

# OE3 Trust Funds

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## OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND

**SUMMARY PLAN DESCRIPTION  
AND RULES AND REGULATIONS**

**2012**

# OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND

Summary Plan Description  
and Rules and Regulations

January 2012



**OPERATING ENGINEERS  
HEALTH AND WELFARE TRUST FUND**

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## **OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND**

TO OPERATING ENGINEERS AND THEIR FAMILIES:

We are pleased to provide you with this booklet describing your health care and insurance benefits under the Operating Engineers Health and Welfare Trust Fund as of July 2011.

Here is what you'll find inside:

- An overview of your benefits,
- Information on eligibility and enrollment,
- Chapters on the individual benefits (medical, prescription drug, dental, vision care, life insurance, accidental death and dismemberment, burial expense), and
- Other important Plan information.

This booklet also includes the Rules and Regulations of the Operating Engineers Health and Welfare Trust Fund.

### ***Summary Plan Description***

The part of the booklet before the Rules and Regulations is your Summary Plan Description (SPD). It is meant to describe major provisions of the Plan in simplified language. The SPD is not intended to provide full details or interpret Plan provisions or to extend or change in any way the provisions of the Plan or the service agreements or insurance contracts.

If there are any conflicts between the simplified descriptions in the SPD and the Plan Rules and Regulations or the Trust Agreement, the Rules and Regulations and the Trust Agreement will take precedence.

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Inglés. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contacto con la Trust Fund Office a la dirección y teléfono en el Quick Reference Chart de este documento.

### ***Making the Most of Your Benefits***

You can make the most of your benefits and keep costs down for everyone by using contract health care providers. These providers have contract arrangements with the Plan's Preferred Provider Organization that are designed to lower costs without reducing the level of care available to you. Contract Providers offer services at special rates to Plan participants. Refer to the Contract Provider directory or contact the Trust Fund Office for more information.

### ***Questions?***

We encourage you to read this booklet carefully and keep it handy for future reference. If you are married, please share the booklet with your spouse. If you have questions about your benefits, contact the Trust Fund Office or the Fringe Benefits Service Center, where the staff will be pleased to assist you.

Sincerely,  
BOARD OF TRUSTEES

# Contacts

<b>TRUST FUND OFFICE</b>	
Eligibility information and Enrollment forms	(800) 251-5014 or (510) 433-4422 or (510) 271-0222
Claims information and Contract Provider updates	(800) 251-5013 or (510) 433-4422

<b>FRINGE BENEFITS SERVICE CENTER</b>	
Benefits questions	(800) 532-2105 or (510) 748-7450

<b>ANTHEM BLUE CROSS</b> (For comprehensive medical plan participants in California)	
Help finding Contract Providers	Use the Provider Finder feature on <a href="http://www.anthem.com/ca">www.anthem.com/ca</a>  (or call the Trust Fund Office)
Required pre-authorizations for Hospital admissions, surgery, and organ or tissue transplants	Have your doctor call (800) 274-7767

<b>BLUE CARD</b> (For comprehensive medical plan participants outside of California)	
Help finding Contract Providers	<a href="http://www.bluecares.com">www.bluecares.com</a> or call (800) 810-2583
Required pre-authorizations for Hospital admissions, surgery, and organ or tissue transplants	Have your doctor call (800) 274-7767

<b>AMERICAN IMAGING MANAGEMENT (AIM)</b> (For comprehensive medical plan participants)	
Required pre-authorizations for certain outpatient diagnostic imaging procedures	Have your doctor call (877) 291-0360

<b>ASSISTANCE RECOVERY PROGRAM (ARP)</b> (For comprehensive medical plan and HMO participants)	
Referrals and required pre-authorizations for chemical dependency (substance abuse) treatment	(800) 562-3277 <a href="http://www.arpinc.org">www.arpinc.org</a>

<b>CVS CAREMARK</b>	
Prescription drug benefits if you are in the comprehensive health plan	(888) 790-4258 www.caremark.com
	for TDD assistance, call (800) 231-4403
	Specialty pharmacy services, call (800) 237-2767
<i>(If you are in Kaiser, call Kaiser about prescription drugs instead)</i>	

<b>DELTA DENTAL PLAN OF CALIFORNIA</b> (Dental benefits for all participants)	
Help finding Delta PPO dentists	(800) 765-6003 or www.deltadentalins.com
Questions or complaints regarding denial of dental services or claims	(800) 765-6003

<b>HEALTH DYNAMICS</b> (Preventive Care Program for participants and spouses in the comprehensive medical plan)	
For updates on provider locations	(414) 443-0200 www.hdhelpsu.com user name and password: hdhelpsu

<b>HEARPO</b>	
Special rates for hearing aids	(888) 432-7464

<b>KAISER HMO PLAN</b>	
Kaiser Permanente	(800) 464-4000

<b>SMOKING CESSATION ASSISTANCE (California only)</b>	
Smokers' Helpline	(800) 662-8887 (English) (800) 456-6386 (Spanish)

<b>VISION SERVICE PLAN</b>	www.vsp.com
Vision care benefits	(800) 877-7195





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# Chapter 1: Overview

In this chapter you'll find:

- An overview of your benefits
- Privacy of health information
- Information on filing claims

Overview of Benefits Available	
Benefit	Description
<b>Medical</b>	<p>If you enroll in the Plan's comprehensive medical benefits, you can choose any licensed providers for Hospital and outpatient services with no lifetime maximum.</p> <p>A Contract Provider feature allows you to keep your share of the costs down when you use Contract Providers.</p> <p><b>Note:</b> You have the option of enrolling in the Kaiser HMO plan instead of the comprehensive medical plan if you live in the Kaiser service area. Kaiser enrollees have their hearing aid and chemical dependency treatment benefits under the Plan's comprehensive medical benefits.</p>
<b>Prescription Drugs</b>	<p>The Plan covers the cost of generic and brand-name prescription drugs after you pay your share of costs. A participating pharmacy feature allows you to keep your share of the costs down.</p> <p>The Plan also offers a mail order service for medications you take on a long-term basis.</p> <p><b>Note:</b> If you enroll in Kaiser, you will have prescription drug coverage through Kaiser.</p>
<b>Dental</b>	<p>The Plan pays up to \$2,500 per year in preventive, basic, and major restorative dental services per person.</p> <p>Orthodontic services are covered up to a lifetime maximum of \$2,500 per person for dependent children through age 18.</p>
<b>Vision Care</b>	<p>The Plan pays benefits for eye exams and glasses or contact lenses. The VSP Contract Provider feature allows you to keep your share of the costs down.</p>
<b>Employee Life Insurance</b>	<p>Pays \$10,000 to your beneficiary in the event of your death.</p>
<b>Dependent Life Insurance</b>	<p>Pays \$1,000 to you if your spouse dies or \$100 - \$500 (depending on age) if your dependent child dies.</p>
<b>Accidental Death and Dismemberment (AD&amp;D)</b>	<p>Pays \$5,000 to your beneficiary in the event of your death from an accident. Pays a benefit to you if you suffer the loss of certain body parts (e.g., foot, hand, eye) in an accident.</p>
<b>Employee Burial Expense</b>	<p>Pays \$2,500 to your beneficiary to cover burial expenses in the event of your death.</p>

More detailed information on your benefits, including charts showing specific benefits, can be found in the chapters describing the individual benefits. Also see chapter 12, "Other Important Plan Information," for general provisions regarding your benefits.

### **Unfamiliar Term?**

If you see a word whose meaning you are unsure of, check the Definitions section in Article I of the Rules and Regulations that follow the SPD. It contains definitions of the terms used in the SPD.

### **Privacy of Health Information**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's Notice of Privacy Practices, distributed to all Plan participants, explains what information is considered "Protected Health Information." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information.

If you have misplaced your copy of the Plan's privacy notice, please contact the Trust Fund Office to request a replacement.

The Rules and Regulations included in this booklet also provide information on the use and disclosure of PHI.

### **Filing Claims**

Information on how to file claims is included at the end of each of the chapters describing the individual benefits.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" in chapter 12.

# Chapter 2: Eligibility and Enrollment

In this chapter you'll find:

- Employee eligibility
- Dependent eligibility
- Enrollment
- Medical plan choices

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## EMPLOYEE ELIGIBILITY

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Three types of Employees are potentially eligible for the benefits described in this booklet:

- hourly Employees,
- flat-rate Employees (including non-bargaining unit office Employees and company officers), and
- Owner-Operators.

Coverage for hourly and flat-rate Employees is provided through contributions made by Contributing Employers, under the terms of a collective bargaining agreement negotiated by Operating Engineers Local Union No. 3 or another agreement. Contributions are made according to hours worked for hourly Employees and at a monthly flat rate for flat-rate Employees.

Owner-Operators who meet certain criteria and are not eligible through employment with Contributing Employers may make flat-rate contributions on their own behalf.

Each group is described separately below.

Most collective bargaining unit Employees are hourly Employees, but some are flat-rate Employees. If you are a bargaining unit Employee and you are unsure what group you are in, refer to your collective bargaining agreement or contact the Trust Fund Office.

*Unless the context requires otherwise, the term "Employee" as used in this booklet includes an Owner-Operator who is eligible for benefits under the Plan.*

### Eligibility Rules for Hourly Employees

The hours you work for Contributing Employers are reported to the Fund and credited to an hour bank established for you.

You will become eligible for Plan benefits on:

- the first day of the calendar month after Contributing Employers report at least 360 hours on your behalf during a period of 3 consecutive months or less.

See the box on the next page for more information on hour banks.

**For example**, if you worked 110 hours in July, 120 hours in August, and 130 hours in September, your eligibility would start October 1.

Once you have established eligibility, your eligibility will continue during any subsequent month for which 120 hours are deducted from your hour bank.



If you lose your eligibility for benefits, you may temporarily extend coverage by paying it for yourself. See “Extended Coverage by Self-Payment and COBRA Continuation of Health Care Coverage” in chapter 3 for more information. (Note that under COBRA, you may continue only health care benefits—not, life insurance, accidental death and dismemberment, or burial expense benefits.)

### **Hour Banks**

If you are an hourly Employee, the hours you work for Contributing Employers are credited to an hour bank established for you. 120 hours are deducted from your hour bank for each month of eligibility.

#### ***Lag Month***

To allow sufficient time for employer reports to be received and processed by the Trust Fund Office, a “lag” month will be used in determining monthly eligibility. The lag month is the month between the payroll period in which the hours were worked and the month of eligibility provided by those hours.

***For example***, hours worked in January are credited to your hour bank to provide eligibility for the month of March.

#### ***Excess Hours***

Whenever you have more than 120 hours credited for a month, the excess hours will be put in your hour bank to provide subsequent eligibility. You may accumulate up to 990 excess hours in your hour bank, for up to 8 months of future eligibility. (If you established initial eligibility before July 1992, you may accumulate up to 1,320 hours in your hour bank, for up to 11 months of future eligibility.)

When you retire, any hours remaining in your hour bank will be used to provide you with coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund (if you are receiving a pension from the Pension Trust Fund for Operating Engineers). See “Options When You Retire” in chapter 3 for more information.

You may not use your hour bank to extend coverage while you are working in non-qualifying employment (work of the type covered by the collective bargaining agreement under which you earned your hour bank but performed for a non-Contributing Employer). During periods of such employment, you will not be eligible for Plan benefits. Your hour bank will be frozen until you are once again employed with a Contributing Employer, retire, or become unemployed. If you do not become employed with a Contributing Employer, retire, or become unemployed within 12 months after the freezing of your hour bank, any hours remaining in your hour bank will be cancelled.

***Note:*** A reduced level of comprehensive medical benefits will apply to you if your employer pays a contribution that is less than the minimum required rate. See Chapter 4 - Comprehensive Medical Benefits.

## **Reinstatement of Eligibility for Hourly Employees**

If your eligibility terminates, it will be reinstated on:

- the first day of the second calendar month after your hour bank is credited with at least 120 hours, provided this occurs within the 12-month period immediately following the termination of eligibility.

If you are not reinstated within the 12-month period, any hours in your hour bank will be cancelled and you will again need to meet the initial eligibility requirements described above.

**For example**, if you were last eligible for benefits in March 2011 and your hour bank is next credited with 120 hours in July 2011, you would be eligible for benefits in September 2011. However, if you were last eligible in March 2011 but do not work 120 hours again until April 2012, you will need to re-establish eligibility by working 360 hours in a period of 3 consecutive months or less.

## **Reciprocity**

If your hours of employment are divided among different plans, reciprocity may help you meet benefits eligibility requirements.

The Operating Engineers Health Plan has reciprocal agreements covering engineers who work in more than one area of Local 3, as well as with Southern California Operating Engineers, the Western Conference of Operating Engineers and the International Union of Operating Engineers & Pipe Line Employers Health and Welfare Fund.

If you have worked under a plan that may be covered by a reciprocal agreement, or if you have questions about reciprocity, please contact the Trust Fund Office or the administrator of the plan under whose jurisdiction you are working.

## **Eligibility Rules for Flat-Rate Employees**

You will be eligible for Plan benefits on:

- the first day of the month following 3 consecutive months for which contributions are received.

Benefits for a pre-existing medical condition may be limited initially (but not for any individual under age 19); see “Pre-Existing Condition Limitation” in chapter 4 for more information.

Each flat-rate contribution provides only a single month of eligibility. Flat-Rate Employees do not have an hour bank.

If you lose your eligibility for benefits, you may temporarily extend coverage by paying it for yourself. See “Extended Coverage by Self-Payment and COBRA Continuation of Health Care Coverage” in chapter 3 for more information. (Note that under COBRA, you may continue only health care benefits—not, life insurance, accidental death and dismemberment, or burial expense benefits.)

**Note:** A reduced level of comprehensive medical benefits will apply to you if your employer pays a contribution that is less than the minimum required rate. See page 27.

## Eligibility Rules for Owner-Operators

If you are an Owner-Operator not eligible as a result of employment with Contributing Employers, you may elect to participate in the Plan by making the required monthly contribution to the Trust Fund on your own behalf, provided you have executed an approved Owner-Operator Subscriber Agreement and are a dues-paying member or pay a service fee to Operating Engineers Local 3. You must meet all additional participation rules contained in the Owner-Operator Subscriber Agreement

Owner-Operator contributions do not provide an hour bank accumulation.
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The required contribution amount is determined by the Board of Trustees.

If you meet the above participation rules you will become eligible on:

- the first day of the calendar month following receipt of your required contribution.

Benefits for a pre-existing medical condition may be limited initially (but not for any individual under age 19); see “Pre-Existing Condition Provision” in chapter 4 for more information.

If you elect to go on a Contributing Employer’s payroll, the individual employer will be required to pay the full health and welfare contribution from the first day of employment.

**Note:** A reduced level of comprehensive medical benefits will apply to you if you (or an employer) pay a contribution that is less than the minimum required rate. See page 27.

## Coverage During Military Service

The Plan complies with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

- If you enter military service with the uniformed services of the United States for a period of less than 31 days, your eligibility will be continued with no payment required from you (unless you are an Owner-Operator required to make contributions on your own behalf), provided you were eligible under the Plan when the military leave began.
- For military service lasting longer than 31 days, you may continue eligibility through self-payments for up to 24 months from the date the military leave began. During the first 18 months of coverage, you will have the same rights as if you had elected COBRA continuation coverage, described in Chapter 3. However, COBRA provisions, 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.

**Note:** USERRA continuation coverage is an alternative to COBRA. You can choose either 18 months of COBRA continuation coverage or 24 months of USERRA continuation coverage.

If you have an hour bank and you elect to self-pay for coverage during the military leave, or if you choose not to be covered by the Fund during the leave, your hour bank will be frozen and can be used when the leave ends. (You can also use your hour bank to continue Fund coverage during the military leave.) If you elect to use any accumulated hour bank eligibility for coverage during the leave, no charge will be made for the period of eligibility provided by the hour bank.

## Requirement to Notify Trust Fund Office of Military Leave

You must notify the Trust Fund Office in writing of your entry into military service as soon as possible, but no later than 60 days after your military service begins. Your notice should indicate whether you wish to:

- self-pay to continue Fund coverage during the military leave,
- not be covered by the Fund during your leave, or
- use your accumulated hour bank eligibility to continue Fund coverage during your leave (if you are an hourly Employee)

### **After You Return From Military Service**

If you return to work or become available for work for a Contributing Employer after discharge from military service, you will be eligible for the balance of the calendar month in which you return to work and for the next calendar month, provided you give written notice to the Trust Fund Office within the following time frames:

- 90 days after discharge from military service if your service lasted more than 180 days, or
- 14 days after discharge from military service if your service lasted 31 to 180 days.

After that you will be entitled to eligibility based on any accumulated hours in your frozen hour bank.

### **Coverage During a Family and Medical Leave**

If your employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you and your eligible dependents will continue to be covered under this Plan, provided you are eligible when the leave begins and provided your employer makes the required contributions during the leave.

It is not the role of the Fund to determine whether or not you are entitled to FMLA leave with health and welfare coverage. Any question regarding entitlement to FMLA leave with continuing health coverage must be resolved with the Employer.

## **DEPENDENT ELIGIBILITY**

Eligible dependents can be covered for medical, prescription drug, dental, and vision care benefits and for dependent life insurance.

If you have eligible dependents when you first become eligible for benefits, they will have the same eligibility date you do. If you acquire new dependents after that time, you may enroll them as explained under “Enrollment” later in this chapter.

Your eligible dependents are

- your legal spouse.
- your natural, legally adopted or stepchildren under age 26, whether married or unmarried. Adopted children are eligible when they are placed with you for adoption.
- your unmarried child under age 26 for whom you have been appointed legal guardian, provided the child is considered your dependent for federal income tax purposes.

See coverage for domestic partners and children of domestic partners on page 8.

**Exceptions:** *Children are eligible only up to age 19 for the Delta Dental orthodontic benefit and up to age 21 for the dependent life insurance benefit.*

A spouse of a dependent child (the participant’s son-in-law/daughter-in-law) or a child of a dependent child (participant’s grandchild) are not eligible for coverage under the Plan

## Qualified Medical Child Support Orders

The Plan will recognize a Qualified Medical Child Support Order (QMCSO) and enroll a dependent child under age 26 specified by the Order. A QMCSO is any judgment, decree, or order (including a National Medical and Support Notice or approval of a domestic relations settlement agreement) issued by a court or by an administrative agency that requires you to provide health coverage to the child.

You may enroll a child if a qualified QMCSO requires you to provide health coverage to that child. To be considered qualified, a medical child support order must include:

- your name and current mailing address,
- the name and last known address of each child covered by the Order,
- the type of coverage to be provided to each child, and
- the period of time the coverage is to be provided.

The Trust Fund Office will determine if the court order is qualified. A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

The Plan's procedures for handling Qualified Medical Child Support Orders are available at the Trust Fund Office and will be provided free of charge.

## Extended Eligibility for Disabled Children

You may continue coverage for an unmarried child beyond age 26 if the child is incapable of self-sustaining employment because of a mental or physical disability and is primarily dependent upon you for support. To qualify for the extended eligibility, the following conditions must be met:

- The child must be eligible as a dependent under this Plan (or under any other multi-employer health and welfare plan maintained by Operating Engineers Local No. 3) and already disabled when he or she reaches age 26.
- You must provide evidence of the child's dependence and incapacity within 31 days after the date the child becomes age 26 and within 31 days after any time the Plan requests it.

## Coverage for Domestic Partners and Children of Domestic Partners

If you are enrolled in the comprehensive medical plan, your domestic partner and domestic partner's children may be eligible **only if** your employer is legally required by law to provide domestic partner coverage. Contact the Trust Fund Office for information on whether the domestic partner requirements apply to your employment. Criteria for a qualifying domestic partner relationship can be found in the Rule and Regulations included in this booklet.

There is an exception to the above rules if you are enrolled in Kaiser. California law requires the HMOs to enroll domestic partners who are registered with the appropriate state agency. Regardless of whether or not your employer is required to provide domestic partner coverage, a domestic partner who is registered with the state of California may be enrolled in the HMO plan.

**Note:** You will be responsible for paying income tax on the imputed income value of the benefits provided to a domestic partner or child of a domestic partner if they do not meet the definition of a dependent as outlined in the Internal Revenue Code §152(c) or §152(d). You must make payment

to the Trust Fund Office for the federal taxes on the value of the provided coverage. Failure to pay these taxes will result in termination of coverage for your domestic partner and any children of your domestic partner.

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## ENROLLMENT

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The new member packet you receive when you first become eligible for benefits includes an enrollment form for choosing a medical plan and providing information on yourself and your dependents.

Please return your completed enrollment form (including any required documentation) to the Trust Fund Office within **2 weeks** of receiving your new member packet. Note that if you want to choose **Kaiser** as your medical plan, you **must** submit your enrollment card within **60 days**.

If you do not return your enrollment form within these time periods, you will be automatically enrolled in the comprehensive medical plan.

You should also submit a beneficiary designation form naming your beneficiary or beneficiaries for your life insurance, accidental death and dismemberment, and burial expense benefits. Beneficiary designation forms are available from the Fringe Benefits Service Center.

### Enrolling New Dependents

If you get married or have a new child after you become eligible for benefits, you should enroll the new dependent in the Plan **within 30 days** of the date of the marriage, birth, placement for adoption, or legal guardianship (or domestic partnership, if applicable.) To enroll a new dependent, contact the Trust Fund Office, the Fringe Benefits Service Center, District Office, or Local Union Office for the necessary enrollment form and send the completed form to the Trust Fund Office. Include any required documentation (copy of the marriage certificate, birth certificate, adoption or legal guardianship papers) with the enrollment form.

Coverage for the new dependent will become effective on the first day of the month in which the Trust Fund Office receives the enrollment form and required documentation.

### Keeping the Trust Fund Office Informed of Changes

You must notify the Trust Fund Office when ANY change occurs in the information provided on the enrollment form – for example, marriage, birth of a child, death, divorce, or any other change in your family status. You should also notify the Trust Fund Office if you change your address.

It is very important that you notify the Trust Fund Office if you and your spouse divorce. **Any claims paid for expenses incurred by ineligible dependents after the date of the divorce will become the responsibility of the participant.** You will be required to reimburse the Trust Fund for these claims. Also, if the Trust Fund Office is not notified of a divorce within 60 days, the former spouse may lose rights to COBRA continuation coverage.

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## MEDICAL PLAN CHOICES

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You will have your choice of two options for medical coverage:

- the comprehensive medical benefits paid directly by the Fund, or
- Kaiser HMO coverage

You and your dependents must all be enrolled in the same medical plan.
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To be eligible for Kaiser coverage, you must live in the Kaiser service area. (Check the ZIP code list in your new member packet or contact the Trust Fund Office if you are not sure whether your residence is in the service area.)

### Coverage for Other Benefits If You Choose Kaiser

If you choose the Kaiser HMO plan, you will have your prescription drug coverage through Kaiser. However, you will have coverage for hearing aids and chemical dependency treatment through the Trust Fund. See chapter 4 for information on those two benefits.

The other benefits described in this booklet (dental, vision care, life insurance, accidental death and dismemberment, and the burial expenses benefit) are unaffected by what medical coverage you choose.

### Changing Your Medical Plan

Once you choose a medical plan option, you must remain in that plan for at least 12 months. An exception will be made only if you elected an HMO and you move out of the HMO service area or it ceases to be available where you live (or the Board approves a change).

Once you've satisfied the 12-month requirement, you may change your medical plan option. If you change plans, you must remain in your new plan for at least 12 months before you can change again (subject to the exceptions mentioned above).

To make a change, contact the Trust Fund Office for an enrollment form. Any change in medical plan options will be effective on the first day of the second calendar month following the date the Trust Fund Office receives your enrollment form.

# Chapter 3: When Eligibility Ends

In this chapter you'll find:

- Termination of eligibility
- Extended coverage by self-payment
- Extension of medical benefits for disability
- Options when you retire
- COBRA continuation coverage
- Certificate of creditable coverage

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## TERMINATION OF ELIGIBILITY

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### Termination of Your Eligibility

Your eligibility will terminate on the earliest of the following dates:

- the first day of the month following exhaustion of coverage provided by your hour bank, if you are an hourly Employee, or
- the first day of the 4th month following the month for which the last contribution was made on your behalf, if you are a flat-rate Employee, or
- the first day of the month for which the required contribution is not made, if you are an Owner-Operator, or
- the first day of the month in which you become a Retired Employee (you are a “Retired Employee” if you are receiving a pension from the Pension Trust Fund for Operating Engineers; however, if you are age 70 ½ and working for a Contributing Employer, you will not be considered a Retired Employee until you no longer have enough hours reported to provide you with active eligibility under this Plan).

### Termination of Your Dependents' Eligibility

A dependent's eligibility will terminate when your eligibility terminates or on the last day of the month in which the dependent ceases to qualify as an eligible dependent, whichever is sooner.

Coverage for a domestic partner and any children of the domestic partner will terminate on the date you are no longer working for an employer who is required by law to provide domestic partner coverage, or on the date you fail to pay the required taxes for domestic partner benefits.

In the event of your death, if you are an hourly Employee, your dependents' coverage will continue until the last day of the month in which your hour bank balance falls below 120 hours.

### *Retroactive Cancellation of Coverage*

In accordance with the requirements in the Affordable Care Act, the Fund will not retroactively cancel coverage **except** in cases of fraud or intentional misrepresentation of a material fact. If your coverage is terminated for either of these reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.



## HIPAA Certificate of Creditable Coverage When Coverage Ends

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), when your eligibility ends, you and/or your covered dependents will automatically be provided with a Certificate of Coverage (free of charge) that indicates the period of time you and/or they were covered under the Plan. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

The certificate will be sent to you by mail shortly after the Fund knows or has reason to know that eligibility for you and/or your dependent(s) has ended. In addition, a certificate will be provided upon request if the request is received by the Trust Fund Office within two years after the date Plan coverage ended. To request a certificate, call the eligibility department of the Trust Fund Office.

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## EXTENDED COVERAGE BY SELF-PAYMENT

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### *For Bargaining Unit Employees Only*

If you are a bargaining-unit Employee, you may continue full benefits for up to 3 months after your eligibility terminates by making monthly payments to the Fund in the amount determined by the Board of Trustees.

The first monthly payment must be made to the Trust Fund Office no later than 45 days after the date you mail your COBRA election form. The two subsequent payments must be made by the 15<sup>th</sup> day of the month prior to the month of coverage. Payments must be continuous.

At the end of the 3-month period, you may continue your health care benefits under COBRA (as described under “COBRA Continuation Coverage” beginning on page 14).

The 3-month self-payment continuation coverage will count toward the maximum duration of continuation coverage provided under COBRA.

You may not use this self-payment option to continue your coverage if your eligibility terminates because you are performing non-qualifying employment (see the “Hour Banks” box in the eligibility section of chapter 2) and your hour bank is cancelled.

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## EXTENSION OF MEDICAL BENEFITS FOR DISABILITY

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If you or your dependent are Totally Disabled, as certified by a Physician, when eligibility terminates for any reason, the disabled individual will remain eligible for comprehensive medical benefits **for that disability only** for up to **12 months following the date eligibility terminated**.

For purposes of this provision, the terms “disabled” and “disability” mean that because of Illness or Injury, an individual is

- under a Physician’s care,
- not able to perform substantially all the normal activities of a person of the same age and sex who is in good health, and
- unable to engage in any occupation or business for income or profit (does not apply to children or unemployed spouses).

This extension of benefits will end on the earliest of the following occurrences:

- when the individual ceases to be disabled,
- when 12 months have passed since eligibility terminated, or
- when the disabled individual becomes eligible under another group plan or another plan's COBRA continuation coverage or any conversion policy.

**Please note**, anyone who elects to receive benefits under this free extension of benefits provision will not be eligible to elect COBRA continuation coverage under this Plan (see page 14 for information on COBRA continuation coverage). This extension applies to comprehensive medical benefits only; it does not apply to any other benefits of the Plan.

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## WHEN YOU RETIRE

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### *Hourly Employees*

If you are an hourly Employee, any hours remaining in your hour bank when you retire will be used to provide you with coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund.

If your hour bank has enough hours for at least one month of eligibility when you retire, you will receive 3 additional months of hour bank eligibility that will provide coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund if you qualify for and elect Pensioned Health and Welfare coverage. These additional 3 months apply only if you qualify for and elect coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund.

Note: "Retire" means you are receiving a pension from the Pension Trust Fund for Operating Engineers.

You will not be required to pay contributions for pensioned health and welfare coverage until your hour bank and the 3 additional months of coverage, if applicable, have been exhausted.

You also have the option of enrolling in COBRA continuation coverage to continue active plan benefits for the period of COBRA coverage. If you enroll in COBRA, any hour bank eligibility will be counted toward your COBRA continuation coverage period instead of providing retiree health coverage. At the end of the COBRA period, you may enroll in the Pensioned Operating Engineers Health and Welfare Trust Fund if you are eligible.

### *Flat Rate Employees*

If you are a flat-rate Employee or an Owner-Operator, you will not have the hour bank option for extended coverage described above. When you retire, you may enroll in COBRA continuation coverage and then retiree coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund (provided you are eligible), or you may enroll in retiree coverage (if you are eligible) without enrolling in COBRA continuation coverage first.

**Note:** The Pensioned Operating Engineers Health and Welfare Trust Fund is a separate plan that is described in another booklet. It has different benefits than the Plan covering active Employees, and specific conditions apply for eligibility. If you are anticipating retirement, you should request a copy of the booklet for the Pensioned Operating Engineers Health and Welfare Trust Fund from the Trust Fund Office, the Fringe Benefits Service Center or District Office of the Union. A booklet is also provided when a pension is awarded.

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## COBRA CONTINUATION OF HEALTH CARE COVERAGE

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### Have Your Family Members Read This Section

If you do not elect COBRA continuation coverage, your spouse and each eligible dependent child will have a separate right to elect it independently. Therefore, it is important that you, your spouse, and your children all read this section of this booklet.

**Note:** This COBRA Continuation Coverage does not apply to Domestic Partners or their children. See page 21 for Domestic Partner continuation coverage provisions.

If your or your dependents' coverage under the Operating Engineers Health and Welfare Trust Fund ends due to a "qualifying event," the federal Consolidated Omnibus Budget Reconciliation Act (commonly known as "COBRA") allows you to continue your health care coverage temporarily by paying for it yourself.

Qualifying events are shown in the chart below. You may only continue health care coverage that was in effect at the time of the qualifying event. COBRA continuation coverage does not include life insurance, accidental death and dismemberment benefits, or the burial expense benefit.

**Note:** *You are not eligible for COBRA continuation coverage if you elect the free extension of medical benefits available in a case of total disability (see page 12).*

COBRA Continuation Coverage		
COBRA Qualifying Event	Who May Continue Benefits	Maximum Period of Continuation Coverage*
You lose eligibility due to <ul style="list-style-type: none"> <li>• a reduction in your hour bank below 120 hours,</li> <li>• termination of your employment for reasons other than gross misconduct, or</li> <li>• retirement</li> </ul>	You, your spouse, and/or your dependent children	18 months**
You die	Your spouse and/or your dependent children	36 months
You and your spouse divorce	Your former spouse	36 months
Your child ceases to meet the Plan's definition of an eligible dependent (for example, because of a change in age)	The affected dependent child	36 months
<p>* <b>Adjustment for extension of benefits by self-payment:</b> The maximum duration for COBRA continuation coverage will be reduced by the number of months for which you extended benefits by self-payment (see "Extended Coverage by Self-Payment" above).</p> <p>** <b>Disability extension:</b> Coverage for all enrolled family members may be continued an additional 11 months (for a total of 29 months) if you or a covered dependent becomes Totally Disabled before or during the first 60 days of COBRA continuation coverage. See "Extended COBRA Period for Disability" later in this section.</p> <p><b>Effect of prior Medicare enrollment:</b> If the low hours, termination of employment, or retirement occurs less than 18 months after the date you become entitled to Medicare (Part A, Part B, or both), the maximum period of continuation coverage for your dependents covered under the Plan will be 36 months after the date of your Medicare entitlement.</p>		

## Qualified Beneficiaries

Under the law, only “qualified beneficiaries” are entitled to COBRA continuation coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the COBRA qualifying event by virtue of being an Employee on that day, the spouse of an Employee, or the dependent child of an Employee.

A child who becomes a dependent child by birth, adoption, or placement for adoption with you during a period of COBRA continuation coverage and is enrolled within 30 days is also a qualified beneficiary and will have the same COBRA rights as a spouse or children who were covered by the Plan before the qualifying event that triggered the COBRA continuation coverage.

A spouse who becomes your spouse during a period of COBRA continuation coverage may be added to your coverage during the period you remain eligible for COBRA continuation coverage. (See “Special COBRA Enrollment Rights” later in this section.) However, the new spouse would not be a qualified beneficiary (in other words, the spouse would not have any independent enrollment rights or be eligible for additional months of coverage if one of the “second qualifying events” described below occurred).

## Extended COBRA Period for Disability

If you lose eligibility because of low hours or termination or retirement and you or one of your covered dependents is determined by the Social Security Administration to have been Totally Disabled at the time of the qualifying event or within 60 days of the qualifying event, coverage may be extended for you and all enrolled dependents beyond the original 18 months up to 29 months.

See “COBRA Notification Responsibilities” below for information on procedures and timeframes for notifying the Trust Fund Office of Social Security Administration determinations.

A higher premium will be charged for the additional 11 months of coverage.

## If a Second COBRA Qualifying Event Occurs

If your dependents are in an 18-month COBRA continuation coverage period because of your low hours or your termination of employment or retirement (or a 29-month period, in the case of disability) and one of the following qualifying events occurs, the maximum COBRA continuation period for your dependents will switch to 36 months (provided you and/or your dependents notify the Trust Fund Office of the second qualifying event within the timeframe discussed in “Notification Responsibilities” below):

- you get divorced,
- you die,
- you become entitled to Medicare (enrolled in Part A or Part B),
- your child ceases to meet the Plan’s definition of an eligible dependent (in this case, only the child may extend coverage).

**For example . . .** Tom stops working (the first COBRA qualifying event), and enrolls himself and his family in COBRA continuation coverage for 18 months. Three months after his COBRA continuation coverage begins, Tom’s child turns 26 and no longer qualifies as a dependent child under the Plan’s definition. Tom’s child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

Employees are not entitled to COBRA continuation coverage for more than a total of 18 months (unless you are entitled to an additional 11 months' continuation coverage because of a disability). Even if you experience a reduction in your work hours followed by retirement or termination of your employment, the retirement or termination is *not* treated as a second qualifying event and you may not extend your coverage.

### **Notification Responsibilities**

You and/or your dependents are responsible for providing the Trust Fund Office with timely notice of the following qualifying events:

- your (the Employee's) divorce from your spouse or
- a child's ceasing to be eligible for coverage under the Plan as a "dependent child."

In addition, you and/or your dependents are responsible for notifying the Trust Fund Office, within the timeframe noted below, of the following:

- a determination by the Social Security Administration that a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months is disabled, or
- a determination by the Social Security Administration that such a qualified beneficiary is no longer disabled, or
- the occurrence of a second qualifying event, as described under "If a Second COBRA Qualifying Event Occurs" above.

**You must make sure that the Trust Fund Office is notified of any of the occurrences listed above.** Failure to provide this notice within the form and timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

Your employer is responsible for notifying the Trust Fund Office of your death, termination of employment, or retirement. Determinations of low hours will be the responsibility of the Trust Fund Office. However, you are encouraged to inform the Trust Fund Office of any qualifying event to assure prompt handling of your COBRA rights

The Trust Fund Office will notify you and/or your dependents of your rights to choose continuation coverage within 14 days of receiving notification of a qualifying event.

A notice sent to your spouse will be deemed to have also been sent to any eligible dependent children residing with your spouse at the time.

