOTICE OF MATERIAL MODIFICATIONS TO THE SUMMARY OF BENEFITS AND COVERAGE

The changes outlined above also modify the information contained in the Summary of Benefits and Coverage that was previously sent to you. Attached is a revised Summary of Benefits and Coverage for the Coverage Period of June 1, 2013 through December 31, 2013.

STATEMENT OF GRANDFATHERED STATUS

Federal regulations require us to advise you that this group health plan 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 the law was passed. 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 Administrative Manager at:

Employers and Operating Engineers Local 520 Health and Welfare Fund
Eight Executive Woods Court
Swansea, Illinois 62226
618-233-7978

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A FINAL NOTE

Please take some time to review this announcement. If you are married, share this information with your spouse. Contact the Fund Office at 618-233-7978 if you have any questions about the benefits described in this notice.

Sincerely,

The Board of Trustees

This announcement, which serves as a Summary of Material Modification to the Summary Plan Description and Plan Document and Notice of Material Modification to the Plan's Summary of Benefits and Coverage, contains only highlights of recent changes to the Employers and Operating Engineers Local No. 520 Health and Welfare 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.