SUMMARY PLAN DESCRIPTION AND WEEKLY DISABILITY BENEFITS BOOKLET (AS OF NOVEMBER 1, 2017)

Trade Mark Reg.

OPERATING ENGINEERS LOCAL 501 SECURITY FUND NEVADA ONLY

PLEASE KEEP THIS BOOKLET WHEN YOU BECOME COVERED. IT IS YOUR SUMMARY PLAN DESCRIPTION OF DISABILITY INSURANCE

ADMINISTRATIVE OFFICE
BeneSys Administrators
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

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INTRODUCTION

The Board of Trustees is pleased to provide you with this booklet describing the short term Disability benefits through the Operating Engineers Local 501 Security Fund. You are a participant in the Weekly Disability Benefit Plan if your Employer is required by a collective bargaining or participation agreement to contribute the required contributions to fund the short term disability benefits provided by the Plan. We have prepared this booklet to serve as a guide and reference concerning your short term Disability benefits.

The Weekly Disability Benefit Plan is a self-funded plan offered by the Fund and administered by BeneSys Administrators. This is a non-contributory plan, meaning the contributions are made solely by the Contributing Employers.

Please review this booklet and the Schedule of Benefits that applies to your Employer carefully so that you will be fully aware of the benefits to which you are entitled and how to file a claim.

The only parties authorized to answer any questions concerning the Fund and the Plan are the Board of Trustees and the Administrative Office. The Trustees reserve the right to interpret and apply the provisions of the benefit plan(s) created and administered by them, and to, in turn, amend the benefit plan(s), in whole or in part, in their discretion. The Trustees may also in their discretion terminate the benefit plan(s), in whole or in part, at any time if such action(s) is deemed necessary by the Trustees. No participating Employer, Employer association, or labor organization, nor any individual employed thereby, has such authority. Should you have any questions concerning the Weekly Disability Benefit Plan, please contact:

ADMINISTRATIVE OFFICE
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P.O. Box 990
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ELIGIBILITY RULES

You are eligible if you are:

1. An Employee of a Contributing Employer that provides for contributions to fund the short term Disability benefits provided by the Plan on their behalf and whose employment is covered by a collective bargaining agreement in effect between the Contributing Employer and the Union.
2. An Employee of the Union.
3. An Employee of an Apprenticeship Fund affiliated with Local 501 and approved by the Fund for participation in the Fund.
4. An Employee whose employment is covered by any collective bargaining agreement and/or participation agreement approved by the Fund which requires contributions be made on their behalf to the Fund.

If you perform services for more than one Contributing Employer, you shall not be entitled to benefits greater than those which would apply if your services were performed but for one such Contributing Employer.

Coverage Effective Date

Your coverage will become effective on the first day of the second calendar month following any calendar month in which you work at least 72 hours for a Contributing Employer, provided the required contributions for this Plan are made to the Fund on your behalf.

To continue to be covered under this Fund, you must work at least 72 hours per month and have the required contributions made to the Fund on your behalf.

To Be Eligible for this Benefit

The Disability for which benefits are claimed must have been incurred while you were employed by a Contributing Employer.

Benefit Termination

Your coverage will automatically terminate on the earliest of the following dates:

A. The date the Plan terminates.

B. The end of the month for which the last contribution was made on your behalf entitling you to coverage.

C. The date your employment for a Contributing Employer terminates.

Eligibility for Dependents

Dependents are not eligible for short term Disability benefits.

HEALTH CONTINUATION COVERAGE UNDER COBRA OR USERRA

COBRA and USERRA do not apply to weekly Disability benefit.

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA

The Plan will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and the regulations promulgated thereunder.

PHI is defined as individually identifiable health information that is maintained or transmitted in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, health plan (including this Plan), employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of you or your eligible dependents; the provision of health care to you or your eligible dependents; or the past, present, or future payment for the provision of health care to you or your eligible dependents. When held by this Plan, it also means information that identifies you or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Another example is the amount of contributions paid by your Contributing Employer for your coverage.

PHI excludes individually identifiable health information in certain education records, in records of post-secondary education students made by a doctor or other professional in connection with treatment to the student, in employment records held by a Covered Entity in its role as an employer, and regarding a person who has been deceased for more than 50 years.

THE FOLLOWING USES AND DISCLOSURES OF PHI,
AND CORRESPONDING RIGHTS AND DUTIES, APPLY TO YOU
AND YOUR ELIGIBLE DEPENDENTS

Permitted Uses and Disclosures of PHI

Except with respect to the prohibited uses and disclosures described below, this Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment, and health care operations, subject to the minimum necessary standard discussed below. Treatment includes but is not limited to the provision, coordination, or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services, consulting services, and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

Required Uses and Disclosures of PHI

This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, and in response to your request for an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of the U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to investigate or determine this Plan's compliance with the Privacy Rule.

Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Use or Disclosure

This Plan will disclose PHI to family members, other relatives, or close personal friends if the information is directly relevant to the family's or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected, or if you are deceased and the disclosure is not inconsistent with any prior expressed preferences known to the Plan.

Allowed Uses and Disclosures of PHI for which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, workers' compensation programs, correctional facilities, and when necessary to prevent or lessen a serious and imminent threat to health and safety. These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Administrative Office.

Prohibited Uses and Disclosures of PHI

The Plan will not use or disclose PHI that is genetic information for underwriting purposes, including determining eligibility or benefits under the Plan, for computing any contribution amounts under the Plan, or for other activities related to the enrollment and/or continued eligibility under the Plan. In addition, the Plan will not sell PHI or receive remuneration in exchange for the use or disclosure of PHI, unless authorization is obtained, as described below.

Uses and Disclosures of PHI that Require Your Written Authorization

The Fund must obtain your written authorization for any use or disclosure of your PHI not specifically required or permitted by law or described in this Notice. The Fund does not anticipate using or disclosing your PHI in a manner that would require your authorization. However, should an authorization be required, the Fund will provide you with an authorization

form. You have the right to revoke your authorization at any time. All revocations will be honored by the Fund. If you do provide written authorization, it will allow PHI to be used and disclosed by both the Fund and its Business Associates.

Your written authorization will be obtained before the Fund will use or disclose psychotherapy notes about you from your psychotherapist, if applicable. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund may use and disclose such notes without your written authorization when needed by the Fund to defend against litigation filed by you. Written authorization will also be obtained if PHI is used or disclosed for marketing purposes or is sold.

Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

1. You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment, or health care operations, or to restrict uses and disclosures to family members, relatives, friends, or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request with one exception. The Plan is required to comply with a restriction request if you request restricted disclosure of PHI to the Plan for payment or health care operations purposes (not for treatment purposes) and the PHI at issue relates solely to a health care item or service for which you (or person other than the Plan, on your behalf) have paid the health care provider in full. In any other circumstances, if this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

2. You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such requests if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a form requesting to receive communications of PHI by alternative means or at alternative locations.

3. You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan; or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a form requesting

access to PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days, whether the requested information is maintained onsite or offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If access is granted, the Plan will provide access to the PHI in the form requested by you, if readily producible in such form or format; or, if not, in a readable hard copy form or other form agreed to by the Plan and you. As described further below, if the PHI is maintained electronically, and if you request an electronic copy, the Plan will provide access in the electronic form and format requested by you if it is readily producible; or, if not, in a readable electronic form and format agreed to by the Fund and you. This Plan may charge a reasonable fee for the costs of the paper copy or electronic media, as applicable. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or HHS or its OCR.

4. You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a form to request an amendment to the PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. The Plan may deny your request to amend for any of the following reasons: (i) the request for amendment is not in writing; (ii) the request for amendment does not provide any reason(s) for the requested amendment; (iii) the PHI or record that is the subject of the request was not created by the Fund unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment; (iv) the PHI or record that is the subject of the request is not part of a Designated Record Set; (v) the PHI or record that is the subject of the request is accurate or complete; or (vi) the PHI or record would not be available to you for inspection or copying as discussed above under the Access to PHI section. If the request is denied in whole or part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

5. You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for a six-year period starting from the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment, or health care operations or disclosures made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures: (i) incident to a use or disclosure otherwise permitted or required by law; (ii) made pursuant to your authorization; (iii) to individuals involved in your care or for notification purposes permitted by law; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement officials; and (vi) of a limited data set. You will be required to complete a form requesting an accounting of PHI disclosures by this Plan. The Plan will provide an accounting of disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons

for the delay and the date by which the accounting will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

6. You have the right to request access to any Electronic Health Records ("EHRs") used or maintained by the Plan and the Plan will provide access to your EHRs in the electronic form and format requested by you if it is readily producible; or, if not, in a readable electronic form and format agreed to by the Plan and you. EHRs are electronic records of health-related information on an individual that are created, gathered, managed, and consulted by authorized health care clinicians and staff. In addition, you have the right to request that the Plan provide your EHRs to another entity or individual in electronic format so long as your request is clear, conspicuous, and specific. The Plan is entitled to charge you a reasonable fee for any labor costs or supplies (e.g., portable electronic media) incurred in providing the electronic information. You will be required to complete a form requesting access to any EHRs or to have your EHRs provided to another entity or individual.

Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with a limited health care power of attorney regarding a specific treatment, such as use of artificial life support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

This Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Administrative Office has designated this group of employees to include Claims Adjustors, Claims File Clerks, Mail Clerks, Eligibility Certifiers, Supervisors, and Managers. The

employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures; or will post the Notice on its website by the effective date of the material change, with a copy of the revised Notice in its next annual mailing.

This Plan will limit, to the extent practicable, the PHI subject to use and disclosure to de-identified information, which excludes certain information that could be used to identify you. However, to the extent the Plan deems it necessary, it may use, disclose, or request more than de-identified information so long as it does not disclose, use, or request more than the minimum amount of your PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes; disclosures made to you; uses or disclosures pursuant to your authorization; disclosures made to HHS or its OCR for enforcement purposes; uses or disclosures that are required by law; or uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

Notification of Breach of Unsecured PHI

The Plan is required to notify you following a Breach of Unsecured PHI. No later than 60 days from the discovery of any Breach of Unsecured PHI, the Plan will provide you with notice of such Breach. Unsecured PHI includes PHI in electronic form that is not encrypted and PHI in paper form that has not been destroyed. A Breach of Unsecured PHI is an impermissible acquisition, access, use, or disclosure that compromises the security or privacy of such information unless the Plan (or Business Associate of the Fund, as applicable) can demonstrate that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated. However, an impermissible acquisition, access, use, or disclosure of PHI will not be considered a Breach if it is within one of the following three exceptions: (i) an unintentional acquisition, access, use, or disclosure of PHI by a workforce member or person acting under the authority of the Plan or one of its Business Associates if made in good faith and within the scope of authority so long as the information is not further acquired, accessed, used, or disclosed by any person; (ii) an inadvertent disclosure by

an individual who is authorized to access PHI at the Plan or a Business Associate to another person who is also authorized to access PHI at the Plan or the Business Associate if the information is not further used or disclosed without authorization; or (iii) a disclosure of PHI for which the Plan or its Business Associate has a good faith belief that the unauthorized individual to whom the disclosure was made would not reasonably be able to retain it.

In the event of a Breach of Unsecured PHI, the Plan's written notification to you will include the following information: the date of the breach; the date of discovery of the breach; the type of PHI involved; the steps you should take to protect yourself from potential harm from the Breach; an explanation of what steps the Plan is taking to investigate the Breach, mitigate harm to you and to protect against further breaches; and contact procedures for you to obtain additional information. If the Plan lacks current contact information for you, it will provide substitute notice, which will be by email, telephone, or may be by other means including posting notice on the Plan's website or conspicuous notice in major print or broadcast media in the geographic area where you are likely to reside. In circumstances in which the Breach of Unsecured PHI is reasonably believed by the Plan to have affected more than 500 individuals in a particular state or jurisdiction, the Plan will provide additional notice to prominent media outlets within the state or jurisdiction no later than 60 days after discovery of the Breach. Finally, the Plan will report any Breach of Unsecured PHI to HHS as required by HHS.

Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you. For example, health information is de-identified if certain identifiers are removed, including but not limited to your name, geographic identifiers (e.g., address, etc.), all elements of dates relating to you (e.g., your birth date), Social Security Number, telephone number, medical record number, etc.

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is information that may be individually identifiable information, and that summarizes your claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

Although the Plan is allowed to use and disclose your PHI for marketing purposes with your written authorization, this Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as making a communication about a product or service that encourages recipients of the communication to purchase or use the product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase. However, marketing does not include the following communications made, unless direct or indirect payment is received from or on behalf of a third party whose product or service is being described: (i) to provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual (payment may be received if it is reasonably related to the cost of making the communication); (ii) for the treatment of an individual by a health care provider, including case management or care coordinating for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to

the individual; (iii) to describe a health-related product or service (or payment for such product or service) that is provided by, or included in the plan of benefits of the entity making the communication, including communications about participating in a health care provider network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan enrollee that add value to, but are not a part of, a plan of benefits; or (iv) for case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions.

This Plan does not anticipate making any fundraising communications; however, to the extent the Plan provides you with any written fundraising communication that is a healthcare operation as defined under the Privacy Rule, it shall provide in a clear and conspicuous manner that you are entitled to elect not to receive any further such communication and such election shall be treated as a revocation of authorization.

The Board of Trustees' Duties

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended the Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the Plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administrative Office.

Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address: BeneSys Administrators, P.O. Box 990, West Covina, CA 91793. **A complaint may also be filed with HHS in writing, either electronically via the OCR Complaint Portal, or on paper by faxing, emailing, or mailing it to the applicable OCR regional office. For more information on filing a complaint with HHS, please visit www.hhs.gov/ocr/privacy/hipaa/complaints/ or call 800-368-1019 to request a copy of a complaint form.**

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

WEEKLY DISABILITY BENEFIT

Weekly Disability Benefits are provided on the same basis as they are for a non-occupational disease if a female Employee, while covered under the group policy, is absent from employment because of a disabling pregnancy-related condition. Certification by a Physician that the Disability is caused by the condition will be necessary. Further, the Fund may request any additional evidence it feels is necessary before deciding that benefits are payable.

After any applicable Waiting Period, the Plan will pay the Weekly Benefit in force for each week, as set forth below, of a Disability absence which starts while you are covered.

A Disability absence is any absence from work caused by a non-occupational Injury or non-occupational Disease, as defined in the General Information section.

What is Payable Under the Weekly Disability Benefits Plan?
$300 per week

1/7 of the weekly benefit is payable for each day of Disability. Only full days of Disability are considered for payment. Benefits commence on the 1st day if Disability is due to an Accident. Benefits commence on the 8th day if your Disability is due to Illness. However, if hospitalization is necessary due to an Illness, benefits will commence with the 1st day of hospitalization.

Maximum period of payment: 26 weeks (182 days)

What is Considered a Disability?
Full Disability is an Illness or Injury for which the Employee is under the regular care and attendance of a Physician and is unable to perform any of the material duties of their regular job.

Partial Disability is an Illness or Injury for which the Employee is under the regular care and attendance of a Physician and, while unable to perform each of the material duties of his or her regular job on a full-time basis, the Employee is able to perform at least one of the material duties of his or her regular job or has other gainful work or service on a part-time or full-time basis while earning at least 20% less per week than his or her Basic Weekly Earnings, due to the same Illness or Injury.

When Will My Benefits Be Paid?
Benefits commence on the 1st day if your Disability is due to an Accident. Benefits commence on the 8th day if your Disability is due to Illness. However, if hospitalization is necessary due to an Illness, benefits will commence with the 1st day of hospitalization. Benefits will be paid as soon as the necessary written proof to support the claim is received.

How Will Benefits Be Paid?
All benefits are payable only to the Employee. All benefits will be paid by check. To ensure timely receipt of benefits, the Employee must keep the Plan Administrator advised of any change in the Employee's address or contact information.

What if I have More than One Occurrence of Disability?

All Disability absence due to the same or related causes and separated by less than 2 consecutive weeks of full-time work will be considered to be in the same period of Disability, and thus considered a Disability Occurrence.

A new Disability Occurrence due to a cause different from that of any prior Disability must be separated from the prior Disability by at least one day of full-time work in order for you to become eligible for a new Maximum Period of Payment.

Summary of Coverage

Benefit for all covered Employees is $300 per week

1/7 of the weekly benefit is payable for each calendar day of Disability. Only full days of Disability are considered for payment. Benefits commence on the 1st day if Disability is due to an Accident. Benefits commence on the 8th day if your Disability is due to Illness. However, if hospitalization is necessary due to an Illness, benefits will commence with the 1st day of hospitalization.

Maximum period of payment is 26 weeks (182 days).

How Long Are Benefits Payable?

Benefits will be payable up to the Maximum Period of Payment for any one period of Disability. One period of Disability may include more than one Disability Occurrence.

Please note that this Plan is not a substitute for Workers' Compensation Insurance. This Plan is not in lieu of and does not affect Workers Compensation Insurance.

No Assignment of Coverage

The rights and benefits arising from coverage under this Plan may not be assigned.

Exclusions

What is Not Covered?

This Plan will not cover disabilities related to any of the following:

1. A Dependent Disability.
2. Any Disability Occurrence that exceeds the maximum number of weeks applicable to your bargaining unit.
3. A Disability for which the Plan does not receive notice of claim within 90 days of the Disability.
4. Any Disability Occurrence that begins while the Participant is receiving Continuation of Coverage under COBRA or FMLA.
5. A Disability Occurrence for a day on which the Participant worked for compensation or profit; nor for a day on which the Participant was not under the care of a Physician. The

Participant must have been personally seen and treated by a Physician to be considered under his care.

Definitions

Wherever used in this booklet, the following terms shall be deemed to have the meanings described below:

Trust Fund or Fund. Operating Engineers Local 501 Security Fund.

Union. International Union of Operating Engineers, Local No. 501.

Contributing Employer. Any Employer which makes contributions to the Trust Fund in accordance with a collective bargaining agreement and/or a participation agreement in effect between the Contributing Employer and the Operating Engineers Local 501.

Individual. A person who is covered under the Plan pursuant to the terms of the Individual's plan provisions.

Accident. An incident that gives rise to an Injury that does not include any act of intentional, self-inflicted bodily injury.

Administrator. The person or organization designated by the Trustees of the Fund to act in its behalf.

Disability. An Illness or Injury that causes an Employee to have a Full and/or Partial Disability.

Disability Occurrence. Any one continuous period of Full and/or Partial Disability.

Disease. Any disease classified under the current International Classification of Diseases (ICD).

Employee. Any employee who meets the eligibility requirements and whose Contributing Employer is required to make and does make contributions to the Fund for weekly Disability benefits.

Full Disability. Any Illness or Injury for which the Employee is under the regular care and attendance of a Physician and is unable to perform any of the material duties of their regular job.

Illness. Any sickness, disease or pregnancy.

Injury. Any bodily injury that is the result of an Accident, and resulting independently of all other causes.

Maximum Period of Payment. The maximum period in which short term Disability benefits will be paid (26 weeks).

Partial Disability. An Illness or Injury for which the Employee is under the regular care and attendance of a Physician and, while unable to perform each of the material duties of his or her regular job on a full-time basis, the Employee is able to perform at least one of the material duties of his or her regular job or has other gainful work or service on a part-time or full-time basis while earning at least 20% less per week than his or her Basic Weekly Earnings, due to the same Illness or Injury.

Physician. A Physician licensed as a medical doctor (M.D.), osteopath (D.O.), podiatrist (D.P.M.), chiropractor (D.C.), chiropodist (D.S.C.), dentist (D.D.S.), psychiatrist (M.D.), or other service provider practicing within the scope of their license or certification, as applicable and to the extent that benefits are provided.

Waiting Period. The number of consecutive days of Full Disability before short term Disability benefits become payable under the Plan.

Workers' Compensation Benefits. Temporary disability benefits under a Workers' Compensation law. This Plan is not a substitute for Workers Compensation Insurance. This Plan is not in lieu of and does not affect Workers Compensation Insurance.

Coordination of Short Term Disability Benefits

The Weekly Disability Benefits Plan does not cover dependents; therefore, coordination of benefits does not apply in this situation.

Time Limitation for a Section 502(a) Lawsuit

A lawsuit under Section 502(a) of ERISA must be filed within one year of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination. Please see the section of the booklet entitled Weekly Disability Benefits Plan Summary for the detailed Benefit Claim and Appeal Procedures starting on page 21.

WEEKLY DISABILITY BENEFITS PLAN SUMMARY

a. Name of the Plan

The name of the Plan is the Operating Engineers Local 501 Security Fund.

b. Name, Address, and Telephone Number of the Board of Trustees

Operating Engineers Local 501 Security Fund
c/o BeneSys Administrators
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

c. Identification Number

The taxpayer identification number assigned to the Plan by the Internal Revenue is **95-6049026**. The Plan number is 501.

d. Type of Plan

The Plan is a group health plan as defined by ERISA Section 733. The Plan provides a self-insured short term Disability benefits program for Employees only.

e. Type of Administration

The Plan is administered by the Board of Trustees utilizing the services of a third party contract administrator, BeneSys Administrators ("BeneSys").

f. Name, Address, and Telephone Number of Plan Administrator

Operating Engineers Local 501 Security Fund
BeneSys Administrators
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

g. Name and Address of Agent for Service of Process

Barry Osharow
C/o Operating Engineers Local 501 Security Fund
BeneSys Administrators
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

h. Board of Trustees

Employer Trustees

Jeff Palmer
Able Engineering Services
235 Pine Street, Suite 600
San Francisco, CA 94104

Kevin Gleason
Starwood Hotels and Resorts
585 9th Street, Suite 345
Oakland, CA 94607

Thomas Crosser
Cushman & Wakefield
3760 Convoy Street, Suite 220
San Diego, CA 92111

Will Webster
ABM Onsite Services
1150 S. Olive Street, Floor 19
Los Angeles, CA 90015

Union Trustees

Ed Curly
Operating Engineers Local 501
2405 W. Third Street
Los Angeles, CA 90057

Denise Vukojevich
Operating Engineers Local 501
2405 W. Third Street
Los Angeles, CA 90057

Thomas O'Mahar
Operating Engineers Local 501
301 Deauville Street
Las Vegas, NV 89106

Mike Narez
Operating Engineers Local 501
2405 W. Third Street
Los Angeles, CA 90057

Alternate Trustees

Eric G. Flett
ABM, Onsite Services-West, Inc.
1150 S. Olive Street 19th Floor
Los Angeles, CA 90015

i. Description of Collective Bargaining Agreements and/or Participation Agreements

The Plan is funded primarily from Employer contributions. Collective bargaining agreements and/or participation agreements obligate Contributing Employers to pay each month with the understanding payments are made in the month following a month of 72 hours or more work. Contributing Employers make contributions for bargaining unit Employees as required by the terms of various collective bargaining agreements and/or participation agreements. Generally, the collective bargaining agreements and/or participation agreements provide that the Contributing Employers will contribute at a specified rate per Employee per month. The Trustees determine the contribution rates and the available benefits.

Copies of the applicable collective bargaining agreements and/or participation agreements will be furnished upon written request to the Administrative Office. A reasonable charge may be imposed for these copies. Also, copies are available for examination at the Administrative Office.

j. Participation, Eligibility, and Benefits

Participation	See pages 2 to 3 of this booklet for the summary of these rules.
Eligibility	See pages 2 to 3 of this booklet for the summary of these rules.
Benefits	See pages 12 to 14 of this booklet for the summary of these benefits.

k. Circumstances Which May Result in Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction, or Recovery of Benefits

An Employee who is eligible for benefits may become ineligible as a result of the following circumstances:

1. The failure of your Contributing Employer to report the hours and remit correct contributions on your behalf to the Fund.

2. The failure of your Contributing Employer to enter into a signed written collective bargaining agreement and/or participation agreement, or renewal thereof.

An Employee who is eligible may be denied benefits as a result of any of the following circumstances:

1. The failure of the Employee or beneficiary to file a claim for benefits within 90 days following the date of loss. However, if the Employee or beneficiary (through no fault of their own) were unable to meet the deadline for filing the claim, the claim will still be accepted if they file as soon as reasonably possible, but not later than one year after the deadline unless they are legally incapacitated.

2. The failure of the Employee to file a complete and truthful benefit application.

3. The failure of the Employee to remain under the attendance of a Physician, which means the Employee is fully complying with the treatment plan prescribed by the Physician.

The information provided is intended as a summary of the circumstances that would result in a denial of eligibility or benefits. It is not intended to be an exhaustive list of all such circumstances. Please refer to the remainder of this booklet for additional circumstances.

l. COBRA Rights

COBRA does not apply to short term Disability benefits.

m. Compliance with ERISA and the Internal Revenue Code

The Trustees believe that the Plan fully complies with the Employee Retirement Income Security Act of 1974, as amended, the Internal Revenue Code, as amended, and any other applicable federal law. Any omissions or oversights will be resolved in accordance with the statute or other applicable law(s).

n. Plan Amendments or Plan Termination

The Trustees reserve the right to interpret and apply the provisions of the benefit plan(s) created and administered by them, and to, in turn, amend the benefit plan(s), in whole or in part, in their discretion. The Trustees may also in their discretion terminate the benefit plan(s), in whole or in part, at any time if such action(s) is deemed necessary by the Trustees. In any event, the benefit plan(s) shall be automatically terminated upon the expiration of all collective bargaining agreements, participation agreements and any other special agreements requiring the payment of contributions to the Fund, provided that for purposes of this provision a collective bargaining agreement, participation agreement or any other special agreement shall not be deemed to have expired in a strike or lockout situation, unless said strike or lockout continues for more than six (6) months. You and your eligible dependents will be provided with a Summary of Material Modifications (SMM) no later than 60 days after the adoption date of the modification or change. Any modification or change in the Summary of Benefits and Coverage (SBC) will be provided at least 60 days in advance of the adoption date of the modification or change. If the benefit plan(s) is terminated, the Participants will be notified as soon as reasonably possible. In the event of the termination of all benefit plans, Article X, Section 5 of the Trust Agreement governs the disbursement of any remaining monies or assets. At no time, including but not limited to the termination of this Trust, will any monies or assets being held by the Trust be recoverable by any Contributing Employer, Employer organization, or labor organization.

o. Source of Contributions

Contributions are made by the Contributing Employers under the terms of any applicable collective bargaining agreements and/or participation agreements.

p. Plan Year

The Plan Year is October 1 through September 30.

q. Entities Used For Accumulation of Assets, Employer Contributions, and Payment of Benefits

All Employer contributions are received, collected, and deposited by a designated bank or trust company. The funds are then used to pay benefits directly when applicable, pay the expenses of administration, and to provide reserves.

r. Insurers and Providers of Service to the Plan

BeneSys Administrators provides third party administration to the Plan, including payment of claims for the Weekly Indemnity Benefits Plan.

The provider of service to the Plan for the benefits described in this booklet is:

Operating Engineers Local 501 Security Fund
BeneSys Administrators
P.O. Box 990 West Covina, CA 91793

(self-insured plan administered by BeneSys Administrators)

s. Benefit Claim and Appeal Procedures

The benefits provided to you under the Weekly Indemnity Benefits Plan will only be available if you comply with the procedures set forth below.

You must furnish written notice of any claim to the Administrative Office within 20 days after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter as is reasonably possible. Notice given by you or on your behalf, to the Trust Fund with information sufficient to identify you shall be deemed notice of claim.

The Administrative Office will furnish you with claim forms upon notice of the claim. If forms are not furnished, written proof of loss must still be furnished as provided in the following section.

You can contact the Administrative Office at:

BeneSys Administrators
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

Your claim must be submitted to the Administrative Office in writing and it must give proof of the nature and extent of the loss. Claim forms are available at the Administrative Office.

All claims should be reported promptly. The deadline for filing a claim for benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are unable to meet the deadline for filing claim, the Board of Trustees may, at its sole discretion, decide to accept your claim. The Board of Trustees may request supporting documentation or other proof that you filed your claim as soon as reasonably possible. Under no circumstances will a late-filed claim be accepted by the Board of Trustees if it is filed later than one year after the date upon which the Claim should have been filed in accordance with the terms of this Plan. Late claims not accepted by the Board of Trustees will not be covered.

ADMINISTRATIVE REVIEW

Filing A Claim

If you file a claim, the Administrative Office will notify you of its decision within 45 days of receipt of the claim. The Plan is allowed two 30-day maximum extension if the claim decision cannot be made for reasons beyond the control of the Plan and the Administrative Office notifies you prior to the expiration of the initial 45-day period, explains the circumstances for the extension, and identifies the date it expects to render a decision. You and the Administrative Office may agree to further extensions of these time periods.

Incomplete Claims

If you fail to follow the above procedures or do not provide sufficient information to decide a claim, the Administrative Office will notify you within 30 days of the failure and inform you what is required to file a complete claim. You will have at least 45 days from receipt of the notice within which to provide the specified information. You and the Administrative Office may agree to further extensions of this time period. The time period for deciding a claim shall be tolled from the date on which notification of the extension is sent to you until the date you respond to the request for additional information.

Notice of Claims Denial/Notice of Adverse Benefit Determination

If any claim is denied in whole or in part on the basis of eligibility or that the benefits will not be paid under the Plan because they are not covered, you will be provided with a notice of claims denial/notice of adverse benefit determination, which will contain:

1. The specific reason or reasons for the denial, and a reference to the specific Plan provision(s) on which the denial is based. This will include a discussion of:
    a) The basis for disagreeing with or not following the views of any healthcare professional(s) treating you and vocations professionals who evaluated you (but only to the extent you notified the Plan of such treatment or evaluation(s) prior to the Plan's determination on your claim), and;

b) The basis for disagreeing with or not following any disability determination made on your behalf by the Social Security Administration, and;

2. A statement that you are entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim for benefits including any new or additional evidence considered, relied upon, or generated by the Plan in connect with your claim;

3. A description of the Plan's standard used in denying the claim, if any, including a statement that:

   a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in the denial and a statement that the internal rule, guideline, protocol, or other criterion will be provided free of charge to you upon request (or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist); or

   b) if the denial was based on medical necessity or experimental treatment or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical/disability circumstances, will be provided free of charge to you upon request;

4. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

5. An explanation of the Appeal Procedures and time limits applicable to such procedures, including a statement of your right to file a civil action under Section 502(a) of ERISA following the exhaustion of the Internal Appeal Procedures (see below);

6. The contact information for the applicable office of the Department of Labor, Employee Benefit Security Administration, to assist you with questions you may have about your rights, the adverse benefit determination notice, or for other assistance; and

7. A statement about the availability of language services on notices sent to addresses in applicable counties.

APPEAL PROCEDURES

These appeal procedures shall be the exclusive procedures available to an Employee who is dissatisfied with an eligibility determination, benefit award, or who is otherwise adversely affected by any action of the Board of Trustees. These procedures must be exhausted before you ("Claimant") may file a lawsuit under Section 502(a) of ERISA.

The Claimant may request an appeal within 180 days of receipt of an administrative claims denial/notice of adverse benefit determination. The Administrative Office shall provide Claimant with access to and copies of documents, records, and other information free of charge that are relevant to the claim, including any new or additional evidence considered in connection with the claim, or any new or additional rationale upon which the final adverse benefit determination will be based. This will be provided as soon as possible and sufficiently in advance or the appeal so Claimant can respond prior to that date. Claimant will have the opportunity to submit written comments, documents, records, or any other information in support of the appeal.

A Claimant may file a request for an appeal of any claim denial by the Administrative Office. Claims denied are subject to mandatory appeal procedures as follows:

The appeal will be heard by written submission no later than the Board of Trustees' quarterly meeting that immediately follows the receipt of a request for appeal except if the request for an appeal is filed within 30 days of the date of the meeting. In such a case, an appeal decision will be made no later than the date of the second meeting following the Plan's receipt of the Claimant's request.

If there are special circumstances, the appeal will be heard and decided no later than the third meeting date following the Plan's receipt of the request for an appeal. If such an extension is required, the Claimant will be provided with notice in advance of the extension that will describe the special circumstances and identify the date the appeal will be heard and decided.

Claimant will be notified of all appeal decisions no later than five days after the decision is made. Claimant and the Board of Trustees may agree to further extension of these time periods.

The Board of Trustees may request an in-person hearing in which the Claimant and/or authorized representative will be asked to attend and present information and documentation in support of the appeal. Such a hearing will be scheduled only if the Board of Trustees cannot decide an appeal from the written submission. The hearing will occur within the time frames identified above and are an example of a special circumstance.

Incomplete Claims

If the Claimant fails to follow the above-referenced procedures or does not provide sufficient information to decide an appeal, the Plan will notify the Claimant prior to the appeal date. The Claimant will have 45 days from receipt of the notification within which to provide the additional information. The Plan, in its sole discretion, may agree to further extensions of this time period. All time periods for deciding an appeal mentioned above shall be tolled from the date on which the notification of any extension(s) is sent to the Claimant until the date on which the Claimant responds to the request for additional material.

Notice of Appeal Decision/Notice of Final Adverse Benefit Determination

All appeal decisions, whether adverse or not, will be provided to you in writing or by electronic notification. If the appeal is denied, in whole or in part, the notification will contain the following information.

1. The specific reason or reasons for the denial, and a reference to the specific Plan provision(s) on which the denial is based. This will include a discussion of:
    a) The basis for disagreeing with or not following the views of any healthcare professional(s) treating you and vocations professionals who evaluated you (but only to the extent you notified the Plan of such treatment or evaluation(s) prior to the Plan's determination on your claim), and;
    b) The basis for disagreeing with or not following any disability determination made on your behalf by the Social Security Administration
2. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits including any new or additional evidence considered, relied upon, or generated by the Plan in connect with your claim;
3. A description of the Plan's standard used in denying the claim, if any, including a statement that:
    a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in the denial and a statement that the internal rule, guideline, protocol, or other criterion will be provided free of charge to you upon request (or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist); or
    b) if the denial was based on medical necessity or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request; and
    c) a discussion of the decision denying the claim;
4. A statement of the Claimant's right to bring an action under Section 502(a) of ERISA within one-year following the Plan's final adverse benefit determination;
5. The contact information for the applicable office of the Department of Labor, Employee Benefits Security Administration, for questions about

your rights, the final adverse benefit determination notice, or for assistance; and

6. A statement about the availability of language services on notices sent to addresses in applicable counties.

Internal Appeal Standards

The Board of Trustees' review of a Claimant's request for appeal will be a de novo review. It will take into account all information submitted by the Claimant without regard to whether such information was submitted or considered during the administrative review phase.

The Board of Trustees may consult with a health care professional who has appropriate training and experience in the field of medicine if the decision under appeal was based in whole or in part on a medical judgment. The health care professional will be independent from any person who was involved in the initial administrative review phase.

The Board of Trustees will provide for the identification of any medical or vocational experts whose advice was obtained in connection with the claim under appeal.

Any entity reviewing the Board of Trustees' decision may not consider evidence or facts that were not presented during the appeal. The Board of Trustees has the sole power and discretion to construe any and all terms of the Plan, and any such construction shall be binding on all persons concerned to the fullest extent of the law.

All claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

MISCELLANEOUS BENEFIT CLAIM AND APPEAL PROCEDURES

The claim and appeal rights described herein cannot be assigned to any other person or entity. Therefore, all benefit claims, appeals, and Section 502(a) actions shall be made by you. You may authorize a personal representative to participate in the benefit claim process or to act on your behalf, however, the authorization must be made by you in writing or by electronic means to the Administrative Office.

The Benefit Claim and Appeal Procedures contained in this booklet are in compliance with ERISA Section 503 and the Department of Labor Regulations set forth at 29 CFR 2560-503.1 and the regulations and guidance promulgated thereunder, and as such are intended to be reasonable and offer a full and fair review process. Any omissions or oversights will be interpreted in accordance with the applicable law and its corresponding regulations.

t. Statement of ERISA Rights

Participants in the Operating Engineers Local 501 Security Fund are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Receive Information About Your Plan And Benefits

   Examine, without charge, at the Administrative Office and at other locations (worksites or Union offices), all plan documents, including insurance contracts, collective bargaining agreements, participation 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 Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, participation agreements, a copy of the latest annual report (Form 5500 series), and an updated summary plan description. The Plan Administrator may impose a reasonable charge for the copies.

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

2. 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 you and other plan participants and beneficiaries. No one, including your Contributing Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

   If your claim for a Disability benefit is denied, 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. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court subject to the exhaustion of the Plan's Benefit Claim and Appeal Procedures.

   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 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. 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. 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.

4. Assistance with Your Questions

If you have 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, N.W., 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 or through the website on the internet at www.dol.gov/ebsa.

The foregoing is a Summary Plan Description required by federal law. Of necessity, this booklet describes in general terms the benefits provided through the Fund. It is not to be considered a contract of insurance. All statements made in this booklet are subject to the complete terms of the Plan, its policies, procedures, etc. of the Operating Engineers Local 501 Security Fund.

All questions with respect to Plan participation, eligibility for benefits, the nature and amount of benefits, or with respect to any matter of Fund or Plan administration should be referred to the Administrative Office of the Fund.

No representations made to a participant, Physician, Hospital or other medical provider concerning eligibility, entitlement to benefits or amount of benefits payable is binding on the Fund unless the representation is in writing and made by the Board of Trustees or the Administrative Manager.

The only parties authorized to answer any questions concerning the Fund and Plan are the Board of Trustees and the Fund Administrative Office. No Contributing Employer, Employer association, or labor organization, nor any individual employed thereby, has any such authority.

Executed on 11th day of October, 2017

Edward Curly
Chairman

Kevin Gleason
Secretary

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