### **How to Provide Notice to the Trust Fund Office**

Notice of any of the five situations listed above must be provided in writing. Send a letter to the Trust Fund Office containing the following information:

- your (the Employee's) name and Social Security number,
- the name of the Fund ("Operating Engineers Health and Welfare Trust Fund")
- the event you are providing notice for,
- the date of the event, and

- the individual(s) affected by the qualifying event and their relationship to you.

If the qualifying event is a divorce from your spouse, you may be required to provide verification of the termination of your marriage.

### ***Where to Send the Notice***

Notice must be sent by U.S. mail to the following address:

COBRA Administrator  
Operating Engineers Health and Welfare Trust Fund  
P.O. Box 23190  
Oakland, CA 94623-0190

Please keep a copy, for your records, of any notices you send to the Trust Fund Office.

### ***Deadline for Sending the Notice***

Assuming you have been furnished with a copy of this booklet or a general (initial) notice by the Plan informing you of the responsibility to provide these notices and these notice procedures, timeframes for providing notice are as follows:

- If you are providing notice of a divorce, a dependent child's losing eligibility for coverage, or a second qualifying event, you must send the notice no later than **60 days after** the date of the relevant qualifying event.
- If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than **60 days after the latest of** (1) the date of the disability determination by the Social Security Administration, (2) the date of the qualifying event, or (3) the date on which the qualified beneficiary would lose coverage under the Plan due to the qualifying event.
- If you are providing notice of a Social Security Administration determination that you or your dependent **is no longer** disabled, notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you or your dependent is no longer disabled.

### ***Who Can Provide Notice***

Notice may be provided by the qualified beneficiary with respect to the qualifying event (you—the Employee—or your dependents, as applicable) or any representative acting on behalf of the qualified beneficiary.

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if you (the Employee), your spouse, and your child are all covered by the Plan and your child ceases to be a dependent under the plan, a single notice sent by you or your spouse would satisfy this requirement.

If you or your dependents send a notice to the Trust Fund Office as described above and the Trust Fund Office determines that you are not entitled to COBRA continuation coverage, the Trust Fund Office will send you a written notice stating the reason why you are not eligible for COBRA continuation coverage. This will be provided within 14 days after the Trust Fund Office receives your notice.

## Electing Coverage

You and/or your covered dependents have **60 days** to make your election from the later of:

- the date you would have lost coverage because of the qualifying event or
- the date you received the COBRA notice from the Trust Fund Office.

Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both you (the Employee) and your spouse may elect COBRA continuation coverage, or only one of you may elect COBRA continuation coverage.

A parent or legal guardian may elect COBRA continuation coverage for a minor child. If you or your spouse elects COBRA continuation coverage, you will be deemed to be electing it for your eligible dependent children as well, unless you specify otherwise in the election. If you and your spouse do not elect COBRA continuation coverage, your dependent children will be able to elect it or reject it independently of your rejection.

**If you and/or your dependents do not elect COBRA within the 60-day period allowed, you will forfeit all rights to COBRA continuation coverage and your health care coverage will end.** If you are enrolled in Kaiser, you may apply for an individual conversion policy.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law:

- First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans (election of COBRA continuation coverage may prevent such a gap).
- Second, if you do not get continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions.
- Finally, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

## Coverage Options

You may elect to continue

- core coverage—medical and prescription drug coverage only—or
- core coverage plus dental and vision benefits.

You may not elect any coverage you did not have immediately before the qualifying event.

Your initial continuation coverage will be identical to coverage provided to Eligible Individuals who have not experienced a qualifying event. It may be modified if coverage later changes for other participants.



### ***Sending in Payment***

Premiums for COBRA continuation coverage are payable monthly, in amounts established by the Board of Trustees.

You have a maximum of 45 days from the date you mail your COBRA election form to the Trust Fund Office in which to submit your first payment. This first payment must include the cost of coverage retroactive to the first day your coverage would have otherwise terminated.

All subsequent monthly premium payments are due on the 15th day of the month prior to the month for which continuation coverage is elected. A 30-day grace period for premium payment will be allowed before coverage is terminated.

### ***Additional COBRA Election Period and Tax Credit In Cases of Eligibility for Benefits Under TAA***

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Adjustment Assistance Act Amendments of 2002 (TAA), you should contact the Trust Fund Office. You may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit.

### ***Special COBRA Enrollment Rights***

If you marry, have a newborn child, adopt a child, or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll your new spouse or child for coverage for the balance of the period of COBRA continuation coverage. You must enroll your new dependent within 30 days of the marriage, birth, adoption, or placement for adoption.

Special enrollment for the balance of your COBRA period is also allowed for dependents who lose other coverage. For this to occur,

- your dependent must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage,
- your dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it, and
- you must enroll that dependent within 30 days after the termination of the other coverage or contributions.

Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

### ***Termination of COBRA Continuation Coverage***

COBRA continuation coverage will terminate on the earliest of the following dates:

- the last day of the maximum period of coverage (18, 29, or 36 months, as applicable)
- the date you or your dependent fails to make the monthly payment on time (you will be allowed a 30-day grace period from the premium due date)
- the date the person receiving the coverage becomes covered under another group health plan (which does not limit or exclude any pre-existing condition the person might have)



- the date the person receiving the coverage becomes covered under Part A or Part B of Medicare
- the date your employer terminates its participation in the Plan (If your employer replaces the Plan, you may be entitled to coverage under the replacement plan)
- the date the Social Security Administration determines that an individual on extended disability coverage is no longer disabled (This applies only to the 19th through 29th month of an extended COBRA period for a disability)

If COBRA continuation coverage is terminated before the end of the maximum period of coverage, the Trust Fund Office will send you a written notice as soon as practicable following its determination that COBRA continuation coverage will terminate. The notice will set out the reason COBRA continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

### **Post-COBRA Coverage Under an HMO**

The following provisions apply only to Kaiser enrollees.

#### **California COBRA Law**

If you are a COBRA participant enrolled in Kaiser, California law has a provision that affects the length of time you may continue coverage. This law only applies to Kaiser coverage, not to any other benefits usually available under COBRA. If your qualifying event was low hours, termination of your employment, or retirement and you exhaust the 18 months of coverage normally available after such a qualifying event (or the 29 months available in the case of disability), you may continue your Kaiser coverage an additional 18 months (or an additional 7 months in the case of a disability).

**Note:** All arrangements for additional months of coverage under the California COBRA law must be made directly with Kaiser and not through the Trust Fund Office.

#### **Conversion to Individual Coverage for HMO Members**

At the end of the COBRA continuation coverage period, you or your eligible dependents may enroll in any individual conversion plan offered by Kaiser, provided you were enrolled in the HMO before your continuation coverage ended.

*Check your Kaiser Evidence of Coverage for more information on how to elect post-COBRA extended coverage under California law or enroll in a conversion plan. You can also call the HMO's Member Service departments.*

### **Questions or Changes**

If you have any questions regarding COBRA continuation coverage, please contact the COBRA Administrator at the Operating Engineers Health and Welfare Trust Fund, P.O. Box 23190, Oakland, CA 94623-0190; tel. (510) 433-4422 or (510) 271-0222 or (800) 251-5014.

If you change your marital status or add new dependents, please notify the Trust Fund Office immediately. To protect your family's rights, you should also keep the Trust Fund Office informed of any changes in the addresses of family members.

If Federal legislation alters the provisions of COBRA in existence at the time this Summary Plan Description is printed, you will be advised of any such modification as required.

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## HIPAA CERTIFICATE OF CREDITABLE COVERAGE

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If your coverage under this Plan ends and you become eligible for a new health plan, the length of time you were covered under this Plan (including COBRA continuation coverage) may be used to reduce the length of any pre-existing condition exclusion period contained in your new plan.

When your coverage ends under this Plan, you will automatically receive a certificate of creditable coverage. This certificate provides information your new plan may need. You should check with your new plan's administrator to verify whether your new plan restricts coverage for pre-existing conditions and how creditable coverage is applied under that plan. Present your certificate to your new plan so that your new plan will know to apply your creditable coverage to the pre-existing condition exclusion period under your new plan.

If a dependent loses eligibility separately from you and the Trust Fund Office is notified that the dependent is no longer an eligible dependent, a separate certificate will be provided for that dependent.

You or a dependent may also request a copy of the certificate at any time within 24 months after your coverage terminates.
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## CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS AND CHILDREN OF DOMESTIC PARTNERS

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### ***Continuation Coverage***

Eligible domestic partners of Employees and eligible children of domestic partners who lose eligibility under the Plan may continue coverage through self-payment for a limited period of time. The domestic partner and children of the domestic partner who lose eligibility under the Plan may continue Plan coverage (except dependent life insurance) when eligibility is lost due to any of the following reasons:

- A reduction your hour bank below 120 hours
- Termination of your employment for reasons other than gross misconduct or your retirement
- Your death
- Cessation of child's Dependent status under the Plan

### ***Premiums***

A premium for continuation coverage will be charged to the domestic partner or Dependent child, or both, in amounts established by the Board of Trustees. The premium is payable in monthly installments.

### ***Duration of Domestic Partner Continuation Coverage***

- In the case of your reduction in hours, termination of employment or retirement, coverage may be continued on a self-payment basis for up to 18 months from the date of the event that resulted in the loss of eligibility
- In all other circumstances, coverage may be continued for up to 36 months from the date of the event that resulted in loss of eligibility

Continuation coverage will be terminated before the end of the 18-month or 36-month period upon the occurrence of any of the following events:

- The required premium payment for continuation coverage is not paid when due
- Your employer terminates its participation in this Plan
- The domestic partner or Dependent child becomes covered under any other Group Plan (as a participant or otherwise) or becomes entitled to Medicare coverage

***Election and Notice Procedure for Domestic Partner Continuation Coverage***

The domestic partner or child or both must elect continuation coverage within 60 days after the later of:

- The date of any of the events described above under “Continuation Coverage”; or
- The date of the notice from the Fund Office notifying the individual of his/her right to continuation coverage.

# Chapter 4: Comprehensive Medical Benefits

In this chapter you'll find:

- A quick-reference summary of benefits
- Contract Providers
- Annual deductible
- Annual out of pocket limit
- Required pre-authorizations
- Emergencies
- What the Plan covers
- Preventive care benefits
- Hearing aid benefit
- Chemical dependency benefits
- Exclusions from coverage
- Information on filing claims

## About This Chapter

This chapter applies to individuals enrolled in the Plan's comprehensive medical benefits. If you chose Kaiser coverage, ONLY the benefits and procedures described for hearing aids and chemical dependency treatment apply to you; see your Kaiser Evidence of Coverage for information on your other medical benefits.

Your comprehensive medical benefits provide coverage for diagnosis and treatment of non-occupational illnesses and injuries, as well as certain preventive care. Included are visits to the doctor, hospitalization, surgery, hearing aids, and treatment for mental health conditions or chemical dependency, among other medical services.

More detailed information, including conditions for payment of different benefits, follows the Summary of Benefits chart.

**Note: *Reduced Benefits Will Apply if Your Employer Pays a Sub-Standard Contribution Rate.*** Your comprehensive medical benefit will be reduced if your employer makes a contribution to the Fund that is less than the minimum required contribution. See the description of these reduced benefit levels that follows the Summary of Benefits chart.

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## SUMMARY OF BENEFITS

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Comprehensive Medical Benefits	
<b>Calendar-year Deductible</b>	\$500 per person, \$1,500 maximum deductible per family
<b>Calendar-year Out-of-Pocket Limit</b>  <b>This limit applies to comprehensive medical benefits only. It does not include the deductible.</b>	After you pay the calendar-year deductible:  Contract Providers: \$5,000 per person with a \$15,000 family limit  Non-contract Providers: \$10,000 per person with a \$30,000 family limit

Benefits for Covered Services and Supplies	
The percentages shown assume you have not yet met the “out-of-pocket limit.”	
<b>Hospital services and supplies:</b> <b>Accommodations in semi-private room or CCU or ICU</b> <b>Use of operating and delivery rooms</b> <b>Ancillary services and supplies</b> <b>Outpatient services billed by a Hospital or Ambulatory Surgery Facility</b>	<b>Contract Facility:</b> After deductible, Plan pays 90% of contract rate  <b>Non-contract Facility in area:</b> After deductible, Plan pays 90% of the contract rate you would have been charged at the closest Contract Facility  <b>Non-contract Facility for an Emergency Medical Condition or out of area if you live out of area:</b> After deductible, Plan pays 90% of the Allowed Charge  Benefits are reduced if you do not obtain required pre-authorizations.
<b>Hospital emergency room</b>  \$100 Copayment	<b>Contract Facility:</b> After deductible, Plan pays 90% of contract rate after you pay a \$100 Copayment.  <b>Non-contract Facility for an Emergency Medical Condition or out of area if you live out of area:</b> After deductible, Plan pays 90% of the Allowed Charge after you pay a \$100 Copayment.  <b>Non-contract Facility in area if not an Emergency Medical Condition:</b> After deductible, Plan pays 90% of the contract rate you would have been charged at the closest Contract Facility after you pay a \$100 Copayment.  The \$100 Copayment is waived if you are admitted to the Hospital from the emergency room. The Copayment is not part of the Plan’s out-of-pocket limit feature.

### Benefits for Covered Services and Supplies

The percentages shown assume you have not yet met the “out-of-pocket limit.”

<b>Ambulance</b>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays 80% of Allowed Charge (or 90% of Allowed Charge for an Emergency Medical Condition or out of area if you live out of area)</p>
<b>Inpatient Physician visits</b>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays 80% of Allowed Charge (or 90% of Allowed Charge for an Emergency Medical Condition or out of area if you live out of area)</p>
<b>Outpatient Physician visits</b>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays 80% of Allowed Charge (or 90% of Allowed Charge for an Emergency Medical Condition or if you live out of area)</p>
<b>Surgery – professional services</b>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays 80% of Allowed Charge (or 90% of Allowed Charge for an Emergency Medical Condition or out of area if you live out of area)</p>
<b>Outpatient laboratory and X-ray services</b>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays 80% of Allowed Charge (or 90% of Allowed Charge for an Emergency Medical Condition or out of area if you live out of area)</p>
<b>Routine physical exam (Employee and spouse only)</b> (Deductible waived)	<p>Plan pays 100% of Allowed Charge for one exam in any 12-month period</p> <p>Charges for physical exams do not count toward the Plan’s out-of-pocket limit</p>
<b>Colon cancer screening</b> (Deductible waived)	<p><b>Contract Provider:</b> Plan pays 100% of contract rate</p> <p><b>Non-Contract Provider:</b> Plan pays same benefits as above for doctor visits (<i>see Preventive Care later in this section for more details</i>)</p>
<b>Routine mammograms and pap smears</b> (Deductible waived)	<p><b>Contract Provider:</b> Plan pays 100% of contract rate</p> <p><b>Non-contract Provider:</b> Plan pays 80% of the Allowed Charge (or 90% of Allowed Charge if you live out of area)</p>
<p><b>Note,</b> see page 50 for additional preventive care benefits required by health care reform – payable if you use Contract Providers.</p>	

### Benefits for Covered Services and Supplies

The percentages shown assume you have not yet met the “out-of-pocket limit.”

<p><b>Well child care (including immunizations and Physician visits)</b>  (Deductible waived)</p>	<p><b>Contract Provider:</b> Plan pays 100% of the contract rate</p> <p><b>Non-contract Provider:</b> Plan pays 100% of the Allowed Charge</p> <p>Immunizations are covered in accordance with the schedule published by the Bright Futures/American Academy of Pediatrics.</p> <p>Charges for well child care do not count toward the Plan’s out-of-pocket limit</p>
<p><b>Adult immunizations (for Employees and spouses)</b>  (Deductible waived)</p>	<p><b>Contract Provider:</b> Plan pays 100% of the contract rate (see page 50)</p> <p><b>Non-Contract Provider:</b> Plan pays 80% of Allowed Charge (or 90% of Allowed Charge if you live out of area)</p>
<p><b>Inpatient mental health services</b>  Limited to 30 days per calendar year</p>	<p>Covered same as other Hospital services and supplies or other inpatient visits</p> <p>(Deductible applies)</p>
<p><b>Outpatient mental health services</b>  Limited to 26 visits per calendar year</p>	<p><b>Contract Provider:</b> After deductible, Plan pays 50% of the contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays 50% of the Allowed Charge</p> <p>Charges for outpatient treatment are not part of the Plan’s out-of-pocket limit feature.</p>
<p><b>Physical therapy or occupational therapy (outpatient)</b></p>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of the contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays</p> <ul style="list-style-type: none"> <li>• In Area: 80% of the Allowed Charge</li> <li>• Out of Area: 90% of Allowed Charge if you live out of area</li> </ul> <p>Limited to 20 visits per year, or</p> <p>Limited to 40 visits per year, if provided in the 24 months before or after a related surgery or a stroke)</p>
<p><b>Chiropractic treatment</b>  Limited to a maximum of 20 visits per calendar year</p>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of the contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays:</p> <ul style="list-style-type: none"> <li>• In Area: 80% of the Allowed Charge</li> <li>• Out of Area: 90% of Allowed Charge, if you live out of area</li> </ul>

Benefits for Covered Services and Supplies	
The percentages shown assume you have not yet met the “out-of-pocket limit.”	
<p><b>Organ and Tissue Transplants (Pre-authorization Required)</b></p> <ul style="list-style-type: none"> <li>• Organ or tissue procurement and transportation</li> <li>• Surgery</li> <li>• Follow-up care</li> <li>• Immunosuppressant drugs</li> </ul>	<p><b>Contract Provider:</b> After deductible, Plan pays 90% of the contract rate</p> <p><b>Non-contract Provider:</b> After deductible, Plan pays 80% of the Allowed Charge (or 90% of the Allowed Charge out of area if you live out of area)</p>
<p><b>Hearing Aid Benefit</b> (Deductible waived)</p> <ul style="list-style-type: none"> <li>• Examination and hearing aid device (limit of one per ear during any 4-year period)</li> </ul>	<p>Plan pays 100% of Covered Expenses, up to a maximum benefit of \$1,350 per ear.</p> <p>(The hearing aid benefit is not part of the Plan's out-of-pocket feature)</p>

### Reduced Comprehensive Medical Benefits

If your employer makes a contribution to the Fund that is less than the minimum standard employer contribution rate, a reduced level of comprehensive medical benefits will be payable, as shown in the following chart.

Reduced Comprehensive Medical Benefits Payable If Employer Contribution is Less than the Minimum Standard Contribution	
If Employer Contribution is:	You will receive the following percentage of <u>normal</u> benefits:
between 95% and 100% of standard contribution rate	<b>95%</b> (or 85.5% of most Covered Expenses)
between 90% and 95% of standard contribution rate	<b>90%</b> (or 81% of most Covered Expenses)
between 85% and 90% of standard contribution rate	<b>85%</b> (or 76.5% of most Covered Expenses)
between 80% and 85% of standard contribution rate	<b>80%</b> (or 72% of most Covered Expenses)
between 75% and 80% of standard contribution rate	<b>75%</b> (or 67.5% of most Covered Expenses)
between 70% and 75% of standard contribution rate (Flat Rate Employees only)	<b>70%</b> (or 63% of most Covered Expenses)

**Hourly Employees.** If you are an hourly Employee, the benefit reduction will apply if more than one-half of the total hours reported for you in a month are reported from an employer that makes a contribution to the Fund that is less than the minimum standard contribution rate.

For example, if you work 120 hours in July, but more than 60 of those hours were worked for an employer who paid only 80% of the minimum standard contribution, you would receive 80% of normal benefits for Covered Expenses you incur in September (due to lag month). If you submit a \$100 claim, and the normal benefit is \$90 ( $\$100 \times 90\% = \$90$ ), the Fund will pay only \$72 instead (normal benefit of \$90 x 80% benefit reduction = \$72).



**Flat Rate Employees.** If you are a flat rate Employee, the reduced benefit percentage will apply for any month for which your employer contributes less than the minimum standard contribution rate.

**Out-of-pocket limit.** The reduced benefit percentages will continue to apply after you reach the annual out of pocket limit. For example, if you are subject to a 95% reduced benefit percentage, after you reach the annual out-of-pocket limit, your claims will be reimbursed at 95% of Covered Expenses for the balance of the calendar year, instead of 100%.

The reduced benefit levels apply to all comprehensive medical benefits, except chemical dependency benefits.

<b>Benefits for Covered Services for Chemical Dependency Treatment</b> <b>REFERRAL THROUGH ASSISTANCE RECOVERY PROGRAM (ARP) REQUIRED</b> Not available for dependent children and not part of the Plan's out-of-pocket limit feature	
<b>Residential treatment (limited to 3 admissions per lifetime of up to 30 days each)</b>  <b>First admission</b>  <b>Second admission</b>  <b>Third admission</b>	Plan pays 100% of contract charges  Plan pays 85% of contract charges  Plan pays 75% of contract charges  The Plan will also pay 100% of contract charges for up to 30 days per calendar year for follow-up treatment in a recovery home.
<b>Outpatient treatment (limited to 3 series per lifetime and 50 visits per benefit year)</b>  <b>First treatment series</b>  <b>Second treatment series</b>  <b>Third treatment series</b>	Plan pays 100% of contract charges  Plan pays 85% of contract charges  Plan pays 75% of contract charges
<b>Diversion program</b>	Plan pays 100% of contract charge for one program lifetime

**If You Have Coverage Elsewhere**

If you or your dependents have other group medical coverage, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage—you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See “Coordination of Benefits” in chapter 12 for more information.

## Pre-Existing Condition Limitation for Non-Bargained Employees and Owner Operators

### *Does not apply to any individual under age 19*

You are subject to the Plan’s pre-existing condition provision only if you are a non-bargaining unit office Employee or company officer or an Owner-Operator. (*Exception: if you are an Owner-Operator who had contributions made by Contributing Employers to the Fund because of covered work immediately prior to your becoming signatory to the Owner-Operator agreement, the pre-existing condition provision does not apply to you.*)

Under this provision, benefits for any medical conditions that you or a dependent (except for an individual under age 19) have at the time you first become eligible for benefits will be limited to \$2,000 for the first 12 consecutive months you are eligible for benefits under this Plan.

A “pre-existing condition” is defined as an Illness or Injury for which you received medical advice or treatment (including taking a prescription drug) during the 6 months immediately preceding your eligibility date for Plan benefits. The Illness or Injury will no longer be considered a pre-existing medical condition after 12 consecutive months of eligibility under this Plan.

The benefit limit on pre-existing conditions does not apply to newborns, pregnancy-related expenses, information from genetic testing, or to any individual under 19 years of age.

### **Reducing the Period of Limited Benefits**

You can reduce or eliminate the time during which benefits for a pre-existing condition are limited by demonstrating prior creditable coverage. Your prior coverage will count toward the benefit-limit period for the pre-existing condition if any break in coverage between the old coverage and this Plan lasted less than 63 days.

**For example . . .** If you were covered under a prior plan for 9 months and there were less than 63 days between the date your prior coverage ended and your eligibility under this Plan began, the Plan will apply the pre-existing condition limit for only 3 months. If you had at least 12 months of creditable coverage under the prior plan, the Plan will not apply any pre-existing condition limit.

You will need to present a copy of a certificate of creditable coverage from your old coverage (you have the right to request such a certificate from your prior plan). If you need assistance obtaining that certificate, please contact the Trust Fund Office.

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## CONTRACT PROVIDERS

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Your medical benefits have been structured to provide financial incentives for you to use the Plan’s network of contract health care providers—Physicians, Hospitals, or other health care professionals or facilities that have contracted with the Plan’s Preferred Provider Organization (Anthem Blue Cross) to provide services at contract rates.

- If you use a Contract Provider, you pay only your percentage of the negotiated fee. The provider cannot charge you more than this contract rate.
- If you use Non-contract Providers, covered charges are limited to the Plan’s Allowed Charges (as defined in the Rules and Regulations at the end of this SPD). In most cases, these will be

less than the billed fee. Non-contract Providers are under no obligation to limit their charges to the amounts the Plan considers the Allowed Charge.

For some services and supplies, the Fund also pays a lower percentage of Covered Expenses when you use a Non-contract Provider.

If you go to a Contract Hospital, you should not assume that all providers in the Hospital are also Contract Providers. To receive the maximum possible benefits, you should request that all your provider services (such as services by an anesthesiologist) be performed by Contract Providers whenever you enter a Hospital.

**Note:** The fact that a provider is a Contract Provider does not necessarily mean that all services you receive from that provider will be covered benefits under the Plan.

### **Contract Provider Service Area**

For some services and supplies, the benefit paid by the Fund when you use a Non-contract Provider will depend on whether you live within the contract service provider area or outside of it.

The Contract Provider Service Area is defined as the geographic area that is within 30 miles of a Contract Provider. If you are unsure whether your residence is inside or outside of the Contract Provider Service Area, contact the Trust Fund Office.

### **How to Find Contract Providers**

It is always a good idea to confirm that a health care provider is currently participating in the Contract Provider network before receiving care.

- To find out if a provider is in the network, either ask the provider's office, contact the Trust Fund Office or visit the Anthem Blue Cross website [www.anthem.com/ca](http://www.anthem.com/ca).
- If you live outside of California, you can find Blue Card providers online at [www.bluecares.com](http://www.bluecares.com), or you can call (800) 810-2583. (Note: outside of California, Contract Providers are called "PPO Providers" or "Blue Card Providers.")
- For treatment of alcoholism or other chemical dependency, you should call the Assistance Recovery Program at (800) 562-3277 instead of the contacts above. If treatment is authorized, you will be referred to a contract chemical dependency treatment provider.
- For hearing aids, the most favorable benefit coverage depends on your using the HearPO network for hearing aids, (888) 432-7464.

The *Directory of Participating Providers* is used for a large number of groups. It includes some providers whose services may not be covered by the Plan.

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## **ANNUAL DEDUCTIBLE**

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The deductible is the amount of Covered Expenses that you pay each calendar year before the Plan begins to pay benefits. The deductible amount is \$500 per covered person each calendar year.

The deductible applies separately to each covered person, but no more than \$1,500 will be applied to deductibles for all members of your family in a calendar year, no matter how many dependents are in your family. No more than \$500 will be applied to any one person's deductible for the calendar year.

There is a 3-month deductible carry-over feature. If Covered Expenses are incurred in the last 3 months of a calendar year and are applied to the deductible for that year, they will also be applied to the deductible for the following year.

### ***Some Benefits Are Not Subject to the Deductible***

The deductible does not apply to:

- the Plan’s preventive care benefits (well child care, adult immunizations, routine mammograms and pap smears, the colorectal cancer screening benefit);
- the Employee and spouse physical exam benefit;
- chemical dependency treatment benefits; or
- the hearing aid benefit

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## **ANNUAL OUT OF POCKET LIMIT**

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Once you and your family member have met your deductible each year, you and the Fund each pay a portion of most Covered Expenses. For example, when you use Contract Providers, the Fund pays 90% for most Covered Expenses and you pay 10%. The percentage you pay is called your “Coinsurance.”

There is an annual cap, or limit, on the amount of Coinsurance you pay for each person, and an overall limit for a family. This cap is called the out of pocket limit. Your payments start accumulating to the out of pocket limit after you have met the calendar year deductible.

When you use **Contract Providers**, your out of pocket limit is:

- \$5,000 for each person, not to exceed
- \$15,000 for your family

When you use **Non-contract Providers**, your out of pocket limit is:

- \$10,000 for each person, not to exceed
- \$30,000 for your family

The annual out-of-pocket limit applies only to the comprehensive medical benefits, not to prescription drugs or any other benefits described in other chapters of this booklet.
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Once your payments (not including the deductible) for a particular individual’s (yourself or a dependent) Covered Expenses for the year reach \$5,000 (Contract Providers) or \$10,000 (Non-contract Providers), the Fund will pay 100% of Covered Expenses for that person for the rest of the calendar year (with the exceptions noted below).

**Family Limit.** Once your payments (not including the deductible) for your entire family’s Covered Expenses for the year total \$15,000 (Contract Providers) or \$30,000 (Non-contract Providers), the Fund will pay 100% of Covered Expenses for you and each member of your family for the rest of the calendar year (with the exceptions noted below).

### ***Expenses Not Counted Toward the Out of Pocket Limit***

The following do not count toward the out of pocket limit:

- amounts applied to the deductible
- any charges for non-Covered Expenses and any charges above benefit-specific limits, or above the Allowed Charges for Non-contract Providers

- amounts you pay for services or supplies that are not covered by the Plan
- any Covered Expenses for which the Plan normally pays 100%
- Covered Expenses for hearing aids, outpatient mental health treatment, or chemical dependency treatment (and the amount or percentage paid by the Fund for these services will not increase after you reach the out of pocket limit)
- your \$100 Copayment for use of emergency rooms (and the need to pay this Copayment will not end after you reach the out of pocket limit)

Any benefit-specific limits of the Plan continue to apply after you have met the annual out-of-pocket limit.

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## REQUIRED PRE-AUTHORIZATIONS

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If you want to receive unreduced benefit coverage for a Hospital stay, outpatient surgery, an organ or tissue transplant or bariatric surgery, you must get approval of the Hospital stay, transplant, or bariatric surgery from Anthem Blue Cross (Anthem). It is also recommended that you get prior approval from Anthem for medical equipment if it will cost more than \$500.

Certain outpatient diagnostic imaging procedures require pre-authorization from American Imaging Management.

If you want to receive benefit coverage for chemical dependency treatment, you must get a referral from the Assistance Recovery Program (ARP).

You do not have to obtain prior authorization before seeking treatment of an Emergency Medical Condition in a Hospital emergency room.

These pre-authorization requirements are summarized in the following chart.

Plan Requirements for Pre-Authorization	
Situation	Pre-Authorization Requirement
Elective, non-emergency hospitalization at an acute-care Hospital or Skilled Nursing Facility	Anthem Blue Cross must approve the Hospital stay <b>before admission</b> .
Hospitalization as a result of an Emergency Medical Condition	You or someone acting on your behalf must contact Anthem <b>within 24 hours of admission</b> so that Anthem can approve the Hospital stay as soon as possible after admission.
Admission for childbirth	You do not need pre-authorization for a Hospital stay for mother and newborn of less than 48 hours following a vaginal delivery or a stay of less than 96 hours following a cesarean section.
Surgical procedure scheduled for a Hospital outpatient department or free-standing Ambulatory Surgery Facility	The procedure must be approved by Anthem Blue Cross <b>before it is performed</b> .

Plan Requirements for Pre-Authorization	
Situation	Pre-Authorization Requirement
Outpatient Diagnostic Imaging Procedures, including: <ul style="list-style-type: none"> <li>• CT/ CTA</li> <li>• MRI/ MRA</li> <li>• Nuclear Cardiology</li> <li>• PET</li> <li>• Echocardiography</li> </ul>	Your physician must contact American Imaging Management for approval of these imaging procedures <b>before you have the test or service.</b>
Organ or tissue transplant	All planned services must be approved by Anthem Blue Cross <b>before services begin.</b>
Bariatric surgery for weight loss	All planned services must be approved by Anthem Blue Cross <b>before services begin.</b>
Durable Medical Equipment	It is recommended that equipment costing more than \$500 be approved by Anthem Blue Cross <b>before buying or renting.</b>
Treatment for chemical dependency	You must contact the ARP office and be referred to an appropriate authorized treatment program <b>before seeking treatment.</b>
Admission to an acute-care Hospital for detoxification on an emergency basis	You, your Physician, or someone acting on your behalf must contact Anthem Blue Cross <b>within 24 hours of admission.</b>

### **How the Process Works for Hospital Stays**

Anthem Blue Cross will conduct a Pre-admission Review to determine whether a planned inpatient Hospital stay is Medically Necessary and if so, how many pre-authorized days are eligible for unreduced benefit coverage.

If you use a Contract Hospital, the Hospital will automatically take care of pre-authorization. If you use a Non-contract Hospital, your doctor must call Anthem Blue Cross at (800) 274-7767 to provide the necessary information and apply for approval.

Anthem Blue Cross and your doctor will go over the facts about your case to determine if hospitalization is necessary. Sometimes Anthem will suggest that effective treatment can be given in a less intensive setting such as outpatient care or suggest a shorter stay in the Hospital.

- The Plan will **not pay any benefits** for your Hospital charges if you are admitted without a required pre-authorization and Anthem Blue Cross determines that your Hospital stay was not Medically Necessary.

If your stay is found Medically Necessary but you are admitted without a required pre-authorization, **the Plan's payment will be reduced by \$300.**

- If pre-authorization is obtained but your stay exceeds the number of authorized days, no benefits will be paid for the additional days.

Once you have been admitted to a Hospital, Anthem Blue Cross will monitor your progress every day or two to help make sure that you are discharged as soon as it is medically safe to discharge you. This is called "concurrent care review."

Here are some other requirements for different circumstances:

- If you require a transfer from one Hospital to another, Anthem Blue Cross must be contacted in advance about the transfer, unless it is necessary because of a life-threatening Emergency Medical Condition.
- If you require specialized services that are available only at a Non-contract Hospital, the Plan will pay benefits on the basis of Allowed Charges (rather than basing benefits on what a Contract Provider would have charged) if your Physician gets approval of your admission to the Non-contract Hospital from Anthem Blue Cross in advance.

If you or a dependent is admitted to a Hospital for an Emergency Medical Condition, you or someone acting on your behalf must contact Anthem Blue Cross within 24 hours of admission.

### ***How the Process Works for Outpatient Surgery***

Your doctor must call Anthem Blue Cross to provide necessary information and request pre-authorization of a surgical procedure to be performed in a Hospital outpatient department or Ambulatory Surgery Facility. **You are responsible** for seeing that he or she has done so and that pre-authorization has been obtained before the procedure is begun.

Your doctor must call Anthem Blue Cross at (800) 274-7767 for pre-authorization.

If you have the surgery/procedure without pre-authorization, services are subject to retrospective review by Anthem Blue Cross, and **no benefits will be payable** for any services deemed not Medically Necessary.

### ***How the Process Works for Diagnostic Imaging Procedures***

In order to assure the appropriate use of advanced diagnostic imaging, your physician must call American Imaging Management for approval before scheduling any of the scans or imaging procedures shown in the chart on page 33. Contract Providers should automatically take care of the approval process. If you use a Non-contract Provider, make sure the doctor calls American Imaging Management at (877) 291-0360 for approval before scheduling your test.

Your doctor must call American Imaging Management at (877) 291-0360 to pre-authorize the imaging procedure.

If you have the scan or other imaging procedure without pre-authorization, **benefits may be denied** for any service deemed not Medically Necessary by American Imaging Management.

### ***How the Process Works for Organ or Tissue Transplants and Bariatric Surgery***

Your Physician must call Anthem Blue Cross to provide necessary information and apply for pre-authorization of the organ or tissue transplant or bariatric surgery for weight loss. **You are responsible** for seeing that he or she has done so and that pre-authorization has been obtained before services are begun. Anthem will advise your doctor if the surgery must be performed at a *Center of Medical Excellence* facility and a list those facilities in your area.

- If you proceed with the transplant without pre-authorization, services are subject to retrospective review by Anthem Blue Cross, and no benefits will be payable for any services deemed not Medically Necessary.
- If you have bariatric surgery at a facility that is not a *Center of Medical Excellence* without pre-authorization, **no benefits will be payable** for the surgery or facility charges.



### ***How the Process Works for Chemical Dependency Treatment***

Benefits for treatment of alcoholism and other chemical dependency are provided only if you or your spouse receives treatment under the Operating Engineers Assistance Recovery Program (ARP).

Before seeking treatment, you must contact the ARP office. The ARP coordinator will assist in making a referral to an appropriate authorized treatment program. All communication with the ARP will be strictly confidential.

You can contact the ARP office at (800) 562-3277.
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### **The Plan will not pay benefits for any chemical dependency treatment that has not been pre-authorized by the ARP.**

If you need to be admitted to an acute-care Hospital for detoxification on an emergency basis, you, your Physician, or someone acting on your behalf must contact Anthem Blue Cross at (800) 274-7767 within 24 hours of admission.

### ***Response Time***

Requests for pre-authorization are usually considered “pre-service claims.” Decisions are generally made within 15 days. Decision making will be expedited if your case warrants treatment as an “urgent claim,” meaning that following the time frames just described for pre-service claim decisions:

- could seriously jeopardize your life or health or your ability to regain maximum function, or
- in the opinion of a Physician with knowledge of your condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the request for pre-authorization.

A decision on a case meriting treatment as an urgent claim will be made as soon as possible, taking into account the medical necessity, but not later than within 72 hours. Your doctor should alert Anthem Blue Cross (or you should alert the ARP) if your pre-authorization request needs to be handled as an urgent claim. (“Urgent claims” are not to be confused with treatment of an Emergency Medical Condition or treatment at an urgent care facility, which do not require pre-authorization.)

### ***Large Case Management***

Anthem Blue Cross also provides large case management services, which determines if a person who has a severe medical condition, such as traumatic brain or spinal cord Injury, cancer or stroke, can be treated in an alternative setting instead of an acute care Hospital. The alternative care may include home health care, a rehabilitation facility, hospice care or Skilled Nursing Facility. The case manager works with the Physician, patient and/or patient’s family to determine whether alternative care is suitable and arranges and oversees the care. There is no charge to you or your dependents for the services of the case manager.

Alternative care, which may be services that are normally not covered by the Plan, will be covered if Anthem Blue Cross determines that it is less costly than an acute care Hospital and pre-authorizes the care.



### ***Intent of Required Pre-Authorizations***

The pre-authorizations required under the utilization review program work to control your costs, for example, by preventing unnecessary hospitalization and Hospital stays that extend beyond the time it is medically safe to discharge a patient..

You should note that:

- The fact that your doctor recommends surgery, Hospitalization or any other medical service or supplies doesn't mean that the service or supplies will be a covered expense under the Plan
- Neither the Plan, Anthem Blue Cross, American Imaging Management or ARP is responsible for either the quality of health care services actually provided or for the results if a participant chooses not to receive health care services that have not been certified as Medically Necessary.
- All treatment decisions rest with you and your Physician. You should follow whatever course of treatment you and your Physician believe to be the most appropriate. (However, the benefits payable by the Plan may be affected by the determination of the review Organization. The Plan will not pay benefits for any services or supplies deemed not Medically Necessary.)
- The Utilization Review program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Certification of medical necessity does not necessarily mean benefits will be paid. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, if the services were not covered by the Plan, or the maximum benefit had already been paid.

You may also appeal an adverse decision. See "Claims and Appeals Procedures" in chapter 11.

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## **EMERGENCIES**

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For an Emergency Medical Condition, you should seek the necessary treatment immediately. You do not have to obtain prior authorization from Anthem Blue Cross before going to a Hospital emergency room for treatment of an Emergency Medical Condition.

The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The Plan pays the same Coinsurance percentage whether you obtain services for an Emergency Medical Condition from a Contract Hospital or from a Non-contract Hospital. However, if you go to a Non-contract Hospital, that Hospital may bill you separately if the Hospital's charges exceed what the Plan pays that Hospital on your behalf.

### ***Hospital Emergency Room Copayment***

If you visit a Hospital emergency room, you will have to pay a Copayment of \$100 in addition to the charges you would normally pay for treatment of an emergency and subject to the annual deductible if it has not been met. This Copayment will be waived if you are admitted to the

Hospital from the emergency room. The Copayment does not apply to urgent care centers. See page 38 for more information on the emergency room benefit.

### **Hospitalization for an Emergency Medical Condition**

If you are admitted to a Hospital as an inpatient for an Emergency Medical Condition, you (or someone acting in your behalf) must call Anthem Blue Cross at (800) 274-7767 within 24 hours of admission. If you are in a Contract Hospital, the Hospital will automatically handle the pre-authorization.

If the Hospital is a Non-contract Hospital, the Plan may require you to be transferred to a Contract Hospital upon the advice of a Physician that it is medically safe to transfer you and the acute emergency period has ended. If you decide to remain in the Non-contract Hospital instead, Covered Expenses for the period of confinement after the acute emergency period has ended will be limited to the contract rate that would have been charged at the nearest Contract Hospital.

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## **WHAT THE PLAN COVERS**

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Covered services and supplies include those described below. Exclusions and limits that apply to specific services and supplies are described with those services and supplies; others are described in the “Exclusions from Coverage” that follow the covered services and supplies.

To be covered, a service or supply must be Medically Necessary, as defined in the Rules and Regulations at the end of this SPD (an exception is made for the preventive care services specifically covered by the Plan), and it must be rendered in accordance with generally accepted U.S. medical standards accepted by the medical community as a whole.

All benefits described in this section are payable after you have satisfied the annual deductible, unless the benefit indicates the deductible does not apply.
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### **Special Provisions Regarding Women’s Health Care**

Federal law guarantees certain rights to women:

- Under the ***Newborns’ and Mothers’ Health Protection Act of 1996***, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the Physician), after consultation with the mother, discharges the mother or newborn earlier.

Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization requirements in such a case, contact the Trust Fund Office.

- Under the ***Women’s Health and Cancer Rights Act of 1998***, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must

include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. These services are elective and are chosen by the patient in consultation with the attending Physician. They are subject to the Plan's usual Coinsurance and Copayment provisions.

### **Inpatient Hospital Services and Supplies**

See "Required Pre-Authorizations" on page 32 for information on approvals necessary for maximum benefits for Hospital admissions.

After the deductible, the Plan pays benefits for Hospital services and supplies as shown below, assuming the required pre-authorization has been obtained.

- Contract Hospital: 90% of the contract rate
- Non-contract Hospital within the Contract Provider Service Area: 90% of the contract rate at the closest Contract Facility
- Non-contract Hospital if admitted for an Emergency Medical Condition or if you live outside the Contract Provider Service Area: 90% of Allowed Charge

In the case of an Emergency Medical Conditions, if the patient declines to move to a Contract Hospital after such a transfer is medically safe, payments of benefits will change to 90% of the contract rate at the closest Contract Hospital.

- Non-contract Hospital if you require specialized services available only at the Non-contract Hospital: 90% of Allowed Charge

### **Covered**

*(limited to 30 days per calendar year if the stay is for treatment of a mental health condition)*

- Accommodations in a semi-private room or cardiac care or intensive care unit
- Use of operating and delivery rooms, anesthesia
- Blood transfusions, including the cost of unreplaced blood, blood products, and blood processing
- Ancillary services, including supplies, oxygen, laboratory, pathology, and radiology and any professional component of these services
- Drugs and medicines that are supplied by the Hospital for the Illness, Injury, or condition for which you are hospitalized (including take-home drugs, if you are using a Contract Hospital)

### **Not Covered**

- Take-home drugs if you are using a Non-contract Hospital
- Custodial Hospital care

### **Hospital Emergency Room**

After you pay a \$100 Copayment per visit and satisfy the annual deductible, benefits for Hospital emergency room charges will be paid as follows:

- Contract Hospital: 90% of the remaining contract rate

- Non-contract Hospital for treatment of an Emergency Medical Condition or if you live out of area: 90% of the remaining Allowed Charge
- Non-contract Hospital within the Contract Provider Service Area if Not an Emergency Medical Condition: 90% of the remaining contract rate of the closest Contract Facility

The \$100 Copayment will be waived if you are admitted to the Hospital from the emergency room. This Copayment is not part of the Plan's out-of-pocket limit feature.

### **Outpatient Hospital or Ambulatory Surgery Facility**

*See "Required Pre-Authorizations" on page 32 for information on approvals necessary for outpatient surgical procedures. See "Surgery" on page 41 for benefits payable for the surgeon's charge.*

After the deductible, the Plan pays benefits for outpatient services and supplies at a Hospital or Ambulatory Surgery Facility as shown below (assumes the required pre-authorization has been obtained):

- Contract Hospital or Facility: 90% of the contract rate
- Non-contract Hospital or Facility within the Contract Provider Service Area: 90% of the contract rate at the closest Contract Facility
- Non-contract Hospital or Facility if you live outside the Contract Provider Service Area: 90% of Allowed Charge

### **Covered**

- Outpatient services billed by a Hospital or Ambulatory Surgery Facility, including outpatient treatment and surgery rooms, supplies, ancillary services, laboratory and radiology services, and drugs and medicines provided by the facility

### **Skilled Nursing Facility**

*See "Required Pre-Authorizations" on page 32 for information on approvals necessary for maximum benefits.*

Skilled Nursing Facility benefits are paid the same as other Hospital benefits. The benefit payable will depend on whether you use a contract or Non-contract Facility. See "Hospital Services and Supplies" above for more information.

You must meet the conditions below to qualify for Skilled Nursing Facility benefits:

- You must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those that are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with your Illness, Injury, degree of disability and medical need, as determined by Anthem Blue Cross.
- You must remain under the active medical supervision of a Physician treating the Illness or Injury for which you have been admitted.

Benefits are provided only for the number of days required to treat the Illness or Injury.

### **Covered**

- Accommodations (if you use a Non-contract Facility, this means accommodations in a room of two or more beds; if a private room is used, benefits will be based on the prevailing charge for accommodations in a room of two or more beds in that facility)
- Laboratory services, physical, occupational, and speech therapy
- Oxygen and other inhalation therapy
- Drugs and medicines that are administered in the facility
- Blood transfusions, blood products, and blood processing

### **Not Covered**

- Custodial Hospital care

### **Outpatient Physician Visits**

After the deductible, benefits for Physician office visits are paid as follows:

- For Contract Physician visits: 90% of the contract rate
- For Non-contract Physician visits in the Contract Provider Service Area: 80% of the Allowed Charge
- For Non-contract Physician visits for an Emergency Medical Condition or if you live outside of the Contract Provider Service Area: 90% of the Allowed Charge

*Note:* The benefits described above do not apply to outpatient well child doctor visits or outpatient doctor visits for mental health treatment, they also do not apply to visiting a doctor or other health care practitioner for a routine physical exam, physical therapy, occupational therapy, chiropractic treatment or X-ray and laboratory charges. See the specific benefit descriptions in this chapter for information on benefits for those types of visits or services.

### **Covered**

- Visits to a Physician's office (including specialist consultations)
- Visits by a Physician to your home

### **Not Covered**

- More than one home or office "visit" charge per day by any one Physician. The term "visit" means a personal interview between you and the Physician and does not include telephone calls or other situations where you are not personally examined by a Physician.

### **Inpatient Physician Visits**

After the deductible, benefits for Physician visits when you are in the Hospital are paid as follows:

- For Contract Physician visits: 90% of the contract rate
- For Non-contract Physician visits in the Contract Provider Service Area: 80% of the Allowed Charge
- For Non-contract Physician visits for an Emergency Medical Condition or if you live outside the Contract Provider Service Area: 90% of the Allowed Charge

## **Use of Physician Assistants and Other Licensed Providers**

The Plan covers the services of a licensed Physician assistant for assistant-at-surgery, physical examinations, administering injections, minor setting of casts for simple fractures, interpreting X-rays, and changing dressings. These services must be performed under the supervision of a Physician, billed under the tax identification number of the supervising Physician, and be services that would be considered covered Physician services if provided by an M.D. or D.O.

- If you use Contract Providers, Covered Expenses for the services of a licensed Physician assistant or other licensed provider are limited to the contract rate.
- If you use Non-contract Providers, Covered Expenses are limited to 85% of the applicable Physician's Allowed Charge for the services performed.

The Plan also covers other licensed providers when they are performing covered services within the scope of their licenses (including a Certified Surgical Assistant, Registered Nurse First Assistant and Nurse Practitioner).

## **Surgery**

*See "Required Pre-Authorizations" on page 32 for information on approvals necessary for outpatient surgical procedures, bariatric surgery and organ or tissue transplants. See "Outpatient Hospital or Ambulatory Surgery Facility" on page 39 for coverage of facility charges for surgery performed in the outpatient department of a Hospital or Ambulatory Surgery Facility.*

After the deductible, the Plan pays benefits for the surgeon, assistant surgeon and anesthesiologist as follows:

- For Contract Providers: 90% of the contract rate
- For Non-contract Providers in the Contract Provider Service Area: 80% of the Allowed Charge
- For Non-contract Providers for an Emergency Medical Condition or if you live outside the Contract Provider Service Area: 90% of the Allowed Charge

Covered Expenses for the services of a licensed Physician assistant or other licensed provider acting as assistant-at-surgery will be limited to the contract rate if you use a Contract Provider, or 85% of the amount that would be allowed if the services were performed by a Physician serving as an assistant-at-surgery if you use a Non-contract Provider.

### **Covered**

- Surgery to correct functional disorders or performed as a result of an Injury
- Anesthesia and its administration
- Reconstructive surgery following a mastectomy performed under the Plan: reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of all stages of mastectomy, including lymphedemas
- A second surgical opinion for the purpose of determining the necessity for prescribed surgery

### **Not Covered**

- Surgery for Cosmetic purposes, except as described immediately above under "Covered"

- Eye surgery for correction of myopia or any other refractive eye surgery
- Expenses for transportation of surgeons

## Centers of Medical Excellence Required for Bariatric Surgery and Organ or Tissue Transplants

Bariatric surgery for weight loss and certain organ and tissue transplants, including kidney transplants, must be performed in a facility designated by Anthem Blue Cross as a *Center of Medical Excellence* (CME) in order for Plan benefits to be paid. Anthem has two networks with *Centers of Medical Excellence*: 1) the Blue Distinction Centers for Specialty Care managed by the Blue Cross Blue Shield Association nationwide; and 2) the Anthem Centers of Medical Excellence network that is managed by Anthem. As a participant in the Trust Fund, you have access to both programs.

Your doctor must call Anthem Blue Cross at (800) 274-7767 for pre-authorization and referral to a Center of Medical Excellence.

**No benefits will be payable for any bariatric surgery or specified organ transplants performed at a Hospital or facility that is not an Anthem Blue Cross *Center of Medical Excellence*.** These surgeries must be pre-authorized in advance by Anthem. During the pre-authorization process, Anthem will advise you of the list of CMEs that are closest to you.

### Bariatric Surgery

The Plan will cover bariatric surgery for weight loss only if it is considered to be Medically Necessary treatment for morbid obesity and pre-approved by Anthem Blue Cross. Morbid obesity is defined as having a body mass index (BMI) greater than 40. Approved bariatric surgery must be performed at a facility that is designated by Anthem Blue Cross as a Center of Medical Excellence (CME).

### Travel Benefit for Bariatric Surgery

If the nearest CME is more than 50 miles from your home, the Fund will reimburse travel expenses as follows, subject to the deductible.

- The patient's transportation to and from the CME is limited to \$130/person/trip for 3 trips (pre-surgical visit, initial surgery and one follow-up visit);
- One companion's transportation to and from the CME is limited to \$130/person/trip for 2 trips (initial surgery and one follow-up visit);
- Hotel for the patient and one companion is limited to one room, double occupancy and \$100/day for 2 days/trip, or as Medically Necessary, for pre-surgical and follow-up visit. Benefits for hotel for one companion is limited to one room double occupancy and \$100/day for duration of the patient's initial surgery stay for 4 days.
- Other reasonable expenses limited to \$25/day/person for 4 days/trip. These expenses will not include meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the Patient and his/her designated family member/travel companion.

Please be aware that a portion of the above travel benefit may be considered taxable income to you. You are advised to check with your tax advisor if you receive the travel benefit.



## Organ or Tissue Transplants

Benefits related to covered organ or tissue transplants are paid according to the type of service involved (Hospital charges, surgeon's professional fees, office visits). See the applicable sections of this chapter for benefit payment information.

To qualify for benefits, the transplant must meet all of the following conditions:

- The recipient of the organ or tissue must be an individual who is eligible for benefits under this Plan.
- The transplant cannot be considered Experimental or Investigational.
- The transplant must be pre-authorized by Anthem Blue Cross. Some transplant procedures, including kidney transplants, must be performed in a Hospital or facility that is designated as a *Center of Medical Excellence* by Anthem Blue Cross in order to be covered by the Plan. Anthem will advise you and your doctor if the transplant is subject to this requirement during the pre-authorization process.

Your doctor must call Anthem Blue Cross at (800) 274-7767 for pre-authorization and referral to a Center of Medical Excellence.
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If the organ or tissue donor is not covered under this Plan, any benefits payable for the donor will be reduced by any benefits paid or payable by the donor's own health coverage.

### Covered

- Patient screening
- Benefits for unrelated donor search are limited to a maximum of \$30,000 per transplant
- Surgery and follow-up care in the home or a Hospital
- Transplant travel expense for an approved transplant required to be performed at a *Center of Medical Excellence* is limited to \$10,000 per transplant for the organ recipient and companion and/or donor transportation

### Not Covered

- Expenses for transportation of the donor, surgeons, or family members, other than specified above under "Covered" for travel to a *Center of Medical Excellence* when required
- The following expenses are not covered under the transplant travel expense benefit: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his/her designated companion or donor
- Any transplant that has not been pre-authorized by Anthem Blue Cross

## Maternity Services and Infertility Consultation

Benefits for maternity services and infertility consultations are paid as applicable for the type of service (Hospital charges, outpatient doctor visits, professional services for surgery, laboratory charges, etc.). See the applicable areas elsewhere in this section for benefit payment information. Benefits for infertility services are limited to the initial consultation only.

### Covered

- Hospital and Physician services for pregnancy and childbirth (available only to female Employees or spouses, not to dependent children)



- Services of a stand-by pediatric Physician at a cesarean section delivery or other at-risk delivery, but only when the stand-by Physician is actually present in the delivery room (**available only to female Employees or spouses, not to dependent children**)
- Infertility consultation (**initial consultation only**), including laboratory tests and screening laparoscopy for the purpose of determining the cause of infertility

### Not Covered

- A dependent daughter's pregnancy, maternity care, or abortion
- Infertility treatment (except those listed above under "Covered"), along with services to induce pregnancy and complications resulting from those services, including but not limited to: services, drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, donor egg/semen or other fees, cryostorage of egg/sperm, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services and surgical impregnation procedures
- Surrogate parenting, any expenses related to the maternity care and delivery associated with a surrogate mother's pregnancy
- Adoption expenses
- Reversal of sterilization

### Laboratory and Radiology Services

After the deductible, the Plan will pay benefits as follows:

- For Contract Providers: 90% of the contract rate
- For Non-contract Providers in the Contract Provider Service Area: 80% of the Allowed Charge
- For Non-contract Providers treating an Emergency Medical Condition or if you live outside the Contract Provider Service Area: 90% of the Allowed Charge

### Covered

- Outpatient diagnostic radiology and laboratory services
- Radiation therapy

*See "Mental Health" on page 46 for information on benefits payable for outpatient diagnostic lab and X-ray tests related to treatment of mental illness.*

### Physical Therapy or Occupational Therapy

Benefit payments for physical therapy or occupational therapy **are limited to a maximum of 20 visits per calendar year** (this limit applies to all visits for physical and occupational therapy combined).

If the therapy is provided within 24 months before or after a related surgical procedure, or 24 months after a stroke, the combined maximum benefit will be **40 visits per calendar year**.

After the deductible, benefits are payable as follows:

- Contract Providers: 90% of the contract rate, up to the maximum amounts stated above

- Non-contract providers in the Contract Provider Service Area: 80% of the Allowed Charge, up to the maximum amounts stated above
- Non-contract Providers if you live outside the Contract Provider Service Area: 90% of the Allowed Charge, up to the maximum amounts stated above

#### **Covered**

- Physical or occupational therapy services provided by a registered physical therapist or Physician

### **Chiropractic Treatment**

Benefit payments for chiropractic treatment **are limited to a maximum of 20 visits per calendar year.**

After the deductible, benefits are payable as follows:

- Contract Providers: 90% of the contract rate
- Non-contract Providers in the Contract Provider Service Area: 80% of the Allowed Charge
- Non-contract Providers if you live outside the Contract Provider Service Area: 90% of the Allowed Charge

#### **Covered**

- Chiropractic treatment, services or supplies provided by a licensed chiropractor

### **Medical Equipment, Prosthetic Appliances and Orthotics**

*Pre-authorization is recommended for medical equipment costing more than \$500; see page 32.*

After the deductible, benefits for covered medical equipment, prostheses and orthotics are payable as follows:

- For Contract Providers: 90% of the contract rate.
- For Non-contract Providers in the Contract Provider Service Area: 80% of the Allowed Charge
- For Non-contract Providers if you live outside the Contract Provider Service Area: 90% of the Allowed Charge

#### **Covered**

- Rental or purchase of medical equipment and supplies that are ordered by a Physician, are manufactured specifically for medical use, are of no further use when the medical need ends, are usable only by the patient, and are approved as effective and customary treatment of a condition, as determined by the Plan
- Prosthetic devices or equipment that replaces all or part of a body organ or part or that improve the function of an impaired bodily organ or part
- Diabetic shoes
- Foot Orthotics, limited to a maximum benefit of \$500 for both feet, per calendar year

## Not Covered

- Rental or purchase of equipment or supplies that are primarily for the comfort or hygiene or beautification of the patient, for environmental control (e.g., air purifiers, air conditioners, humidifiers), for exercise, or for prevention purposes
- Rental charges that exceed the purchase price of the equipment
- Dental prosthetic devices (see chapter 6 for dental benefits)
- Expenses for foot orthotics beyond the calendar year maximum
- Orthopedic shoes (except when joined to braces) or shoe inserts (except foot orthotics as provided above)

## Mental Health

**Inpatient:** After the deductible, benefits for inpatient mental health treatment are paid as applicable for the type of service (Hospital charges, charges for inpatient doctor visits, etc.). See the applicable areas in this section for benefit payment information.

Inpatient Hospital charges for mental health treatment will be covered for no more than 30 days per calendar year.

**Outpatient:** For outpatient visits, benefits are payable for up to 26 visits per calendar year (the 26-visit limit does not apply to psychological testing and diagnostic lab and X-ray tests related to treatment of mental illness).

After the deductible, outpatient benefits are payable as follows:

- For Contract Providers: 50% of the contract rate
- For Non-contract Providers: 50% of the Allowed Charge

Outpatient mental health visits are not part of the Plan's out-of-pocket limit feature.

## Covered

- Inpatient mental health treatment, up to 30 days per calendar year
- Outpatient treatment of mental or nervous disorders provided by a psychiatrist, psychologist, licensed clinical social worker (LCSW), or marriage, family and child counselor (MFCC), up to 26 visits per calendar year
- Outpatient psychological testing
- Outpatient diagnostic lab and X-ray tests related to treatment of mental illness

## Not Covered

- Hospital confinements of less than 24 hours for a condition of a mental or nervous disorder (such as partial Hospitalization days or daycare)
- Outpatient psychotherapy and psychological testing except as specifically provided above
- Educational services, as described under "Exclusions from Coverage" later in this chapter
- Goal-oriented behavior modification therapy, as described under "Exclusions from Coverage" later in this chapter

## Hospice Care

Benefits are payable for inpatient and outpatient home Hospice care for terminally ill patients who are assessed to have a life expectancy of 6 months or less. “Hospice” means an agency or organization that provides a program of medical, psychological, social and spiritual care and may provide room and board.

The Hospice must meet all of the following criteria:

- It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located;
- It provides service 24 hours a day, 7 days a week.
- It is under the direct supervision of a Physician.
- It has a nurse coordinator who is a registered nurse (R.N.).

### Covered

- Room and board for confinement in a Hospice and services and supplies provided by the Hospice
- Home Hospice care, including part-time nursing care by or under the supervision of a registered nurse (RN)
- Home health aide services
- Special meals.
- Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for immediate family members of the patient who were covered by this Plan at the time of the patient’s death. The Plan will cover up to 15 sessions during the 6-month period following the eligible patient’s death.

## Temporomandibular Joint (TMJ) Syndrome

Benefits are limited to a **lifetime maximum of \$1,500 per individual**. (Medically Necessary surgical procedures are not subject to the \$1,500 maximum.)

Benefits are paid as applicable for the type of service (hospital charges, outpatient doctor visits, surgery, laboratory charges, etc.) See the applicable areas elsewhere in this chapter for benefit payment information.

### Covered

- Medical treatment or services required to alleviate temporomandibular joint (TMJ) syndrome, myofascial pain dysfunction syndrome, mandibular pain dysfunction, facial pain and mandibular dysfunction, Costen’s syndrome, craniocervical mandibular syndrome, and craniofacial pain and dysfunction

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## PREVENTIVE CARE BENEFITS

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The Plan pays benefits outlined below for the following preventive care services.

The annual deductible does not apply to preventive care benefits.

### Employee / Spouse Physical Examination

This benefit is available only for you and your spouse, not for your dependent children, and only once every 12 months. See “Well Child Care” below for physical exam benefits for children.

- The Plan will pay 100% of Allowed Charges for a routine physical examination performed by a Physician, including charges for any X-ray and laboratory tests ordered as part of the physical.
- This benefit covers certified driver’s license exams.

### Not Covered

- More than one physical examination in any 12-month period
- Eye examinations
- Any examination required by an employer as a condition of employment, except for a certified driver’s license exam

### Health Dynamics Preventive Care Program

You and your spouse also have the option to participate in the *Health Dynamics* Preventive Care Program. This program provides a thorough health screening designed to assess your health status and health risks. The aim of the program is to detect potential health issues early and reduce preventable illnesses. The health screening is covered at 100%, once each calendar year, with no deductible or Copayment.

Along with the health tests, you will receive a one-hour wellness coaching session and a confidential report which address your health-risk scores and provide recommendations and educational materials to review with your doctor.

The Health Dynamics program is offered through a network of regional providers in various geographic locations. You will receive mailings with an updated list of providers throughout the year. These mailings will also provide information on how to schedule an appointment.

For a list of current locations, call the Fund Office or the Fringe Benefits Service Center. You may also call Health Dynamics at (414) 443-0200 or visit their website at [www.hdhelpsu.com](http://www.hdhelpsu.com). (username: hdhelpsu; password: hdhelpsu).

As an incentive to participate in the Health Dynamics program, the 2012 annual deductible **will be reduced by \$250 each for you and your spouse** if you use the program.

### Well Child Care

The Plan will pay 100% of the Allowed Charges for routine well child care, including immunizations and Physician visits up to age 21. Immunizations will be covered in accordance with the immunization schedule published by “Bright Futures/American Academy of Pediatrics.” The deductible does not apply.

## **Adult Immunizations**

This benefit is available for you and your spouse, not for your dependent children. It includes, but is not limited to, the vaccines for hepatitis, influenza (flu), pneumonia, herpes zoster and the HPV vaccine.

Benefits are payable at the percentages shown below for contract and Non-contract Providers. The deductible does not apply.

## **Routine Mammograms and Pap Smears**

Benefits for routine screening mammograms and pap smears are payable at 100% for Contract Providers and 80% for Non-contract Providers (or 90% if outside the Contract Provider Service Area). The deductible does not apply.

## **Colorectal Cancer Screening, Including Colonoscopy**

The Plan will pay the benefits shown below for individuals age 50 and over. Any one of the following testing schedules is covered in accordance with American Cancer Society guidelines:

- yearly fecal occult blood test (FOBT) or fecal immunochemical test (FIT)
- flexible sigmoidoscopy every 5 years
- yearly fecal occult blood test (FOBT) or fecal immunochemical test (FIT), plus flexible Sigmoidoscopy every 5 years
- double-contrast barium enema every 5 years
- colonoscopy every 10 years, or colonoscopy following any positive results from tests listed above.

If recommended by a Physician, the Plan will cover screening before age 50 and more frequently than the schedules listed above for individuals with any of the following risk factors:

- a personal history of colorectal cancer or adenomatous polyps,
- a strong family history of colorectal cancer or polyps,
- a personal history of chronic inflammatory bowel disease, or
- a family history of a hereditary colorectal cancer syndrome (familial adenomatous polyposis or hereditary non-polyposis colon cancer)

### ***Benefits for Adult Immunizations, Routine Mammograms / Pap smears and Colorectal Cancer Screening are Payable as Follows:***

- For Contract Providers: 100% of the contract rate
- For Non-contract Providers in the Contract Provider Service Area: 80% of the Allowed Charge
- For Non-contract Providers if you live outside the Contract Provider Service Area: 90% of the Allowed Charge

## **Smoking Cessation**

Telephone based counseling services to help quit the use of cigarettes or chewing tobacco are available free of charge to California residents. Services range from advice and written materials to more intensive based counseling. You do not need to meet any specific criteria to use the program's telephone services. Simply call the Smokers' Helpline at (800) NO BUTTS (that's 800-

662-8887) and mention that you are a participant in the Operating Engineers Health and Welfare Trust Fund . The helpline is also available in Spanish at 800-456-6386.

Smoking cessation products, such as nicotine gum or patches or prescription drugs are covered for you and your spouse (not dependent children) under prescription drug benefits (*see chapter 5*).

## **Additional Preventive Care Benefits Required by Health Care Reform**

### **Contract Provider Preventive Services**

The following preventive care services that are required to be covered under health care reform will be payable at 100%, with no deductible **when received from a Contract Provider**. Covered preventive services received from a Non-contract Provider will be payable as described beginning on page 48 for adult physical examination, well child care, adult immunizations, routine mammograms and pap smears, and colorectal cancer screening.

Please see the following Government website for a complete description of covered preventive care or call the Fund Office with any questions you have.

<http://www.healthcare.gov/law/about/provisions/services/lists.html>

### **Preventive Care for Children**

Covered Services include but are not limited to:

- Newborn screening lab tests (typically payable as part of hospitalization at birth);
- At least 11 office visits payable during first 30 months of age, then annual office visits are payable from age 3 years through age 18 years;
- Hemoglobin and lead blood tests in first year of life;
- Tuberculosis (TB) skin test in first year of life;
- Hemoglobin blood test in second year of life; and
- CDC recommended immunizations.

### **Preventive Care for Men**

Covered Services include but are not limited to:

- Abdominal aortic aneurysm screening;
- Colonoscopy, sigmoidoscopy or fecal occult blood test;
- Four blood tests for cholesterol/lipid, blood sugar, HIV, syphilis; and
- CDC recommended immunizations.

### **Preventive Care for Women (including pregnant women)**

Covered Services include but are not limited to:

- Screening mammogram for breast cancer;
- Pap smear and Chlamydia screening;
- Osteoporosis screening x-ray;
- Colonoscopy, sigmoidoscopy or fecal occult blood test;
- Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV;
- BRCA 1 and 2 lab test with family history of breast cancer; and
- CDC recommended immunizations.

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## ADDITIONAL COVERED SERVICES AND SUPPLIES

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The Plan will pay benefits shown below for the following services and supplies, subject to any benefit-specific maximums mentioned below and the annual deductible.

- For Contract Providers: 90% of the contract rate
- For Non-contract Providers in the Contract Provider Service Area: 80% of the Allowed Charge
- For Non-contract Providers treating an Emergency Medical Condition or if you live outside the Contract Provider Service Area: 90% of the Allowed Charge

### Covered

- **Licensed ambulance service** for ground transportation to or from a Hospital or other medical facility for medical care  

A licensed air ambulance is also covered if the Plan determines that the location and nature of the Illness or Injury made air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life.
- **Home health care, including** IV drugs and their administration when furnished by a home health care agency.
- Services of licensed nurse practitioners and registered nurse first assistants when performing services within the scope of their license.
- **Acupuncture**— treatment by a licensed acupuncturist (limited to 16 visits per “treatment series.” A new “*treatment* series” will begin after a period of 6 months has passed since the last acupuncture treatment.)
- **Diabetes Education Program**— that is taught by a certified diabetes educator and recognized as an acceptable program by the American Diabetes Association and/or nutritional counseling services provided by a registered dietician to a person diagnosed with diabetes.  

*A diabetes education program is covered when you are first diagnosed with diabetes. A refresher course may be covered once a year for up to 5 times.*
- **Speech therapy** provided by a licensed speech therapist when prescribed by a Physician (covered only if you had normal speech at one time and lost it due to an Illness or Injury).  

*Benefits are payable until understandable speech is attained or until a determination is made that understandable speech cannot be attained.*
- Surgical dressings, splints, casts, and other devices for reduction of fractures or dislocations.
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
- Purchase of a wig when hair loss is the direct result of chemotherapy treatment.
- Dental treatment or services provided by a Dentist but only when the treatment or services are necessary to repair or alleviate damage to teeth resulting from an accident or from radiation treatment for cancer.



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## HEARING AID BENEFIT

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*(Available to enrollees in the comprehensive medical benefits and HMO enrollees. The annual deductible does not apply.)*

The Plan will pay 100% of Covered Expenses, up to a maximum of \$1,350 per ear. Hearing aid expenses do not apply to the Plan's out-of-pocket limit.

### **Covered**

- A hearing examination
- Hearing aid device (limited to one device per ear during any 4-year period)

### **Not Covered**

- More than one hearing aid for each ear
- The replacement of a hearing aid for any reason more often than once during any 4-year period
- Batteries or any other ancillary equipment other than that obtained upon purchase of the hearing aid that can be covered within the \$1,350 maximum benefit
- Servicing or alterations of the hearing aid

You have the option of purchasing hearing aids from any retailer, but see the following section for information on discounted rates through the Contract Provider network.

### **Hearing Aid Contract Provider Network**

The Fund has contracted with HearPO, a national network of hearing aid providers that offers discounted rates for the fitting and dispensing of hearing aids. When you purchase hearing aids from HearPO network providers, you will receive an average discount of approximately 25% off retail prices for hearing aid products and 30% off HearPO's designated usual and customary charges for testing services.

To contact HearPO call 1-888-432-7464
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To access the discounts offered by HearPO, follow these 3 steps:

- Call HearPO to find a provider near you
- HearPO will check your eligibility with the Trust Fund Office and will then mail a referral package to both you and the selected provider
- After you receive your referral package, call the provider you selected to set up an appointment

The provider will send you a bill and it will be your responsibility to send a claim for reimbursement to the Trust Fund Office.

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## CHEMICAL DEPENDENCY TREATMENT

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*(Available to participants and spouses in the comprehensive medical plan and HMO enrollees. The annual deductible does not apply.)*

The Plan pays benefits as noted below for covered services received through the Operating Engineers Assistance Recovery Program (ARP). Benefits for chemical dependency treatment are not part of the Plan's out-of-pocket limit feature.

See "Required Pre-Authorizations" on page 32 for information on referrals necessary for benefits.
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**Note:** Benefits for treatment of alcoholism or other chemical dependency are available **only to you and your spouse**, not to dependent children.

### Covered

- **Residential treatment** in an ARP-approved residential chemical dependency program. The Plan pays benefits as follows for up to three admissions lifetime of up to 30 days each:
  - First admission: 100% of contract charges
  - Second admission: 85% of contract charges
  - Third admission: 75% of contract charges
- **Recovery home treatment** in an ARP-approved recovery home: Provided you enter the recovery home immediately after confinement in an ARP-approved residential program for residential treatment, the Plan will cover up to 30 days per calendar year for recovery home treatment.
- **Outpatient treatment:** Rehabilitation, treatment, and counseling received on an outpatient basis. The Plan pays benefits according to the schedule below for up to three outpatient treatment series per lifetime. "Treatment series" means all outpatient visits and/or services received in a "benefit year" (the period of 12 consecutive months beginning with the first outpatient visit for that series). Outpatient treatment benefits are limited to 50 visits per benefit year.
  - First treatment series: 100% of contract charges
  - Second treatment series: 85% of contract charges
  - Third treatment series: 75% of contract charges
- **Diversion program:** If you have tested positive in a drug or alcohol test but you do not require residential or outpatient chemical dependency treatment, the Plan will pay 100% of the contract charge for one chemical dependency diversion program. Benefits are limited to a lifetime maximum of one program. Diversion program services include evaluation by a substance abuse professional and any prescribed educational diversion program.

### Not Covered

- Inpatient or outpatient care in an acute-care Hospital
- Any treatment or service that has not been approved by the Operating Engineers Assistance Recovery Program
- Services provided to a dependent child

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## EXCLUSIONS FROM COVERAGE

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Comprehensive medical benefits are not payable for the following:

1. Any expenses that:
  - exceed Allowed Charges,
  - are for services and supplies that are not deemed “Medically Necessary” (other than the preventive care services specifically covered by the Plan), or
  - are incurred by you or a dependent on a date you are not covered by the Plan (an expense is deemed to have been incurred on the date the person receives the service or supply for which the charge is made).

*Definitions of “Medically Necessary,” “Allowed Charge,” and other terms used in this section can be found in the Rules and Regulations at the end of this SPD.*
2. Any services or supplies listed as “Not Covered” in relation to specific benefits described earlier in this chapter
3. Services for which benefits are payable under any other programs provided by the Plan
4. Any course of treatment, whether or not prescribed by a Physician, for which charges incurred are not the direct result of an Injury or Illness (except for covered preventive care)
5. Services furnished by a naturopath or any other provider not meeting the definition of Physician, except as may be specifically provided in the Plan (*see the Rules and Regulations at the end of this SPD for a definition of “Physician”*)
6. Professional services received from a provider who lives in your home
7. Custodial care or rest cures or services provided by a rest home, a home for the aged, a nursing home, or any similar facility
8. Dental plates, bridges, crowns, caps, or other dental prostheses, extraction of teeth or any other dental services or treatment to the teeth or gums, except for the following: (*see chapter 6 for information about dental benefits*)
  - treatment or services necessary to repair or alleviate damage to teeth resulting from an accident, or
  - treatment or services necessary to repair or alleviate damage to natural teeth resulting from radiation treatment for cancer.
9. Optometric services; vision therapy, including orthoptics; routine eye exams; or eyeglasses or contact lenses (*see chapter 7 for information about vision care benefits*)
10. Nutritional counseling, or food supplements or substitutes (except for covered diabetes education programs; see page 51)
11. Educational services: such as applied behavioral analysis, applied behavioral therapy or training, auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aides, vision therapy, synthesizers, auxiliary aids such as communication boards, and listening systems), auditory perception or listening/learning skills and/or programs and services to remedy or enhance concentration, memory, motivation, reading or self esteem (*except for covered diabetes education programs; see page 51*)

12. Hypnotism, stress management, massage therapy or any goal-oriented behavior modification therapy (e.g., to quit smoking, lose weight, or control pain) (*see page 49 for information on assistance with smoking cessation and chapter 5 for information on coverage of smoking cessation products*)
13. Services for Cosmetic purposes (except as specifically noted earlier under “Surgery – Professional Services” in “What the Plan Covers
14. Services or programs that are primarily for weight loss (except for covered bariatric surgery), health club memberships, exercise and physical fitness programs or equipment, or spas
15. Treatment of sexual dysfunction (except when caused by a medical condition, as certified by your doctor)
16. Sex changes or care, services, or treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change
17. Chemical dependency treatment, except while confined to a Hospital for acute care of detoxification or as provided under “Chemical Dependency Treatment” on page 53
18. Expenses for transportation of family members
19. Charges for telephone calls between a Physician or other health care provider and a patient, other health care provider, utilization management company, or representative of the Plan for any purpose
20. Charges for preparing medical reports, bills, or claim forms
21. Charges for broken appointments
22. Expenses in connection with occupational injuries or conditions (except as provided under “General Exclusions, Limits, and Reductions” in chapter 12)
23. Any service or supply that is listed under “Not Covered” under each benefit description earlier in this section
24. Contraceptive services for Dependent children
25. Any service or supply that is excluded under “General Exclusions, Limits, and Reductions” in chapter 12

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## HOW TO FILE A CLAIM FOR BENEFITS

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*Note: The information below applies to “post-service claims”—claims you submit after you have received a service. Requests for required pre-authorizations are also considered claims. See “Required Pre-Authorizations” on page 32 and “Claims and Appeals Procedures” in chapter 11 for more information.*

### **Medical Claims**

If you use a provider in the Anthem Blue Cross network (or local Blue Cross Blue Shield network if outside California), show your Plan identification card. The provider will submit your claim for you. A Non-contract provider will usually submit claims for you as well.

### ***Providers In California***

All claims for providers in California must be submitted directly to Anthem Blue Cross, electronically, or by mail to P.O. Box 60007, Los Angeles, CA 90060-0007.

### ***Providers Outside California***

All claims for providers outside California must be submitted to the local Blue Cross Blue Shield Plan.

### **Chemical Dependency Claims**

Chemical Dependency claims should be sent to the Operating Engineers Assistance Recovery Program (ARP), 1620 South Loop Road, Alameda, CA 94502.

### **Deadline for Submission**

You must submit your claim **within 1 year** of the date on which Covered Expenses were incurred.

### ***Questions?***

If you have any questions about submitting your claim, contact the Trust Fund Office.

For information on what to do if you disagree with the decision made in regard to your claim, see “Claims and Appeals Procedures” in chapter 11.

# Chapter 5: Prescription Drug Benefits

In this chapter you'll find:

- Information on the preferred drug list
- A note about PPI drugs
- A quick-reference schedule of benefits
- Retail pharmacy program
- Mail service program
- Specialty pharmacy services
- Plan maximums
- What the Plan covers
- Required pre-authorizations
- Exclusions from coverage
- Information on filing claims

## About This Chapter

You are eligible for the benefits described in this chapter only if you are enrolled in the Plan's comprehensive medical benefits described in chapter 4. Kaiser members receive drug coverage through Kaiser.

The prescription drug program provides benefits for drugs you purchase at a retail pharmacy. It also includes a mail service program for drugs you take on a longer-term basis. When you need a medication for a short time — an antibiotic, for example — it's best to choose the retail pharmacy program. If you are taking medications on a long-term basis, it is usually best to have it filled through the mail service program.

The Plan has contracted with CVS Caremark to provide you with prescription drugs at contract rates when you use a Caremark participating retail pharmacy or the Caremark mail service. When you are eligible, you will receive a Caremark ID card.

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## PREFERRED DRUG LIST / GENERIC AND BRAND NAME DRUGS

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Many medicines are available in both brand name and generic versions. Generic medicines have the same active ingredients, strength and quality as the brand name equivalent. However, generic medications are less costly than brand name medications. **Generics should be the first line of prescribing.** If there is no generic available, there may be more than one brand name medicine to treat a condition.

The CVS Caremark Preferred Drug List is a guide for you and your doctor. These preferred brand-name medicines are listed to identify products that are clinically appropriate and cost effective.

Your Copayment will depend on whether you purchase a generic drug or a preferred or non-preferred brand name drug.

Your Copayments will be lower when you use generic medications.

To save money on your prescriptions, ask your doctor or pharmacist if a generic equivalent is available for the prescriptions you need. If a generic is not available, ask your doctor to consider prescribing a drug from the preferred drug list.

## Note About PPI Drugs

PPI drugs (proton pump inhibitors) are a class of drugs prescribed to treat acid-related stomach disorders, such as acid reflux and ulcers. Examples of these drugs include Aciphex, Nexium, Protonix, Prilosec, Omeprazole, Prevacid and Zantac. Clinical tests have confirmed that all drugs in this class work equally well, including the medications available over the counter. However, the over-the-counter products and generic medications are less costly than the brand name drugs.

You will not pay a per-prescription Copayment for PPI drugs. Instead, the Plan will pay a **fixed first-dollar benefit**, limited to a maximum of \$30 for retail prescriptions, or up to \$90 for mail order prescriptions. **You will be responsible for paying the difference between the cost of the drug and the fixed Plan payment.**

If you choose one of the over-the-counter medications, you may find that the \$30 Plan payment (or \$90 for mail order) will cover the full cost of the drug. Remember, you will need a written prescription from your doctor in order for the Plan to cover an over-the-counter drug.

Over-the-counter PPI drugs will be covered with a written prescription from your doctor.

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## SCHEDULE OF BENEFITS

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The following charts are intended to provide a convenient quick-reference guide to your benefits. More detailed information follows the chart.

General Plan Features	
<b>Maximum benefits payable by Plan</b>	<p>PPI drugs prescribed for ulcers or other acid-related stomach disorders: \$30 for each 34-day supply from a retail pharmacy, or \$90 for each 90-day supply mail order</p> <p>Smoking cessation products: maximum benefit of \$175 in any 12-month period or \$525 lifetime</p>
<b>Calendar-year deductible for brand name drugs</b> (applies only to brand-name drugs obtained from a retail pharmacy)	<p>\$100 each calendar year – only for brand name drugs from a retail pharmacy</p> <p>(Does not apply to generic drugs, PPI drugs or any drugs obtained from the mail service program)</p>
<b>Calendar-year limit on your Copayments</b>	None

*Note: Your prescription drug Copayments do not accumulate to the comprehensive medical plan out-of-pocket limit.*

Your Copayment for Each Prescription or Refill	
<p><b>Note:</b> The Copayments in this chart <b>do not apply to PPI drugs</b> for ulcers or other acid-related stomach disorders. See the following chart for benefits for PPI drugs.</p>	
<p><b>Prescription filled at a participating retail pharmacy</b></p>	<p>You pay the following Copayment for up to a 34-day supply (or 100 tablets or capsules, whichever is greater):</p> <ul style="list-style-type: none"> <li>• Generic drug: <b>\$5</b></li> <li>• Preferred Brand-name drug: <b>\$25 *</b></li> <li>• Non-Preferred Brand-name drug: <b>\$40 *</b></li> </ul>
	<p>* If a generic drug is available, but you receive a brand-name drug for any reason other than the prescribing doctor specified "dispense as written", you must pay the cost difference between the generic and brand medications plus the Copayment.</p>
<p><b>Prescription filled at a non-participating retail pharmacy</b></p>	<p>You pay the Copayments shown above for drugs from participating pharmacies plus any amount the pharmacy charges above the contract amount the participating pharmacy would have charged.</p>
<p><b>Prescription ordered through the Plan's mail order service</b></p>	<p>You pay the following Copayment for up to a 90-day supply:</p> <ul style="list-style-type: none"> <li>• Generic drug: <b>\$10</b></li> <li>• Preferred Brand-name drug: <b>\$50</b></li> <li>• Non-Preferred Brand-name drug: <b>\$80</b></li> </ul> <p>The Plan covers the remaining cost.</p>

*If the cost of the drug is less than the Copayment, you will pay the cost of the drug.*

Your Copayment for PPI Drugs (Drugs Prescribed to Treat Acid-Related Stomach Disorders)	
<p><b>Prescription filled at a retail pharmacy (participating or non-participating)</b></p>	<p>The Plan will pay <b>up to a maximum of \$30</b> for each prescription up to a 34-day supply</p> <p>Your Copayment: You are responsible for paying the difference between the cost of the drug and the \$30 maximum Plan payment</p>
<p><b>Prescription ordered through the Plan's mail order service</b></p>	<p>The Plan will pay <b>up to a maximum of \$90</b> for each 90-day supply.</p> <p>Your Copayment: You are responsible for paying the difference between the cost of the drug and the \$90 maximum Plan payment</p>
<p>Over-the-counter PPI drugs will be covered with a doctor's written prescription.</p>	



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## RETAIL PHARMACY PROGRAM

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The retail pharmacy program is intended for medications you need immediately for acute, short-term use (such as antibiotics).

### **Participating Retail Pharmacy**

The Plan has contracted with CVS Caremark to provide you with prescription drugs at contract rates. When you have a prescription filled at a Caremark participating pharmacy:

- Except for PPI drugs, your payments are limited to the Copayments shown in the Schedule of Benefits chart (and the calendar year deductible for brand name drugs). You don't have to worry about submitting a claim for reimbursement. Simply give the pharmacist your prescription, show your Caremark ID card, pay your Copayment, and that's it. The pharmacy bills the Plan for the remaining cost.
- For a PPI drug, the pharmacist will charge you for the cost of the drug over and above the \$30 maximum Plan benefit.

If you need to fill a prescription when you are without your ID card, give the pharmacist your name and Social Security number and ask him to call Caremark for billing information.

To contact Caremark: call (888) 790-4258
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If there is any problem with your eligibility, you will need to pay the full cost of the prescription and submit a claim to Caremark for reimbursement.

### ***Finding a Participating Pharmacy***

There are over 62,000 participating pharmacies nationwide, including many independent community pharmacies. Most of the retail chain pharmacies are in the Caremark network. To find a pharmacy near you:

- call Caremark at the number shown in the box above,
- ask the pharmacist if they participate in the Caremark network, or
- visit the website at [www.Caremark.com](http://www.Caremark.com) for a complete listing

### **Benefits for Drugs Purchased from a Retail Pharmacy**

#### ***For Other Than PPI Drugs***

If you use a participating pharmacy, you pay a Copayment for each prescription. Your Copayment will depend on whether your medication is:

- a generic drug — you pay \$5
- a preferred brand-name drug you pay — \$25
- a non-preferred brand-name drug — you pay \$40

If you purchase a brand name drug when a generic is available, you will also be charged the difference in cost between the brand name and generic drugs in addition to the Copayment.

### **For PPI Drugs**

- The Plan will pay **up to a maximum of \$30** for each prescription up to a 34-day supply.
- You will be responsible for paying the difference between the cost of the drug and the \$30 maximum Plan payment.

The \$100 brand-name drug deductible described below will not apply to brand-name PPI drugs.

The Plan will cover PPI medications available over the counter with a written prescription from your doctor.

### **Deductible for Retail Brand-Name Drugs**

Each person must satisfy a \$100 deductible each calendar year for brand-name drugs obtained from a retail pharmacy. After you meet this deductible each year, you can receive your prescription from a retail pharmacy after paying the per-prescription Copayment for preferred or non-preferred brand-name drugs.

The deductible does not apply to generic drugs or to PPI drugs.

The participating pharmacy's discounted cost of the drug is applied to the deductible.

### **Supply Limit**

Prescriptions filled at a retail pharmacy cannot exceed a 34-day supply (or 100 tablets or capsules, whichever is greater). Some drugs may be subject to other lower quantity limits. Copayments are the same, whether your supply is for 1 day or 34 days.

### **Non-Participating Retail Pharmacy**

If you purchase your drugs from a non-participating pharmacy, you will need to pay the full cost at the time of purchase and submit a paper claim to Caremark for reimbursement. Caremark will reimburse you for the covered amount, less the applicable Copayment, and less the calendar year deductible for brand name drugs if it has not been met. **The Plan will not cover the difference between the amount the non-participating pharmacy charges and the contract amount a participating pharmacy would have charged.**

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## **MAIL SERVICE PROGRAM**

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The Caremark mail service pharmacies provide a convenient and cost-effective way for you to order medicine that you take on an ongoing basis and have the medicine delivered to your home.

### **Benefits for Drugs Purchased from the Mail Service**

#### **For Other Than PPI Drugs**

When you use the mail service program, you will receive up to a 90-day supply of each prescription or refill for each Copayment. (Some drugs may be subject to other lower quantity limits.) Your Copayment will depend on whether your medication is:

- a generic drug — you pay \$10
- a preferred brand-name drug you pay — \$50
- a non-preferred brand-name drug — you pay \$80

The brand name deductible does not apply to prescriptions filled through the mail service.

### **For PPI Drugs**

- The Plan will pay **up to a maximum of \$90** for each 90-day supply of a PPI drug purchased through the mail service program.
- You will be responsible for paying the difference between the cost of the drug and the \$90 maximum Plan payment.

The Plan will cover PPI medications available over the counter with a written prescription from your doctor.

*Note: By law, Caremark must fill your prescription for the exact quantity of medicine prescribed by your doctor, up to the 90-day limit.*

### **How to Use the Mail Service**

Pre-addressed mail order envelopes are available at the Trust Fund Office and the Fringe Benefits Service Center. You can also request them by calling Caremark at 888-790-4258.

- Ask your doctor for a prescription for up to a 90-day supply, with refills if appropriate.
- Mail the original prescription along with the completed order form to Caremark. Allow 10 to 14 days from the time you mail in your order to receive your prescription(s). Your package will include a new mail service order form and an invoice, if applicable.
- While checks and money orders are accepted, the preferred method of payment of your Copayment is by credit card. For credit card payments, simply include your credit card number and expiration date in the space provided on the mail service order form.
- For faster service, you can also have your doctor call in the prescription using the Caremark “FastStart” number. Be sure to provide your doctor with the ID number from your Caremark ID card and your mailing address. If your doctor prefers to be contacted directly, you can call Caremark and ask a representative to contact your doctor.

See the separate Caremark prescription drug booklet for more detailed information on how to use the Mail Service and Specialty Pharmacy programs.

FastStart number to call in prescriptions: (800) 258-1332

### **First-Time Prescriptions**

If you need to start a long-term medication right away, ask your doctor to write two prescriptions: one for a for a short-term supply that you can have filled right away at a participating retail pharmacy; and another for a refillable long-term supply that you can have filled through the mail service program.

### **Ordering Refills from the Mail Service**

You can order mail service refills in three ways:

- **Online** at [www.caremark.com](http://www.caremark.com) to order refills and inquire about the status of your order any time of day or night. You will need to register and log in to access service.
- **By phone.** Call the Caremark customer care number for fully automated refill service. Have your ID number ready.
- **By mail.** Attach the refill label provided with your last order to a mail service order form. Enclose payment of your Copayment, if applicable.

If you have prescriptions on file at another pharmacy that you would like to receive by mail service, you can call Caremark to request a transfer.

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## PLAN MAXIMUMS

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### *PPI Drugs (Ulcer and Acid Reflux Medications)*

Benefits for PPI drugs are limited to a maximum of \$30 for each 34-day supply of a drug purchased from a retail pharmacy, or \$90 for each 90-day supply of a drug purchased from the mail service program.

### *Smoking Cessation Products*

Benefits for nicotine gum, patches, or other smoking cessation medications for you and your spouse are limited to a maximum of \$175 in any 12-month period and a lifetime maximum of \$525 per person.

**Note:** Copayments you make for prescription drugs, or payments you make beyond the Plan maximums, do not count toward the “out-of-pocket limit” for comprehensive medical benefits.

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## SPECIALTY PHARMACY SERVICES

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Certain chronic and/or genetic conditions, require special pharmacy products. Specialty Drugs are often high cost biotech or biological drugs that may require special handling. Specialty Drugs include any injectable and infused (IV) drugs, as well as some oral medications, that are included on Caremark’s Specialty Drug list. This list is subject to change from time to time. You or your doctor should call Caremark to find out if a drug is a Specialty drug—they will assist you in using the program.

Some examples of conditions that may be treated with Specialty Drugs are Multiple Sclerosis, Rheumatoid Arthritis, Hemophilia, Immune Deficiencies, Hepatitis C, Hemophilia Osteoporosis, Crohn’s Disease, and Renal Disease among others.

The Caremark specialty pharmacy services program provides Specialty Drugs directly to Eligible Individuals, along with the supplies and equipment needed. The program also provides you with personalized services including:

- Pharmacists available 24 hours a day, seven days a week for emergency consultations
- Coordination of care to facilitate medicine needs with you, your doctor and the Plan
- Refill reminders from the Caremark Specialty Pharmacy
- Delivery of your prescriptions directly to you or to your doctor’s office

You must use the Caremark Specialty Pharmacy Services program to obtain any specialty medications. **These medications will not be available from a participating retail pharmacy and charges for specialty medications will not be reimbursed if a paper claim is submitted.** (A one-time exception will apply to the first purchase of a Specialty drug not obtained from the Caremark Specialty Pharmacy; in this case only the first purchase will be covered and payment will be limited to the contract rate that the Caremark Specialty Pharmacy would have charged for the medication.)

You can obtain up to a 34-day supply of your specialty medications. The retail pharmacy Copayments shown in the Schedule of Benefits chart apply to each supply of 34 days or less.
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## **How to Use Specialty Pharmacy Services**

For specialty pharmacy services, or if you have questions regarding your specialty pharmacy prescription, call Caremark at 800-237-2767 Monday through Friday from 4:30 a.m. to 6 p.m. (Pacific Time).

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## **WHAT THE PLAN COVERS**

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The Plan pays benefits for the following drugs and supplies when they are prescribed for the treatment of a non-occupational Illness or Injury:

- Drugs that legally require a written prescription of a Physician or dentist
- Insulin and diabetic supplies, including alcohol wipes, lancets, test strips and syringes
- Proton pump inhibitors (PPI drugs) and smoking cessation products that are available over the counter if you have a doctor's written prescription for the medication (*see page 63 for benefit limits for PPI drugs and smoking cessation products*)
- Drugs, insulin, and diabetic supplies that are furnished by a Hospital for use outside the Hospital in connection with treatment received while you were an inpatient in the Hospital
- Drugs, insulin, and diabetic supplies that are supplied by a Physician or dentist in his or her office and for which a charge is made separately from the charge for any other service
- Charges made by a licensed pharmacist for compounding a dermatological preparation prescribed by a Physician (such as an ointment or lotion)
- Charges made by a licensed pharmacist for therapeutic and prenatal vitamins, cough mixtures, antacids, and eye and ear medications prescribed in writing by a Physician for the treatment of a specified Illness
- Specialty/injectable drugs. These are injectable, infusion (IV) or oral medications that are on Caremark's Specialty Drug List. Specialty drugs are only available through the Caremark Specialty Pharmacy Services Program; they are not available from participating retail pharmacies.
- Charges for nicotine gum, patches, or other smoking cessation medications (limited to a maximum benefit of \$175 in any 12-month period and \$525 per lifetime that is available for **you and your spouse only**, not for your dependent children)  
*Please note*, smoking cessation medications or products that are available over the counter will be covered only with a written prescription from your doctor.
- Contraceptives that legally require the written prescription of a Physician, including oral contraceptives, injectables, and devices (**available to Employees and spouses only, not to dependent children**).

The Plan will cover new FDA approved drugs, subject to all of the limits and exclusions shown below.

## Step Therapy and Quantity Limits

The goal of these programs is to ensure that prescriptions are appropriate for the diagnosed condition and that an appropriate quantity is dispensed.

### Step Therapy

Some drugs will only be covered after an alternative medication in the same drug class has been tried. For example, a brand name drug may be covered only after you have first tried the generic. If you receive a prescription for a drug that requires step therapy, your doctor will be asked to provide additional clinical information to the CVS Caremark Prior Authorization department to support the use of the drug before the drug will be covered by the Plan. This must happen **before** Plan benefits will be payable for your prescription. Please note that if you do not receive prior authorization from CVS Caremark and choose to continue to use the drug(s), you can still purchase the drug, but at your own expense.

The following classes of drugs are subject to step therapy:

- Cholesterol medications
- Pain medications
- Sleep aids
- Blood pressure medications
- Antihistamines/combinations for allergies
- Nasal steroids for allergies
- Urinary antispasmodics for overactive bladder/incontinence
- Bisphosphonates for osteoporosis
- SSRIs for depression
- Selective serotonin agonists/combinations for migraines
- Short acting beta agonists inhalers

### Quantity Limits

Certain medications have quantity limits less than regular 34-day retail supply or 90-day mail order supply. These limits affect only the amount of medication that the Plan will pay for. Examples of some medications subject to special quantity limits include, but are not limited to, respiratory/asthma inhalers, anti-migraine drugs, erectile dysfunction drugs, proton pump inhibitors, intra-nasal corticosteroids and oxycontin.

### Required Pre-Authorizations

Some medications require pre-authorization before they will be covered. Prior approval from Caremark is required for the following:

- Topical acne medications for a person over age 26
- Growth hormones
- Drugs or devices for treatment of sexual dysfunction
- Certain contraceptive devices and injectables, all transdermal contraceptives (patches)
- Oral contraceptives prescribed for dependent daughters for purposes other than birth control
- Oral Fentanyl products
- Oxycontin for supplies exceeding the Plan's quantity limits
- Narcolepsy drugs
- Any drug subject to step therapy

Your doctor may obtain pre-authorization by calling Caremark at (888) 790-4258.
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## EXCLUSIONS FROM COVERAGE

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No prescription drug benefits are provided for the following:

1. Drugs taken or administered while you are confined in a Hospital (these drugs are covered under the comprehensive medical benefits described in chapter 4)
2. Patent, proprietary or over-the-counter medicines not requiring a prescription (*except for insulin, PPI drugs and smoking cessation products provided with a doctor's written prescription*)
3. Appliances, devices, bandages, and any other supplies or equipment, except diabetic supplies
4. Contraceptives for dependent children (*Oral contraceptives prescribed to a dependent daughter for purposes other than birth control require prior approval by Caremark.*)
5. Multiple and non-therapeutic vitamins, cosmetics, nutritional and dietary supplements, health and beauty aids
6. Immunization agents (except for Zostavax), allergy serums
7. Appetite suppressants or any other weight loss medications
8. Infertility medications
9. Medications with no Federal Food and Drug Administration indications
10. Drugs not Medically Necessary for the treatment of an Illness or Injury, medications used for experimental indications, dosage regimens determined to be Experimental or Investigational, or any investigational or unproven drugs or therapies
11. Drugs or devices for treatment of sexual dysfunction (*except when caused by a medical condition as certified by your doctor; requires prior approval by Caremark*)
12. Medications prescribed for Cosmetic purposes only, hair growth stimulants, and hair removal agents
13. Charges for any single prescription filling or refilling in excess of the 34-day, 90-day, or 100-tablet limits mentioned earlier in this chapter or for any quantity exceeding other quantity limits of the Plan
14. Smoking cessation products for dependent children
15. Any specialty drug on the Caremark Specialty Drug list that is obtained from a non-participating pharmacy or from any source other than the Caremark Specialty Pharmacy
16. Charges in excess of the \$30 per-prescription maximum (or \$90 mail service per-prescription maximum) paid by the Plan for proton pump inhibitors (medications to treat ulcers, acid reflux or other acid-related stomach disorders)
17. Charges for smoking cessation medications in excess of the \$175 maximum per 12-month period or the \$525 lifetime maximum
18. Replacement prescriptions resulting from loss, theft, or breakage
19. Any expenses excluded under "General Exclusions, Limits, and Reductions" in chapter 12



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## HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS

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**Participating pharmacy:** If you use a participating pharmacy and present your ID card or if you use the mail service, you pay only your Copayment at the time of purchase, so you do not need to worry about filing claims.

**Non-Participating pharmacy:** If you use a non-participating pharmacy, you must pay the cost of the drug at the time of purchase and request reimbursement by following these steps:

- Obtain a Prescription Drug Claim Form from Caremark, the Trust Fund Office, or the Fringe Benefits Service Center. (You can also download and print a claim form from the Caremark website.)
- Complete your portion of the form (be sure to sign the claim form).
- Attach all original pharmacy receipts to the back of the claim form. (Store cash register receipts will NOT be accepted.) Pharmacy receipts **must** contain all of the following information:
  - Prescription number
  - Name of person for whom prescription was filled
  - Doctor's name or DEA number
  - Pharmacy name and address or NABP number
  - Drug name/strength or NDC number, metric quantity/days supply
  - The date the prescription was filled
  - The charge for the prescription
  - Dispense as written (DAW), if applicable
- Mail the completed claim form with your original prescription receipt(s) to:

Caremark Claims Department,  
P.O. Box 52196,  
Phoenix, AZ 85072-2196.

**Note:** You must submit your claim **within 1 year** from the date on which the prescription was filled. Benefits will not be allowed if you submit your claim more than 1 year after the date your prescription was filled.

### **If You Have Other Prescription Drug Coverage**

Make sure you notify Caremark if you or your dependents have other coverage. If you don't notify Caremark of other drug coverage, they will be unable to coordinate benefits, and this could result in a delay in the processing of your claim.

If you have any questions about submitting your claim, contact Caremark.



# Chapter 6: Dental and Orthodontic Benefits

*Please note that this insured dental coverage is not subject to the requirements of Health Care Reform.*

In this chapter you'll find:

- A quick-reference schedule of benefits
- PPO provider network
- Covered dental and orthodontic services
- Limitations and Exclusions from coverage
- Recommended pre-determinations
- Information on filing claims

### About This Chapter

The benefits described in this chapter are available whether you are enrolled in the Plan's comprehensive medical benefits or in the Kaiser HMO plan.

Unlike the comprehensive medical benefits described, which are paid directly by the Fund, dental benefits are provided through an insurance contract with Delta Dental Plan of California (Delta Dental). The plan is the Delta Dental PPO, a Preferred Provider Organization (PPO) program that provides access to PPO dentists nationwide.

Dental benefits provide coverage for services ranging from checkups and cleanings to dentures when the services are provided by a licensed Dentist and when they are necessary and customary under the generally accepted standards of dental practice.

### SCHEDULE OF BENEFITS

The following chart is intended to provide a quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Dental Benefits	In-PPO Network	Out-of-PPO Network
Deductible	None	None
Diagnostic and Preventive Benefits	Plan pays 100%	Plan pays 100%
Basic Benefits	Plan pays 85%	Plan pays 75%
Crowns, Inlays, Onlays and Cast Restorations	Plan pays 85%	Plan pays 75%
Prosthodontic Benefits	Plan pays 60%	Plan pays 50%
Calendar Year Maximum	\$2,500 per person (Diagnostic and Preventive benefits are not counted toward this maximum)	
Orthodontic Benefits	In-PPO Network	Out-of-PPO Network
For dependent children through age 18 only	Plan pays 80%	Plan pays 70%
Lifetime Maximum for Orthodontic benefits	\$2,500 per child (lifetime)	

If you incur a covered dental expense, the Plan will pay the applicable percentage, listed above, of the Dentist's fees or allowances, up to the calendar year maximum for dental services or the lifetime maximum for orthodontic services. You are responsible for paying any remaining charges, known as your "Coinsurance".

If the Dentist discounts, waives or rebates any portion of your Coinsurance, Delta Dental only provides as benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.

When dental services are provided by a Delta Dental Dentist or a Delta Dental PPO Dentist, you are responsible for your Coinsurance only. If services are provided by a non-Delta Dental Dentist, you are responsible for the difference between the amount the plan pays and the amount charged by the non-Delta Dental Dentist.

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## CHOICE OF DENTISTS / PPO PROVIDERS

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Under the Delta Dental PPO Plan, you are free to use any licensed dentist for treatment, but it is to your advantage to use a Delta Dental Dentist because his or her fees are approved in advance by Delta Dental. Nearly 29,000 dentists in California are Delta Dental Dentists that participate in the Delta Premier network. About 16,500 of these Delta Dental Dentists are also Delta Dental PPO Dentists.

Visit a Delta Dental PPO Dentist for the lowest out of pocket costs.
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### Advantages to Using a Delta Dental PPO Dentist

There are advantages to visiting a Delta Dental PPO network dentist instead of a Premier or non-Delta Dental dentist, including lower out of pocket costs.

- **Delta Dental PPO Dentists.** You will pay the lowest amount for services when you visit a Delta Dental PPO Dentist because the plan pays a higher benefit level for most services and PPO Dentists agree to accept a reduced fee for patients covered under the PPO plan. You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to the Dentist. PPO Dentists will complete claim forms and submit them for you at no charge.
- **Delta Dental Dentists (Premier Network).** While Premier Dentists' contract fees are often slightly higher than PPO Dentists' fees, Premier network Dentists may not balance bill above Delta Dental's approved amount, so your out of pocket costs may be lower than with a non-Delta Dentist. Delta Dental Dentists charge you only the patient's share at the time of treatment and will submit claim forms for you at no charge.  
*(Note: The "In-PPO Network" benefits shown in the chart on page 68 apply only to Delta Dental PPO Dentists, they do not apply to Premier Network Dentists.)*
- **Non-Delta Dental Dentists.** You are responsible for the difference between the amount Delta Dental pays and the amount the non-Delta Dentist bills. Non-Delta Dental Dentists may require you to pay the entire amount of the bill and wait for reimbursement. You may have to complete and submit your own claim forms or pay your non-Delta Dental Dentist a fee to submit them for you.

\*Patient's share is your Coinsurance, any amount over the calendar year maximum and any services the Plan does not cover.

## How to Find a Delta Dentist

- Call 800-765-6003 for a list of Delta Dental PPO Dentists and Delta Dental Premier Dentists.
- You can also log on to the Delta Dental website at [www.deltadentalins.com](http://www.deltadentalins.com) for a current listing of dental offices that are part of Delta Dental's PPO network.
  - Click on "Find a Dentist"
  - Click on the National Online Directory link
  - Select "Delta Dental PPO" and your state, then click "Continue"

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## WHAT THE PLAN COVERS

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The Plan pays the applicable percentage, listed in the Schedule of Benefits, of the following Dentist fees:

- **For a Delta Dental PPO Dentist**, the lesser of the fee actually charged or the fee the Dentist has contractually agreed with Delta Dental to accept for treating patients covered by this plan.
- **For a Delta Dental Dentist**, the lesser of the fee actually charged or the accepted fee that the Dentist has on file with Delta Dental.
- **For a Dentist who is not a Delta Dental Dentist**, the lesser of the fee actually charged or the fee that satisfies the majority of Delta Dental Dentists.

## Covered Dental Services

- **Diagnostic and Preventive Benefits (not counted toward the annual maximum)**
  - Diagnostic procedures to assist the Dentist in evaluating existing conditions to determine the required dental treatment, including oral examination, bite-wing X-rays, emergency treatment of dental pain, specialist consultation
  - Preventive procedures such as prophylaxis (cleaning), fluoride treatment, and sealants
  - Diagnostic and preventive benefits are not counted toward the annual maximum
- **Basic Benefits**
  - X-rays (other than bitewing X-rays) and space maintainers
  - Oral surgery – extractions and certain other surgical procedures, including pre- and post-operative care
  - Restorative – amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Endodontic – treatment of the tooth pulp (such as root canal)
  - Periodontic – treatment of gums and bones that support the teeth
  - Occlusal guards for bruxism
  - Diagnostic casts (only if eligible for orthodontic benefits)

- Adjunctive General Services – general anesthesia, IV sedation, office visit for observation, office visit after regularly scheduled hours, therapeutic drug injection, treatment of post-surgical complications (unusual circumstances), limited occlusal adjustment
- **Crowns, Inlays, Onlays and Cast Restorations** are covered benefits only if they are provided to treat cavities that cannot be restored with amalgam, silicate or direct composite (resin) restorations.
- Prosthodontic Benefits
  - Construction or repair of fixed bridges, partial dentures and complete dentures if provided to replace missing natural teeth or anodontia (congenitally missing teeth)
  - Implant surgical placement and removal and implant supported prosthetics, including implant repair and re-cementation.

**Note on Additional benefits during Pregnancy:** If you are pregnant, the plan will pay for additional services to help improve your oral health during pregnancy. The additional services each calendar year while you are eligible include: one additional oral examination and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant. Written confirmation of pregnancy must be provided by you or your Dentist when the claim is submitted.

### Covered Orthodontic Services

#### *Only For Dependent Children Through Age 18*

Orthodontic benefits cover procedures using appliances or surgery to straighten or realign teeth that otherwise would not function properly. The plan will pay 80% of the Dentist's covered fees, up to a lifetime maximum benefit of \$2,500 per child.

**Note:** Claims for orthodontic treatment that began before January 1, 2008 should be sent to the Trust Fund Office instead of Delta Dental.

### Predetermination of Benefits

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If your proposed dental treatment is extensive and involves crowns or bridges, or if the service will cost more than \$300, it is recommended that you ask your Dentist to request a predetermination from Delta Dental.

<p>A predetermination does not guarantee payment. It is an estimate of the amount the plan will pay if you are eligible at the time the treatment you have planned is completed.</p>
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To receive a predetermination, your Dentist must send a claim form listing the proposed treatment. Delta Dental will send your Dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your Dentist and decide to go ahead with the treatment plan, your Dentist returns the form to Delta for payment when the treatment has been completed.

Predeterminations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued. Payment will depend on the individual's eligibility and the remaining annual maximum available when completed services are submitted to Delta Dental.

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## LIMITATIONS

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Dental and Orthodontic benefits are limited for the following services:

1. Bitewing X-rays are covered once in any six month period. Full mouth X-rays are limited to once every three years. Intraoral/periapical X-rays amounting to 14 or more are considered full mouth X-rays.

A panoramic X-ray provided as an individual service is limited to once every three years.

2. Prophylaxis (cleaning), or a procedure that includes a cleaning, is limited to two treatments in a calendar year. Periodontal prophylaxes are not subject to the two cleanings per calendar year limit. *A third cleaning is covered for pregnant women; see Note on additional benefits during pregnancy.*

Routine prophylaxes are covered as a Diagnostic and Preventive benefit and periodontal prophylaxes are covered as a Basic benefit

3. Fluoride treatments are covered twice each calendar year.
4. An oral examination is covered once every six months while you are eligible under any Delta Dental plan. Specialist consultations are not subject to the once every six months limitation. *See Note on additional benefits during pregnancy.*
5. Sealant benefits include the application of sealants only to permanent posterior molars to age 14 if they are without caries (decay), or restorations on the occlusal surface. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
6. Diagnostic casts are covered only when made in connection with subsequent orthodontic treatment covered by the plan.
7. Direct composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspids. Any other posterior direct composite (resin) restorations are optional services and the plan's payment is limited to the cost of the equivalent amalgam restoration.
8. Periodontal scaling and root planning is covered once for each quadrant each 24-month period. *See Note on additional benefits during pregnancy.*

9. Crowns, inlays, onlays, and cast restorations are covered on the same tooth only once every five years while you are eligible under any Delta Dental plan or the prior Trust Fund plan, unless Delta determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the placement of the restoration.

The above limitation does not apply if the previous crown was a temporary stainless steel crown provided to a dependent child under 19 years of age.

10. Prosthodontic appliances and implants are covered only once every five years, while you are eligible under any Delta Dental plan or the prior Trust Fund plan, unless Delta determines there is such extensive loss of remaining teeth or change in supporting tissues that the existing fixed bridge, partial denture or complete denture cannot be made satisfactory. Replacement of an implant, a prosthetic appliance or an implant supported prosthesis you received under another plan will be covered if Delta determines it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to one for each tooth during the patient's lifetime, whether provided under a Delta Dental or any other dental care plan.

11. The plan pays the applicable percentage of the Dentist's fee for a standard partial or complete denture. A standard partial or complete denture is one made from accepted materials and by conventional methods.
12. Optional Services. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, an allowance will be made for the least expensive, professionally acceptable alternative treatment plan. The plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the Dentist's fee. For example, a crown where an amalgam filling would restore the tooth or a precision denture where a standard denture would suffice.
13. Orthodontic coverage is limited to eligible dependent children through age 18.
14. If orthodontic treatment began before the child became eligible for coverage, Delta Dental's payments will begin with the first payment due the Dentist following his/her eligibility date. (*Note: Orthodontic treatment that began before January 1, 2008 is covered by the Trust Fund and not Delta Dental.*)
15. Delta Dental's orthodontic payments will stop when the first payment is due to the Dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.
16. X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.
17. Delta Dental will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If you select specialized orthodontic appliances or procedures chosen for aesthetic considerations, an allowance will be made for the cost of a standard orthodontic treatment plan and you are responsible for the remainder of the Dentist's fee.

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## EXCLUSIONS

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In addition to any general Plan exclusions, limits, and reductions (see page 114), Delta Dental does not provide benefits for:

1. Any services or procedures that are Experimental in nature or are not within the standards of generally accepted dental practice.
2. Services for Cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, and teeth that are discolored or lacking enamel.
3. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such services are equilibration and periodontal splinting.
4. Any single procedure, bridge, denture or other prosthodontic service which was started before the date you became eligible for the services under this Plan. A single procedure is a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

5. Prescribed Drugs, or applied therapeutic drugs, premedication or analgesia.
6. Charges by any Hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
7. Anesthesia, except for general anesthesia or IV sedation given by a Dentist for covered oral surgery procedures and select Endodontic and Periodontic procedures.
8. Grafting tissues from outside the mouth to tissues inside the mouth (“extraoral grafts”).
9. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues.
10. Replacement of an existing restoration for any purpose other than active tooth decay.
11. Intravenous sedation.
12. Complete occlusal adjustment.
13. Expense you incur for missed appointments.
14. Orthodontic services for other than eligible dependent children under age 19.
15. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan.
16. Any general Plan exclusions, limits or reductions, as listed beginning on page 114.

### **Extension of Dental Benefits**

If you lose eligibility for dental benefits under the Plan, Delta will not pay for services provided after the termination date, except for:

- Major restorative procedures (crowns, onlays), fixed or removable prosthodontic appliances (fixed bridges, partial or complete dentures) and root canals that were begun before coverage terminated.

Adjunctive services, such as X-rays, exams, materials or other services in connection with the delivery or placement of prosthodontic appliances or crowns are not covered services under this extension of benefits provision.

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### **HOW TO FILE A CLAIM FOR DENTAL BENEFITS**

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- Delta PPO Dentist and Delta Premier Dentist – The Dentist will file your claim for you.
- Non-Delta Dental Dentist – Send claims for services from non-Delta Dental Dentists to:

Delta Dental  
P.O. Box 997330  
Sacramento, CA 95899-7330

## Appeals for Denied Dental Benefits

If your claim is denied in whole or in part, you will receive written notification from Delta Dental including the reasons for denial. Any questions of ineligibility should first be handled with the Trust Fund Office.

If you have any question or complaint regarding the denial of dental services or claims, the policies or procedures of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, you may call Delta toll free at (800) 765-6003, contact them on their website ([www.deltadentalins.com](http://www.deltadentalins.com)) or write to the address listed above under “How to File a Claim for Dental Benefits,” Attention: Customer Service Department.

If your claim has been denied or modified, you may file a request for review with Delta Dental within 180 days after receipt of the denial or modification. If in writing, your correspondence must include your group name (Operating Engineers Health and Welfare Trust Fund) and number (9575), the Primary Enrollee’s name and ID number, your telephone number and any additional information that would support the claim for benefits. Your correspondence should also include a copy of the treatment form, notice of payment from Delta, and any other relevant information.

**Note:** You must first exhaust Delta Dental’s appeals process before filing an appeal with the Plan’s Board of Trustees.

### **If You Have Other Dental Coverage**

It is to your advantage to let your Dentist and Delta Dental know if you have other dental coverage. Most dental carriers cooperate to coordinate payments and still allow you to make use of both plans – sometimes paying 100% of your dental bill. Be sure to have your Dentist complete the dual coverage section of the claim form so you will receive all benefit to which you are entitled.



# Chapter 7: Vision Care Benefits

In this chapter you'll find:

- A quick-reference guide to vision care benefits
- How the Plan works
- What the Plan covers
- Low vision benefit
- Limitations and exclusions
- Information on filing claims and appealing denied claims

### About This Chapter

The benefits described in this chapter are available whether you are enrolled in the Plan's comprehensive medical benefits or in the Kaiser HMO plan.

The Fund has contracted with Vision Service Plan (VSP) and the VSP *Value Plan* network of vision care providers, to provide covered vision expenses at contract prices. Your Plan benefits will go farther when you use VSP *Value Plan* providers.

### SCHEDULE OF BENEFITS

The chart below is intended to provide a quick-reference guide to your vision benefits. More detailed information, including conditions for payment of certain benefits, follows the chart.

Vision Benefits	VSP Member Doctor	Non-VSP Provider
Copayment	\$7.50	\$7.50
Vision Examination – Limited to once every 12 months	Plan pays 100%	Plan pays up to \$37 per exam
Lenses – Limited to once every 12 months Single Vision Lined Bifocal Lined Trifocal Lenticular Lens options: Tinted / Photochromic Benefits for lenses are per complete set, not per lens.	Plan pays 100% up to member doctor scheduled allowances	Plan pays up to: \$ 34 \$ 51 \$ 68 \$100 \$ 5
Frames – Limited to once every 24 months	Up to \$170 retail frame allowance	\$40
Visually Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays 75% of approved fee	Plan pays up to \$126 subject to VSP approval
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to \$200 for contact lenses and fitting, (exam covered in full)	Plan pays up to \$100 for exam, lenses and fitting

**Note:** The limitations on frequency of services do not apply to VSP member doctor services for dependent children under age 18.

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## HOW THE PLAN WORKS

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Steps for using a VSP Value Plan provider are as follows:

- Call any VSP Value Plan doctor to make an appointment. Identify yourself as a VSP *Value Plan* member and provide your VSP member identification number (usually your social security number) and the name of the group Plan (“Operating Engineers Health and Welfare Trust Fund”).
- After you have scheduled an appointment, the VSP member doctor will contact VSP to verify your eligibility and Plan coverage. The doctor will also obtain authorization from VSP for services and materials.
- When you go for your visit, pay the VSP member doctor your \$7.50 Copayment and charges for any costs not covered. VSP will pay the doctor directly for the balance of the charges.

If you need assistance locating a VSP Value Plan doctor, call VSP at (800) 877-7195 or log on to the VSP website at [www.vsp.com](http://www.vsp.com) and use the “Find a doctor” feature.

When you use a VSP *Value Plan* provider, you are responsible for payment of the Copayment and any amounts that exceed Plan maximums; you do not need to file a claim for reimbursement.

If you use a non-VSP provider, you must pay for all services and supplies at the time you receive them and then submit a claim for reimbursement. You will be reimbursed the applicable amount shown in the Schedule of Benefits after deduction of your Copayment. There is no assurance that the schedule will be sufficient to pay for the examination or materials. Services received from a Non-VSP provider are in lieu of obtaining services from a VSP member doctor and count toward Plan benefit frequencies. See “How to File a Claim” at the end of this chapter for information on submitting claims for non-VSP provider services.

### The Copayment

The \$7.50 Copayment applies regardless of whether you are using a VSP *Value Plan* Provider or a non-VSP provider. The Copayment is per individual. It applies to all services, except elective contact lenses.

The \$7.50 Copayment is due only once each year, for the first service you receive each year. If you pay the \$7.50 Copayment for your exam, for example, you will have satisfied your Copayment responsibility for the year (unless you qualify for the low vision benefit, which has additional Copayments).

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## WHAT THE PLAN COVERS

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Covered Expenses include:

- Vision exam, including visual analysis of visual functions and prescription of corrective eyewear when indicated, once every 12 months.
- Lenses, once every 12 months.
- Frames, once every 24 months. VSP offers a wide selection of frames within the Plan’s allowance. If more expensive frames are chosen, you will be responsible for the additional amount over the Plan’s maximum allowance.
- Contact Lenses, once in any 12-month period, in lieu of all other lens and frame benefits available. Once you get contact lenses under the Plan, you will not be eligible for other lenses again for 12 months or new frames for 24 months.

The vision exam benefit is a way that diabetics can get their annual retinal eye exam.

- Visually Necessary Contact Lenses. Contact lenses are visually necessary if they are needed to restore or maintain visual acuity and a less expensive professionally acceptable alternative is not available. Coverage for visually necessary contact lenses is subject to approval from VSP regardless of whether they are obtained from a VSP member doctor or a non-VSP provider
- Elective Contact Lenses. If you choose contact lenses for other than the visually necessary circumstances described above, they are considered Elective contact lenses.

### Low Vision Benefit

A Low Vision Benefit is available if you have severe visual problems that are not correctable with regular lenses. If you qualify for this benefit, you may receive supplemental testing, which includes evaluation, diagnosis and prescription of vision aids where indicated, and low vision aids, subject to the maximums outlined in the following chart.

Low Vision Benefits	VSP Member Doctor	Non-Member Provider
Supplemental testing	Covered in full	Plan pays up to \$125
Supplemental Aids	50% of approved amount	50% of approved amount
Maximum Benefit	\$500 per person, every two (2) years	

*Note: The limitations on frequency of services do not apply to VSP member doctor services for dependent children under age 18.*

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## LIMITATIONS AND EXCLUSIONS

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In addition to any general Plan exclusions and limitations (see page 114), Vision Benefits are not paid for the following expenses.

1. The Plan will pay the basic cost of allowed lenses, and you must pay any additional cost when you select any of the following extra items:
  - Optional Cosmetic processes
  - Anti-reflective coating
  - Color coating, mirror coating or scratch coating
  - Blended lenses
  - Laminated lenses
  - Cosmetic lenses
  - Oversize lenses
  - Progressive multifocal lenses
  - UV (ultraviolet) protected lenses
  - A frame that costs more than the Plan allowance
  - Certain limitations on low vision care
2. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a  $\pm 0.50$  diopter power); or two pair of glasses in lieu of bifocals
3. Replacement of lenses and frames that are lost or broken, except at the normal intervals when services are otherwise available

Please note that the Plan is designed to cover visual needs rather than Cosmetic materials.
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4. Medical or surgical treatment of the eyes, including any refractive vision surgery
5. Corrective vision treatment of an Experimental nature
6. Costs for services and/or materials above Plan benefit allowances shown on the Schedule of Benefits
7. Services or materials not shown as covered on the Schedule of Benefits

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## HOW TO FILE A VISION CLAIM

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When you use a VSP participating provider, you do not need to file a claim for reimbursement. If you use a non-VSP provider, call VSP to have an Out-of-Network Reimbursement Form mailed or faxed to you. (You can also fill out the form online at [www.vsp.com](http://www.vsp.com) and print it).

Mail the completed form with your itemized receipt to VSP at:

Vision Service Plan  
Attn: Out-of-Network Provider Claims  
P.O. Box 997105  
Sacramento, CA 95899-7105

If you have any questions about submitting your claim, contact VSP at 800-877-7195.
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**Note:** You must submit your claim **within 1 year** from the date you received the service. Benefits will not be payable if you submit your claim more than 1 year after the date the expense was incurred.

### Appeals of Denied Vision Care Benefits

If your claim is denied, in whole or in part, you will receive written notification from VSP including the reasons for denial. If you do not agree with the denial you may then submit a written request to VSP for reconsideration within 180 days from the date you received the denial. Any request for reconsideration should include documents or records in support of your appeal. VSP will provide a written response to the appeal within 60 days after it is received. Any request to VSP should be sent to the following address:

Vision Service Plan  
Member Appeals  
3333 Quality Drive  
Rancho Cordova, CA 95670

Once you have exhausted VSP's appeals process, you may file a voluntary appeal with the Plan's Board of Trustees.

<b>If You Have Other Vision Coverage</b>
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Make sure you notify your vision provider if you have other vision coverage. If you don't tell the provider about other coverage, VSP will be unable to coordinate benefits, and this could result in a delay in the processing of your claim.
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# Chapter 8: Employee and Dependent Life Insurance

In this chapter you'll find

- Employee life insurance
- Accelerated death benefit in case of terminal illness
- Waiver of life insurance premium during disability
- Life insurance for dependents
- Right to convert to an individual policy
- Information on filing claims

## About This Chapter

The benefits described in this chapter are available whether you are enrolled in the Plan's comprehensive medical benefits or the Kaiser HMO. The Employee and dependent life insurance is provided through an insurance contract with the ReliaStar Life Insurance Company. The group policy number is 62531-1.

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## EMPLOYEE LIFE INSURANCE

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**\$10,000 in group life insurance benefits** will be paid to your beneficiary in the event of your death from any cause while eligible under the Plan.

To receive the benefit payment, the beneficiary must be living on the earlier of the following dates:

- The date the insurance company receives proof of your death
- The tenth day after your death

### Your Beneficiary

Your beneficiary may be any person or persons you name on your beneficiary form. If there is no eligible beneficiary or if you did not name one, benefits will be paid to the surviving person or persons in the following order:

Your

- Spouse or domestic partner
- natural and adopted children
- parents
- brothers and sisters
- estate

If there is more than one beneficiary named each receives an equal share, unless you have requested otherwise in writing.

You may choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

You may request a change of beneficiary at any time by submitting a new beneficiary form to the Trust Fund Office. If you have named an irrevocable beneficiary, the insurance company must first have the written consent of that beneficiary.

A change in beneficiary will take effect as of the date it is signed by you but will not affect any payment the insurance company makes or action it takes before receiving your notice.

### **Accelerated Death Benefit in Case of Terminal Illness**

If it is determined that you have a terminal condition and have a life expectancy of 6 months or less, 50% of your life insurance benefit (or \$5,000) may be paid to you or your legal representative while you are still living.

The Accelerated Benefit applies to Employee Life Insurance only – not to Dependent Life Insurance.

The benefit is paid in one lump sum and is paid only once. This lump sum payout is the only benefit option available to you prior to your death.

*Note:* At this time it is unclear whether you will be required to pay tax on accelerated death benefit proceeds. You should consult with your tax adviser to assess possible tax implications.

### **Applying for the Accelerated Death Benefit**

To receive the Accelerated Death Benefit, **all** of the following conditions must be met. You must:

- Request this benefit in writing while you are living. Send the written request to the Trust Fund Office.
- Be insured as an eligible Employee for Life Insurance benefits.
- Provide to the insurance company a doctor's statement which gives the diagnosis of your medical condition, and states that because of the nature and severity of that condition, your life expectancy is no more than 6 months. The insurance company may require that you be examined by a doctor of its choosing. If the insurance company requires this, it will pay for the exam.
- Provide to the insurance company written consent from any irrevocable beneficiary, assignee and in community property states, from your spouse.

If you are unable to request this benefit yourself, your legal representative may request it for you.

### **Accelerated Death Benefit Payment**

The benefit will be paid to you unless it is shown, to the satisfaction of the insurance company, that both of the following are true:

- You are physically and mentally incapable of receiving and cashing the lump sum payment; and
- A representative appointed by the courts to act on your behalf does not make a claim for the payment.

Only one accelerated benefit payment will be made.

If the insurance company does not pay you because the two above conditions apply, payment will instead will be made to one of the following:

- A person who takes care of you;
- An institution that takes care of you, or

- Any other person the insurance company considers entitled to receive the payments as your trustee.

### **Accelerated Death Benefit Exclusions**

Accelerated benefits will not be paid for a terminal condition if either of the following apply:

1. The terminal condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted Injury, whether sane or insane; or
2. The required Life Insurance premium is due and unpaid.

### **Effects on Life Insurance Coverage**

When the Accelerated Death Benefit has been paid, your Life Insurance Coverage is affected in the following ways:

- Your life insurance benefit is reduced by the amount paid out to you as an accelerated benefit. If you received \$5,000 as an accelerated benefit, your beneficiary would receive \$5,000 after your death.
- Your Life Insurance benefit amount which you may convert to an individual policy is reduced by the Accelerated Death Benefit amount that has been paid.
- Any increase in the Fund's Life Insurance Benefit will not apply to you after the insurance company approves you to receive the Accelerate Death Benefit.
- You will not be able to reinstate your coverage to the full amount in the event of a recovery from a terminal condition.
- Your receipt of an Accelerated Death Benefit does not affect your Accidental Death and Dismemberment (AD&D) Insurance. If you should die in an accident after receiving an Accelerated Death Benefit, your AD&D Insurance will be based on your Life Insurance in force prior to the Accelerated Death Benefit payout, provided your premium is not being waived under the Waiver of Life Insurance Premium Disability Benefit.
- Your dependents' Life Insurance coverage will not be affected by the Accelerated Death Benefit amount paid to you.

### **Waiver of Life Insurance Premium During Disability**

Your life insurance will stay in effect if you become Totally Disabled before you reach age 60 and while you are eligible under this Plan. Your coverage will be continued without any further premium payment so long as the total disability continues and the required proof is submitted to the insurance company, as explained below. This is called a Waiver of Premium.

For purposes of this benefit, "Totally Disabled" means that you are unable, due to sickness or accidental Injury, to work at or perform the material and substantial duties of any job suited to your education, training or experience. You must be continuously Totally Disabled for at least 9 months before you are eligible for the waiver of premium.

The waiver of premium includes life insurance only. It does not include accidental death and dismemberment (AD&D) insurance or dependents' life insurance.

### ***Furnishing Notice and Proof of Disability***

You must send the insurance company (ReliaStar) written notice of claim, including proof that the total disability began while you were insured under the policy and that it has continued for 9 consecutive months, before it will waive any premium. You will need to do this (or have someone do it for you) on your own initiative —do not wait for the insurance company to request it. This notice must be received by ReliaStar:

- while you are living,
- while you are Totally Disabled, and
- within one year from the date the total disability begins. If you cannot give ReliaStar notice within one year, your claim is still valid if you show you gave notice as soon as reasonably possible. Receipt of notice or proof of Total Disability by the Trust Fund Office is not sufficient.

You must notify the Trust Fund Office promptly of your Total Disability and advise it that you want to apply for the Waiver of Premium Benefit so that the required forms can be sent to you for completion.
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The insurance company may require you to have a physical exam by a doctor it chooses and will pay for the exam if it is required. The insurance company can only require one exam a year after premiums have been waived for 2 full years.

### ***Termination of Waiver of Premium***

ReliaStar will stop waiving premiums on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give ReliaStar proof of total disability when asked.

If the insurance company stops waiving your premium, your life insurance will not stay in force unless you meet the eligibility requirements of the Trust Fund.

If you buy an individual policy under the Conversion Rights of the group policy during the first year of your disability, ReliaStar will cancel the individual policy as of its issue date if within 12 months of the date you become Totally Disabled, you

- Apply for the Waiver of Premium benefit and ReliaStar approves it, and
- Surrender the individual policy without claim, except for refund of premiums.

When ReliaStar cancels your individual conversion policy, it will refund all premiums paid for the individual policy and restore your Life Insurance under the group policy Waiver of Premium Benefit. The beneficiary you named under the individual policy will be retained under the group policy unless you ask ReliaStar to change the beneficiary in writing.



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## LIFE INSURANCE FOR DEPENDENTS

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The life insurance amounts shown in the following chart are payable if one of your eligible dependents dies from any cause while insured under the Plan. The amount of the benefit depends on whether the deceased was your spouse or domestic partner or a child. If the dependent was a child, the amount payable depends on the child's age.

### Schedule of Benefits

Dependent	Benefit Amount
Spouse or Domestic Partner	\$1,000
Children – according to age:	
• from age 3 through age 20	\$500
• 2 years but less than 3 years of age	\$400
• 6 months but less than 2 years of age	\$200
• From birth to 6 months of age	\$100

The dependent life insurance benefit is paid to you if you are living on the earlier of the following:

- The date the insurance company receives proof of your insured dependent's death
- The tenth day after your insured dependent dies

If you are not living on either of these dates, the benefit will be paid in the following order:

- Your spouse or domestic partner, if living
- Your estate

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## RIGHT TO CONVERT TO AN INDIVIDUAL POLICY

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During the 31-day period following termination of your eligibility (or your dependent's eligibility), you or your insured dependent may convert this life insurance (excluding any amount paid out as an accelerated death benefit) to an individual policy.

Proof of good health is not required to convert your insurance to an individual policy. You must apply for the individual policy and pay the first premium within 31 days of the date your eligibility ends.

You or your dependent may purchase any individual nonparticipating policy offered by the insurance company, except term insurance. The individual policy will not contain accidental death and dismemberment benefits, accelerated death benefits or disability benefits. The individual policy will be effective at the end of the 31-day period.

The premium for the new policy will be based on your or your dependent's age on the date of conversion.
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If you or your insured dependent dies within the 31-day period allowed for making application to convert, the life insurance benefit in effect prior to termination of eligibility will be paid to the beneficiary, whether or not application for a conversion policy was made. In this case, ReliaStar

will return any premium paid for the individual policy to your or your dependent's beneficiary named under the group policy.

If you wish to convert your coverage to an individual policy, contact the Trust Fund Office or the insurance company at the following address for an application.

ReliaStar Life Insurance Company  
P.O. Box 20  
Minneapolis, Minnesota 55440  
Telephone Number: (800) 955-7736

If you again become eligible under the Trust Fund, conversion coverage will not again be available to you if any individual policy is in effect as a result of a previous conversion.

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## HOW TO FILE A LIFE INSURANCE CLAIM

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Send claims to the Trust Fund Office which will confirm eligibility and forward the claim to the insurance company. Payment of the claim will be made by the ReliaStar Life Insurance Company promptly upon receipt of all necessary proof from the Trust Fund Office.

Whenever there is a death claim, obtain a life insurance claim form from the Trust Fund Office. The completed claim form, along with a certified copy of the death certificate, should be sent to the Trust Fund Office at the following address:

Operating Engineers Health and Welfare Trust Fund  
P.O. Box 23980  
Oakland, CA 94623-0190

The Trust Fund Office will confirm eligibility and forward the claim to the insurance company. The insurance company will pay the claim promptly upon receipt of all necessary proof.

**Note:** For information on how to apply for an accelerated benefit in case of terminal illness, see "Applying for the Accelerated Death Benefit" above.

### Appeals of Denied Life Insurance Claims

If a claim for life insurance benefits is denied either in whole or in part, your beneficiary will receive written notification from either the Trust Fund Office or the ReliaStar Life Insurance Company including the reasons for denial. If the beneficiary does not agree with the denial, he or she must submit a written request to the ReliaStar Life Insurance Company requesting reconsideration within 60 days from the date he/she received the denial. Any request should include documents or records in support of the appeal. The ReliaStar Life Insurance Company will provide a written response to the appeal no later than 120 days after it is received.

Any request to the insurance company should be sent to:

ReliaStar Life Insurance Company  
P.O. Box 20  
Minneapolis, Minnesota 55440

See "Claims and Appeals Procedures" in this booklet for more information.

# Chapter 9: Employee Accidental Death and Dismemberment (AD&D) Benefit

In this chapter you'll find:

- A quick-reference guide to AD&D benefits
- How the plan works
- Exclusions from coverage
- Information on filing claims

## About This Chapter

The benefits described in this chapter are available whether you are enrolled in the Plan's comprehensive medical benefits or the Kaiser HMO.

Like Employee and dependent life insurance, Employee AD&D benefits are provided through an insurance contract with the ReliaStar Life Insurance Company. The group policy number is 62531-1. AD&D coverage is not provided for dependents.

The Plan insures you for **up to \$5,000** against death or dismemberment in an accident on or off the job. The amount payable depends on the nature of the loss, as shown in the chart below.

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## SCHEDULE OF BENEFITS

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The Full Benefit amount is \$5,000.

Description of Loss	The Benefit Amount Is
Loss of Life	Full Amount (\$5,000)
Loss of both hands, both feet or sight of both eyes:	Full Amount (\$5,000)
Loss of one hand and one foot	Full Amount (\$5,000)
Loss of speech and hearing in both ears	Full Amount (\$5,000)
Loss of one hand or one foot and sight of one eye	Full Amount (\$5,000)
Loss of one hand or one foot or sight of one eye	½ Full Amount (\$2,500)
Loss of speech	¼ Full Amount (\$1,250)
Loss of hearing in both ears	¼ Full Amount (\$1,250)
Loss of thumb and index finger of same hand	¼ Full Amount (\$1,250)

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## HOW THE PLAN WORKS

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The accidental death and dismemberment insurance (AD&D) benefit will be paid for any of the losses listed in the above chart if the loss is due to an accident that happens on or off the job. All of the following conditions must be met:

- You are insured under the Plan on the date of the accident,
- The loss occurs within 180 days after the accident, and
- The cause of the loss is not excluded.

If you suffer more than one loss in a single accident, the maximum combined benefit for all losses will be \$5,000 and the insurance company will pay no more than \$5,000 while the Group Policy is in effect. For example, if you had an accident for which you received one-half of the Full Amount, no more than one-half of the Full Amount will be paid for the next loss.

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed. A benefit is not paid for loss of use of the hand or foot or thumb and index finger.

The death benefit is paid to the current beneficiary you have on file at the time of your death. This benefit is in addition to the \$10,000 Employee life insurance benefit described in chapter 8. The benefit for any other AD&D loss will be paid to you, the Employee

Your beneficiary may be any person or persons you name. You may request a change of beneficiary at any time by submitting a new beneficiary form to the Fringe Benefits Service Center. The benefit for any other AD&D loss will be paid to you, the Employee.

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## EXCLUSIONS FROM COVERAGE

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No AD&D benefit is paid for any loss that is caused directly or indirectly by any of the following:

1. Suicide or intentionally self-inflicted Injury, while sane or insane.
2. Physical or mental Illness
3. Bacterial infection or bacterial poisoning. Exception: Infection from a cut or wound caused by an accident.
4. Any armed conflict, whether declared as war or not, involving any country or government.
5. Injury suffered while in the military service for any country or government.
6. Injury which occurs when you commit or attempt to commit a felony.
7. Use of any drug, narcotic or hallucinogenic agent:
  - unless prescribed by a Physician,
  - which is illegal,
  - which is not taken as directed by a Physician or the manufacturer.
8. Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

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## HOW TO FILE A CLAIM FOR AD&D BENEFITS

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If you suffer one of the losses described in this chapter, you or your beneficiary should obtain AD&D information from Trust Fund Office. Any required documentation should be submitted to the Trust Fund Office at the following address:

Operating Engineers Health and Welfare Trust Fund  
P.O. Box 23980  
Oakland, CA 94623-0190

If you have any questions about how to submit a claim, contact the Trust Fund Office.
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The Trust Fund Office will confirm your eligibility and forward the claim to the insurance company. The insurance company will pay the claim promptly upon receipt of all necessary proof.

### Appeals of Denied AD&D Claims

If a claim for accidental death and dismemberment insurance benefits is denied either in whole or in part, you or your beneficiary will receive written notification from either the Trust Fund Office or the ReliaStar Life Insurance Company including the reasons for denial. If you do not agree with the denial, you must submit a written request to the ReliaStar Life Insurance Company requesting reconsideration within 60 days from the date the denial was received. Any request should include documents or records in support of your appeal. The ReliaStar Life Insurance Company will provide a written response to the appeal no later than 120 days after it is received.

Any request to the insurance company should be sent to:

ReliaStar Life Insurance Company  
P.O. Box 20  
Minneapolis, Minnesota 55440

See “Claims and Appeals Procedures” in chapter 11 of this booklet for more information.

# Chapter 10: Employee Burial Expense Benefit

In this chapter you'll find:

- How the Plan works
- Information your beneficiary
- Information on filing claims

## About This Chapter

The benefit described in this chapter is available whether you are enrolled in the Plan's comprehensive medical benefits or in the Kaiser HMO plan.

The Employee burial expense benefit is provided through an insurance contract with the Union Labor Life Insurance Company. The burial expense benefit is not provided for dependents.

<b>Burial Expense Benefit</b>	\$2,500
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## HOW THE PLAN WORKS

The Plan pays a burial expense benefit in the amount of \$2,500 in the event of your death from any cause—on the job or off—while you are insured for this benefit.

The burial expense benefit will be paid to your beneficiary. This benefit is payable in addition to the \$10,000 Employee life insurance benefit and, if death is caused by an accident, the \$5,000 benefit payable under Employee accidental death and dismemberment benefit.

**Note:** If you are not eligible for the burial expense benefit under this Trust Fund, the benefit may be provided for you through other contracts issued to the groups participating in the Operating Engineers Burial Expense Program. Your beneficiary should contact the Union or the Trust Fund Office to ask about payment of this benefit in the case of your death.

## Your Beneficiary

You may name anyone as the designated beneficiary, and you may change the designation at any time by filling out the proper form. To designate or change your beneficiary, complete a new beneficiary designation form (available from the Trust Fund Office, Fringe Benefits Service Center or your Local Union Office) and send it to the Fringe Benefits Service Center.

If you have not named a beneficiary or if your beneficiary predeceases you, payment will be made to the first of the following that survives you:

- your surviving spouse
- your children, in equal shares,
- your parents, in equal shares
- your brothers and sisters, equal shares

If none of the above survives you, the benefit will be paid to the executor or administrator of your estate.

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## HOW TO FILE A CLAIM FOR THE BURIAL EXPENSE BENEFIT

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Your beneficiary should obtain a burial expense benefit claim form from the Trust Fund Office, the Fringe Benefits Service Center or your Local Union Office. The completed form should be submitted with any required documentation to the Trust Fund Office at the following address:

Operating Engineers Health and Welfare Trust Fund  
P.O. Box 23980  
Oakland, CA 94623-0190

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she can request a review of the decision. Please alert your beneficiary to the claims and appeals information provided in chapter 11 of this booklet.

# Chapter 11: Claims and Appeals Procedures

This chapter includes:

- Claims procedures
- Internal appeals procedures
- Legal proceedings
- External review of claims

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## CLAIMS PROCEDURES

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*If you elected Kaiser coverage instead of the comprehensive medical benefits described in chapter 4, the information below will apply to your benefits for hearing aids and chemical dependency treatment. You should refer to your Evidence of Coverage from Kaiser for information on procedures applicable to your Kaiser medical and prescription drug benefits. An exception is made for eligibility questions, which will call for Trust Fund Office involvement; see the “Eligibility Dispute” box under “Appealing an Adverse Benefit Determination” later in this chapter.*

Discussed below are the various types of claims associated with Plan benefits, procedures for filing claims, and the steps involved in appealing a decision with which you disagree.

### Types of Claims

The term “claim” means a request for a benefit made by an eligible individual (referred to as a “claimant”) in accordance with the Plan’s reasonable procedures. There are five types of claims applicable to the benefits described in this booklet. Four of them have to do with health care:

- **Pre-service claim:** A pre-service claim is a claim for a benefit for which the Plan requires prior approval (called precertification or pre-authorization) before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

Under this Plan, prior approval of services is required for:

- non-Emergency Medical Condition Hospital admissions (unless the stay is for childbirth, in which case no prior approval is required for a stay of up to 48 hours following a vaginal delivery or 96 hours following a cesarean section or the Fund is the secondary payer of benefits, as explained in “Coordination of Benefits” earlier in this chapter),
- outpatient surgery at a Hospital or an Ambulatory Surgery Facility,
- organ or tissue transplants and bariatric surgery for weight loss,
- the following outpatient diagnostic imaging procedures: CT/CTA, MRI/MRA, Nuclear Cardiology, PET, Echocardiography;
- chemical dependency treatment, and
- the prescription drugs listed on page 65.

If you fail to get prior approval for these services, your benefits may be reduced or denied.

- **Urgent care claim:** A claim is an urgent care claim if applying the normal Pre-service or Concurrent Care standards for rendering a decision:



- could 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.

The Trust Fund Office or the Plan’s designated review organization for medical claims, Caremark for prescription drug claims or Operating Engineers Assistance Recovery Program (ARP) for chemical dependency claims, will determine whether a claim is an Urgent Care 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 Care Claim, and notifies the Plan of such, it will be treated as an Urgent Care Claim.

- **Concurrent care claim:** A concurrent care claim is 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. (For example, an inpatient Hospital stay originally pre-approved for 5 days is subjected to concurrent review at 3 days to determine if the full 5 days are appropriate.) This category also includes requests by you or your provider to extend a previously approved course of treatment.
- **Post-service claims:** A post-service claim is a claim for benefits that is not a pre-service, urgent care or concurrent care claim. This will generally be a claim for reimbursement for services already rendered. A claim involving a rescission will be treated as a post-service claim.
- **Other claims:** The category “other claims” includes claims for Employee and dependent life insurance benefits, Employee accidental death and dismemberment (AD&D) benefits, and Employee burial expense benefits.

### **Other Definitions**

- **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.
- **Rescission** means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind coverage of an Eligible Individual if he/she performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

### **What Is Not a Claim**

The following are **not** considered claims and are thus not subject to the requirements and timelines described in this section:

- 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 claimant 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.

- 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 (for example, the pre-determination that is recommended, but not required, for certain dental procedures and medical equipment). However, requests for precertification or prior authorization of a benefit where the Plan does require precertification or prior authorization should be submitted as pre-service claims (or urgent care claims, if applicable) as described under Filing a Claim, below.

**Note:** In cases where pre-determination is recommended but not required, such as for medical equipment, you may request a written determination regarding the Plan's coverage of the treatment or service. However, getting an advance determination (like getting pre-authorization) does not guarantee payment of Plan benefits. For example, benefits would not be payable if your eligibility for coverage ended before the medical equipment is obtained.

- A prescription you present to a pharmacy to be filled to the extent benefits are determined based on cost and coverage rules predetermined by the Plan is not considered a claim. (However, if a pharmacy, physician or hospital declines to render services or refuses to fill a prescription unless you pay the entire cost, you should submit a post-service claim for the services or prescription, as described under "How to File a Claim" below.)

## How to File a Claim

Information on how to file a claim is included in each of the chapters describing the individual benefits earlier in this booklet. Here is a brief summary of the information presented there:

- Pre-service claims, urgent care claims, and concurrent care claims to extend approved treatment:
  - For Hospital admissions, outpatient surgery at a Hospital or Ambulatory Surgery Facility, organ or tissue transplants and bariatric surgery, have your Physician call Anthem Blue Cross at (800) 274-7767. If your doctor thinks the request for pre-authorization needs to be handled as an urgent care claim, he or she should indicate this to Anthem Blue Cross.
  - For outpatient diagnostic imaging procedures that require pre-authorization (CT/CTA, MRI/MRA, Nuclear Cardiology, PET, Echocardiography), your Physician should call American Imaging Management at (877) 291-0360.
  - For chemical dependency treatment, call the Assistance Recovery Program (ARP) at (800) 562-3277. If you think your request for a referral needs to be handled as an urgent claim, you should indicate this to ARP.
  - For prescription drugs that require pre-authorization, your Physician should call Caremark at (888) 790-4258.
- **Post-service claims for medical benefits:** Contract Providers will submit your claims for you. All claims for providers in California must be submitted directly to Anthem Blue Cross electronically or by mail to P.O. Box 60007, Los Angeles, CA 90060-0007. All claims for providers outside California must be submitted to the local Blue Cross Blue Shield Plan.
- **Post-service claims for prescription drug benefits** (*necessary only if you use a non-participating pharmacy or you otherwise have to pay the full cost*): Send your claim directly to

Caremark at the following address: Caremark Claims Department, P.O. Box 52196, Phoenix, AZ 85072-2196.

- **Post-service claims for chemical dependency benefits:** Claims should be sent to the Operating Engineers Assistance Recovery Program at 1620 South Loop Road, Alameda, CA 94509.
- **Post-service claims for dental benefits:** A Delta Dental Dentist will file the claim for you. Other dentists should send claims to Delta Dental at the following address: Delta Dental of California, P.O. Box 997330, Sacramento, CA 95899-7330.
- **Post-service claims for vision care benefits** (*necessary only if you use a non-VSP provider*): Send your Out-of-Network Reimbursement Form (available at [www.vsp.com](http://www.vsp.com) or 800-877-7195) with your itemized receipt to the following address: Vision Service Plan, Attn: Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.
- **Other claims:** You or your beneficiary should contact the Trust Fund Office to get a claim form for life insurance, AD&D, or burial expense benefits. The form should be completed and returned with applicable documentation to the following address: Operating Engineers Health and Welfare Trust Fund, P.O. Box 23190, Oakland, CA 94623-0190.

All claims submitted must be accompanied by any information or documentation requested or reasonably required to process such claims.

### **Using an Authorized Representative**

An Authorized Representative, such as a spouse or adult child, may submit a claim or appeal on your behalf if you have designated the individual to act on your behalf in writing on a form available at the Trust Fund Office. The Trust Fund Office may request additional information to verify that the person is authorized to act on your behalf.

For an urgent care claim, a health care professional with knowledge of your medical condition may act as an authorized representative without your having to designate in writing that the health care professional is your authorized representative.

### **Claim Procedures / Timing of Initial Claims Decisions**

*Note: The Plan's designated review organization is American Imaging Management for outpatient diagnostic imaging procedures requiring prior approval or Anthem Blue Cross for all other medical claims.*

A determination on your claim will be made within the following time frames:

#### **Urgent Care Claims**

Urgent Care Claims, which may include requests for Precertification of Hospital admissions and Prior Authorization of services, may be requested orally or in writing to the Plan's designated review organization or the Trust Fund Office for medical claims, Caremark for prescription drug claims or Operating Engineers Assistance Recovery Program (ARP) for chemical dependency claims.

- For properly filed Urgent Care Claims, the Trust Fund Office or the Plan's designated review organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims, will respond to the claimant and provider with a determination by

telephone 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 Care Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Trust Fund Office or the designated review organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims, will notify the claimant 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 claimant 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 claimant 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 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 claimant improperly files an Urgent Care Claim, the Trust Fund Office or designated review organization, Caremark or ARP will notify the claimant as soon as possible but not later than **24 hours** after receipt of the claim of the proper procedures required to file an Urgent Care Claim. Improperly filed claims include, but are not limited to:
  - claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or
  - 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 claimant or authorized representative requests written notification. Unless re-filed properly, an improperly filed claim will not constitute a claim.

### **Pre-Service Claims**

Pre-Service Claim Urgent Care claims may be requested orally to the Plan's designated review organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims. All other Pre-Service Claim must be requested in writing to the Plan's designated review organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims. Any Pre-Service Claim Urgent Care claim requested in writing should prominently designate on its cover that it is an "Urgent Care claim" requiring immediate attention.

- The designated review organization, Caremark or ARP will notify the claimant of an improperly filed Pre-Service Claim and of the proper procedures to be followed in filing a claim, including additional information needed to make the claim complete, as soon as possible, taking into account the medical exigencies, but no later than: (i) **72 hours** after receipt of the claim in the case of Pre-Service Urgent Care, or (2) **5 days** after receipt of the claim in the case of Pre-Service claims.
- For properly filed Pre-Service Claims, the Plan's designated review organization, Caremark or ARP will notify, in writing, claimant and, if requested, claimant's doctor or other provider 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, Caremark or ARP. If an extension is necessary, the

designated review organization, Caremark or ARP will notify, in writing, claimant of the need to extend the initial *15 day* period 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. Claimant has **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** from receipt of the request for additional information; or (ii) the date the participant responds to the request. The review organization, Caremark or ARP shall notify, in writing, the claimant and, if requested, the claimant's doctor or other provider of a decision within **15 days** after receipt of any additional information.

### **Concurrent Care Claims**

A claim involving concurrent care may be filed orally or in writing to the Trust Fund Office or the Plan's designated review organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims,

- If a decision is made to reduce or terminate an approved course of treatment, the participant will be notified sufficiently in advance of the reduction or termination to allow the Participant or Beneficiary to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.
- Concurrent Care Claims that are an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Section for Urgent Care Claims. Concurrent Care Claims that are not an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Section for Pre-Service and Post-Service Claims.
- If the Concurrent Care Claim is approved, the participant will be notified orally followed by written notice provided no later than **3 days** after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, the participant will be notified orally followed by written notice.

### **Post-Service Claims**

A Post-Service Claim must be submitted in writing to Anthem Blue Cross for medical claims in California, the local Blue Cross Blue Shield plan for medical claims outside California (hereafter referred to as Blue Cross), Caremark for prescription drug claims or ARP for chemical dependency claims, in writing, using an appropriate claim form or appropriate electronic claims procedure, **within one (1) year after expenses are incurred**. (This does not apply to dental or vision claims, which must be submitted to Delta Dental Plan or Vision Service Plan, respectively, under the terms and timeframes established by those Plans.) 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. Claimants do not have to

submit an additional claim form if the bill(s) are for a continuing illness and claimant 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 all required information for the request to be considered a claim and for the Plan to be able to decide the claim.

- In the event of death, the Participant's or Beneficiary's estate must obtain a claim form and submit the written claim form and a certified copy of the death certificate to the Trust Fund Office.
- A Post-Service Claim is considered to have been filed upon receipt of the claim by Blue Cross, Caremark or ARP. The Trust Fund Office or Caremark will notify claimants of decisions on Post-Service Claims in writing within **30 days** of receipt of the claim by Blue Cross, Caremark or ARP. The Trust Fund Office, Blue Cross, Caremark or ARP 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 Trust Fund Office or Caremark will notify claimants, in writing, of the need to extend the initial **30 day** period prior to the expiration of the initial **30 day** period, of the circumstances requiring the extension 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 Trust Fund Office, Blue Cross, Caremark or ARP shall request additional information from provider and/or claimant via fax, telephone, Explanation of Benefits (EOB) or letter within 30 days of the receipt of the claim or within **45 days** if a **15 day** extension is taken. The request for additional information shall specify the information needed. Claimant has **45 days** from receipt of the request for additional information 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** from receipt of the request for additional information; or (ii) the date the participant responds to the request. The Trust Fund Office or Caremark shall notify, in writing, the claimant and, if requested, the claimant's doctor or other provider of a decision within **15 days** after receipt of any additional information.

### **Life Insurance Claims**

For life insurance and accidental death and dismemberment claims, including burial expense benefits, the insurance company will make a decision on the claim and notify the claimant of the decision within **90 days** of receipt of the claim. If the insurance company 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 make a decision before the expiration of the **90 day** period. The period for making a decision may be delayed an additional **90 days**.

### **Expiration of Time Periods**

If a claim is not acted upon within the time periods prescribed in this chapter, you may proceed to the appeal procedure as if the claim were denied.

### **Right to Continued Coverage**

If you initiate an internal appeal in compliance with the internal appeals process described in this chapter and if the appeal concerns a previously approved ongoing course of treatments to be



provided over a period of time or number of treatments, the Plan will continue to provide such coverage pending the outcome of the internal appeal.

### **Denied Claims (Adverse Benefit Determinations)**

An “Adverse Benefit Determination” for health care claims 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 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);
- 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;
- a failure to cover an item or service because the Plan considers it to be experimental, investigational, not medically necessary or not medically appropriate;
- a decision that denies a benefit based on a determination that you are not eligible to participate in the Plan;
- A Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time is considered an Adverse Benefit Determination.

### ***New or Additional Rationale or Evidence***

If the Plan bases an adverse benefit decision on new or additional rationale or evidence, you must be provided:

- the new rationale or evidence as soon as possible, and
- reasonable opportunity to respond prior to the due date for the initial benefit decision.

### **Written Notice of Initial Adverse Benefit Determination**

You will be provided with written notice of the initial decision on your claim. If the decision is a denial of the claim (an adverse benefit determination), this notice will include:

1. identification of the claim involved (e.g., date of service, health care provider, claim amount if applicable).
2. the specific reason(s) for the determination, including the denial code, if any, and its corresponding meaning as well as any Plan standards used in denying the claim;
3. reference to the specific Plan provision(s) on which the determination is based;
4. a description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
5. a description of the Plan’s internal appeal procedures and external review processes along with time limits and information regarding how to initiate an internal appeal;
6. a statement that, upon request and free of charge, any applicable diagnosis code and/or treatment code, and their corresponding meanings, will be provided, but that a request for this information will not be treated as a request for Internal Appeal;
7. a statement of your right to bring civil action under ERISA Section 502(a) after the internal appeal and, if applicable, the external review is completed;

8. if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement that such rule, guideline, protocol or criteria that was relied upon will be provided to you upon request free of charge;
9. if the denial was based on medical necessity, experimental or investigational treatment, or similar exclusion or limit, a statement that an explanation regarding the scientific or clinical judgment for the denial will, upon request, be provided to you free of charge;
10. if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
  - the Notice of Adverse Benefit Determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
  - upon request the Plan shall provide a Notice of Adverse Benefit Determination in that non-English language;
  - the Notice of Adverse Benefit Determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language;
  - any customer assistance services provided by the Plan shall be provided in that non-English language;
11. a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) claimant's rights, (2) the notice, or (3) other assistance; and
12. for Urgent Care Claims, a description of the expedited review process applicable to Urgent Care Claims.

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## INTERNAL APPEALS PROCEDURES

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*Note: If you have a vision claim that is denied by VSP, a prescription drug claim that is denied by Caremark, or a dental claim that is denied by Delta Dental, you must exhaust the appeals processes of VSP, Caremark or Delta Dental before filing an appeal with the Board of Trustees.*

If you disagree with the decision made on a claim, you may appeal the decision.

You must submit your appeal within 180 days after you receive the notice of denial of a claim.
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### Appealing an Adverse Benefit Determination

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may appeal the decision in the manner specified below. Appeals must be submitted to the Trust Fund Office within **180 days** after you receive the notice of Adverse Benefit Determination.

Your request for appeals of Adverse Benefit Determinations must include:

- the Patient's name and address
- the Participant's (Employee's) name and address, if different;
- a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
- the date of the Adverse Benefit Determination; and



- the basis of the appeal, i.e., the reason(s) why the claim should not be denied.

- **Urgent Care Claims**

Appeals regarding Urgent Care Claims may be made either in writing to the Plan’s designated review organization or the Trust Fund Office, or orally by calling the Plan’s designated review organization or the Trust Fund Office or by other available similarly expeditious method, including electronic means. A written appeal should prominently designate on the cover that it is an Urgent Care claim requiring immediate attention. An appeal of an Urgent Care claim requiring immediate attention will be reviewed on an expedited basis. All necessary information, including the Plan’s determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, e-mail or other available similarly expeditious method, with written notice to follow within 48 hours.

<p>The Plan’s designated review organization is American Imaging Management for outpatient diagnostic imaging procedures requiring prior approval or Anthem Blue Cross for all other medical claims.</p>
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- **Concurrent Care Claims**

Appeals of Adverse Benefit Determinations regarding Concurrent Care Claims may be made in the same manner as an Urgent Care Claims if the timeframe for a decision would seriously jeopardize the life or health of the claimant or the claimant’s ability 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. All other Concurrent Care Claims should be filed in the same manner as a Pre-Service Claim.

- **Pre-Service Claims**

Appeals of Adverse Benefit Determinations regarding Pre-Service Claims must be submitted in writing to the Plan’s designated review organization or the Trust Fund Office 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 Plan’s designated review organization or the Trust Fund Office in accordance with Plan provisions will not be considered an appeal, but a new Pre-Service Claim.

- **Post-Service Claims**

Appeals of Adverse Benefit Determinations regarding Post-Service Claims must be submitted in writing to the Trust Fund Office or the Plan’s designated review organization via mail or fax.

- **Dental and Vision Claims**

Appeals of denied dental or vision claims must first be submitted to Delta Dental Plan or Vision Service Plan. After exhausting the appeals procedures of Delta Dental Plan or Vision Service plan, you may then submit an appeal in writing to the Trust Fund Office under the appeals process noted in this chapter for Post-Service Claims.

**Eligibility Disputes**

If your claim is denied because you are not shown as eligible in the records of the Trust Fund Office, your eligibility status will be resolved by the Trust Fund Office working with Anthem Blue Cross, the ARP, Caremark, Kaiser, or any other service provider, as necessary, to resolve your claim in accordance with the time lines described under “Timeframes for Sending Notices of Appeal Determinations” on page 101. Eligibility disputes are not subject to the External Review of Claims provisions.

## **The Internal Appeal Process**

The internal appeal process works as follows:

You 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.

You will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents pertaining to your claim if the documents:

- were relied upon in making the initial determination,
- were submitted, considered or generated in the course of making the internal adverse benefit determination even if not relied upon,
- demonstrate that the Plan provisions have been followed and applied consistently with respect to similarly situated individuals, or
- constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, whether or not relied upon.

**Note:** If the additional information you provide when appealing a post-service health care claim allows the Trust Fund Office to provide additional benefits, your appeal will not have to proceed to the meeting of the Appeals Committee of the Board of Trustees.

- A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the claim or the subordinate of such person. 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 claimant.
- If your 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, you 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.
- You shall have no right to personally appear before the named fiduciary for appeals (the Appeals Committee of the Board of Trustees) unless the Appeals Committee in its sole discretion concludes that such an appearance would be of value in enabling it to review the adverse initial determination.

## **Timeframes for Sending Notices of Appeal Determinations**

You will receive notice of the decision made on your appeal according to the following timetable:

- **Urgent claims:** You will receive a notice of a decision on review as soon as possible taking into account the medical exigencies, but not later than **72 hours** of receipt of the appeal by the Trust Fund Office or the Plan's designated review organization.
- **Pre-service claims:** You will be sent a notice of a decision on review within **30 days** of receipt of the appeal by the Trust Fund Office or the Plan's designated review organization.

- **Concurrent claims:** Notice of the appeal determination for a concurrent care claim will be sent by the Trust Fund Office or its designated review organization according to the following time periods:
  - if the concurrent care claim concerns a reduction or termination of an initially approved course of treatment, before the proposed reduction or termination takes place; or
  - for all other claims to extend a concurrent care treatment, the decision must be made in the time periods:
    - for urgent care appeals the notification period is based on the current urgency of the claim;
    - for non-urgent pre-service and post-service concurrent appeals the time periods set forth under each standard.
- **Post-service health care claims:** Ordinarily, decisions on appeals involving post-service claims will be made at the next regularly scheduled meeting of the Appeals Committee of the Board of Trustees following receipt of your request for review. However, if your request for review is received at the Trust Fund Office less than **30 days** before the next regularly scheduled meeting, your appeal may be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than **5 days** after the decision has been reached.
- If the decision on your appeal is not provided to you within the time specified in this section, your claim will be considered denied upon review. In such situation, you may request an External Review for a claim that fits within the parameters for External Review, as described under “External Review of Claims.”

### Written Notice of Final Internal Benefit Determination

You will be provided with written notice of the final internal benefit determination on your claim. The notice for urgent care claims may be provided orally and followed with written notification. If the decision is an adverse benefit determination (if your appeal is denied), the written notice will include:

1. information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable),
2. a statement that, upon request and free of charge, any applicable diagnosis code and/or treatment code, and their corresponding meanings, will be provided, but that a request for this information will not be treated as a request for External Review;
3. the specific reason(s) for the adverse appeal review determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the appeal, including a discussion on how the standard was applied;
4. reference to the specific Plan provision(s) on which the determination is based;
5. a statement that you are entitled to receive, upon written request and free of charge, reasonable access to and copies of all documents relevant to your claim;

6. if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement that such rule, guideline, protocol or criteria that was relied upon will be provided to you free of charge upon request;
7. if the determination was based on medical necessity, experimental or investigational treatment, or other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge to you upon request;
8. a statement of your right to file a request for an External Review, or for an eligibility dispute, to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
9. if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
  - the Notice of Final Internal Adverse Benefit Determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
  - upon request the Plan shall provide a Notice of Final Internal Adverse Benefit Determination in that non-English language;
  - the Notice of Final Internal Adverse Benefit Determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language;
  - any customer assistance services provided by the Plan shall be provided in that non-English language;
10. a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) claimant's rights, (2) the notice, or (3) other assistance;
11. a statement of your right to external review if the final adverse benefit determination involves either medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; or a rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time and, if applicable, a description of the external review process processes along with time limits and information regarding how to initiate an external review;
12. a statement of your right for Urgent Care claims or when you are receiving an ongoing course of treatment, that you shall be allowed to proceed with expedited external review if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from a facility; and a description of the expedited review process.

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## LEGAL PROCEEDINGS

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### Legal Actions

You may pursue your claim for benefits in court under ERISA §502(a) but only after you exhaust your internal appeal and external review remedies as described in this chapter. Failure to exhaust your internal appeal and external review remedies will preclude judicial review.

### Legal Standards

- Except in cases where federal law requires an external review upon request of a claimant, the named fiduciary for appeals is given full discretionary authority:
  - to finally determine all facts relevant to any claim,
  - to finally construe the terms of the Plan and all other documents relevant to the Plan, and
  - to finally determine what benefits are payable from the Plan.
- Any decision made by any named fiduciary for appeals shall be binding on all persons affected to the fullest extent permitted by law.
- No decision of a named fiduciary for appeals shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the named fiduciary for appeals was an abuse of discretion in light of the information actually available to it at the time of its decision.
- A decision of an IRO shall be final and binding unless a Court of competent jurisdiction determines otherwise.

The Board or its designated Appeals Committee is the named fiduciary for appeals.
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## EXTERNAL REVIEW OF CLAIMS

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*This External Review process is intended to comply with the Affordable Care Act (ACA) External Review requirements. For purposes of this section, references to “the claimant” include the participant and any covered dependent(s), and the participant’s and covered dependent(s)’ authorized representatives; and references to “Plan” include the Plan and its designee(s).*

The term “Independent Review Organization or IRO” means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan’s External Review provisions outlined in this section and current federal external review regulations.

The Plan shall either:

- contract with at least two IROs by January 1, 2012 to perform external review services and contract with at least three IROs by July 1, 2012 to perform external review services; or
- contract with a third party administrator who contracts with at least two IROs by January 1, 2012 to perform external review services and contract with at least three IROs by July 1, 2012 to perform external review services, but only if the Plan Sponsor monitors the review process in order to confirm compliance.

If an appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied, the claimant may request further external review by an independent review organization (“IRO”) if the denial fits within the parameters described below:

- The denial involves medical judgment, including but not limited to, those based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or
- The denial is due to a Rescission of coverage (i.e., any cancellation or discontinuance of coverage that has a retroactive effect), regardless of whether the rescission has any effect on any particular benefit at that time.

Generally, an External Review may be requested only after the claimant has exhausted the internal claims and appeals process described in earlier in this chapter. This means that, in the normal course, the claimant may only seek External Review after a final Adverse Determination has been made on an appeal.

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

### **External Review of Standard (Non-Urgent Care) Claims**

A request for External Review of a non-urgent claim must be made, in writing, within **four (4) months** of the date that the claimant receives notice of a denial of an internal appeal. An internal appeal denial is referred to below as an “Adverse Determination.” An External Review request on a non-urgent care claim should be made to the Trust Fund Office.

#### **Preliminary Review of Standard (Non-Urgent Care) Claims**

- Within **five (5) business days** of the Trust Fund Office’s receipt of a request for an External Review of a non-urgent care claim, the Trust Fund Office will complete a preliminary review of the request to determine whether:
  - the claimant is/was covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
  - the Adverse Determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan, or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;
  - the claimant has exhausted the Plan’s internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and
  - the claimant has provided all of the information and forms required to process an External Review.
- The preliminary review by the Trust Fund Office shall take into account all comments, documents, records, and other information submitted by claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination or internal appeal.

- Within **one (1) business day** of completing its preliminary review, the Trust Fund Office will notify the claimant in writing as to whether claimant’s request for External Review meets the above requirements for External Review. This notification will inform the claimant:
  - If claimant’s request is complete and eligible for External Review; or
  - If the request is complete but not eligible for External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
  - If the request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow the claimant to perfect (complete) the request for External Review within the four (4) *month* filing period, or within a 48-hour period following receipt of the notification, whichever is later.

### **Review of Standard (Non-Urgent Care) Claims by an Independent Review Organization (IRO)**

If the request for external review is complete and eligible for an external review, Trust Fund Office shall as soon as practicable refer, on a rotating basis, a proper request for external review to an accredited Independent Review Organization (IRO) with whom the Trust Fund Office has contracted to perform external review services or the Trust Fund Office shall monitor that the third party administrator (TPA) referred as soon as practicable, on a rotating basis, the request for external review to one of the IROs with whom the third party administrator has contracted to perform external review services. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. Once the claim is assigned to an IRO, the following procedure will apply to the IRO and will be monitored by the Trust Fund Office or TPA:

- The assigned IRO will timely notify the claimant in writing of the request’s eligibility and acceptance for External Review, including directions about how the claimant may submit additional information regarding claimant’s claim within ten (10) business days following the date of receipt of the notice. The Trust Fund Office shall monitor to assure that IRO notifies claimant of IRO’s acceptance of claim for review and claimant’s right to submit additional information to IRO within **ten (10) business days** from receipt of notice.
- Within **five (5) business days** after the External Review is assigned to the IRO, the Trust Fund Office shall provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
- If the claimant submits additional information related to the claim to the IRO, the assigned IRO shall, within one (1) business day, forward that information to the Trust Fund Office. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the External Review. If, upon reconsideration, the Plan reverses its Adverse Determination, the Trust Fund Office shall provide written notice of the Plan’s decision to the claimant and the IRO within **one (1) business day** after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with

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

- In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including: information from the claimant's medical records; recommendations or other information from the treating (attending) health care providers; other information from the claimant or the Plan; reports from appropriate health care professionals; appropriate practice guidelines and applicable evidence-based standards; the Plan's applicable clinical review criteria unless the criteria are inconsistent with the Plan or applicable law; and/or the opinion of the IRO's clinical reviewer(s).
- The assigned IRO will provide written notice of its final External Review decision to the claimant and the Trust Fund Office within *forty-five (45) days* after the IRO receives the request for the External Review.
- The decision of the IRO is binding except to the extent that other remedies may be available under state or federal law to the Plan or claimant. If the IRO's final external review decision reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan shall immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- The assigned IRO's decision notice will contain:
  - a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code(s) and the corresponding meaning(s), treatment code(s) and the corresponding meaning(s), reason for the previous denial and denial code(s) and the corresponding meaning(s));
  - the date that the IRO received the request to conduct the External Review and the date of the IRO decision;
  - references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
  - a discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
  - a statement that the IRO's determination is binding on the Plan (unless other remedies may be available to the claimant or the Plan under applicable State or Federal law);
  - a statement that judicial review may be available to the claimant; and
  - if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
    - the Notice of Final External Review Decision must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
    - upon request the Plan shall provide a Notice of Final External Review Decision in that non-English language;



- the Notice of Final External Review Decision must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language;
- any customer assistance services provided by the Plan shall be provided in that non-English language;
- a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) claimant's rights, (2) the notice, or (3) other assistance.

## **External Review of Expedited Urgent Care Claims**

A claimant may request an expedited External Review if:

1. The claimant receives an initial adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize claimant's life or health, or would jeopardize claimant's ability to regain maximum function, and claimant has filed a request for an expedited internal appeal; or
2. The claimant receives a final adverse determination of an appeal that involves a medical condition for which the timeframe for completion of a non-urgent external review would seriously jeopardize claimant's life or health or would jeopardize claimant's ability to regain maximum function; or, the claimant receives a final adverse determination that concerns an admission, availability of care, continued stay, or health care item or service for which claimant received services for an emergency, but claimant has not yet been discharged from a facility.

Requests for external review of expedited urgent care claims should be made to the following Plan designee:

- Anthem Blue Cross with respect to a denied urgent care claim not involving retail or mail order prescription drug expenses; or
- Caremark with respect to a denied urgent care claim involving retail or mail order prescription drug expenses.

The claimant may submit written comments, documents, records or other information relating to the claim.

Contact information for the Anthem Blue Cross and Caremark is shown in the Contacts Chart.

### ***Preliminary Review of an Expedited Urgent Care Claim***

Immediately upon receipt of the request for expedited External Review, Anthem Blue Cross or Caremark will complete a preliminary review of the request for an expedited external review to determine whether the requirements for preliminary review are met (as described under Standard Non-Urgent Care claims above).

Anthem Blue Cross or Caremark will immediately notify the claimant (e.g. telephonically, via fax) as to whether claimant's request for review meets the preliminary review requirements, and if not, will provide or seek the information needed to complete the request as described under Standard Claims above.

### **Review of Expedited Claim by an Independent Review Organization (IRO)**

If Anthem Blue Cross or Caremark determines that a request is eligible for expedited External Review, Anthem Blue Cross or Caremark shall refer, on a rotating basis, a proper request for external review to an accredited Independent Review Organization (IRO) with whom they have contracted to perform external review services. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. Anthem Blue Cross or Caremark will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its initial adverse benefit determination or final adverse determination. Once the claim is assigned to an IRO, the following procedure will apply:

- The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Review of Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.
- The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- The IRO will provide notice of their final expedited External Review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than ***seventy-two (72) hours*** after the IRO receives the request for an expedited External Review. If the notice of the IRO's decision is not in writing, within ***forty-eight (48) hours*** after the date of providing that notice, the IRO must provide written confirmation of the decision to the claimant and the Plan.
- The decision of the IRO is binding except to the extent that other remedies may be available under state or federal law to the Plan or claimant. If the IRO's final External Review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

# Chapter 12: Other Important Plan Information

This chapter includes:

- Coordination of benefits with other plans
- Third party liability
- Factors that could affect your receipt of benefits
- General exclusions, limits, and reductions
- General Plan information
- Information required by ERISA

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## COORDINATION OF BENEFITS WITH OTHER PLANS

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***Note:** This section deals only with health care benefits paid directly by the Fund. If you elected Kaiser coverage instead of the Plan's comprehensive medical benefits, see the materials provided by Kaiser for information regarding how your medical benefits are coordinated.*

The benefits provided by the Fund are “coordinated” with any benefits under any other group plan that covers you or your dependents.

Coordination of benefits means that one plan pays benefits first (the primary payer) and one pays second (the secondary payer), with the combined total of benefits not to exceed 100% of the Covered Expenses incurred.

If the Fund is the primary payer, it pays its benefits first, without regard to any other plan. If the Fund is the secondary payer, it will pay the amount of covered charges not covered by the primary plan (subject to Coinsurance, Copayment, benefit maximums, and other provisions described in this booklet).

### **Covered Expenses**

- If Contract Providers are involved, the Covered Expense will not exceed whichever of the following is lowest: this Plan's contractual rate (if the provider is a Contract Provider under this Plan), the contractual rate under the other plan, or the normal charge billed by the provider for the expense.
- If Non-contract Providers are used, the Covered Expenses will not exceed Allowed Charges that are covered in whole or in part by either plan.

### **Order of Payment**

***Note:** This order of payment applies only if your other plan has a coordination-of-benefits provision. If it does not, your other plan will always be primary.*

The provisions for coordination with Medicare, Medicaid, and HMO plans are different and are explained later below. Otherwise, primary and secondary payers are as follows:

- **Employees:** A plan covering you as an active employee is primary. A plan covering you as a laid-off or retired employee is secondary, provided both plans have this rule.
- **Spouses:** The plan covering the spouse directly, as a nondependent rather than as an Employee's dependent, is the primary plan. The plan covering the spouse as a dependent is the secondary plan.
- **Children:** If the parents **are not separated or divorced**, the primary plan is usually the plan of the parent whose birthday falls earlier in the calendar year. If the other plan does not have this "birthday rule," then the rules of the other plan will determine the order of benefits.

If the parents **are separated or divorced** and two or more plans cover a child as a dependent, benefit payments are first determined in accordance with any court decree. Otherwise, the plans pay benefits for the child in the following order:

- the plan of the parent with custody pays first,
- the plan of the stepparent—the spouse of the parent with custody, if he or she has remarried—pays second, and
- the plan of the parent without custody pays last.

If none of the rules outlined here apply, the plan that has covered someone for a longer period will pay first.

## Coordination with Medicare

If an active Employee has coverage under the Plan's comprehensive medical benefits and is eligible for Medicare, the following special rules apply:

- **Employees:** If you are an active Employee covered under this Plan and you are age 65 or older, you have the option of selecting either this Plan or Medicare as your primary coverage. This Plan will automatically provide you with primary coverage unless you notify the Trust Fund Office in writing that you wish to select Medicare as your primary coverage.

If you choose to have this Plan as your primary plan, this Plan will pay its regular benefits without regard to Medicare. If you select Medicare as your primary plan, Medicare will be your **only** medical coverage. (However, your other Fund coverage will remain in effect as long as you meet the eligibility rules.)

- **Dependent spouse:** If your spouse is age 65 or older, she/he will be eligible for the same benefits as you. If you select Medicare as your primary coverage, your spouse's coverage will also be provided by Medicare. If you do not select Medicare as your primary coverage, your spouse's primary coverage will be provided under this Plan.
- **Totally Disabled participants:** If you or your dependent become Totally Disabled, as determined by the Social Security Administration, and you are eligible for Medicare, this Plan will still be primary.
- **Participants with End-Stage Renal Disease:** If you or any of your covered dependents become eligible for Medicare on the basis of end-stage renal disease (ESRD) while you are an active Employee, benefits for the individual with ESRD will be coordinated with Medicare. This Plan will be the primary plan and Medicare will be secondary for 30 months in most cases; after that, Medicare will be primary. The 30 months begin the month in which Medicare ESRD coverage begins.

## Coordination with Medicaid

Payments by this Plan will be made in compliance with any assignment of rights as required by California's (or any other state's) plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

If the state has paid for medical assistance under Medicaid in any case where this Plan has a legal liability to make payment for such assistance, payment for the benefits will be made in accordance with any state law giving the state rights to such payment with respect to an Eligible Individual. The Plan's reimbursement to the state will be for the amount of Plan benefits or the amount actually paid, whichever is less. The Plan will not pay benefits in such a case for any claim submitted more than 1 year from the date expenses were incurred.

## Coordination with HMOs

If your other coverage is an HMO (or similar prepaid plan, such as an individual practice association), the HMO's benefits are typically available only if you use the HMO's providers. If you use the HMO's providers, benefits payable by the Fund will be limited to reimbursement of the standard Copayment you are required to make when you use the HMO's providers.

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## THIRD-PARTY LIABILITY

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If you or your dependent (any Eligible Individual) are injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

1. The Eligible Individual, or anyone receiving any Plan benefits as a result of the injury to the Eligible Individual, shall be required to pay to the Plan any and all proceeds whatsoever, including but not limited to proceeds designated as being for pain and suffering, received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage) arising out of any claims for money or other damages by the Eligible Individual or his or her heirs, parents, or legal guardians, or anyone else acting on his or her behalf, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. The assets so recovered shall be considered Plan assets and the recipient shall be under a fiduciary duty to pay them over to the Plan. In addition to any other remedy provided hereunder, the Plan shall be entitled to enforce this requirement by way of restitution or constructive trust, equitable lien by agreement or any other remedy permitted by law.
2. Any Eligible Individual, or anyone acting on his or her behalf, who accepts payments from the Plan, or authorizes Plan payments to be made to anyone else, or on whose behalf any benefits are paid with respect to the Eligible Individual's injuries, agrees that a present assignment of the Eligible Individual's rights against such third party is automatically made to the extent of the payments made by the Plan.
3. These rules are automatic, but the Plan may require that any Eligible Individual or his or her representative sign an Agreement to Reimburse or Assignment of Recovery in such form or on such forms as the Plan may require. If an Eligible Individual, or his or her representative, refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan, the Eligible Individual shall not be eligible for Plan benefit payments related to the injury involved. This remedy is in addition to all other remedies the Plan may have.

4. If Plan benefits are paid on behalf of an Eligible Individual and upon recovery of any proceeds from or on behalf of the third party such benefits are not reimbursed to the Plan as set forth above, then the Eligible Individual will be ineligible for any future Plan benefit payment until the Plan has withheld an amount equal to the amount which has not been reimbursed. This remedy is in addition to all other remedies the Plan may have.
5. Any Eligible Individual on whose behalf the Plan pays benefits agrees that the Plan may intervene in any legal action brought against a third party or any insurance company, including the Eligible Individual's own carrier for uninsured motorists coverage.
6. An equitable lien by agreement shall exist in favor of the Plan upon all sums of money recovered by the Eligible Individual against any third party responsible for the injuries to the eligible employee. The lien may, but is not required to, be filed with the third party, the third party's agents, or the court. The Eligible Individual, and those acting on his or her behalf, shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.
7. If an Eligible Individual settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then the Eligible Individual shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim, unless the Plan or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.
8. In addition to all other remedies the Plan may have, the Plan shall be subrogated to the rights of the Eligible Individual against the responsible third party.
9. By accepting benefits under the Plan, a Participant and any Eligible Individual on whose behalf benefits are paid, agrees as a contractual matter enforceable under state or federal law, that upon receipt of recovery from the responsible third party, the person receiving the payment shall reimburse the Plan the amount of benefits it has paid to the Eligible Individual caused by the responsible third party.

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## FACTORS THAT COULD AFFECT YOUR RECEIPT OF BENEFITS

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*Note: If you are enrolled in Kaiser, see also your Evidence of Coverage from Kaiser for information about factors that might affect your receipt of benefits.*

Certain factors could interfere with payment of benefits from the Plan (result in your disqualification or ineligibility, denial of your claim, or loss, forfeiture, or suspension of benefits you might reasonably expect). Examples of such factors include the following:

- **Failure to follow the Plan's provisions for pre-authorization or prior approval, utilization review, and referrals.** The Plan's comprehensive medical benefits require that you follow the procedures described in chapter 4 if you want to receive the maximum benefits available.
- **Failure to submit claims in a timely way.** You must submit your health care claims **within 1 year** from the date Covered Expenses were incurred. Benefits will not be allowed if you submit your claim more than 1 year after the date on which Covered Expenses were incurred. AD&D claims should be submitted within 90 days after the date of loss which is covered by the policy or as soon as reasonably possible, but no later than 1 year from the date of loss.

- **The Plan’s coordination of benefits provisions.** If you or a dependent has health care benefits under another group plan, payment of benefits by the Fund will be coordinated with payment of benefits by that other plan. See “Coordination of Benefits” earlier in this chapter for more information.
- **The Plan’s third-party payment provision.** You must reimburse the Fund for any benefits you receive for an Illness or Injury caused by a third party if you are compensated for that Illness or Injury by the third party or an insurer. See “Third Party Liability” earlier in this chapter for more information.
- **Performance of non-qualifying employment.** If you are an hourly Employee, you will not be eligible for Plan benefits during any period you perform work of the type covered by your collective bargaining agreement but performed for a non-Contributing Employer. Your hour bank will be frozen until you once again become employed with a Contributing Employer, retire, or become unemployed, and any hours remaining in your hour bank will be cancelled if you do not do so within 12 months after the hour bank is frozen.
- **Previous overpayment of benefits.** If benefits were overpaid or paid in duplicate, or if benefits were paid for a person not entitled to the benefits, the Plan may offset the overpaid amounts against future benefit payments. The Plan may also bring legal action against you or any other recipient of the inappropriate payments to collect any duplicate or overpaid benefits.
- **Failure to update your address or enrollment information.** If you move, it is your responsibility to keep the Trust Fund Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits. In addition, you must contact the Trust Fund Office regarding any changes in your family status. You will be held liable for benefit payments based on incorrect information about family members (for example, if you fail to notify the Trust Fund Office that you have divorced or an adoption has been rescinded). In addition, you may be liable for other costs incurred by the Fund as a result of the incorrect information. These costs include (but are not limited to) attorneys’ fees, administrative costs, and reasonable interest.

See also chapters 2 and 3 for information on eligibility and termination of eligibility.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Trust Fund Office at (800) 251-5013.

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## GENERAL EXCLUSIONS, LIMITS, AND REDUCTIONS

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The Fund will not provide benefits for the following:

1. Any amounts in excess of Allowed Charges or any services not considered customary and reasonable
2. Services not specifically listed in the Plan’s Rules and Regulations as covered services or (for medical benefits) those services that are not Medically Necessary (For a definition of “Medically Necessary,” see the Rules and Regulations at the end of this SPD)
3. Services for which you are not legally obligated to pay or are not charged (or would not be charged, if you did not have coverage), except services received at a non-governmental charitable research Hospital that meets all of the following criteria:
  - It is internationally known as being devoted mainly to medical research.
  - At least 10% of its yearly budget is spent on research not directly related to patient care.



- At least one-third of its gross income comes from donations or grants other than gifts or payments for patient care.
  - It accepts patients who are unable to pay.
  - Two-thirds of its patients have conditions directly related to the Hospital’s research.
4. Any work-related Injury or Illness for any Eligible Individual, including Owner-Operators, regardless of whether or not the person is actually covered by Workers’ Compensation benefits, except under the following conditions:
- The Eligible Individual must sign an agreement to diligently prosecute a claim for Workers’ Compensation benefits or for any other available occupational compensation benefits.
  - The Eligible Individual must agree to reimburse the Fund for any benefits paid by the Fund by consenting to a lien against any occupational compensation benefits received through adjudication, settlement, or otherwise.
  - The Eligible Individual must cooperate 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 occupational Injury or Illness.

*This exclusion does not apply to the life insurance, accidental death and dismemberment, or burial expense benefits.*

5. Conditions caused by or arising out of an act of war, armed invasion, or aggression
6. Conditions caused by or arising out of involvement in the commission of a felony
7. Any services provided by a local, state, or Federal government agency or Hospital or any services for which payment may be obtained from any of these agencies (other than Medi-Cal or other state programs or Medicaid), except to the extent benefits are required by Federal law to be paid by the Fund.
8. Any services and supplies in connection with Experimental or Investigational procedures (*see the Rules and Regulations at the end of this SPD for a definition of “Experimental or Investigational”*)
9. Services provided to an ineligible dependent (If you enroll a dependent that is not eligible—or fail to notify the Trust Fund Office when a dependent stops being eligible—and benefits are paid for the dependent, you will be required to reimburse the Fund)
10. Any other expense specifically limited or excluded elsewhere in this booklet

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## GENERAL PLAN INFORMATION

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### **Assignment of Benefits**

You may not sell, transfer, or otherwise dispose of benefits payable under the Plan or your right to receive Plan benefits, nor shall such benefits or rights be subject to the claims of creditors or other claimants. You may, however, direct that benefits be paid directly to a Hospital or other health care provider instead of being paid to you.

If your benefits are overpaid or the Fund pays benefits for which you receive reimbursement elsewhere, the Fund may deduct the overpaid or reimbursed amounts from future benefits due you.



### ***Right to Examinations***

The Fund has the right and opportunity to require as many examinations as reasonably necessary during the claims process (including an autopsy, unless prohibited by law). Such examinations would be at the Fund's expense.

### ***Right to Freedom from Liability for Payment***

There is no liability on the Board or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for such purpose. Any benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for payment.

### ***No Liability for Provider-Related Loss or Injury***

The Fund has no control over any diagnosis, treatment, care, or other services delivered by a health care provider, whether the provider is a Contract Provider or a Non-contract Provider, and disclaims liability for any loss or Injury caused by any provider by reason of negligence, failure to provide treatment, or otherwise.

### ***No Replacement for Workers' Compensation***

The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage under Workers' Compensation insurance laws or similar legislation.

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## **INFORMATION REQUIRED BY ERISA**

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### **Plan Facts**

<b>Name of Plan</b>	Operating Engineers Health and Welfare Trust Fund
<b>Type of Plan</b>	Employee welfare benefit plan maintained for the purpose of providing comprehensive medical, prescription drug, dental, vision care, life insurance, accidental death and dismemberment, and burial expense benefits to eligible Employees and their eligible dependents.
<b>Plan Sponsor</b>	A joint labor-management Board of Trustees
<b>IRS Employer Identification Number (EIN)</b>	94-2784001
<b>Plan Number</b>	501
<b>Plan Year</b>	The date of the end of the Plan year is December 31.
<b>Funding Medium</b>	<p>Benefits are provided from the Trust Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and are held for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.</p> <p>Health care benefits (other than HMO benefits and dental benefits) are paid directly from the Fund and are not insured by any contract of insurance. HMO benefits, life insurance, accidental death and dismemberment, and burial expense benefits are provided through carriers and are fully insured or otherwise guaranteed.</p> <p>For more information, see "Organizations Through Which Benefits Are Provided" below.</p>

<b>Source of Contributions</b>	<p>Contributions to the Plan are made by employers in accordance with their collective bargaining agreements with Operating Engineers Local Union No. 3 and by certain other employers pursuant to the provisions of the Trust Agreement. The collective bargaining agreements require contributions to the Plan at fixed rates.</p> <p>Contributions for continuing coverage after eligibility ends are made by participants in an amount determined by the Board of Trustees.</p>
<b>Plan Administrator</b>	<p>The Board of Trustees  Operating Engineers Health and Welfare Trust Fund  1640 South Loop Road  Alameda, CA 94502  P.O. Box 23190  Oakland, CA 94623-0190  Telephone: (510) 433-4422 or (510) 271-0222</p> <p>Names and addresses of the Trustees as of the date this booklet was issued are shown later in this section.</p>
<b>Agent for Service of Legal Process</b>	<p>Greg Trento  Operating Engineers Health and Welfare Trust Fund  1640 South Loop Road  Alameda, CA 94502  P.O. Box 23190  Oakland, CA 94623-0190  Telephone: (510) 433-4422 or (510) 271-0222</p> <p>Service of legal process may also be made upon a Fund trustee or the Board of Trustees.</p>
<b>Discretionary Authority of the Board of Trustees</b>	<p>The Board of Trustees is responsible for the operation of the Fund and has full power to interpret the Plan and all Plan documents, agreements, rules and regulations and to decide all questions concerning the Plan.</p>

## Administration of the Plan

The Plan is administered and maintained by a joint labor-management Board of Trustees, with the assistance of a contract Fund administrator. The Fund administrator and the address of the administrative office are as follows:

Associated Third Party Administrators (ATPA)  
Operating Engineers Health and Welfare Trust Fund  
1640 South Loop Road  
Alameda, CA 94502  
P.O. Box 23190  
Oakland, CA 94623-0190  
Telephone: (510) 433-4422 or (510) 271-0222

The Fund administrator's office is staffed with persons competent in the fields of accounting, data processing, and claims processing. The Fund administrator bills all participating employers monthly, receives the employer contributions, maintains complete financial records, produces a monthly financial statement, maintains work records and eligibility records, and receives claims.

## Board of Trustees

The names and addresses of the Trustees as of the date of this booklet are listed below:

### Employee Trustees

Russell E. Burns, Co-Chairman  
Operating Engineers Local Union No. 3  
1620 South Loop Road  
Alameda, CA 94502

Justin Diston  
Operating Engineers Local Union No. 3  
1958 W.N. Temple  
Salt Lake City, UT 94116

Pete Figueiredo  
1620 South Loop Road  
Alameda, CA 94502

Carl Goff  
Operating Engineers Local Union No. 3  
1620 South Loop Road  
Alameda, CA 94502

Steve Harris  
Operating Engineers Local Union No. 3  
325 Digital Drive  
Morgan Hill, CA 95037

Fred Herschbach  
Operating Engineers Local Union No. 3,  
1620 South Loop Road  
Alameda, CA 94502

Ken Oku  
Operating Engineers Local Union No. 3  
828 Mahler Road, Suite B  
Burlingame, CA 94010

Dan Reding  
Operating Engineers Local Union No. 3  
1620 South Loop Road  
Alameda, CA 94502

### Employer Trustees

F. G. Crosthwaite, Co-Chairman  
PO Box 6531  
Folsom, CA 95763-6531

Kevin Albanese  
Joseph J. Albanese, Inc.  
986 Walsh Avenue  
Santa Clara, CA 95050

John Anderson  
Bay Cities Crane & Rigging/Bragg Crane  
Service  
457 Parr Blvd.  
Richmond, CA 94801

Jeffrey Clyde  
W.W. Clyde & Company  
P.O. Box 350  
375 North Main  
Springville, UT 84663

Michael Ghilotti  
Ghilotti Bros, Inc.  
525 Jacoby Street  
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Michael J. Vlaming  
Crane Owners' Association, Inc.  
447 Georgia Street  
Vallejo, CA 94590

**Your Rights Under ERISA**

As a participant in the Plan of the Operating Engineers Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

***Receive Information About Your Plan and Benefits***

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

***Continue Group Health Plan Coverage***

You also have the right to:

- Continue health care coverage for yourself, your spouse, or your dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. Your dependents may have

to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - you lose coverage under the plan,
  - you become entitled to elect COBRA continuation coverage, or
  - your COBRA continuation coverage ceases,

You may also request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### ***Prudent Actions by Plan Fiduciaries***

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### ***Enforce Your Rights***

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted the Plan’s internal claim appeal and external review process. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### ***Assistance With Your Questions***

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the

Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory.

Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquiries  
 Employee Benefits Security Administration  
 U.S. Department of Labor  
 200 Constitution Avenue N.W.  
 Washington, D.C. 20210

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at (866) 444-3272 or contacting the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the website of EBSA at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

***Organizations Through Which Benefits Are Provided or Administered***

<p><b>American Imaging Management, Inc.</b>        8600 West Bryn Mawr Ave.        South Tower, Suite 800        Chicago, IL 60631</p> <p>Administers diagnostic imaging pre-authorization program for comprehensive medical benefits; does not insure or guarantee payment of medical benefits, which are self-funded by the Trust Fund.</p>	<p><b>Anthem Blue Cross</b>        21555 Oxnard Street        Woodland Hills, CA 91367</p> <p>Administers Preferred Provider Organization and utilization review programs for comprehensive medical benefits; does not insure or guarantee payment of medical benefits, which are self-funded by the Trust Fund.</p>
<p><b>Assistance Recovery Program</b>        1620 South Loop Road        Alameda, CA 94502</p> <p>Administers the chemical dependency treatment benefits; does not guarantee payment of these benefits. Benefits are self-funded by the Trust Fund.</p>	<p><b>CVS Caremark</b>        2211 Sanders Road        Northbrook, IL 60062</p> <p>Administers the prescription drug plan; does not insure or guarantee payment of prescription drug benefits. Benefits are self-funded by the Trust Fund.</p>
<p><b>Delta Dental Plan of California</b>        100 First Street        San Francisco, CA 94105</p> <p>Insures and administers dental and orthodontic benefits, with guaranteed payment of those benefits.</p>	<p><b>Health Dynamics</b>        111 E. Wisconsin Avenue, Suite 2000        Milwaukee, WI 53202</p> <p>Administers a preventive care program providing health screening for Employees and spouses in the comprehensive medical plan. Benefits are self-funded by the Trust Fund.</p>
<p><b>HearPO</b>        5000 Chesire Lane North, Dept. A-1        Plymouth, MN 55446</p> <p>Provides discounted Contract Provider prices for hearing aids and testing services; does not insure or guarantee payment of hearing aid benefits. Benefits are self-funded by the Trust Fund.</p>	<p><b>Kaiser Foundation Health Plan</b>        Northern California Region        1950 Franklin Street        Oakland, CA 94612</p> <p>Provides prepaid medical and prescription drug benefits, with guaranteed payment of those benefits.</p>

<p><b>ReliaStar Life Insurance Company</b>  P.O. Box 20  Minneapolis, MN 55440</p> <p>Insures the life insurance and accidental death and dismemberment benefits, with guaranteed payment of those benefits.</p>	<p><b>Union Labor Life Insurance Company</b>  111 Massachusetts Avenue, N.W.  Washington, DC 20001</p> <p>Insures the burial expense benefit.</p>
<p><b>Vision Service Plan</b>  3333 Quality Drive  Rancho Cordova, CA 95670</p> <p>Administers vision plan; does not guarantee payment of benefits. Benefits are self-funded by the Trust Fund.</p>	

**Trust Fund Consultants**

In accordance with prudent management standards, the following professional consultants are retained by the Fund to assist the Board of Trustees and the Fund administrator in the operation of the Fund:

- A benefit plans consultant, who assists the Board of Trustees in technical matters relating to the operations of the Fund, such as the design of benefit programs and eligibility provisions, analysis of emerging loss experience and projections of anticipated benefit costs, preparation of specifications for competitive bids when necessary, etc.
- A Certified Public Accountant, who is responsible for auditing the records of the Trust Fund.
- Co-Counsel, who assist and counsel the Board of Trustees on all legal matters, including interpretations of the many laws and regulations under which the Trust Fund operates.

**Authority**

Although the Trustees, Union representatives, and other persons familiar with the Plan may be able to answer certain questions for you, the Plan cannot be bound to any inaccurate information they may give. At the direction of the Board of Trustees, the Trust Fund Office is authorized to give you answers to your questions, but only if you have furnished in writing full and accurate information concerning your situation. If you wish to be certain of your right to any particular benefit, contact the Trust Fund Office and obtain written confirmation of the right with which you are concerned.

Only the Board of Trustees is authorized to interpret the plan of benefits described in this booklet. No employer or local union or any representative of an employer or union is authorized to interpret this Plan on behalf of the Board.

Any dispute as to eligibility, type, amount, or duration of benefits or any right or claim to payments from the Fund shall be resolved by the Board or its duly authorized designee in accordance with the Plan Rules and Regulations and the Trust Agreement. Any decisions will be binding on all parties, subject only to such judicial review as may be in harmony with Federal labor law.

See “Claims and Appeals Procedures” earlier in this chapter for information on what to do if you disagree with the decision made in regard to a claim you have filed.

**Plan Documents**

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Trust Fund Office during regular business hours. Upon written request, copies of these documents will be provided.

The Trustees may make a reasonable charge for the copies. The Fund administrator will state the charge for specific documents on request, so you may know the cost before ordering.

### **Collective Bargaining Agreements**

This program is maintained pursuant to collective bargaining agreements between Local Union No. 3 Operating Engineers and the employers who are parties to these bargaining agreements. A copy of the bargaining agreements may be obtained by making written request to the Trust Fund Office, and the agreements are available for inspection at the Trust Fund Office. A copy of any of the collective bargaining agreements will also be available for inspection within 10 calendar days after written request at any of the local union offices or at the office of any Contributing Employer to which at least 50 Plan participants report each day.

### **Plan Amendment or Termination**

In furtherance of its commitment to provide benefits to Employees, the Board reserves the right, solely at its discretion, to amend the Plan at any time.

This right includes, but is not limited to:

- the right to terminate or change Covered Expenses, benefit payments and Coinsurance or Copayment amounts, deductibles and annual maximums,
- the right to alter or postpone the method of payment of any benefit, and
- the right to change the Plan to implement various cost control measures.

Such termination or amendment may affect the amount of any benefit payable for charges incurred before the effective date of such changes or termination.

In the event the Trust Fund is terminated, all assets remaining in the Trust Fund, after payment of expenses, will be used to continue the benefits provided by the then-existing benefit plans, until such assets have been exhausted.





**OPERATING ENGINEERS HEALTH  
AND WELFARE TRUST FUND**

**Rules and Regulations**

Amended and Restated Effective January 1, 2012

(Includes Through Amendment No. 16)



# Operating Engineers Health and Welfare Trust Fund

## Rules and Regulations

Amended and Restated Effective January 1, 2012

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## ARTICLE 1. DEFINITIONS

Unless the context or subject matter otherwise requires, the following definitions will govern in these Rules and Regulations:

**Section 1.01. “Allowed Charge”** means the lesser of:

- a. The dollar amount this Plan has determined it will allow for covered Medically Necessary services or supplies provided by Non-Contract Providers as determined by the Plan’s Preferred Provider Organization based on appropriate and reasonable charges for the services in the geographical area where the services are provided. With respect to Non-Contract Hospitals or Facilities within the Contract Provider Service Area for other than an Emergency Medical Condition, the allowed charge will be the same as the Schedule of Allowances defined in Section 1.54. The Plan’s Allowed Charge is not based on or intended to be reflective of fees that have traditionally been described as usual and customary (U&C), usual, customary and reasonable (UCR) or any other traditional term. Non-Contract Providers’ bills often exceed the Plan’s Allowed Charge, and in such cases the Plan’s benefits will be based on the Allowed Charge not the Non-Contract Providers billed rate. In cases of an Emergency Medical Condition, or when the Patient has not had a reasonable opportunity to select a Contract Provider, the Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the Allowed Charge for the submitted claim. When using Non-Contract Providers, the Eligible Individual is responsible for any difference between the actual billed charge and the Plan’s Allowed Charge, in addition to any Copayment and percentage coinsurance required by the Plan.
- b. The Non-Contract Provider’s actual billed charge.

**Section 1.02. “Ambulatory Surgery Facility”** means a health facility that is accredited by the *Accreditation Association for Ambulatory Health Care*.

**Section 1.03. “Assistance Recovery Program (ARP)”** means that program adopted by the Fund which coordinates and authorizes services for the treatment of substance abuse for Eligible Employees and Dependent Spouses.

**Section 1.04. “Board”** means the Board of Trustees of the Operating Engineers Health and Welfare Trust Fund.

**Section 1.05. “Coinsurance”** means the arrangement by which the Participant and the Fund share expenses covered by the Plan.

**Section 1.06. “Concurrent Review”** means the process whereby the Professional Review Organization (PRO) determines the number of authorized days considered Medically Necessary and which are eligible for unreduced benefit coverage according to the terms of the Plan. This occurs after an Eligible Individual has been admitted to a Hospital.

**Section 1.07. “Contract Hospital”** means a Hospital that has a contract in effect with the Fund’s Preferred Provider Organization.

**Section 1.08. “Contract Facility”** means a health care facility or substance abuse treatment facility that has a contract in effect with the Fund’s Preferred Provider Organization.

**Section 1.09. “Contract Physician”** means a Physician who has a contract in effect with the Fund’s Preferred Provider Organization.

**Section 1.10. “Contract Provider”** means any Hospital, facility, Physician or other health care provider that has a contract in effect with the Fund’s Preferred Provider Organization.

**Section 1.11. “Contract Provider Service Area”** means the geographic area that is within 30 miles of a Contract Provider.

**Section 1.12. “Contributing Employer”** or “Employer”. See Section 2.01.

**Section 1.13. “Copayment”** means the amount the Eligible Individual is required to pay for a service, supply, or prescription Drug before the Plan pays its share of the cost.

**Section 1.14. “Covered Expense(s)”** means charges that do not exceed the Plan’s Allowed Charge in the case of Non-Contract Providers, or which are the negotiated charge for Contract Providers, and that are made for the Medically Necessary care and treatment of a non-occupational Illness or Injury, except that certain preventive care services are considered Covered Expenses when specifically provided by the Plan. Covered Expenses include only those charges incurred by an Eligible Individual while eligible for benefits under this Plan..

**Section 1.15. “Custodial”** care means treatment, services, or confinement that could be rendered safely and reasonably by a person not medically skilled and that is designed mainly to help the Patient with activities of daily life. Custodial care includes personal care, homemaking services, moving the Patient, acting as companion or sitter, or supervising medication that Patients can usually administer themselves.

**Section 1.16. “Dentist”** means a dentist licensed to practice dentistry in the state in which he provides treatment.

**Section 1.17. “Dependent”** means:

- a. The Employee’s lawful Spouse; and
- b. A child who is:
  - (1) the Employee’s natural child, stepchild or legally adopted child, or a child of the Employee required to be covered under a Qualified Medical Child Support Order, who is younger than 26 years of age, whether married or unmarried. Adopted children are eligible under the Plan when they are placed for adoption.;
  - (2) an unmarried child younger than 26 years of age for whom the Employee has been appointed legal guardian, provided the child is considered the Employee’s dependent for federal income tax purposes; or
  - (3) an unmarried child of the Employee (or the Employee’s spouse) by birth, adoption or legal guardianship who is older than 26 years of age and incapable of self-supporting employment because of total and permanent disability, provided the child became so disabled before reaching age 26 and while eligible under this Plan or under any other

multiemployer health and welfare plan maintained by Operating Engineers Local No. 3, and provided the child is considered the Employee's dependent for federal income tax purposes. Written evidence of the individual's incapacity must be provided to the Plan within 31 days after the individual attains age 26, and within 31 days after any other time the Plan requests such evidence.

- c. A spouse or child of a Dependent child is not eligible for coverage under the Plan.
- d. In accordance with ERISA Section 609(a)(2)(A), the Plan will provide coverage for an Employee's child under 26 years of age if required by a Qualified Medical Child Support Order, including a National Medical Support Order.
- e. Children of the Employee's qualified Domestic Partner are eligible in accordance with Subsection 2.02.a.(5).

**Section 1.18. "Drug(s)"** means any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

**Section 1.19. "Eligible Individual"** means each eligible Employee and each of his eligible Dependents, if any.

**Section 1.20. "Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or of her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Fund Office or its designee has the discretion and authority to determine if a treatment, service or supply is or should be classified as treatment of an Emergency Medical Condition.

**Section 1.21. "Employee"** means each person who meets the eligibility rules set forth in Section 2.02.

**Section 1.22. "Employer" or "Contributing Employer"**. See Section 2.01.

**Section 1.23. "Experimental or Investigational"**. See Section 11.01.h.

**Section 1.24. "Fund" and "Plan"** means the Operating Engineers Health and Welfare Trust Fund.

**Section 1.25. "Generic Drug"**. See Section 4.02

**Section 1.26. "Group Plan"** means any Plan providing benefits of the type provided by this Plan which is supported wholly or in part by employer payments.

**Section 1.27. “Hospital”** means an acute care hospital which is licensed under any applicable state statute and must provide: (a) 24-hour inpatient care, and (b) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. 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 treatment.

**Section 1.28. “Hour Bank”.** See Section 2.01.

**Section 1.29. “Illness(es)”** means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes. For purposes of this Plan, pregnancy is considered an Illness for an Employee and Dependent Spouse only.

**Section 1.30. “Injury(ies)”** means physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

**Section 1.31. “Licensed Pharmacist”** means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

**Section 1.32. “Medically Necessary”** with respect to services and supplies received for treatment of an Illness or Injury means those services or supplies determined to be:

- a. Appropriate and necessary for the symptoms, diagnosis or treatment of the Illness or Injury, and
- b. Provided for the diagnosis or direct care and treatment of the Illness or Injury, and
- c. Within standards of good medical practice within the organized medical community, and
- d. Not primarily for the personal comfort or convenience of the Patient, the Patient’s family, any person who cares for the Patient, any health care practitioner, or any Hospital or specialized health care facility. The fact that a Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered Medically Necessary for the medical coverage provided by the Plan, and
- e. The most appropriate supply or level of service which can safely be provided. For Hospital confinement, this means that acute care as a bed patient is needed due to the kind of services the Patient is receiving or the severity of the Patient’s condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

**Section 1.33. “Medicare”** means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

**Section 1.34. “Non-Contract Hospital”** means a Hospital which does not have a contract in effect with the Fund’s Preferred Provider Organization.

**Section 1.35. “Non-Contract Facility”** means a health care facility or substance treatment facility that does not have a contract in effect with the Fund’s Preferred Provider Organization.



**Section 1.36. “Non-Contract Physician”** means a Physician who does not have a contract in effect with the Fund’s Preferred Provider Organization.

**Section 1.37. “Non-Contract Provider”** means a Hospital, Facility, Physician or other health care provider that does not have a contract in effect with the Fund’s Preferred Provider Organization.

**Section 1.38. “Non-Participating Pharmacy”**. See Section 4.02.

**Section 1.39. “Non-Qualifying Employment”**. See Section 2.01.

**Section 1.40. “Outpatient Services Review”** means the process whereby the Professional Review Organization (PRO) under contract to the Fund determines the medical necessity of services performed and the most cost effective choice of treatment, setting and procedures when provided on an outpatient basis, prior to or after the date services occur.

**Section 1.41. “Owner-Operator”**. See Section 2.01.

**Section 1.42. “Participating Pharmacy”**. See Section 4.02.

**Section 1.43. “Patient”** means that Eligible Individual who is receiving medical treatment, services, or supplies covered by the Plan.

**Section 1.44. “Physician”** means a physician (M.D.), an Osteopath (D.O.), or a Dentist (D.D.S. or D.M.D.) licensed to practice medicine in the state in which he practices.

**Section 1.45. “Plan”** means the Rules and Regulations of the Operating Engineers Health and Welfare Trust Fund, including any amendments.

**Section 1.46. “Plan A”** means the Plan of benefits available to Employees who are employed by Employers who are subject to a Collective Bargaining Agreement requiring contributions to provide Plan A benefits.

**Section 1.47. “Pre-admission Review”** and **“Pre-admission Certification”** means the process whereby the Professional Review Organization (PRO) determines the Medical Necessity of an Eligible Individual’s confinement in a Hospital, and if Medically Necessary, the number of pre-authorized days eligible for unreduced benefit coverage according to the terms of the Plan, *prior* to the Hospital confinement.

**Section 1.48. “Pre-existing Medical Condition”** means an Illness or Injury for which the Eligible Individual received medical advice or treatment during the 6 month period prior to becoming eligible for Plan benefits. The Illness or Injury will no longer be considered a Pre-existing Medical Condition after 12 consecutive months of eligibility under this Plan. Any period of coverage under a prior health plan can be used to reduce the 12-month limitation period under this Plan, provided there is not a break in coverage of 63 days or more between the prior health plan coverage and the date of initial eligibility under this Plan.

**Section 1.49. “Preferred Brand Name Drug.”** See Section 4.02.

**Section 1.50. “Preferred Provider Organization (PPO)”** means the entity under contract with the Fund that is responsible for negotiating contracts with Hospitals, Physicians, facilities

and other health care providers who agree to provide hospital and medical services to Eligible Individuals on the basis of negotiated rates.

**Section 1.51. “Professional Review Organization (PRO)”** means an organization, under contract to the Fund, which is responsible for determining:

- a. whether the confinement of an Eligible Individual in a Hospital is Medically Necessary, and if Medically Necessary, the number of Medically Necessary days for the confinement; or
- b. whether the services prescribed for the care and treatment of an Eligible Individual’s Illness or Injury are Medically Necessary, and if Medically Necessary, to determine the customary course of treatment.

The sole purpose of the review is to determine whether an Eligible Individual is eligible to receive unreduced benefit coverage according to the terms of the Plan.

**Section 1.52. “Reciprocity Agreement”** means the agreement which establishes the administrative procedures for reciprocity between the funds signatory to the Western Conference of Operating Engineers Health and Welfare Reciprocity Agreement, including any amendment, extension or renewal of that Agreement.

**Section 1.53. “Retired Employee”** means a person receiving a pension from the Pension Trust Fund for Operating Engineers. A person who continues to be an Employee after attaining age 70 1/2 and who is receiving a pension as required by IRC Section 401(a)(9)(c), will not be considered a Retired Employee until he no longer meets the requirements of Section 2.02.a.

**Section 1.54. “Schedule of Allowances”** applicable to Non-Contract Hospitals or Facilities within the Contract Provider Service Area, means the negotiated contract rate of the Contract Hospital or Facility that is geographically nearest to the Hospital or Facility where treatment was received.

**Section 1.55. “Skilled Nursing Facility”** means an institution which (1) provides skilled nursing care under 24 hour supervision of a Physician or graduate Registered Nurse, (2) has available at all time the services of a Physician who is a staff member of a hospital, (3) provides 24 hour a day nursing service by a graduate Registered Nurse, Licensed Vocational Nurse or skilled practical nurse and has a graduate Registered Nurse on duty at least 8 hours per day, (4) maintains a daily medical record for each Patient, (5) is not a place for rest, custodial care, for the aged, for drug addicts or alcoholics, nor is a hotel or similar institution.

**Section 1.56. “Spouse”** means the legal spouse of the Participant, or when eligible according to the rules of the Plan, the Domestic Partner of the Participant.

**Section 1.57. “Trust Agreement”** means the Trust Agreement establishing the Operating Engineers Health and Welfare Trust Fund, including any amendment, extension or renewal of that Agreement.

**Section 1.58. “Union”**. See Section 2.01.

**Section 1.59. “Utilization Review (UR) Program”** means a program whereby an Eligible Individual who is scheduled for confinement in a Hospital on a non-Emergency Medical Condition basis must obtain Pre-admission Review and Concurrent Review from the Professional Review Organization (PRO) as to the Medical Necessity of that confinement in order to receive unreduced benefit from the Plan. For Emergency Medical Condition confinements, the review must be obtained retrospectively.

## **ARTICLE 2. ELIGIBILITY FOR BENEFITS**

**Section 2.01. Definitions.** The following definitions will govern in this Article:

- a. The term “Contributing Employer” or “Employer” means any employer who is required by a collective bargaining agreement to make payments into the Fund, or by an Agreement to Train Apprentices to make payments into the Fund, and who does in fact make one or more payments into the Fund. The term “Contributing Employer” also includes the Union, a Joint Labor-Management Fund or Joint Apprenticeship Committee or Committees on which the Union is represented and the Operating Engineers Local Union No. 3 Credit Union, provided that any of these entities will be a Contributing Employer solely for the purpose of making payments with respect to the work of its Employees and will have no other rights or privileges under this Trust Agreement as a Contributing Employer.
- b. The term “Union” means Operating Engineers Local Union No. 3 of the International Union of Operating Engineers, a labor organization as defined in the Labor-Management Relations Act, 1947 (29 U.S.C. § 141 et seq.).
- c. The term “Hour Bank” means the account established for an Employee to which are credited hours for which contributions are made by Contributing Employers, or are required to be made to the Fund with respect to that Employee’s work.
- d. The term “Non-Qualifying Employment” means work for a non-contributing employer of the type covered by the collective bargaining agreement under which an Hour Bank was earned.
- e. The term “Owner-Operator” means a person who is not in the employ of a Contributing Employer, but who is signatory to an approved Owner-Operator Subscriber Agreement with the Operating Engineers Local Union Number 3 requiring flat rate contributions to this Fund, and is a dues paying member or service fees payor of the Union.

**Section 2.02. Eligibility Rules.**

a. **Establishment and Maintenance of Eligibility.**

- (1) A person who is an employee of one or more Employers with respect to whose work contributions are required to be made to the Fund by a collective bargaining agreement or a subscriber’s agreement for the maintenance of a health and welfare plan will become eligible for Plan benefits on the first day of the calendar month which follows a period of not more than 3 calendar months during which he had reported at least 360 hours for one or more Employers. Once eligibility is established, an Employee’s eligibility will continue during any subsequent month for which the appropriate deduction is made from his Hour Bank.
- (2) A person who is an Owner-Operator, who is not eligible as a result of employment with an Employer, will be eligible for Plan benefits on the first day of the calendar month following receipt of his required contribution in the amount determined by the Board, subject to the following:

- (a) The Owner-Operator must have executed an Owner-Operator Subscriber Agreement and satisfied all additional participation rules contained in the Owner-Operator Subscriber Agreement.
  - (b) Benefits for any Pre-existing Medical Condition of the Owner-Operator or his Dependent are limited to a maximum of \$2,000 per person during the first 12 consecutive months of eligibility under the Plan. Any period of coverage under a prior health plan will be used to reduce the 12-month limitation period under this Plan, provided there is not a break in coverage of 63 days or more between the prior health plan coverage and the date of initial eligibility under this Plan. However, this Pre-existing Medical Condition limitation does not apply to any Eligible Individual who is under 19 years of age
  - (c) Owner-Operator contributions do not provide an Hour Bank accumulation.
- (3) A person who is an Employee of an Employer (including a non-bargaining unit office Employee or a company officer) for whom contributions are made by the Employer at a monthly flat rate, as determined by the Board, will be eligible for Plan benefits on the first day of the month following 3 consecutive months for which contributions are made to the Fund, subject to the following:
- (a) Benefits for any Pre-existing Medical Condition of a non-bargaining unit office Employee, a company officer, or a Dependent of either, are limited to a maximum of \$2,000 during the first 12 consecutive months of eligibility under the Plan. Any period of coverage under a prior health plan will be used to reduce the 12-month limitation period under this Plan, provided there is not a break in coverage of 63 days or more between the prior health plan coverage and the date of initial eligibility under this Plan. However, this Pre-existing Medical Condition limitation does not apply to any Eligible Individual who is under 19 years of age
  - (b) Monthly flat rate contributions do not provide an Hour Bank accumulation.
- (4) An Employee's Dependent will be eligible for Plan benefits on the date the Employee becomes eligible or on the date the person becomes a Dependent, whichever is later.
- (5) Qualified Domestic Partners of eligible Employees whose Individual Employers are required by law to provide Domestic Partner health coverage are eligible to enroll in the Plan provided the Employee remits the required tax payments to the Fund. Children of qualified Domestic Partners are eligible provided they meet the Plan's eligibility requirements for Dependent Children. A Domestic Partner and child(ren) of the Domestic Partner will remain eligible only so long as the Employee's Individual Employer is legally obligated to provide Domestic Partner health coverage and the required taxes are paid. An Employee who voluntarily elects to discontinue coverage for his Domestic Partner, or who fails to submit the required tax payment to the Fund timely, will not be eligible to re-enroll that Domestic Partner in the Plan until the Employee's next open enrollment period.

The term “Domestic Partner” means a person who resides with the Employee in the same residence, is at least 18 years of age and whose relationship with the Employee meets the following requirements:

- (a) The Domestic Partner and the Employee have a committed relationship of mutual care and are each other’s sole Domestic Partner,
- (b) The Domestic Partner and the Employee share joint responsibility for each other’s common welfare and financial obligations and can submit proof of that relationship as required by the Board of Trustees;
- (c) Neither the Domestic Partner nor the Employee is married;
- (d) The Domestic Partner and Employee are each competent to contract;
- (e) The Domestic Partner and Employee are not related by blood closer than would prohibit legal marriage in the State of California;
- (f) Any prior domestic partnership of either person has been terminated not less than 6 months prior to the date of the signing of the final declaration of domestic partnership with the Trust Fund Office; and
- (g) Application for domestic partnership with the Employee is properly made as required by the Board of Trustees.

**b. Hour Bank Deductions.**

- (1) 120 hours are deducted from the Employee’s Hour Bank for each month of eligibility. A lag month will exist between the month in which the hours are worked and the month of eligibility provided by those hours; therefore, hours worked in a month provide eligibility for the second month following the month in which the hours were worked.
  - (a) Exception for Employees Eligible as of December 31, 2009. 110 hours will be deducted from the Employee’s Hour Bank for each month of eligibility until the earlier of: July 1, 2010 or the date the Employee’s Hour Bank drops below 110 hours.
  - (b) An Employee eligible on December 31, 2009 who loses eligibility prior to July 1, 2010 will have 120 hours deducted from his Hour Bank for each month of eligibility after his eligibility has been reinstated in accordance with Section 2.02.d.
- (2) Hour Bank Maximum. The maximum hours in an Employee’s Hour Bank after deducting 120 hours for the current month’s eligibility is: 1320 hours for an Employee who established initial eligibility prior to July 1, 1992; or 990 hours for an Employee who re-establishes eligibility or becomes initially eligible on or after July 1, 1992.

- (3) Bank hours cannot be used to extend coverage for periods in which an Employee is working in Non-Qualifying Employment.

**c. Termination of Eligibility.**

- (1) Except as provided in Section 2.02.e., an Employee's eligibility will terminate on the earliest of the following dates:
  - (a) The first day of the month following exhaustion of coverage provided by his Hour Bank; or
  - (b) The first day of the month in which the Employee becomes a Retired Employee. Any hours remaining in the Employee's hour bank on the date he retires will be used to provide coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund. Until July 1, 2010, 110 hours will be deducted from the hour bank for each month of eligibility under the Pensioned Operating Engineers Health and Welfare Trust Fund. After July 1, 2010, 120 hours will be deducted for each month of eligibility under that plan.
  - (c) For Owner-Operators, the first day of the month for which the required contribution is not paid.
  - (d) For Employees for whom contributions are made on a monthly flat rate basis, the first day of the fourth month following the month for which the last contribution was made on the Employee's behalf.
- (2) The eligibility of a Dependent will terminate on the earlier of the following dates:
  - (a) On the date the Employee's eligibility terminates or, in the event of the death of the Employee, on the date his eligibility would have terminated but for his death; or
  - (b) On the last day of the month in which the individual no longer qualifies as a Dependent.
- (3) Exception to Termination of Eligibility for Dependent Students. A Dependent child 19 years of age or older whose eligibility is based on student status will continue to be eligible during a Medically Necessary leave of absence from school, subject to the following:
  - (a) Eligibility will continue for up to 12 months or until eligibility would otherwise terminate under the Plan's eligibility rules, whichever comes first.
  - (b) Eligibility will terminate before 12 months on the date the Medical Necessity for the leave no longer exists
  - (c) The Dependent or Participant must submit documentation to the Fund Office, including a Physician's certification of the medical necessity for the leave. The certification form must be submitted to the Fund Office at least 30 days prior to the medical leave of absence if it is foreseeable, or 30 days after the start of the leave of absence in any other case.

- (d) If eligibility is extended under this provision for a child who is no longer eligible for tax-free health coverage, the Participant parent of the Dependent may be required to certify in writing to the Plan as to the child's tax status.

**d. Reinstatement of Eligibility of an Employee with an Hour Bank.**

- (1) If the eligibility of an employee with an Hour Bank has terminated, his eligibility will be reinstated on the first day of the second calendar month after his Hour Bank is credited with a total of at least 120 hours, provided the required number of hours were accumulated within the 12-month period immediately following the termination of his previous eligibility.
- (2) An Employee with an Hour Bank who fails to reinstate his eligibility in accordance with paragraph (1) will again become eligible upon meeting the requirements of Subsection 2.02.a.(1).

**e. Extended Coverage by Self-Payment – For Bargaining Unit Employees Only.** Except as described in Subsection f., an Employee whose eligibility terminates may continue coverage for himself and his Dependents for up to 3 months, provided he makes the required monthly payments to the Fund, in the amount determined by the Board, in accordance with the following rules:

- (1) The first monthly payment must be made during the month eligibility is lost, by the date stated in the self payment notice provided by the Fund; and
- (2) Payments must be continuous for so long as the person is otherwise ineligible; and
- (3) Each monthly payment must be made by the 15th day of the month for which coverage is desired.
- (4) At the end of the 3 month period, an Employee may elect to extend coverage through the COBRA provisions of the Plan as outlined in Article 9.
- (5) The Fund assumes no responsibility for an Employee's failure to take timely advantage of this Self Payment provision.

**f. Freezing of Hour Bank.** An Employee may not use his Hour Bank to extend coverage while he performs Non-Qualifying Employment. During periods of Non-Qualifying employment, the Hour Bank will be frozen until the Employee once again becomes employed by a Contributing Employer, retires or becomes unemployed. If the Employee does not become employed with a Contributing Employer, retire or become unemployed within 12 months after the freezing of his Hour Bank, the Hour Bank will be cancelled. An Employee whose eligibility terminates due to the cancellation of his Hour Bank may not extend coverage by making self-payments, as provided in Subsection e.



- g. **Military Service.** An Employee who enters military service with the Uniformed Services of the United States may continue his eligibility under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, provided he was eligible under the Plan when the military service began. The term “Uniformed Services” means the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.
- (1) An Employee whose period of military service is less than 31 days will have his eligibility continued during the period of military service with no self-payment.
  - (2) An Employee whose period of military service is 31 days or more may continue his eligibility by self-payment for up to 18 months, as described in Article 9. COBRA Continuation Coverage. Participants whose continuation period begins on and after December 10, 2004 may continue 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.
  - (3) If the Employee elects to use any accumulated hour bank eligibility for coverage during the leave, no charge will be made for that period of eligibility provided by his hour bank.
  - (4) If an Employee elects to self-pay for coverage or elects to not be covered by the Fund during the military leave, his hour bank will be frozen.
  - (5) If the Employee returns to work or becomes available for work for a Contributing Employer within 90 days after separation from military service, he will be eligible for the balance of the calendar month in which he returns to work and for the next calendar month, provided the Employee provides written notice to the Fund Office within 14 days after separation from military service if the military service lasted 31 to 180 days or within 90 days after separation from military service if the service lasted more than 180 days. Thereafter, the Employee will be entitled to eligibility based on any accumulated hours in his frozen hour bank. Eligibility will be reinstated without exclusion or waiting period.
  - (6) No later than 60 days after the military leave begins, the Employee must notify the Fund Office in writing whether he wishes to self-pay to continue eligibility, use hour bank eligibility, or not be covered by the Fund during the military leave.
- h. **Extension of Hour Bank Upon Retirement.** The Hour Bank of an Employee who retires will be extended by 3 months provided the Employee has at least 1 month of accumulated eligibility at the time of retirement and enrolls in the Pensioned Operating Engineers Health and Welfare Trust Fund. For Employees who retire on and after January 1, 2010, the 3 months of Hour Bank eligibility added by this provision will be used to provide coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund at no cost to the Retired Employee.

**Section 2.03. Family and Medical Leave Act of 1993.** If an Employee's Employer approves taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Employee and eligible Dependents will continue to be covered under this Plan provided the Employee was eligible when the leave began and provided the Employer makes the required contributions to the Fund during the leave. It is not the role of the Fund to determine whether or not an Employee is entitled to FMLA leave with medical coverage. Any determination regarding entitlement to FMLA leave with continuing medical coverage must be made by the Employer.

**Section 2.04. Election of Coverage.**

- a. Each Employee will have the opportunity to elect the comprehensive health plan benefits provided directly by the Fund, as described in Article 3, or the coverage then being offered through any health maintenance organization (HMO) plan offered by the Fund. An Eligible Individual must live within the service area of the HMO to enroll in that plan. The health plan coverage selected by the Employee will also apply to any eligible Dependents of the Employee.
- b. An Eligible Individual who elects to be covered by an HMO will be entitled to the following benefits provided directly by the Fund as described in these rules and regulations:
  - (1) Chemical Dependency Treatment Benefits described in Article 6,
  - (2) Hearing Aid benefits described in Section 3.11,
  - (3) Vision Coverage described in Article 7, and
  - (4) Dental Benefits described in Article 8.
- c. Changes in Coverage. Eligible Individuals must remain in the health plan selected for a minimum of 12 months, unless the Employee moves out of the HMO plan's service area or a change is approved by the Board of Trustees. Each Employee may change health plans once in any 12-month period. Any change in plans will be effective on the first day of the second calendar month following the date the enrollment form is received by the Fund.

**Section 2.05. Reduced Comprehensive Health Plan Benefit Level Applicable to Employees who Work for Employers that Contribute to the Fund at Less than the Minimum Required Contribution Rate.** If an Employee's Employer makes contributions to the Fund at a rate less than the minimum contribution rate required for Plan A Comprehensive Health Plan Benefits, the Employee and his Dependents will receive the reduced level of Plan A Comprehensive Health Plan Benefits as specified in Subsections 2.05.a. or 2.05.b. The minimum Employer contribution rates required for hourly Employees and flat rate Employees are determined by the Board of Trustees and may be changed by the Board at any time in its sole discretion.

- a. Hourly Employees Benefit Reduction Schedule. If the Employer pays less than the minimum Plan A contribution rate to the Fund, the Employee and his or her Dependents will receive the following reduced level of Plan A benefits. The benefit reduction will apply if more than one-half of the total hours reported for the Employee in a month are

reported from an Employer that pays a contribution to the Fund that is less than the minimum required contribution.

<b>If Employer Hourly Contribution Rate Is:</b>	<b>Per Cent of Regular Plan A Comprehensive Health Plan Benefits Payable by the Plan:</b>
at least 95% but less than 100% of minimum required contribution rate:	95%
at least 90% but less than 95% of minimum required contribution rate:	90%
at least 85% but less than 90% of minimum required contribution rate:	85%
at least 80% but less than 85% of minimum required contribution rate:	80%
at least 75% but less than 80% of minimum required contribution rate:	75%

- b. Flat Rate Employees Benefit Reduction Schedule. If the Employer pays less than the minimum Plan A contribution rate to the Fund, the Employee and his or her Dependents will receive the following reduced level of Plan A benefits. The benefit reduction will apply for any month in which the Employee's Employer makes a contribution to the Fund that is less than the minimum required contribution.

<b>If Employer Flat Rate Monthly Contribution Rate Is:</b>	<b>Per Cent of Regular Plan A Comprehensive Health Plan Benefits Payable by the Plan:</b>
at least 95% but less than 100% of minimum required contribution rate:	95%
at least 90% but less than 95% of minimum required contribution rate:	90%
at least 85% but less than 90% of minimum required contribution rate:	85%
at least 80% but less than 85% of minimum required contribution rate:	80%
at least 75% but less than 80% of minimum required contribution rate:	75%
at least 70% but less than 75% of minimum required contribution rate:	70%

### ARTICLE 3. COMPREHENSIVE HEALTH PLAN BENEFITS

The benefits described in this Article are provided for Covered Expense incurred for Medically Necessary treatment of a non-occupational Illness or Injury. An expense is incurred on the date the Eligible Individual receives the service or supply for which the charge is made. The benefits available under this Article are subject to all other provisions of the Plan, which may limit benefits or result in benefits not being payable.

**Section 3.01. Deductible.** The Plan will not begin to pay benefits in any calendar year until the deductible amount shown in Subsection a. is satisfied. The deductible applies separately to each Eligible Individual, but no one family will be required to satisfy more than the maximum family deductible in any calendar year. The deductible is applied to each member of a family until the aggregate amount applied to some or all family members totals the maximum family deductible amount. No more than \$500 will be applied to any one individual's deductible for the calendar year.

a. Deductible Amount:

Per Eligible Individual:	\$500
Maximum Family Deductible:	\$1,500

b. Deductible Carry-Over. If Covered Expenses are incurred in the last 3 months of the calendar year and are applied to the deductible for that calendar year, they will be carried over and also applied to the deductible for the next calendar year.

c. The deductible does not apply to the following benefits:

- (1) the Employee and Spouse physical examination benefit described in Article 5;
- (2) chemical dependency treatment benefits described in Article 6;
- (3) hearing aid benefits; or
- (4) the following preventive care benefits: well child care, adult immunizations, routine mammograms and pap smears and the colorectal cancer screening benefit.

d. An Employee and/or Spouse who participates in the Health Dynamics health screening program sponsored by the Fund will each receive a \$200 credit to their deductible for 2011. If the Employee and/or Spouse already satisfied the 2011 deductible when they participated in the Health Dynamics program in 2011, the \$200 credit will be applied to the deductible for 2012. An Employee and/or Spouse who participates in the Health Dynamics program during 2012 will each receive a \$250 credit to their deductible for 2012.

**Section 3.02. Payment.** Except as otherwise specifically stated in Sections 3.03.a., 3.07, 3.08, 3.10 and 3.11, payment for Covered Expenses is provided as follows:

a. Contract Providers: 90% of the negotiated contract rate;

Non-Contract Providers Within the Contract Provider Service Area: 80% of Allowed Charge.

Non-Contract Providers Outside the Contract Provider Service Area: 90% of Allowed Charge incurred only if the Patient resides outside the Contract Provider Service Area.

- b. **Annual Out of Pocket Limit:** Each calendar year, after an Eligible Individual or family incurs the maximum out of pocket cost for Covered Expenses specified below in Subsections (1) or (2), the Plan will pay 100% of Covered Expenses incurred during the remainder of that calendar year. Only Covered Expenses paid by the Plan at less than 100% are counted toward the Out of Pocket Limit.
- (1) Contract Providers: \$5,000 per Eligible Individual, maximum of \$15,000 per family
  - (2) Non-Contract Providers: \$10,000 per Eligible Individual, maximum of \$30,000 per family
  - (3) Exceptions to Annual Out of Pocket Limit: The following expenses are not counted toward the Annual Out of Pocket Limit and are not payable at 100% after the limit is reached:
    - (a) Amounts applied to the calendar year deductible and Hospital emergency room Copayment.
    - (b) Outpatient mental health expenses.
    - (b) Chemical dependency treatment benefits payable under Article 6.
    - (c) Expenses in excess of Allowed Charges for Non-Contract Providers.
    - (d) Hearing aid expenses in excess of the Plan maximum amount specified for that benefit.
- c. Reduced Plan A Benefits Applicable to Employees Who Work for Employers that Contribute to the Fund at Less than the Minimum Required Contribution Rate. The Plan A benefit payments described in this Article 3 will be reduced for an Employee and his Dependents if the contribution paid to the Fund on behalf of the Employee is less than the minimum required contribution rate. The percentage of normal Plan A benefits payable is set forth in Section 2.05.a. for hourly Employees and in Section 2.05.b. for flat rate Employees.

### **Section 3.03. Hospital and Ambulatory Surgery Facility Benefits.**

- a. The following benefits are payable for Covered Expenses billed by a Hospital or Ambulatory Surgery Facility.
- (1) Contract Hospital or Facility: The Plan will pay 90% of the negotiated contract rates.
  - (2) Non-Contract Hospital or Facility Within the Contract Provider Service Area: The Plan will pay 90% of the Schedule of Allowances. The Schedule of Allowances is limited to the contract rate of the Contract Hospital or Facility that is nearest to the provider where the Eligible Individual received treatment.

- (3) Non-Contract Hospital or Facility Outside the Contract Provider Service Area: The Plan will pay 90% of Allowed Charges only if the Patient resides outside of the Contract Provider Service Area.
- (4) Non-Contract Hospital for Emergency Medical Condition: The Plan will pay 90% of Allowed Charges. However, the Fund may require the Eligible Individual to be transferred to a Contract Hospital upon the advice of a Physician that it is medically safe to transfer the individual and the acute Emergency period has ended. If the Eligible Individual remains in a Non-Contract Hospital after the acute Emergency period, the Fund will pay benefits in accordance with Subsection 3.03.a.(2) for the period of confinement following the acute Emergency period.
- (5) **Hospital Emergency Room Copayment**. A \$100 Copayment will be applied to each visit to a Hospital emergency room. The Copayment is in addition to the calendar year deductible. Covered Expenses in excess of the Copayment will be paid at the percentages indicated in Subsections (1) through (4) above after the calendar year deductible is satisfied. Prior authorization is not required before seeking emergency services in a Hospital emergency room.
  - (a) The Copayment applies regardless of whether or not the emergency room visit is for an Emergency Medical Condition.
  - (b) The Copayment is waived if the Eligible Individual is admitted to the Hospital as an inpatient from the emergency room.
- (6) Preferred Provider Organization (PPO) Centers of Excellence for Organ and Tissue Transplants and Bariatric Surgery. Covered bariatric surgery and specified organ and tissue transplant procedures are covered only when performed at a Contract Hospital or Facility that is a “Center of Medical Excellence” in the PPO network administered by Anthem Blue Cross or a “Blue Distinction Center” in the PPO network administered by the Blue Cross and Blue Shield Association. No Plan benefits will be payable for bariatric surgery or for specified organ or tissue transplant procedures performed in a Hospital or Facility that is not an Anthem Blue Cross “Center of Medical Excellence” or a “Blue Distinction Center.” Plan coverage is subject to compliance with the Pre-admission review requirement outlined in Section 3.03.b. The Professional Review Organization will determine, prior to surgery, if the transplant procedure is one that is subject to this limitation.

**b. Utilization Review Program.**

- (1) Utilization Review. If an Eligible Individual is to be confined in a Hospital or Skilled Nursing Facility as an inpatient on a Non-Emergency Medical Condition basis, the Physician must obtain Pre-Admission Review by the Professional Review Organization (PRO) to determine, prior to the admission, the Medical Necessity of the Hospital confinement, and if Medically Necessary, the number of pre-authorized days, if any, determined to be Medically Necessary for the confinement. However, Pre-Admission Review is not required for childbirth for a length of stay of 48 hours or less in cases of normal delivery or 96 hours or less for cesarean deliveries.

- (a) If Pre-admission Review is not obtained, and the PRO subsequently finds the confinement Medically Necessary, the Plan will deduct \$300 from the benefits otherwise payable for that confinement, as described in Subsection 3.02.a.
- (b) If Pre-admission Review by the PRO determines that confinement in a Hospital is not Medically Necessary, and the Eligible Individual is nevertheless confined in a Hospital, no benefits will be payable for Hospital charges incurred during that confinement.
- (c) If the PRO pre-authorizes a specified number of days as Medically Necessary for a Hospital confinement, and the Eligible Individual is confined in the Hospital for a greater number of days than pre-authorized by the PRO, no benefits will be payable for Hospital charges incurred during the portion of the confinement not authorized by the PRO.
- (d) If an Eligible Individual is admitted to a Hospital that does not participate in a Concurrent Review program, the Hospital confinement will be reviewed on a retrospective basis. If the PRO finds that a portion of the confinement was not Medically Necessary, no benefits will be payable for Hospital charges incurred during the portion of the confinement determined to be not Medically Necessary.
- (e) If an Eligible Individual requires a transfer from one Hospital to another, the PRO must be contacted in advance unless the transfer is necessitated by a life threatening Emergency Medical Condition.
- (f) Large Case Management/Alternative Care. The Professional Review Organization (PRO) also provides large case management services to determine if an Eligible Individual who has a severe medical condition, such as traumatic brain or spinal cord injury, cancer or stroke, can be treated in an alternative care setting instead of in an acute care Hospital. Alternative care may include hospice care, home health care or care in a rehabilitation facility or Skilled Nursing Facility. The case manager works with the Patient's Physician and family to determine whether alternative care is suitable for the Patient, and arranges for and oversees the care to ensure that services are provided in a manner that provides continuity of care. There is no charge to the Patient for the services of the case manager.

Alternative care, which may not normally be covered by the Plan, must be pre-approved and overseen by the PRO in order for benefits to be payable. In addition, the case manager must determine that the cost of the alternative care will be less than the cost for an acute care Hospital confinement.

- (2) Exception to Non-Contract Hospital Benefits. If an Eligible Individual resides within the Fund's Contract Provider Service Area and requires specialized services which are not available at a Contract Hospital, the Plan will pay 90% of the Allowed Charges incurred for confinement in a Non-Contract Hospital that can provide the specialized services, in accordance with Subsection 3.03.a.(3), provided the Eligible Individual's Physician obtains approval by the PRO prior to the confinement.

### **Section 3.04. Covered Hospital Services.**

- a. Inpatient. Benefits are payable for the following services billed by the Hospital when an Eligible Individual is confined as a registered bed patient with the approval of a Physician. Benefits are payable for up to 365 days per calendar year, except that Hospital confinements for treatment of mental illness are limited to 30 days per calendar year.
- (1) Accommodations in a semi-private room or in cardiac care units and intensive care units.
  - (2) Operating and delivery rooms.
  - (3) Anesthesia, physical therapy, supplies, oxygen, and ancillary services including laboratory, pathology and radiology. Any professional component of these services.
  - (4) In a Contract Hospital, Drugs and medicines which are supplied by the Hospital for the Illness or Injury for which the Eligible Individual is hospitalized, including take-home drugs dispensed by the Hospital's pharmacy at the time of the Eligible Individual's discharge.  
  
In a Non-Contract Hospital, Drugs and which are supplied by the Hospital for use during the Eligible Individual's confinement in the Hospital.
  - (5) Blood transfusions including the cost of unreplaced blood, blood products and blood processing.
- b. Outpatient. Benefits are payable for Covered Expenses incurred for outpatient services billed by a Hospital or Ambulatory Surgery Facility, including emergency room, outpatient treatment and surgery rooms, supplies, ancillary services, laboratory and radiology services, Drugs and medicines.

### **Section 3.05. Outpatient Services Review.**

- a. Outpatient Surgery. If an Eligible Individual is scheduled to undergo a surgical procedure in a Hospital outpatient department or a free standing Ambulatory Surgery Facility, the Physician must obtain certification from the Review Organization before the surgery is performed.
- b. Outpatient Diagnostic Imaging Services. The Physician must also obtain pre-authorization from the Review Organization for the following outpatient diagnostic imaging services before they are received:
- (1) CT/CTA
  - (2) MR/MRI
  - (3) nuclear cardiology
  - (4) PET scans
  - (5) echocardiography



- c. If an Eligible Individual receives an outpatient service noted above without pre-authorization, the service is subject to retrospective review by the Review Organization and no benefits will be payable for any service deemed not Medically Necessary.

**Section 3.06. Skilled Nursing Facility Benefits.**

- a. Payment. Skilled Nursing Facility benefits for Contract Facilities and Non-Contract Facilities are provided on the same basis as Hospital care as stated in Subsection 3.03.a.
- b. Days Covered. Two days of Skilled Nursing Facility care count as one day in an acute care Hospital.
- c. Covered Services.
  - (1) Accommodations in a room of 2 or more beds, or the prevailing charge for a 2-bed room accommodation in that facility if a private room is used.
  - (2) Physical, occupational and speech therapy. Laboratory services. Oxygen and other inhalation therapy.
  - (3) Drugs and medicines which are administered in the facility.
  - (4) Blood transfusions, blood products and blood processing.
- d. Conditions of Service.
  - (1) The Eligible Individual must be referred to the Skilled Nursing Facility by a Physician.
  - (2) Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
  - (3) The services must be consistent with the Illness, Injury, degree of disability and medical needs of the Eligible Individual, as determined by the PRO. Benefits are provided only for the number of days required to treat the Eligible Individual's Illness or Injury.
  - (4) The Eligible Individual must remain under the active medical supervision of a Physician. The Physician must be treating the Illness or Injury for which the Eligible Individual is confined in the Skilled Nursing Facility.

**Section 3.07. Professional Physician, Laboratory and Radiology Services.**

If an Eligible Individual receives the professional services of a Physician, Physician's Assistant or laboratory/radiology facility, the following benefits are payable.

- a. For services of a Contract Provider: The Plan will pay 90% of the negotiated contract rates.
- b. For services of a Non-Contract Provider Within the Contract Provider Service Area: The Plan will pay 80% of Covered Expenses.

- c. For services of a Non-Contract Provider for an Emergency Medical Condition or Outside the Contract Provider Service Area: The Plan will pay 90% of Covered Expenses incurred if the Patient resides outside the Contract Provider Service Area or in cases of Emergency Medical Condition.
- d. Covered Professional Services.
- (1) Professional services of a Physician.
  - (2) Outpatient diagnostic radiology and laboratory services.
  - (3) Radiation therapy.
  - (4) Services of a stand-by pediatric Physician at a C-Section delivery or other at-risk delivery, but only when the stand-by physician is actually present in the delivery room.
  - (5) Initial infertility consultation, including laboratory tests and screening laparoscopy for the purpose of determining the cause of infertility.
  - (6) Second Surgical Opinion consultation obtained for the purpose of determining the necessity for prescribed surgery.
  - (7) Services of a licensed Physician Assistant or other licensed provider acting within the scope of his or her license, including a Certified Surgical Assistant and Registered Nurse First Assistant, provided the services are performed under the supervision of a Physician, and subject to the following requirements:
    - (a) Covered Expenses are limited to assistant-at-surgery, physical examinations, administering injections, minor setting of casts for simple fractures, interpreting x-rays and changing dressings.
    - (b) Services of the Physician Assistant must be billed under the tax identification number of the supervising Physician.
    - (c) Services must be of the type that would be considered Physician services if provided by an M.D. or D.O.
    - (d) For Non-Contract Providers only, Covered Expenses are limited as follows:
      - (i) For assistant-at-surgery services, 85% of the amount that otherwise would be allowed if the services were performed by a Physician serving as an assistant-at-surgery, or
      - (ii) For other covered services, 85% of the applicable Physician's Allowed Charge for services performed.
    - (e) For Contract Providers, Covered Expenses are limited to the Contract Provider negotiated rate.
  - (8) Reconstructive surgery. Benefits are payable for reconstructive surgery as follows:

- (a) Surgery to correct functional disorders or surgery performed as a result of Injury, and
  - (b) If an Eligible Individual who has received benefits under the Plan in connection with a mastectomy elects breast reconstruction, normal Plan benefits are payable for:
    - (i) Reconstruction of the breast on which the mastectomy was performed;
    - (ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    - (iii) Prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- (9) Bariatric Surgery for weight loss is covered subject to utilization review, only when Medically Necessary for morbid obesity and only when performed at a Contract Provider Center of Medical Excellence (CME) or Blue Distinction Center. Bariatric travel expense is covered when the Patient's home is 50 miles or more from the nearest Bariatric CME or Blue Distinction Center, with benefits payable subject to the following limitations:
- (a) The Patient's transportation to and from CME or Blue Distinction Center is limited to \$130/person/trip for 3 trips (pre-surgical visit, initial surgery and one follow-up visit);
  - (b) One companion's transportation to and from CME or Blue Distinction Center is limited to \$130/person/trip for 2 trips (initial surgery and one follow-up visit);
  - (c) Hotel for Patient and one companion is limited to one room, double occupancy and \$100/day for 2 days/trip, or as Medically Necessary, for pre-surgical and follow-up visit. Benefit for hotel for one companion is limited to one room double occupancy and \$100/day for duration of Patient's initial surgery stay for 4 days.
  - (d) Other reasonable expenses limited to \$25/day/person for 4 days/trip). These expenses will not include meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the Patient and his/her designated family member/travel companion.

**Section 3.08. Outpatient Mental Health Benefits.** Benefits are payable for outpatient treatment of mental or nervous disorders provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage, family and child counselor (MFCC), limited to 26 visits per calendar year, payable as follows:

- a. For services of a Contract Provider: The Plan will pay 50% of the negotiated contract rate.
- b. For services of a Non-Contract Provider: The Plan will pay 50% of Covered Expenses.

- c. Psychological testing and diagnostic lab and x-ray tests related to treatment of a mental illness are payable at 50% of Covered Expenses, or of the Schedule of Allowances if applicable, but are not subject to the 26-visit maximum per calendar year.

**Section 3.09. Physical Therapy, Occupational Therapy, Chiropractic Services.** Benefits for physical therapy, occupational therapy or chiropractic services are payable at the percentages described in 3.02.a. for Contract and Non-Contract Providers, subject to the following limitations:

- a. Plan benefits for treatment by a Physician or registered physical or occupational therapist for physical therapy or occupational therapy are limited a maximum of 20 visits per calendar year.
- b. If the physical or occupational therapy is provided within 24 months before or after a related surgical procedure or stroke, Plan benefit are limited to a maximum of 40 visits per calendar year.
- c. Plan benefits for treatment by a chiropractor are limited to a maximum of 20 visits per calendar year.

**Section 3.10. Preventive Care Benefits.** The calendar year deductible does not apply to the following Preventive Care benefits described in this Section. The benefits of this Section are in addition to the Physical Examination Benefit for Employees and Spouses described in Article 5.

- a. Well Child Care Benefit. The Plan will pay the following benefits for pediatric preventive health care as recommended by “Bright Futures/American Academy of Pediatrics,” including visits and age-appropriate screenings and immunizations.
  - (1) Services of a Contract Provider: 100% of the contract rate
  - (2) Services of a Non-Contract Provider: 100% of the Allowed Charge
- b. Preventive Care for Adults - Contract Providers Only. The Plan will pay 100% of the contract rate for services from a Contract Provider for the following services and other services as required by the United States Preventive Care Task Force and/or the Advisory Committee on Immunization Practices of the CDC:
  - (1) Abdominal aortic aneurysm screening for men ages 65-75 who have ever smoked
  - (2) Colonoscopy, sigmoidoscopy or fecal occult blood test
  - (3) Four blood tests for cholesterol/lipid, blood sugar, HIV, syphilis
  - (4) CDC recommended immunizations
  - (5) Cholesterol screening
- c. Preventive Care for Women Including Pregnant Women – Contract Providers Only. The Plan will pay 100% of the contract rate for the following services and other services as required by the United States Preventive Care Task Force and/or the Advisory Committee on Immunization Practices of the CDC:

- (1) Breast cancer screening mammography
  - (2) Cervical cancer screening and Chlamydia screening
  - (3) Osteoporosis screening
- d. Other Preventive Care Services From Non-Contract Providers. The Plan will pay benefits at the following payment percentages for covered preventive care services provided by Non-Contract Providers:
- (1) Within the Contract Provider Service Area: 80% of Allowed Charge
  - (2) Outside the Contract Provider Service Area: 90% of Allowed Charge
  - (3) Covered services include:
    - (a) Routine Mammograms and Pap Smears.
    - (b) Immunizations for Employees and Spouses, including but not limited to the vaccines for hepatitis, influenza, pneumonia, herpes zoster and the HPV vaccine.
    - (c) Colorectal Cancer Screening, including colonoscopy, in accordance with the American Cancer Society Guidelines.

**Section 3.11. Hearing Aid Benefits.**

- a. Effective for services incurred and devices purchased on or after July 1, 2008, if an Eligible Individual has a hearing loss that may be lessened by the use of a hearing aid, the Plan will pay 100% of the Covered Expense incurred for the examination and hearing aid, up to a maximum payment of \$1,350 per ear.
- b. Exclusions. No benefits will be provided for:
  - (1) More than one hearing aid for each ear;
  - (2) The replacement of a hearing aid for any reason more often than once during any 4-year period;
  - (3) Batteries or any other ancillary equipment other than that obtained when the hearing aid was purchased and which can be covered within the \$1,350 maximum benefit; or
  - (4) Servicing or alterations of a hearing aid.

**Section 3.12. Temporomandibular Joint Syndrome.**

Regular Plan benefits are payable for medical treatment or services required to alleviate temporomandibular joint syndrome (TMJ), myofascial pain dysfunction syndrome, mandibular pain dysfunction), facial pain and mandibular dysfunction, Costen's syndrome, craniocervical mandibular syndrome, and craniofacial pain and dysfunction, subject to the following:

- a. Benefits payable will not to exceed a Plan maximum of \$1,500 per Eligible Individual.
- b. Medically Necessary surgical procedures are not subject to the \$1,500 Plan maximum.

### **Section 3.13. Other Covered Expenses.**

- a. Services of a licensed ambulance for ground transportation of an Eligible Individual to or from a Hospital or other medical facility for medical care. A licensed air ambulance is also covered if the Fund determines that the location and nature of the Illness or Injury made air transportation cost effective or necessary to avoid the possibility of serious complications or loss of life.
- b. Services of a registered nurse or Licensed Vocational Nurse.
- c. Home Health Care, including IV drugs and their administration when furnished by a home health care agency.
- d. Treatment by a licensed acupuncturist, limited to a maximum of 16 visits per treatment series. A new treatment series will begin after a period of 6 months has passed since the last acupuncture treatment.
- e. Speech therapy, only when prescribed by a Physician and provided by a licensed speech therapist to a person who had normal speech at one time and lost it due to Illness or Injury. Benefits are payable until understandable speech is attained or until a determination is made that understandable speech cannot be attained.
- f. Surgical dressings, splints, casts and other devices for reduction of fractures or dislocations.
- g. Prosthetic devices or equipment that replaces all or part of a body organ or part or that improve the function of an impaired bodily organ or part, except dental appliances.
- h. Orthotics, limited to a maximum benefit of \$500 for both feet, payable every calendar year.
- i. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
- j. Purchase of a wig when hair loss is the direct result of chemotherapy treatment.
- k. Rental or purchase of other medical equipment and supplies, provided the rental cost does not exceed the purchase price, and provided the equipment and supplies are:
  - (1) ordered by a Physician;
  - (2) of no further use when medical need ends;
  - (3) usable only by the Patient;
  - (4) not primarily for the comfort or hygiene of the Eligible Individual;
  - (5) not for environmental control;
  - (6) not for exercise;
  - (7) manufactured specifically for medical use;

- (8) approved as effective and customary treatment of a condition as determined by the PRO; and
  - (9) not for prevention purposes.
- l. Organ and Tissue Transplants. Plan benefits will be payable for Covered Expenses incurred by the organ donor and the organ recipient when the organ recipient is an Eligible Individual. Covered Expenses in connection with the organ transplant include: Patient screening, organ procurement and transportation of the organ, surgery, follow-up care in the home or a Hospital and immunosuppressant Drugs, under the following conditions:
- (1) The transplant is not considered Experimental or Investigational;
  - (2) