June 2010

To All Participants in the following Local No. 731 Health and Welfare Funds:

Health and Welfare Fund of the Excavating, Grading and Asphalt Craft, Local No. 731
Local No. 731, I.B. of T., Private Scavengers Health and Welfare Fund
Local No. 731, I.B. of T., Garage Attendants, Linen and Laundry Health and Welfare Fund

The Trustees have revised the Fund's Summary Plan Description effective May 1, 2010 to account for the following changes:

- DiaTri, has replaced MedLink as the Plan's preferred provider network for imaging services.
- Devices and appliances to treat sleep apnea will have a lifetime limit of $3,500 per covered family member.
- Employees may retire after a period of COBRA coverage or self-payment and still be eligible for pre-age 65 retiree insurance.
- Retired Employees who return to Covered Employment will be eligible for retiree insurance until their active coverage resumes (up to a maximum of six months).
- Retired Employees may return to Covered Employment twice per lifetime and retain their right to pre-age 65 retiree coverage.
- When the Fund is recouping overpayments from Employees and their covered family members, the Fund will pay only 5% of the eligible expenses for in-network claims until the amount owed is recouped. This payment will result in the reduction of such expenses in accordance with Blue Cross Blue Shield's contracts with network providers.

The Trustees have also included a reminder to you that you are required to notify the Fund in the event of divorce. If you do not notify the Fund of your divorce and the Fund pays claims on behalf of a former spouse, you will be responsible for repaying the Fund the cost of those claims.

## Lifetime Limit for Sleep Apnea Patients

The following provision is being added to No. 13 of the Summary Plan Description, under the Funds' Covered Medical Expenses section.

**(i) For Participants with a diagnosis of sleep apnea, the Fund will cover the costs of a device or appliance to treat the condition (such as a CPAP machine or an oral appliance). There shall be a maximum lifetime limit on this benefit of $3,500 per Participant. However, the Fund will cover 10% of the costs of a replacement device provided that the replacement is Medically Necessary as set forth in item d above.**

You should keep in mind that the Plan allows replacement of an appliance, such as a CPAP machine, only if it is worn out or no longer serviceable. If you currently have a CPAP machine that is in good working order, the Fund will not pay any amount toward a replacement or an oral appliance.

## Retiree Coverage

The rules with respect to coverage for a pre-age 65 retiree have been changed (1) to allow participants to be eligible for retiree coverage if they have a period of self-payment or COBRA coverage prior to retirement and (2) to provide retiree coverage to those retirees who return to work up until the date that their active coverage resumes (up to a maximum of six months). The Trustees have amended the Summary Plan Description with respect to retiree insurance under the Funds eligibility section, as follows:

**ELIGIBILITY FOR EMPLOYEES RETIRING BEFORE AGE 65 AND THEIR SPOUSES PRIOR TO REACHING AGE 65**

An Eligible Employee, who is retired from work under covered employment and whose eligibility for benefits is terminated in accordance with the eligibility rules, may apply to continue eligibility for medical benefits by making self-payments in a manner prescribed by the Trustees provided that:

1. He/she has retired from active employment **or retired after a period of COBRA coverage or self-payment coverage**, and

2. He/she is receiving either Normal, Early or Disability Retirement Benefits under the applicable Local 731 Pension Fund, and

3. At the time of retirement, he/she was eligible to receive the benefits of the Plan **either as an active Employee, a COBRA Participant, or a Participant covered through self-payments** and

4. Has been eligible for coverage during the 60 consecutive months immediately preceding the date of retirement (5 consecutive years). **All periods of active, self-payment and COBRA coverage are counted for the purpose of satisfying the 60-month requirement.**

If a qualified Pre-Age 65 Retiree does not apply and make the necessary payment for this coverage in the first month for which he/she is eligible, he/she will forfeit the opportunity for continued coverage.

If a Pre-Age 65 Retiree returns to work in covered employment, he/she will be eligible for Employee Benefits upon satisfying the Initial Eligibility requirements of the Plan. In no event can an Employee be eligible for both Employee Benefits and Pre-Age 65 Retiree Benefits. **Pre-Age 65 Retirees may return to Covered Employment twice per lifetime and still retain the right to Pre-Age 65 Retiree Benefits. If a Pre-Age 65 Retiree returns to Covered Employment after a third retirement, he/she will not be eligible for Pre-Age 65 Benefits.**

If you choose this self-payment coverage, you and your Dependent spouse waive your rights to COBRA Coverage. After your retiree self-pay period starts, you will not be allowed to change to COBRA Coverage or receive any extended coverage as a result of a second COBRA qualifying event. However, in the event of your death or divorce while you are making these self-payments, your Dependent spouse will be eligible to make self-payments for an additional 36 months of coverage. The amount of those self-payments is determined by the Trustees. This extended coverage will end earlier if the Dependent reaches age 65 or becomes eligible for Medicare, Medicaid or another group health plan.

**TERMINATION OF ELIGIBILITY - PRE-AGE 65 RETIREES /DISABLED RETIREES AND THEIR SPOUSE**

A Retired Employee's and his spouse's eligibility will terminate upon the occurrence of the first of the following:

1. **The date on which coverage for Employee Benefits resumes after the Retired Employee or spouse satisfies the Initial Eligibility requirements of the Plan after returning to Covered Employment. (However, the maximum period that the Pre-Age 65 Retiree Benefits will continue after satisfying the Initial Eligibility requirements is six months.)**

2. **The date on which the Retired Employee begins working in a job that is considered Disqualifying Employment (but not Covered Employment).**

3. The Disabled Retiree having recovered and no longer entitled to Total and Permanent Disability Benefits.

4. The failure to make the required self-payments.

5. The Retired Employee or spouse enters full-time active duty with the Armed Forces of the United States.

6. The Retired Employee or spouse becomes eligible for any other group health plan coverage.

A Retired Employee's eligibility only will terminate (and the eligible spouse's eligibility may continue subject to the requirements of this section) upon the occurrence of the first of the following:

1. The Retired Employee attains age 65.

2. The Retired Employee becomes eligible for benefits under the provisions of the Health Insurance for the Aged under the Social Security Laws of the United States, including both the Base Plan (Hospital Insurance) and the Voluntary Plan (Medical Insurance), whether or not the Retired Employee shall have applied for the same.

3. The failure to make the required self-payments for the Retired Employee's coverage.

A Retired Employee's spouse's eligibility only (and the eligible Retired Employee's eligibility may continue subject to the requirements of this section) will terminate upon the occurrence of the first of the following:

1. The spouse attains age 65.

2. The spouse becomes eligible for benefits under the provisions of the Health Insurance for the Aged under the Social Security Laws of the United States, including both the Base Plan (Hospital Insurance) and the Voluntary Plan (Medical Insurance), whether or not the spouse shall have applied for the same.

3. The date the Retired Employee and spouse divorce.

4. The failure to make the required self-payments for the Retired Employee's spouse's coverage.

## Offsetting Plan Benefits

If the Fund pays claims for which it is not required to pay (such as payments on behalf of a former spouse), the Fund may offset future claims of you and your covered family members. The Fund used to pay nothing for those claims that were subject to offset. However, PPO providers were requiring the Employees to repay the entire billed amount of the claim instead of offering their PPO discount. In order to maintain the network discounts for claims that are subject to offset, the Fund will now pay 5% of the eligible expense of those claims subject to offset until the amount owed is recouped. You will be responsible for the remaining 95% of the eligible expenses.

To account for this change, Subsection 4 of the Filing a Claim section of the Plan is revised to state as follows:

> 4. The Fund will pay claims only when covered under the terms of the Plan. If the Fund pays a claim that it is not required to pay, it may recover and collect payments from the Claimant or any other entity or organization that was required to make the payment. Recovery of such payments from a Claimant may be made through, but is not limited to, offset or reduction of future benefits payable to the Claimant or the Claimant's covered family members. **When offsetting benefits for claims from PPO providers, the Fund will pay only 5% of the eligible expenses rather than 80% until the amount owed to the Fund is recouped. The Fund's payment of claims from non-PPO providers will not count the Claimant's reimbursement responsibility.**

Here is an example of how the recoupment process will work:

> Example: John divorces his spouse in 2004 and fails to notify the Fund. The Fund pays $20,000 in claims on behalf of John's former spouse. Because John is unable to repay the Fund $20,000, the Fund notifies John that the Fund will offset all of the future claims of John and his dependent children until the $20,000 is repaid. After notifying John of his repayment obligation, John's son Allen goes to the emergency room at Central Hospital and the amount of the bill is $10,000. Since Central Hospital is part of the PPO network, the Fund will confirm that his son is eligible, but will pay only 5% of claims until the $20,000 is recouped. The bill for Central Hospital is discounted and the Covered Medical Expense is $2,000. The Fund pays 5% of the Covered Medical Expense, which is $100. John is responsible for the remaining 95% of the Covered Medical Expense, which is $1,900. Under normal circumstances, the Fund would have paid 80% of the Covered Medical Expense, which would have been $1,600. The Fund thus paid $1,500 less than it normally would have ($1,600 - $100). Therefore, John's repayment obligation is reduced by $1,500 and he now owes the Fund $18,500 ($20,000 - $1,500). The Fund will process the claims of John and his dependent children in this manner until the remaining $18,500 is recouped and will continue to advise providers of his limited eligibility.

For out-of-network claims, the Fund will not pay any amount until the amount owed is recouped and the denied out-of-network claims will not count toward the repayment obligation. However, in the event of an emergency, the Fund will pay any out-of-network claims as is they were network claims (5% of the eligible expense) and will reduce the participant's repayment obligation accordingly.

## Notification Responsibilities Upon Divorce

This is a reminder that if you do not notify the Fund Office of your divorce, YOU will be responsible for any claims that the Fund pays on behalf of your former spouse. As clearly set forth in the Plan, your dependent spouse's coverage ends on the date of divorce. You are required to notify the Fund in the event of a divorce. If you fail to notify the Fund of your divorce and the Fund pays claims on behalf of your former spouse, you will be responsible for reimbursing the Fund for the cost of those claims. If you fail to reimburse the Fund in such a case, the Fund will offset the claims of you and any of your other dependents until the total amount paid is recouped by the Fund.

## New MRI/CT Imaging Network

DiaTri has replaced MedLink as the Plan's preferred provider network for diagnostic imaging services such as MRIs and CAT (CT) scans.

**To use the DiaTri network call 1-800-331-5720.** Let DiaTri know that you are a participant of the Local 731 Funds, and they will assist you in setting up an appointment for your MRI/CAT Scan.

**Your MRI/CAT scan benefit has not changed.** If you use the DiaTri network for services covered by the Funds, your services will be paid at 100% with no deductible.

This change is effective June 1, 2010.

Please keep this notice with your Summary Plan Description booklet.

Summary of Material Modifications
EIN 36-6073849/PN 501
EIN 36-6073848/PN 501
EIN 36-2392752/PN 501

2010-1