TRUST AGREEMENT
OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND

THIS TRUST AGREEMENT is made effective September 1, 1998, by and between Operating Engineers Local Union No. 3 of the International Union of Operating Engineers (hereinafter referred to as "Union") and IEDA, a California Nonprofit Corporation (hereinafter referred to as the "Employer").

RECITALS:

1. The Employer is a representative of parties to collective bargaining agreements with the Union, which provide that each individual employer shall pay contributions under the terms of various collective bargaining agreements to the Operating Engineers Public and Miscellaneous Employees Heath and Welfare Trust Fund, or its predecessor in interest, the Operating Engineers Public Employees Health and Welfare Trust Fund (hereinafter "Trust Fund" or "Fund") at rates specified from time to time in said Agreements.

2. The parties have agreed that such contributions shall be payable to and be deposited in the Trust Fund created and established by this trust agreement.

3. The purpose of this Trust Agreement is to provide for the establishment of such Trust Fund and for the maintenance of Health and Welfare Plans in accordance with the terms of various collective bargaining agreements and subscriber agreements.

PROVISIONS:

In consideration of the foregoing, and of the mutual promises hereinafter provided, the parties agree as follows:

ARTICLE I.
DEFINITIONS

Section 1. "*Board of Trustees*" means the Board of Trustees established by this Trust Agreement in Article III.

Section 2. "*Collective Bargaining Agreements*" includes any collective bargaining agreement between the Union, or any of its affiliated local unions, and any employer organization or individual employer which provides for the making of employer contributions to the Fund, and any extension or renewal of any of said agreements which provides for the making of employer contributions to the Fund.

Section 3. *"Code"* means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements, or replaces such section of subsection.

Section 4. *"Employee"* means any employee of a contributing employer for whom the contributing employer makes contributions to the Fund.

Section 5. *"Individual Employer"* means any employer who is required by any of the collective bargaining agreements to make contributions to the Fund, or who does in fact make one or more contributions to the Fund.

Section 6. *"Subscriber Agreement"* means any written agreement between the Fund and an employer which provides for the making of employer contributions to the Fund.

Section 7. "*Health and Welfare Plan*" or "*Plan*" mean the Health and Welfare Plan established pursuant to this Trust Agreement, and any amendments to or modifications of the Plan pursuant to such Agreement.

Section 8. *"ERISA"* means the Employee Retirement Income Security Act of 1974, as amended, and any valid regulation issued consistent with the Act.

Section 9. *"Signatory Association"* means any employer organization, other than the Employer, which signs this agreement on behalf of its members or executes on behalf of such members a written acceptance of any agreement to be bound by the terms of this Agreement.

Section 10. *"Trust Fund"* means the trust estate of the Operating Engineers Public Employees Health and Welfare Trust Fund created by this Agreement.

Section 11. *"Trustee"* means the designated trustee acting at any time under this Trust Agreement.

ARTICLE II.
TRUST FUND

Section 1. There is hereby created the Operating Engineers Public Employees Health and Welfare Trust Fund which shall consist of all contributions required by the collective bargaining agreements, memorandums of understanding, or subscriber agreements to be made for the establishment and maintenance of the Health and Welfare Plan, and all interest, income and other returns thereon of any kind whatsoever.

Section 2. The Trust Fund shall have its principal office in the City and County of Alameda, State of California, or at such other place as the Board of Trustees may from time to time designate.

Section 3. Contributions to the Trust Fund shall not constitute or be deemed to be wages due to the employees with respect to whose work such payments are made and no employee shall be entitled to receive any part of the contributions made or required to be made into the Trust Fund in lieu of the benefits or any of them provided by the Health and Welfare Plan.

Section 4. Neither the Employer, any signatory association, any individual employer, the Union, any beneficiary of the Health and Welfare Plan, nor any other person shall have any right, title, or interest in the Trust Fund other than as specifically provided in this agreement, and no part of the Trust Fund shall revert to the Union, the Employer, any signatory association, any individual employer, any beneficiary, or any Employee, except for such contributions, if any, as may be returned to an Individual Employer, as paid by a mistake of fact, within one year of the payment thereof or as may otherwise be permitted by ERISA. Neither the Trust Fund nor any contributions to the Trust Fund shall be in any manner liable for or subject to the debts, contracts, or liabilities of the Employer, any signatory association, any individual employer, the Union, any beneficiary, or any Employee. No part of the Trust Fund, nor any benefits payable in accordance with the Health and Welfare Plan, shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; provided, however, that the Board of Trustees shall establish a procedure whereby any Employee may direct that benefits due him be paid to an institution in which he is hospitalized, in consideration for medical or hospital services rendered or to be rendered, and may establish a procedure whereby an Employee may direct that any such benefits be paid to any other person, entity, or institution furnishing services or supplies for which such benefits are payable.

Section 5. The Employer's liability to the Trust Fund or with respect to the Health and Welfare Plan, shall be limited to the payments or contributions required by the collective bargaining agreements or memorandums of understanding, and in no event shall the Employer be liable or responsible for any portion of the contributions due from other Employers. The basis on which payments or contributions are made to the Trust Fund shall be specified in the collective bargaining agreements, memorandums of understanding, and in this Trust Agreement, and the Employers shall not be required to make any further payments or contributions to the cost of operation of the Trust Fund or of the Plan, except as may be provided in such Agreements or in ERISA.

Section 6. Neither the Employer, any signatory association, any individual employer, the Union, nor an Employee shall be liable or responsible for any debts, liabilities, or obligations of the Trust Fund or the Board of Trustees.

Section 7. Contributions to the Trust Fund shall be payable in the City of Alameda, State of California, in regular monthly installments starting on or before the effective date of a collective bargaining agreement, and continuing from month to month thereafter subject to the

provisions of the collective bargaining agreements. Each monthly contribution shall be accompanied by a report in a form prescribed by the Board of Trustees which shall provide the due dates for any contributions to the Trust Fund.

Section 8. Each contribution to the Trust Fund shall be made promptly, and in any event on before the 25th day of the calendar month in which it becomes payable, on which date of said contribution, if not then paid in full, shall be delinquent. The Board of Trustees, in its discretion, may establish an earlier contribution due date. Unless otherwise notified by the Board of Trustees, if any Employer fails to make his or its monthly contribution in full on or before the 25th day of the month on four occasions within any twelve-month period, the Board of Trustees may provide by resolution that thereafter during the twelve-month period immediately following such resolution the 15th day of the month shall be the delinquency date for such Employer. The parties recognize and acknowledge that the regular and prompt payment of Employer contributions to the Trust Fund is essential to the maintenance in effect of the Health and Welfare Plan, and that it would be extremely difficult, if not impracticable, to fix the actual expense and damage to the Trust Fund and to the Health and Welfare Plan which would result from the failure of an Employer to pay such monthly contributions in full within the time above provided. Therefore, the amount of damage to the Trust Fund and Health and Welfare Plan resulting from any such failure shall be presumed to be the sum of $20 per delinquency or 10% of the amount of the contribution or contributions due, whichever is greater, which amount shall become due and payable to the Trust Fund as liquidated damages and not as a penalty, in the City of Alameda, State of California, upon the day immediately following the date on which the contribution or contributions become delinquent. Said delinquent contribution or contributions shall be increased by the amount of said liquidated damages and such contributions, as thus increased, shall be the payments specified in this Trust Agreement and the Health and Welfare Plan pursuant to ERISA as required to be made to the Fund.

ARTICLE III.
BOARD OF TRUSTEES

Section 1. The Trust Fund shall be administered by a Board of Trustees which shall consist of six (6) Trustees. Three Trustees representing the individual employer shall be appointed in writing by the Employer, who are hereby irrevocably designated by each individual employer as his or its attorneys in fact for the purpose of appointing and removing trustees and successor trustees. Three Trustees representing the employees shall be appointed by the Union by an instrument in writing signed by the Executive Officer of the Union. The Employer and the Union expressly designate the Trustees jointly as named fiduciaries, who shall have exclusive authority and discretion acting as the Board of Trustees as herein provided, to control and manage the operation and administration of the Trust Fund and the Health and Welfare Plan. Each of the Trustees expressly accepts designation as a fiduciary and as Trustee by written acceptance and signature of this Trust Agreement and assumes the duties, responsibilities, and obligations of the Trustees as created and established by this Trust Agreement and under

applicable law. Any Trustee named hereafter shall do likewise by signing the Trust Agreement or a written acceptance thereof, in a form approved by and filed with the Board of Trustees.

Section 2. The Board of Trustees shall select one of their number to act as Chairman of the Board of Trustees and one to act as Secretary, to serve for such period as the Board of Trustees shall determine. When the Chairman is selected from among the Employer Trustees, the Secretary shall be selected from among the Employee Trustees, and vice versa.

Section 3. Each Trustee shall serve until his death, resignation, or removal from office.

Section 4. A Trustee may resign at any time by serving written notice of such resignation upon the Chairman of the Board of Trustees, at least 30 days prior to the date on which such resignation is to be effective. The Secretary shall promptly notify in writing the Chairman and Secretary of the Board, and the Employer and the Union of such resignation.

Section 5. Any Employer Trustee may be removed from office at any time, for any reason, by a writing signed by the Employer and served on the Secretary of the Board of Trustees. Any Employee Trustee may be removed from office at any time, for any reason, by an instrument in writing signed by the Executive Officer of the Union and served on the Secretary of the Board of Trustees. The Secretary shall promptly notify in writing the Chairman and Secretary of the Board, the Trustee being removed, and the Union.

Section 6. If any Trustee dies, resigns, or is removed from office, a successor Trustee shall be appointed forthwith by an instrument in writing signed by the appropriate Executive Officer of the Union, or the Employer, as the case may be.

ARTICLE IV.
FUNCTIONS AND POWERS OF BOARD OF TRUSTEES

Section 1. The Board of Trustees acting jointly shall have the power to control and manage the assets, operations, and administration of the Fund and the Plan as a fiduciary and shall exercise such authority with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent Board acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims; provided, however, that the Board may:

(a) appoint an investment manager or managers (as defined in ERISA) to manage (including the power to acquire and dispose of) any assets of the Fund,

(b) enter into an agreement allocating among Trustees such specific responsibilities, obligations, or duties as the Board shall determine, after receiving and considering the written reports and recommendations of the consultant-actuary, legal counsel and the qualified public accountant engaged by the Fund, may be properly so allocated,

(c) designate, pursuant to the same procedure, persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under this Trust Agreement or the Plan,

(d) employ one or more persons to render advice with regard to any responsibility the Board has under this Trust Agreement or Plan, or

(e) do any one or more of the foregoing.

Any person or entity so appointed, designated, or employed shall act solely in the interests of the participants and beneficiaries of the Trust Fund and Plan.

Section 2. All contributions to the Plan or the Trust Fund shall be due and payable at the City of Alameda, State of California, and shall be paid to, received, and held subject to the trust established by this Trust Agreement and all the terms and provisions hereof. The acceptance and cashing of any checks for such contributions, and the disposition of the moneys covered thereby in accordance with this Trust Agreement, shall not release or discharge the Employer from his or its obligations under the collective bargaining agreement or memorandum of understanding for hours worked under said Agreements for which no contribution has actually been received, notwithstanding any statement, restriction, or qualification appearing on the check or any attachment thereto.

Section 3. The Board of Trustees shall have the power, in the name of the Trust Fund, in the name of its joint delinquency committee or jointly with other funds, or otherwise as in its discretion may be deemed necessary or desirable, to demand and enforce, by suit in court or otherwise, the prompt payment of contributions to the Trust Fund, including payments due to delinquencies as provided in Section 8 of Article II without being limited or restricted by any grievance or arbitration procedures provided in a Collective Bargaining Agreement, Memorandum of Understanding, and to assert and enforce all priorities, lien rights, and other claims or rights with respect to any contributions or payments belonging to the Trust Fund, this Trust or any of its beneficiaries, including the right to file priority and other claims in bankruptcy. If any Employer defaults in the making of such contributions or payments and if the Board consults or causes to be consulted legal counsel with respect thereto, or files or causes to be filed any suit or claim with respect thereto, there shall be added to the obligation of the Employer who is in default, reasonable attorneys' fees, court costs, and all other reasonable expenses incurred in connection with such suit or claim, including any and all appellate proceedings therein.

Section 4. The Board of Trustees shall establish the Health and Welfare Plan, which shall consist of (a) the benefits provided by and the other terms and conditions of the contracts and insurance policies entered into pursuant to the provisions of this section and, in the alternative or in combination, (b) such written statement of benefits and rules and regulations as may be established by the Board pursuant to this section to govern the direct payment of benefits. The

Board shall promptly use the moneys available in the Trust Fund first to provide the benefits specified in the Plan. The Board shall have power to enter into contracts and procure insurance policies necessary to place into effect and maintain all or any part of the Plan, to terminate, modify, or renew any such contracts or policies subject to the provisions of the Plan, and to exercise and claim all rights and benefits granted to the Board or the Trust Fund by any such contracts or policies. Any such contract may be executed in the name of the Trust Fund, and any such policy may be procured in such name. If, after reviewing the matter, the Board deems it advisable to do so, the Board shall also have power (c) to provide for the direct payment out of the Trust Fund of all or any part of the benefits to be furnished under the Plan, and (d) to provide for contributions by Employees to the Trust Fund to defray all or any part of the cost of any such benefits, but only to the extent that such payment or contribution is permitted by any applicable laws and regulations and subject to the terms and conditions of any such law or regulation. In the event that the Board elects to provide for the direct payment of any benefit or benefits the detailed basis on which such payments are to be made shall be set forth in a written statement, which statement, and any amendment, or modification thereof, shall be signed on behalf of the Board by the Chairman and Secretary thereof, and when so signed shall be a part of this Agreement for all purposes of the Labor Management Relations Act, as amended, or of any other law or regulation. An accurate summary of such benefit or benefits, and the terms and conditions of the payment thereof, shall be printed and made available to each active or retired employee who is eligible for any such benefit or benefits.

Section 5. The Board of Trustees shall have power:

(a) To pay out of the Trust Fund the reasonable expenses incurred in the establishment of the Trust Fund and the Health and Welfare Plan.

(b) To establish and accumulate such reserve funds as may be adequate to provide for administration expenses and other obligations of the Trust Fund, including the maintenance in effect of the Health and Welfare Plan.

(c) To provide a procedure for establishing and carrying out the funding policy and method consistent with the objectives of the Health and Welfare Plan and the requirements of ERISA in adopting a plan of benefits and in amending the plan.

(d) To employ such executive, consultant, corporate custodian or co-trustee, accounting, administrative, clerical, secretarial and legal personnel and other employees and assistants, as may be necessary, in connection with the administration of the Trust Fund and the Health and Welfare Plan, and to pay or cause to be paid, out of the Trust Fund, the compensation and necessary expenses of such personnel and assistants and the cost of office space, furnishings and supplies and other essentials required in such administration. If the Board is unable to agree upon the employment of either a consultant or an attorney pursuant to this clause, the Trustees may each select either a consultant or an attorney, or both, as the case may require, who shall be directed to act jointly with each other in connection with the administration of the Trust Fund, and the reasonable cost of such advice or services shall be paid from the Trust Fund.

(e) To incur and pay out of the Trust Fund any other expenses reasonably incidental to the administration of the Trust Fund or the Health and Welfare Plan.

(f) To compromise, settle, or release claims or demands in favor of or against the Trust Fund on such terms and conditions as the Board may deem desirable, including the power to continue, maintain, and from time to time modify or revoke, in whole or in part, a policy and procedure for the waiver of all or any part of the liquidated damages portion of any contribution or contributions upon such terms and conditions as the Board determines would be in the interests of the Trust Fund and its participants and beneficiaries; provided, however, that this clause shall not excuse any violation of any of the collective bargaining agreements or memorandums of understanding.

(g) If no investment manager is designated and appointed by the Board, to invest and reinvest or cause to be invested and reinvested the assets of the Trust Fund, in accordance with all applicable laws. Investments may be made with a bank or other fiduciary to the fullest extent permitted by law. No indicia of ownership shall be maintained outside the jurisdiction of the district courts of the United States, except to the extent permitted by law.

(h) To purchase, exchange, lease, mortgage or otherwise hypothecate, or otherwise acquire, or cause to be purchased, exchanged, leased, mortgaged or otherwise hypothecated, or otherwise acquired, any property, real, personal or mixed, on such terms as it may deem proper, and to execute and deliver or cause to be executed and delivered, any and all instruments in connection therewith.

(i) To sell, exchange, lease, convey, or otherwise dispose of or to cause to be sold exchanged, leased, conveyed, or otherwise disposed of, any property of any kind forming a part of the Trust Fund upon such terms as it may deem proper, and to execute and deliver or cause to be executed and delivered, any and all instruments of conveyance or transfer in connection therewith.

(j) To borrow money, and to encumber or hypothecate real or personal property by mortgage, deed of trust (with power of sale), contract of sale, security Agreement, pledge or otherwise; to borrow money on the credit of the trust estate; and to purchase real or personal property subject to, and assume the obligation secured by, mortgage, deed of trust (with power of sale), contract of sale, security Agreement, pledge or otherwise.

(k) To construe the provisions of this Trust Agreement and the Plan and any such construction adopted by the Board of Trustees in good faith which shall be binding upon any and all parties or persons affected thereby.

(l) To pay or cause to be paid any and all real or personal property taxes, income taxes, or other taxes or assessments of any or all kinds levied or assessed upon or with respect to the Trust Fund or the Plan.

(m) To maintain or cause to be maintained, on a current basis, all actuarial data, records and information in connection with the administration of the Plan and to cause the books and records to be checked and evaluated annually, or more often if the Board so determines, by the Trust Fund consultant-actuary or consultant-actuaries as the case may be, whose reports shall be available for inspection by interested persons at reasonable times and upon proper notice, at such place or places as may be designated by the Board; and the Board shall have the right to rely upon all such reports and records.

(n) To prepare or cause to be prepared such reports, descriptions, summaries and other information as are or may be required by law or as the Board in its discretion deems necessary or advisable, and to file and furnish such reports, descriptions, summaries and information to participants and their beneficiaries, Unions, the Employers, the Trustees, or other persons or entities, including government agencies, as required by law.

(o) To maintain or cause to be maintained such bank account or bank accounts as may be necessary or advisable in the administration of the Trust Fund or the Plan, and to designate the person or persons authorized to sign checks and withdrawal orders on any such accounts.

(p) With or without any of the contracts or policies mentioned in Section 4 of this Article, to pay or cause to be paid all or any part of the benefits provided in the Plan to the persons entitled thereto under the Plan, and in accordance with the terms and provisions of the Plan, which shall be the basis on which payments are made from the Plan.

(q) To adopt and prescribe reasonable rules and procedures, which shall not be inconsistent with the provisions of this Trust Agreement or of the Plan, governing the reporting of contributions, the entitlement to benefits, the method of applying for benefits, and any and all other matters in connection with the Fund and the Plan.

(r) To exercise and perform any and all of the other powers and duties specified in this Trust Agreement or the Plan.

Section 6. The Board of Trustees shall engage an independent qualified public accountant on behalf of all Plan participants as required by ERISA.

Section 7. The Board of Trustees shall provide at the expense of the Trust Fund, when and to the extent permissible by applicable law, insurance and bonding protection for the Trust Fund and for each Trustee, former Trustee or estate of a deceased Trustee or former Trustee, and all other persons who handle funds or other property of the Fund for any purpose whatsoever. The protection shall be from such companies as the Board shall determine.

Section 8. All checks, drafts, vouchers, or other withdrawals of money from the Trust Fund shall be authorized in writing or countersigned by at least one Employer Trustee and one Employee Trustee.

Section 9. The Board of Trustees shall maintain suitable and adequate records of and for the administration of the Fund and the Health and Welfare Plan. The Board may require the Employers, any signatory association, any individual employer, the Union, any employee or any other beneficiary under the Health and Welfare Plan to submit to it any information, data, report, or documents reasonably relevant to and suitable for the purposes of such administration; provided, however, that the Union shall not be required to submit lists of membership. The parties agree that they will use their best efforts to secure compliance with any reasonable request of the Board for any such information, data, report, or documents. Upon request in writing from the Board, any Individual Employer will permit a Trust Fund Auditor to enter upon the premises of such Individual Employer during business hours, at a reasonable time or times, not less than two (2) working days after such request, and to examine and copy such books, records, papers, or reports of such Individual Employer as may be necessary to determine whether the Individual Employer is making full and prompt payment of all sums required to be paid by him or it to the Fund.

Section 10. The books of account and records of the Board of Trustees, including the books of account and records pertaining to the Trust Fund, shall be audited at least once each year by an independent qualified public accountant engaged by the Board of Trustees on behalf of all Plan participants who shall conduct such an examination of any financial statements of the Trust Fund and Plan, and of the books and records of the Trust Fund and Plan, as may be required by ERISA. The Board of Trustees shall also make all other reports required by law. A statement of the results of the annual audit shall be available for inspection by interested persons at the principal office of the Trust Fund and at such other suitable place as the Board may designate from time to time. Copies of such statement shall be delivered to the Employers, the Union, and each Trustee within five days after the statement is prepared.

Section 11. The Board of Trustees may coordinate its activities in the administration of the Trust Fund and the Health and Welfare Plan with the administrative activities of the boards of trustees of other trust funds and health and welfare plans to such extent as may be necessary or desirable to minimize administrative costs, eliminate unnecessary bookkeeping and other expenses for the Employers and avoid or eliminate duplicating Employer contributions or insurance coverage with relation to the same Employee. The Board may agree to exercise and exercise any of its functions and powers jointly with any one or more of the board of trustees of such other trust funds, and it may agree to join with and join with any one or more of said boards in establishing a joint office or joint administrative personnel.

ARTICLE V.
PROCEDURE OF BOARD OF TRUSTEES

Section 1. The Board of Trustees shall determine the time and place of its regular periodic meetings. The Chairman, or any two (2) members of the Board of Trustees, may call a special meeting of the Board of Trustees by giving written notice to all other Trustees of the time

and place of such meeting at least five days before the date set for the meeting. Any such notice of special meeting shall be sufficient if sent by ordinary mail or by electronic mail addressed to the Trustee at his address as shown in the records of the Board of Trustees. Any meeting at which all Trustees are present, or concerning which all Trustees have waived notice in writing, shall be a valid meeting without the giving of any notice.

Section 2. The Board shall appoint a secretary who shall keep minutes of records of all meetings, proceedings, and acts of the Board. Such minutes need not be verbatim.

Section 3. The Board shall not take any action or make any decision on any matter coming before it or presented to it for consideration or exercise any power or right given or reserved to it or conferred upon it by this Trust Agreement, except upon the vote of a majority of all of the Trustees at a meeting of the Board duly and regularly called or except by the signed concurrence of all Trustees without a meeting, as provided in Section 5 of this Article. In the event of the absence of any Employer Trustee from a meeting of the Board, the Employer Trustees present at such meeting may vote on behalf of such absent Trustee and if such Employer Trustees cannot all agree as to how the vote of such absent Employer Trustee shall be cast, then it shall be cast as the majority of them shall determine or, in the absence of such majority determination, it shall be cast as the Employer Trustee Chairman or Secretary of the Board shall determine. In the event of the absence of any Employee Trustee from a meeting of the Board, the Employee Trustees present at such meeting may vote on behalf of such absent Trustee pursuant to the same method and in the same manner as above provided for Employer Trustees to cast the vote of any absent Employer Trustee.

Section 4. All meetings of the Board of Trustees shall be held at the principal office of the Trust Fund, unless another place is designated from time to time by the Board of Trustees, and all business may be conducted upon the attendance of one Employer Trustee and One Union Trustee.

Section 5. Upon any matter which may properly come before the Board of Trustees, the Board of Trustees may act in writing without a meeting, provided such action has the affirmative concurrence in writing of all Trustees

ARTICLE VI.
GENERAL PROVISIONS APPLICABLE TO TRUSTEES

Section 1. The provisions of this Article are subject to and qualified by the provisions of ERISA to the extent that such provisions are constitutionally applicable. In order to induce experienced, competent, and qualified persons and entities to serve as fiduciaries, to deal with the Trust Fund and the Board of Trustees and to participate in other ways in the administration and operation of the Trust Fund and Plan and thus to further the interests of the participants and beneficiaries of the Plan, it is the intent and purpose of the parties to provide herein for the maximum permissible protection and indemnification of such persons or entities from and

against personal liability, loss, cost, or expense as a result of such service, dealing, or participation, and the provisions of this Article shall be liberally construed and applied to accomplish this objective.

Section 2. No party who has verified that he or it is dealing with the duly appointed Trustees, or any of them, shall be obligated to see to the application of any moneys or property of the Trust Fund, or to see that terms of this Trust Agreement have been complied with, or to inquire as to the necessity or expedience of any act of the trustees. Every instrument executed by the Board of Trustees or by its direction shall be conclusive in favor of every person who relies on it, that (a) at the time of the delivery of the instrument this Trust Agreement was in full force and effect, (b) the instrument was executed in accordance with the terms and conditions of this Trust Agreement, and (c) the Board was duly authorized to execute the instrument or direct its execution.

Section 3. The duties, responsibilities, liabilities, and disabilities of any Trustee under this Agreement shall be determined solely by the express provisions of the Agreement and no further duties, responsibilities, liabilities, or disabilities shall be implied or imposed.

Section 4. The Trustees shall incur no liability, either collectively or individually, in acting upon any papers, documents, data, or information believed by them to be genuine and accurate and to have been made, executed, delivered, or assembled by the proper parties. The Trustees may delegate any of their ministerial powers or duties to any of their agents or employees. No Trustee shall incur any liability for simple negligence, oversight, or carelessness in connection with the performance of his duties as such Trustee. No Trustee shall be liable for the act or omission of any other Trustee. The Trust Fund shall exonerate, reimburse, and hold harmless the trustees, individually and collectively, against any and all liabilities and reasonable expenses arising out of their trusteeship, except (as to the individual Trustee or Trustees directly involved) for expenses or liabilities arising out of willful misconduct or gross negligence. No expense shall be deemed reasonable under this section unless and until approved by the Board of Trustees.

Section 5. (a) Except as otherwise provided in Sub-Section (b) of this Section, upon request of a Trustee or former Trustee, or the legal representative of a deceased Trustee or former Trustee, the Board of Trustees shall provide for the defense of any civil action or proceeding brought against the Trustee, former Trustee, or estate of a deceased Trustee or former Trustee, in his or her capacity as such Trustee or former Trustee or in his or her individual capacity or in both, on account of any act or omission in the scope of his or her service or duties as a Trustee of the Fund. For the purposes of this Section, a cross-action, counterclaim, cross-complaint, or administrative or arbitration proceeding against a Trustee or former Trustee or estate shall be deemed to be a civil action or proceeding brought against him or her or it.

(b) The Board of Trustees may refuse to provide for the defense of a civil action or proceeding brought against a Trustee or former Trustee or estate if the Board determines that:

(1) The act or omission was not within the scope of his or her service as a Trustee of the Fund; or

(2) He or she acted or failed to act in breach of his or her fiduciary duty because of willful misconduct or gross negligence; or

(3) The defense of the action or proceeding by the Board would create a conflict of interest between the Board or Trust Fund and the Trustee, former Trustee, or estate.

(c) The Board of Trustees may provide for the defense of a criminal action brought against a Trustee or former Trustee if:

(1) The criminal action or proceeding is brought on account of an act or omission in the scope of his or her services or duties as a Trustee or Former Trustee; and

(2) The Board determines that such defense would be in the best interests of the Fund and its participants and beneficiaries and that the Trustee or former Trustee acted, or failed to act, in good faith, without actual malice and in the apparent interests of the Fund and its participants and beneficiaries.

(d) The Board may provide for a defense pursuant to this section by Trust Fund counsel or by employing other counsel for such purpose or by purchasing insurance which requires that the insurer provide the defense. All of the expenses of providing a defense pursuant to this Section are proper charges against the Trust Fund. The Trust Fund shall have no right to recover such expenses from the Trustee, former Trustee, or estate.

(e) If after request, the Board fails or refuses to provide a Trustee, former Trustee, or estate with a defense against a civil action or proceeding brought against him or her or it and the Trustee or former Trustee or legal representative retains his or her own counsel to defend the action or proceeding, he or she shall be entitled to recover from the Trust Fund such reasonable attorneys fees, costs, and expenses as are necessarily incurred by him or her in defending the action or proceeding if the action or proceeding arose out of an act or omission in the scope of his or her service or duties as a Trustee of the Trust Fund, unless the Board establishes that the Trustee or former Trustee acted or failed to act in breach of his or her fiduciary duty because of willful misconduct or gross negligence.

Section 6. Neither the Employers, the Union, nor any of the Trustees shall be responsible or liable for:

(a) The validity of this Trust Agreement or the Health and Welfare Plan.

(b) The form, validity, sufficiency, or effect of any contract or policy for Health and Welfare benefits which may be entered into.

(c) Any delay occasioned by any restriction or provision in this Trust Agreement, the Health and Welfare Plan, the rules and procedures of the Board of Trustees issued hereunder, any contract or policy procured in the course of the administration of the Trust Fund, or by any other proper procedure in such administration; provided, however, that this clause shall not excuse any violation of any of the collective bargaining agreements or memorandums of understanding.

(d) The making or retention of any deposit or investment of the Trust Fund or any portion thereof, or the disposition of any such investment, or the failure to make any investment of the Trust Fund, or any portion thereof, or any loss or diminution of the Trust Fund, except as to the particular person involved, such loss as may be due to the gross neglect or willful misconduct of such person.

Section 7. Neither the Employer, any signatory association, any individual employee or the Union shall be liable in any respect for any of the obligations or acts of the Trustees because such Trustees are in any way associated with such Employer or Union.

Section 8. Subject to and within the limitations provided in ERISA, The Board of Trustees may provide for the reimbursement to the Trustees for expenses incurred in the performance of their duties as Trustees, including attendance at educational or training conferences, institutes or other meetings relevant to such duties as authorized by the Board, and for a reasonable payment to the Trustees for attendance at meetings or other services rendered to the Trust Fund at the request or direction of the Board.

Section 9. Any trustee who resigns or is removed from office shall forthwith turn over to the Chairman or Secretary of the Board of Trustees at the principal office of the Trust Fund any and all records, books, documents, moneys, and other property in his or her possession or under his or her control which belong to the Trust Fund or which were received by him or her in his or her capacity as such Trustee.

Section 10. The name of the Trust Fund may be used to designate the Trustees collectively and all instruments may be effected by the Board of Trustees in such name.

ARTICLE VII
ARBITRATION

Section 1. In the event that the trustees deadlock on any matter arising in connection with the administration of the Trust Fund or the Health and Welfare Plan, they shall agree upon a neutral person to serve as an impartial umpire to decide the dispute. The Trustees may, by mutual agreement, select two representatives from the trustee group to sit with the umpire to constitute a Board of Arbitration. If such is done, the decision of a majority of this Board shall be final and binding upon the Trustees and the parties and beneficiaries of this agreement and of the Health and Welfare Plan. Otherwise, the decision of the impartial umpire shall be final and binding upon the trustees, the parties, and the beneficiaries of the agreement and the Health and

Welfare Plan. Any matter in dispute and to be arbitrated shall be submitted to the Board of Arbitration or the impartial umpire, as the case may be, in writing, and in making its or his or her decision, the Board or umpire shall be bound by the provisions of this agreement, the Health and Welfare Plan, the collective bargaining agreements and memorandums of understanding and shall have no authority to alter or amend the terms of any thereof. If the Trustees cannot jointly agree upon a statement submitting said matter to arbitration, each Trustee shall prepare and state in writing its version of the dispute and the question or questions involved. The decision of the Board of Arbitration or the impartial umpire, as the case may be, shall be rendered in writing within ten (10) days after the submission of the dispute.

Section 2. If no agreement on an impartial umpire is reached within ten (10) days, or within such further time as the Trustees may allow for such purpose by mutual agreement, such umpire shall, on petition of the Trustees, be appointed by the United States District Court for the Northern District of California.

Section 3. The reasonable expenses of any such arbitration, including any necessary court proceedings to secure the appointment of an umpire or the enforcement of the arbitration award (excluding the fees and expenses of witnesses called by the parties and the cost of any attorneys other than the Trust Fund attorneys selected pursuant to Section 5 (d) of Article IV, shall be a proper charge against the Trust Fund. No expenses shall be deemed reasonable under this section unless and until approved by the Board of Trustees.

Section 4. No matter in connection with the interpretation or enforcement of any collective bargaining agreement or memorandum of understanding shall be subject to arbitration under this Article. No matter which is subject to arbitration under this Article shall be subject to the grievance procedure or any other arbitration procedure provided in any of the collective bargaining agreements or memorandums of understanding.

ARTICLE VIII.
GENERAL PROVISIONS

Section 1. Subject to the provisions of the collective bargaining agreements, memorandums of understanding, the rights and duties of all parties, including the Employer, the Union, the Employees and the Trustees, shall be governed by the provisions of this Trust Agreement and the Health and Welfare Plan and any insurance policies or contracts procured or executed pursuant to this Trust Agreement.

Section 2. No employee or other beneficiary or person shall have any right or claim to benefits under the Plan other than as specified in the Plan. Any and every claim to benefits from the Trust Fund, and any claim or right asserted under the Plan or against the Trust Fund, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred, shall be resolved by the Board of Trustees under and pursuant

to the Plan and its decision with regard to the claim or right shall be final and binding upon all persons affected by the decision. The Board of Trustees shall establish a procedure for the presentation, consideration and determination of any such claim or right, which procedure shall comply with ERISA. No action may be brought for benefits under the Plan or to enforce any right or claim under the Plan or against the Trust Fund until after the claim for benefits or other claim has been submitted to and determined by the Board in accordance with the procedure thus established and thereafter the only action which may be brought is one to enforce the decision of the Board or to clarify the rights of the claimant under such decision. Neither the Employer, the Union, nor any of the Trustees shall be liable for the failure or omission for any reason to pay any benefits under the Plan.

Section 3. Any notice required to be given under the terms of this Trust Agreement, the Health and Welfare Plan, or the rules and regulations of the Board of Trustees shall be deemed to have been duly served if delivered personally to the person to be notified, or if mailed in a sealed envelop, postage prepaid, or such person at his or her last known address as shown in the records of the Trust Fund, or if sent by wire or other means of written communication to such person at said last known address.

Section 4. This Trust Agreement shall be binding upon and inure to the benefit of all Employer and the heirs, executors, administrators, successors, purchasers, and assigns of the Employer, and the employees and beneficiaries, the Union and the Trustees.

Section 5. All questions pertaining to this Trust Agreement, the Trust Fund or the Health and Welfare Plan, and their validity, administration and construction, shall be determined in accordance with the law of the State of California and with any pertinent laws of the United States.

Section 6. If any provision of this Trust Agreement, the Health and Welfare Plan, the rules and procedures made pursuant thereto, or any step in the administration of the Trust Fund or the Health and Welfare Plan is held to be illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining portions of the Trust Agreement or Plan or the rules and regulations, unless such illegality or invalidity prevents accomplishment of the objectives and purpose of the Trust Agreement and the Plan. In the event of any such holding, the parties will immediately commence negotiations to remedy any such defect.

Section 7. Except to the extent necessary for the proper administration of the Trust Fund or the Health and Welfare Plan, all books, records, reports, documents, or other information obtained with respect to the Trust Fund or the Plan shall be confidential and shall not be made public or used for any other purpose. Nothing in this section shall prohibit the preparation and publication of statistical data and summary reports with respect to the operations of the Trust Fund and the Plan.

Section 8. Any payment required by a decision of the Board shall be due and payable in the County of Alameda, State of California, and any action or proceeding to enforce or clarify

such decision shall be brought in a court of competent jurisdiction in that County. Any action or proceeding affecting the Trust Fund, the Plan or the Trust hereby established shall be brought solely against the Fund as an entity, and solely by or on behalf of the claimant in the claims procedure established pursuant to Section 2 of this Article, and neither the Employer nor the Union, any employee, any beneficiary or other person shall be entitled to notice of any such action or proceeding or to service of process therein. Any final judgment entered in any such action or proceeding shall be binding upon all of the above mentioned parties so long as such judgment does not attempt or purport to impose any personal liability upon or against any party not joined or not served in any such action or proceeding.

Section 9. The section headings and numbers are included only for convenience of reference and are not to be taken as limiting or extending the meaning of any of the terms and provisions of this Plan and Trust Agreement. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

ARTICLE IX.
AMENDMENT AND TERMINATION

Section 1. The provisions of this Trust Agreement may be amended, altered, or modified at any time, and from time to time, by the Board of Trustees with the consent of the Union and the Employer shall be in writing subject to the terms and conditions of the collective bargaining agreements, memorandums of understanding, and any applicable law or regulation.

Section 2. The provisions of this Trust Agreement shall continue in effect during the term of the collective bargaining agreements, memorandums of understanding, and any renewals or extensions thereof with respect to such collective bargaining agreements and memorandums of understanding, as provided for the continuation of payments into the Trust Fund and of the Health and Welfare Plan.

Section 3. This Trust Agreement may be terminated by the Board of Trustees with the consent of the Union and the Employer by an instrument in writing executed by mutual consent at any time.

Section 4. In no event shall the trust established by this agreement continue for a longer period than is permitted by law.

Section 5. Upon the termination of the trust herein provided, any and all moneys remaining in the Trust Fund after the payment of all expenses shall be used for the continuance of one or more benefits of the type provided by the Health and Welfare Plan, until such moneys have been exhausted.

Employer:

By: Keith Fleming

Keith Fleming
President
IEDA
a California Nonprofit Corporation

Union:

By:

Donald Doser
Business Manager
OPERATING ENGINEERS
LOCAL UNION NO. 3
a labor organization

AMENDMENT NO. 1

to the

Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations

Effective August 1, 1999

Effective August 1 1999, Article 12. Exclusions, Limitations and Reductions is amended by adding a new Section 12.05. to read as follows:

Section 12.05. Coordination with Medicare.

A. If the Eligible Individual is a Retired Participant or Dependent of a Retired Participant and is entitled to Medicare, Medicare will be the primary payer and this Plan will be the secondary payer. Fund benefits will be coordinated with benefits paid by Medicare. If the individual does not enroll in Medicare when eligible, this Plan will coordinate benefits as though the individual is receiving benefits under Parts A and B of Medicare. The Plan will estimate that Medicare's payment is 80% of Covered Expenses incurred.

B. If the Eligible Individual is an Active Participant or Dependent of an Active Participant and is entitled to Medicare either because of age or because he is entitled to a disability pension from Social Security, this Plan's benefits will be payable without reduction. However, if the Active Participant or his Dependent specifically elects to have Medicare be the primary payer, no benefits will be payable by this Plan.

Executed this 14 day of January, 2002.

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

144472/03532.001

AMENDMENT NO. 2

to the

Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations

Effective August 1, 1999

Effective July 1, 2001, Subsection A. of **Section 2.02. Eligibility Rules for Retired Participants** is restated in its entirety as follows.

A. Establishment and Maintenance of Eligibility. To become eligible for benefits as a Retired Participant, each of the following requirements must be satisfied:

(1) The Participant must have been covered under this Plan as an Active Employee for the 12 consecutive months prior to retirement;

(2) The Participant must be eligible to receive pension benefits from his former Employer;

(3) The required contributions must be paid to the Fund; and

(4) Application to enroll in the Plan as a Retired Participant must be filed with the Fund Office within 30 days of retirement and coverage under the Plan must be continuous with no break in coverage.

Executed this 14 day of January, 2002

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

144470/03532.001

AMENDMENT NO. 3

to the

Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations

Effective August 1, 1999

Effective October 1, 2001, the following changes are made to the Plan:

1. Article 6 is re-named **Chemical Dependency Rehabilitation Treatment Benefits**

2. The first paragraph of Section 6.01 is restated as follows:

   Section 6.01. Benefits. If an Eligible Individual receives treatment for alcohol or other chemical dependency under the Operating Engineers Addiction Recovery Program (ARP), the Plan will pay the following benefits for treatment that has been pre-authorized by the Addiction Recovery Program.

3. Subsection E. of **Section 6.02. Exclusions and Limitations.** is deleted, and Subsection F. is re-lettered as Subsection E.

Executed this 14 day of January, 2002

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

147836/03532.001

AMENDMENT NO. 4

to the

Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations

Effective August 1, 1999

Effective January 1, 2003, the following change is made to Article 12 of the Plan:

Section **12.01. Exclusions and Limitations** is amended by restating Section 12.01.C. in its entirety as follows:

C. Work-related conditions, regardless of whether or not the Eligible Individual is covered under workers' compensation insurance or an occupational disease law, unless worker's compensation insurance was unavailable to the Eligible Individual, in which case this exclusion will not apply. Workers' compensation insurance will not be considered "unavailable" based on the cost of the coverage. The Plan will, however, pay benefits on behalf of an Eligible Individual who has incurred an occupational Injury or Illness and who is covered by workers' compensation insurance, on the following conditions:

(1) The Eligible Individual signs an agreement to diligently prosecute his claim for workers' compensation benefits or for any other available occupational compensation benefits;

(2) The Eligible Individual agrees to reimburse the Fund for benefits paid on his behalf by consenting to a lien against any occupational compensation benefits received through adjudication, settlement or otherwise; and

(3) The Eligible Individual cooperates with the Fund or its designated representative by taking reasonably necessary steps to secure reimbursement, through legal action or otherwise, for any benefits paid for the Eligible Individual's occupational Injury or Illness.

Executed this 27th day of January, 2003.

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

161665/03532.001

AMENDMENT NO. 5

to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations

Effective August 1, 1999

Effective January 1, 2002, the following changes are made to Article 2 of the Plan:

1. **Section 2.02. Eligibility Rules for Retired Participants** is amended by adding a new Section 2.02.C. as follows:

   C. **Exception to Termination of Eligibility.** A Retired Participant who becomes ineligible pursuant to Section 2.02.B. as a result of his bargaining unit decertifying itself with the Union may continue Plan coverage provided the following conditions are met:

      (1) The Retired Participant became retired when his Employer was a Contributing Employer in the Trust Fund; and

      (2) The Retired Participant meets all other eligibility rules under the Plan.

Executed this 27th day of January 2003.

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

AMENDMENT NO. 6

to the Rules and Regulations

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations
Effective August 1, 1999

Effective April 14, 2003, the following changes are made to the Plan:

A new **Section 13.10** is added to **Article 13. General Provisions.**, as follows:

Section 13.10. Use and Disclosure of Protected Health Information

A. Use and Disclosure of Protected Health Information (PHI): The Plan will use Protected Health Information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

(1) Payment. "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(a) Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim),

(b) Coordination of benefits,

(c) Adjudication of health benefit claims (including appeals and other payment disputes),

(d) Subrogation of health benefit claims,

(e) Establishing employee contributions,

(f) Risk adjusting amounts due based on enrollee health status and demographic characteristics,

(g) Billing, collection activities and related health care data processing,

(h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,

(i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).

(j) Medical necessity reviews, or reviews of appropriateness of care or justification of charges,

(k) Utilization review, including Precertification, Preauthorization, concurrent review and retrospective review,

(l) Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan), and

(m) Reimbursement to the Plan.

(2) Health Care Operations. "Health Care Operations" include, but are not limited to, the following activities:

(a) Quality Assessment,

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,

(c) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,

(d) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),

(e) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,

(g) Business management and general administrative activities of the entity, including, but not limited to:

(h) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,

(i) Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,

(j) Resolution of internal grievances, and

(k) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

(l) Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

B. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the pension plan for purposes related to administration of that plan.

C. For purposes of this Amendment, the Board of Trustees of the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund is the "Plan Sponsor." The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

D. With respect to PHI, the Plan Sponsor agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information,

(3) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,

(4) Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual.

(5) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

(6) Make PHI available to the individual in accordance with the access requirements of HIPAA,

(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

(8) Make available the information required to provide an accounting of disclosures.

(9) Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA, and

(10) If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

D. Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(1) The Plan Administrator, and

(2) The following staff designated by the Plan Administrator:

(a) Claims adjustors
(b) Clerical staff
(c) Team leaders and managers
(d) Data processing staff
(e) Billing and eligibility staff
(f) Other staff as designated by the Plan Administrator as needed

E. The persons described in Section E may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

F. If the persons described in Section E do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

G. For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

May 19, 2003
Date

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

165372/03532.001

AMENDMENT NO. 7

to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations

Effective August 1, 1999

Effective August 1, 2003, the following changes are made to the Plan:

1. A new **Article 17. Weekly Disability Benefits,** is added as follows:

Section 17.01. Eligibility. Only Employees of the Incline Village General Improvement District have coverage under this Article 17. Eligibility for this benefit begins on the first day of the month in which an Employee of the Incline Village General Improvement District satisfies the eligibility requirements for coverage under the Fund.

Section 17.02. Definition of Disability. For purposes of this Article, "Disability" and "Disabled" mean that:

A. The Active Employee is unable, due to Illness, Injury, or Pregnancy, to perform the substantial and material duties of the occupation in which he or she was engaged when he or she became Disabled; and

B. The Active Employee is not engaged in any gainful occupation.

Section 17.03. Benefits. If an Active Employee, while eligible under this Plan, becomes Disabled, the Fund will pay 60% of his or her average weekly salary, up to a maximum of $500 per week, subject to the following provisions:

A. Benefits are payable for a maximum duration of ninety (90) days per Period of Disability.

B. Benefits begin with the thirtieth (30^{th}) day of a Disability.

C. A physician's written certification of Disability is required before benefits are payable.

D. For occupational injuries covered by Workers' Compensation Temporary Disability, available Weekly Disability Benefits will be reduced by any amounts payable under Workers' Compensation Temporary Disability, so that the total amount payable to the Employee from both sources does not exceed 60% of his or her average weekly salary not to exceed $500 per week.

E. Plan benefits are based on a seven day calendar week. Partial weeks of Disability are payable at one-seventh of the weekly benefit amount for each full day of Disability. No benefit will be paid for part of a day.

Section 17.04. Periods of Disability. Successive periods of Disability will be considered separate Periods of Disability:

A. if due to an unrelated cause(s) and separated by at least one full day of active full-time employment with the Contributing Employer; or

B. if due to related cause(s) and separated by at least two consecutive weeks of active full-time employment with the Contributing Employer.

Section 17.05. Exclusions. No benefits are payable:

A. For a Disability which commenced before the individual became eligible under the Fund.

B. For any bodily Illness or Injury for which a Physician's written certification of Disability is not furnished to the Fund.

C. Once the Employee is receiving permanent disability benefits. Permanent disability is defined as being certified as physically unable to engage in any employment for wages or profit for a period of at least six (6) months.

D. Once the Employee is receiving Social Security benefits.

E. Once the Employee is receiving pension benefits.

F. For a Dependent.

G. For an Active Employee who has returned to work on modified duty that is allowed by the Employer.

2. The first sentence of Section 1.49 is changed to read as follows: "For all benefits other than the Weekly Disability Benefits described in Article 17, the term "Total Disability" or "Totally Disabled" means:"

Executed this 31st day of December, 2004.

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

174475/03532.001

AMENDMENT NO. 8
to the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund
Rules and Regulations
Effective August 1, 1999

Effective January 1, 2004, the following changes are made to the Plan.

1. Section 4.09.V. is restated in its entirety as follows:

   V. Speech and Occupational Therapy, when prescribed by a Physician and provided by a licensed speech or occupational therapist, subject to the following conditions:

      (1) Speech therapy benefits are provided for Patients who had normal speech at one time but lost it due to Illness or Injury. Benefits are payable only until understandable speech is attained or until a determination is made that understandable speech cannot be attained.

      (2) Benefits for speech therapy provided for any condition other than those specified in paragraph (1) above are limited to a maximum payment of $1,000.00 per calendar year or $2,000.00 lifetime. However, the Physician's evaluation of the need for speech therapy will not be applied to these maximums. Benefits are payable only until understandable speech is attained or until a determination is made that understandable speech cannot be attained

2. Section 4.10.D. is restated in its entirety as follows:

   D. Hyperkinetic syndromes, learning disabilities, behavioral problems, developmental delay, attention deficit disorders, mental retardation or autistic disease, except that the exclusion of developmental delay will not apply to covered speech therapy services provided to a Dependent child who has failed to attain age appropriate speech.

Executed this 18 day of October, 2004.

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

176536/03532.001

AMENDMENT NO. 9

to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations

Effective August 1, 1999

Effective January 1, 2004, the following changes are made to the Plan:

1. Section 1.16.B.(2) is deleted in its entirety and replaced with the following:

   (2) Stepchildren or children for whom the Participant has been appointed legal guardian, provided the child is under 23 years of age, lives with the Participant and is claimed as a dependent on the Participant's federal income tax return. However, if the Participant and natural parent of the stepchild(ren) are legally separated, the stepchildren do not need to be living with the Participant to remain eligible under this Plan until the Participant's divorce from their natural parent is finalized. Stepchildren are no longer eligible once there is a final dissolution of the marriage of their natural parent and the Participant.

Executed this 5TH day of AUGUST, 2004.

Chairman JOHN A. BONILLA

Co-Chairman AUSTRIS RUNGIS

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

178479/03532.001

AMENDMENT NO. 10
to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations
Effective August 1, 1999

Effective January 1, 2003, the following changes are made to Article 16 of the Plan:

ARTICLE 16. CLAIM APPEAL PROCEDURES, is deleted in its entirety and restated as follows:

ARTICLE 16. CLAIMS AND APPEALS PROCEDURES

A. **Definitions.**

(1) Adverse Benefit Determination. An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(a) a payment of less than 100% of a Claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible);

(b) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;

(c) a failure to cover an item or service because the Plan considers it to be experimental, investigational, not medically necessary or not medically appropriate;

(d) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the participant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Plan).

(2) Claim. The term "Claim" means a request for a benefit made by a participant in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a participant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the participant pays the entire cost, the participant should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

A request for Precertification or Prior Authorization of a benefit that does not require Precertification or Prior Authorization by the Plan as a condition for receiving maximum benefits is not considered a Claim. However, requests for Precertification or Prior Authorization of a benefit where the Plan does require Precertification or Prior Authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

(a) Claims are Categorized as Follows:

(i) Pre-Service Claim. The term "Pre-Service Claim" means a Claim for a benefit for which the Plan requires Precertification or Prior Authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

(ii) Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

(iii) Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of the previously approved benefit.

(iv) Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a Claim for reimbursement for services already rendered.

(3) Relevant Documents. "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

B. **Claim Procedures.**

(1) Pre-Service Claims. Under the terms of this Plan, claimants are required to obtain Precertification for Hospital admission and chemical dependency services in order to receive maximum benefits.

The Plan's designated Review Organization will notify the participant of an improperly filed Pre-Service Claim as soon as possible, but no later than 5 days after receipt of the Claim, of the proper procedures to be followed in filing a Claim. In order for the Plan to notify a participant of an improperly filed Pre-service Claim, the Claim must be submitted to the appropriate office and include: (i) participant's name, (ii) participant's specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Any submissions that do not contain said information will not constitute a Claim.

For properly filed Pre-Service Claims, the participant [and the claimant's doctor] will be notified of a decision within *15 days* after receipt of the Claim unless additional time is needed. The time for response may be extended for up to an additional *15 days* if necessary due to matters beyond the control of the Review Organization. If an extension is necessary, the participant will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is required because the Plan needs additional information from the participant, the Plan will issue a request for additional information that specifies the information needed. The participant will have 45 days from the date of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until the earlier of: (i) 45 days; or (ii) the date the participant responds to the request. The Review Organization then has 15 days to make a determination on the Claim.

(2) Urgent Claims. The Plan will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies the Plan of such, it will be treated as an Urgent Claim.

Urgent Claims, which may include requests for Precertification of hospital admissions and Prior Authorization of services, must be submitted by telephone. Urgent Claims may **not** be submitted via the US Postal service.

For properly filed Urgent Claims, the Plan or its designated Review Organization will respond to the participant and provider with a determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Plan or its designated Review Organization will notify the participant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The participant must provide the specified information within 48 hours after receiving the request for additional information. If the information is not provided within that time, the Claim will be denied.

During the period in which the participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information.

If a participant improperly files an Urgent Claim, the Trust Fund office or its designated Review Organization will notify the participant as soon as possible but not later than 24 hours after receipt of the Claim of the proper procedures required to file an Urgent Claim. Improperly filed Claims include, but are not limited to: (i) Claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or (ii) Claims that do not name a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. The notification may be oral unless the participant or authorized representative requests written notification. Unless refiled properly, it will not constitute a Claim.

(3) Concurrent Claims. Any request by a participant to extend an approved Urgent Claim will be acted upon by the Review Organization within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a Plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

(4) Post-Service Claims. A Post-Service Claim must be submitted to the Trust Fund Office in writing, using an appropriate Claim form, as soon as reasonably possible but in no event later than one (1) year after expenses are incurred. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim within such time. However, in that case, the Claim must be submitted as soon as reasonably possible after the date the charges were incurred. The Board of Trustees has absolute discretion to make a determination as to whether benefits are to be issued after the one (1) year time period has elapsed.

The Claim form must be completed in full and an itemized bill(s) must be attached to the Claim form in order for the request for benefits to be considered a Claim. Participants do not have to submit an additional Claim form if the bill(s) are for a continuing illness and participant filed a signed Claim form within the past calendar year period. The provider or physician may file the Claim on the participant's behalf. The Claim form and/or itemized bill(s) must include the following information for the request to be considered a Claim and for the Plan to be able to decide the Claim:

Participant completes:

(a) Participant or retiree name
(b) Patient Name
(c) Patient's Date of Birth
(d) SSN of Participant or retiree
(e) Date of Service
(f) Information on other insurance coverage, if any, including coverage that may be available to participant's spouse through his or her employer
(g) If treatment is due to an accident, accident details

Provider completes:

(a) CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association) or HCPC code
(b) ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
(c) Number of Units (for anesthesia and certain other Claims)
(c) Billed charge (bills must be itemized with all dates of Physician visits shown)
(d) Federal taxpayer identification number (TIN) of the provider
(e) Provider's billing name, address and phone number

In the event of death, participant must obtain a Claim form and submit the written Claim form and a certified copy of the death certificate to the Fund Office.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Trust Fund Office.

Ordinarily, participants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Trust Fund Office. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the participant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the Plan needs additional information from the participant, the Plan will request additional information from provider and/or participant via fax, telephone, Explanation of Benefits (EOB) or letter. The request shall specify the information needed. The participant will then have 45 days from receipt of the request to supply the additional information. If the information is not provided within that time, the Claim will be denied. The deadline for making a decision on the Claim will be suspended from the date of the request for additional information until the earlier of: (i) 45 days after the request is sent; or (ii) the date the participant responds to the request. The Plan then has 15 days to make a decision and notify the participant of its determination.

If the Plan determines that additional information is required from the participant, and the participant fails to provide any requested information within 45 days, the Planwill issue a notice of adverse benefit determination.

(6) Burial Expense Benefit. For burial expense benefits, the underwriter will make a decision on the Claim and notify the claimant of the decision within 90 days of receipt of the Claim. If the underwriter requires an extension of time due to matters beyond their control, they will notify the claimant of the reason for the delay and the date by which they expect to render a decision before the expiration of the 90-day period. The period for making a decision may be delayed an additional 90 days.

(7) Authorized Representatives. An authorized representative, such as a spouse or an adult child, may submit a Claim or appeal on behalf of a participant if the participant has previously designated the individual to act on his or her behalf through a form available at the Fund Office. The Trust Fund office may request additional information to verify that the designated person is authorized to act on the participant's behalf. Even if participant has designated an authorized representative, the participant must personally sign a Claim form and file it with the Fund Office at least annually.

A health care professional with knowledge of the participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the participant having to designate an authorized representative.

(8) Notice of Initial Benefit Determination. The participant will be provided with written notice of the initial benefit determination. If the determination is an Adverse Benefit Determination, the notice will include:

(a) the specific reason(s) for the determination;
(b) reference to the specific Plan provision(s) on which the determination is based;
(c) a description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
(d) a description of the appeal procedures and applicable time limits;
(e) a statement of the participant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;
(f) if an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;
(g) if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
(h) for Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

C. **Appeal Procedures.**

(1) Appealing an Adverse Benefit Determination. If any Claim is denied in whole or in part, or if the participant disagrees with the decision made on a Claim, the participant may appeal the decision in the manner specified below. Appeals must be submitted to the Trust Fund office within 180 days after the participant receives the notice of Adverse Benefit Determination, must be accompanied by any pertinent material not already furnished to the Plan, and must state why the participant believes the Claim should not have been denied.

(a) Pre-Service Claims. Appeals of Adverse Benefit Determinations regarding Pre-Service Claims must be in writing via mail or facsimile. A Pre-Service Claim appeal that is received with additional information which, upon review, allows additional benefits to be approved by the Trust Fund office or its designated Review Organization in accordance with Plan provisions will not be considered an appeal, but a new Pre-Service Claim.

(b) Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made either by calling the designated Review Organization or by other available similarly expeditious method, including electronic means.

Appeals of Urgent Claims may **not** be submitted via the US Postal service.

(c) Concurrent Claims. Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

(b) Post-Service and Burial Expense Benefit Claims. The appeal of a Post-Service, or Burial Expense Benefit Claim must be submitted in writing to the Trust Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

(i) the patient's name and address
(ii) the participant's name and address, if different;
(iii) a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
(iv) the date of the Adverse Benefit Determination; and
(v) the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

(2) The Appeal Process. The participant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The participant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the participant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the participant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

(3) Timeframes for Sending Notices of Appeal Determinations.

(a) Pre-Service Claims. Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal by the Trust Fund Office or designated Review Organization.

(b) Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Trust Fund office or designated Review Organization.

(c) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim will be sent by the Trust Fund office or its designated Review Organization prior to the termination of the benefit.

(d) Post-Service and Death Benefits Claims. Ordinarily, decisions on appeals involving Post Service or Death Benefits Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of participant's request for review. However, if the request for review is received at the Trust Fund Office less than 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the participant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the participant's request for review may be necessary. The participant will be advised in writing in advance of this extension. Once a decision on review of participant's Claim has been reached, the participant will be notified as soon as possible, but no later than 5 days after the date of the decision.

(b) If the decision on review is not furnished to the participant within the time specified in this subsection c.(3), participant's Claim shall be deemed denied upon review. Participant shall be free to bring an action upon his Claim in accordance with subsection c.(5), below.

(4) Content of Appeal Determination Notices. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

(a) the specific reason(s) for the determination;
(b) reference to the specific Plan provision(s) on which the determination is based;
(c) a statement that the participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
(d) a statement of the participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
(e) if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and
(f) if the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

(5) When a Lawsuit may be Started. No Employee, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A participant may not start a lawsuit to obtain benefits until after either: (1) the participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since participant filed a request for review and participant has not received a final decision or notice that an extension will be necessary to reach a final decision. The denial of a Claim to which the right to review has been waived, or the decision of the Board with respect to a petition for review, is final and binding upon all parties including the claimant or the petitioner, subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration. The provisions of this Article 16 shall apply to and include any and every Claim to benefits from the Fund, and any Claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the Claim, and regardless of when the act or omission upon which the Claim is based occurred, and regardless of whether or not the claimant is a "participant" or "beneficiary" of the Plan within the meaning of those terms as defined in ERISA. Such Claim shall be limited to benefits due under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any Claim or right to damages, either compensatory or punitive.

December 31, 2004

Date

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

165347/03532.001

RESOLUTION OF OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND

WHEREAS, the Board of Trustees of Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund (hereinafter "Board") previously established a plan to provide health and welfare benefits under the Rules and Regulations of the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund (hereinafter "Plan") for the exclusive benefit of eligible Participants and their Dependents;

WHEREAS, the Board of Trustees reserves the right to amend the Plan as provided for in Article 14, Section 14.01. C. of the Plan;

WHEREAS, Retired Participants are not eligible to participate in the Plan when a unit de-certifies itself with Operating Engineers Local Union no. 3 of the International Union of Operating Engineers (hereinafter "Union");

RESOLVED, that effective January 1, 2003, it is the intent of the Board of Trustees to adopt an amendment to Article 2, Section 2.02. of the Plan which allows a Retired Participant to maintain his health and welfare coverage through the Plan even if his unit has decertified itself with the Union provided: (1) the Retired Participant became retired when his unit was active in the Plan; and (2) the Retired Participant meets all other eligibility rules under the Plan.

RESOLVED FURTHER, that it is the intent of the Board of Trustees to adopt said amendment at the next Board of Trustees meeting scheduled for January 27, 2003.

Dated: January 7, 2003

DON DOSER

AUSTRIS RUNGIS

JOHN BONILLA

T. ROBERT MILLER

KURT BENFIELD

1/290804

Board of Trustees
of the
Operating Engineers Public & Miscellaneous Employees Health and Welfare Trust Fund

RESOLUTION

Appeal Determinations for Urgent and Pre-Service Claims

Whereas, the Board of Trustees has contracted with Blue Cross of California, an independent medical review organization, to provide medical review services for participants of the Fund, and the Trustees, as fiduciaries of the Plan, rely on Blue Cross to provide the medical expertise they do not possess in making medical review decisions involving Urgent and Pre-Service Claims, and

Whereas, the ERISA Claims and Appeals regulations require that notice of appeal determinations for Urgent Claims must be sent to the claimant within 72 hours of receipt of the appeal by Blue Cross and notice of appeal determinations for Pre-Service Claims must be sent to the claimant within 30 days of receipt of the appeal,

It is hereby resolved, that the Appeals Committee of the Board of Trustees accepts and adopts as its own all determinations made by Blue Cross regarding appeals of adverse benefit determinations involving Urgent and Pre-Service Claims.

Approved and adopted this 19th day of May, 2003.

Chairman

Co-Chairman

Board of Trustees
Operating Engineers Public & Miscellaneous Employees Health and Welfare Trust Fund

165651/03532.001

AMENDMENT NO. 11
to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations
Effective August 1, 1999

Effective April 20, 2005, Section 13.10 Use and Disclosure of Protected Health Information is amended by adding a new Subsection H. as follows:

H. The Board of Trustees of the Operating Engineers Public & Miscellaneous Employees Health and Welfare Trust Fund, who are the Plan Sponsor:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

(2) Ensure that the adequate separation discussed in E. above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

May 23, 2005
Date

Chairman

May 23, 2005
Date

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

184606/03532.001

AMENDMENT NO. 12
to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations
Effective August 1, 1999

A. Effective January 1, 2004, the following changes are made to the Plan:

1. The following sentences are added to the definition of Hospital in **Section 1.25.**:

A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to state law. The requirement that a Hospital must provide surgical, anesthesia and/or radiology services does not apply to facilities for mental, nervous and/or substance abuse treatments.

2. The last sentence of Section 8.05.P. is revised to read as follows:

If the Plan makes an allowance toward the cost of such procedures, the Plan will not pay for any replacement placed within five (5) years thereafter.

B. Effective December 10, 2004, Section 2.06 **Leave of Absence Due to Military Leave** is amended by restating Subsection B. as follows:

B. Participants whose period of military service is 31 days or more may continue their eligibility by self-payment for up to 18 months, as described in Section 2.03. Continuation Coverage Under COBRA. Participants whose continuation period begins on and after December 10, 2004 may continue their eligibility for a total of 24 months. During the first 18 months of coverage the Participant will have all COBRA rights. COBRA rights, such as the right to elect additional months of coverage in the event of a second Qualifying Event or a Social Security disability determination, do not apply during the last 6 months of the 24-month period.

May 23, 2005
Date

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

184591/03532.001

AMENDMENT NO. 13
to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations
Effective August 1, 1999

A. Effective April 1, 2007, the following changes are made to the Plan:

1. Section 12.02, Third Party Liability, is restated in its entirety as follows:

Section 12.02. Third Party Liability.

If an Eligible Individual has an Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission, or insurance coverage of that third party or parties (hereinafter referred to collectively as "responsible third party"), the Fund shall not be liable to pay any benefits. However, upon the execution and delivery to the Fund of all documents it requires to secure the Plan's right of reimbursement, including without limitation a Reimbursement Agreement, the Fund may pay benefits on account of Hospital, medical or other expenses in connection with, or arising out of, such Illness, Injury, disease or other condition. Such payment shall be considered only as an advance or loan to the Eligible Individual and the Fund shall have all rights as set forth herein.

The Fund shall be reimbursed first, before any other claims, for 100% of this advance or loan from any recovery received by way of judgment, arbitration award, verdict, settlement or other source by the Eligible Individual or by any other person or party for the Eligible Individual, pursuant to such Illness, Injury, disease or other condition, including recovery from any under-insured or uninsured motorist coverage or other insurance, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. The Fund shall be reimbursed from said recovery without any deduction for legal fees incurred or paid by the Eligible Individual. The Eligible Individual promises not to waive or impair any of the rights of the Fund without written consent. In addition, the Fund shall be reimbursed for any legal fees incurred or paid by the Fund to secure reimbursement of the advance or loan.

If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund shall also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is

due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien shall be satisfied from any recovery received by the Eligible Individual, however classified, allocated, or held.

If reimbursement is not made as specified, the Fund, at its sole option, may take any legal and/or equitable action to recover the amount that was paid for the Eligible Individual's Illness, Injury, disease or other condition (including any legal expenses incurred or paid by the Fund) and/or may offset future benefits payments by the amount of such reimbursement (including any legal fees incurred or paid by the Fund). The Fund, at its sole option, may cease advancing benefits, if there is a reasonable basis to determine that the Eligible Individual will not honor the terms of the Plan, or there is a reasonable basis to determine that this section is not enforceable.

By accepting benefits from the Fund, the Eligible Individual further agrees:

(a) To prosecute any claim for damages diligently;

(b) To promptly advise the Fund whenever a claim is made against the responsible third party with respect to any loss for which Fund benefits have been or will be paid because of an Illness, Injury, disease or other condition caused by the responsible third party;

(c) The Fund's reimbursement rights shall be considered as a first priority claim against another person or entity, to be reimbursed before any other claims, including claims for general damages;

(d) To cooperate and assist the Fund in obtaining reimbursement for payments made, and to refrain from any act or omission that might hinder any reimbursement;

(e) To provide the Fund with all relevant information or documents requested;

(f) To consent to the lien and/or constructive trust that shall exist in favor of the Fund upon all funds recovered by the Eligible Individual against the responsible third party;

(g) To hold proceeds of any settlement, verdict, judgment or other recovery in trust for the benefit of the Fund, and that the Fund shall be entitled to recover reasonable attorney's fees incurred in collecting reimbursement of benefits due;

(h) To execute any documents necessary to secure reimbursement;

(i) Not to assign any rights or cause of action that the Eligible Individual may have against the responsible third party to recover medical expenses without the express written consent of the Fund;

(j) The Fund has the right to intervene, independently of the Eligible Individual, in any legal action brought against the third party or any insurance company, including the Eligible Individual's own carrier for uninsured motorists coverage;

(k) The Fund's right of first reimbursement will not be affected, reduced or eliminated by the make whole doctrine, comparative fault or regulatory diligence or the common fund doctrine;

(l) It will constitute an immediate breach of the agreement and a failure to comply with the terms of the Plan, if, within 30 days following recovery from the responsible third party or insurer, the Eligible Individual does not agree to reimburse the Fund pursuant to this Section 12.02, and pay the reimbursement amount. If the Eligible Individual breaches the agreement and/or fails to comply with this Section 12.02, the amount of benefits advanced by the Fund which are related to the Injury, Illness, disease or other condition will become immediately due and payable together with interest, and all costs of collection, including reasonable attorney fees and court costs.

If the Eligible Individual does not receive any payment from a third party to reimburse for the Illness, Injury, disease or other condition caused by the responsible third party, the Eligible Individual does not have to reimburse the Fund for any benefits properly paid to the Eligible Individual. If the Eligible Individual receives payment from the responsible third party, the Eligible Individual does not have to pay the Fund more than the amount the responsible third party paid to the Eligible Individual.

Feb. 14, 2007

Date

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

1/448566

AMENDMENT NO. 14
to the

Operating Engineers Public & Miscellaneous Employees
Health and Welfare Trust Fund

Rules and Regulations
Effective August 1, 1999

Effective May 1, 2007, the following changes are made to Article 9. Orthodontic Benefits:

1. Section 9.01 is restated in its entirety as follows:

   Section 9.01. Eligibility for Orthodontic Benefits. Certain Collective Bargaining Agreements provide for orthodontic benefits under the Trust Fund. ***This benefit may be provided for Dependent Children under age 23 only, or for all Eligible Individuals, depending on the Collective Bargaining Agreement in effect between the Union and the Employer and the contribution amount paid by the Employer for orthodontic benefits.*** Employers that pay a contribution for orthodontic benefits must pay the contribution for all of their eligible employees. The Participant must be eligible for the Comprehensive Health Plan benefits of the Plan in order to be eligible for orthodontic benefits. Participants should contact the Fund Office to determine if they are eligible for this benefit.

2. The first paragraph of **Section 9.03. Benefits** is restated in its entirety as follows:

   If an Eligible Individual receives treatment provided by a licensed Orthodontist, the Plan will pay 50% of the Customary and Reasonable charges incurred for Covered Orthodontic Services, not to exceed a lifetime maximum benefit of $2,500 per person.

3. The word "child" is deleted from the last sentence of the second paragraph of **Section 9.03;** this sentence is restated as follows:

   No payment will be made during any month in which the Participant is not eligible or the Dependent does not meet the Plan definition of a Dependent.

4. **Section 9.05. Exclusions** is amended by restating Subsections A, B and E as follows:

   A. An Eligible Individual whose initial banding occurred: (1) prior to the date he or she became eligible under the Plan, or (2) prior to the date the Participant's Employer was first required to contribute to the Fund for orthodontic benefits.

   B. Orthodontic treatment for the Participant or Spouse unless the Employer's Collective Bargaining Agreement provides orthodontic benefits for all Eligible Individuals.

   E. Any month in which the Participant is not eligible or the Dependent does not meet the Plan definition of Dependent.

May 17, 2007

Date

Chairman

Co-Chairman

Board of Trustees
of the
Operating Engineers Public and Miscellaneous Employees
Health and Welfare Trust Fund

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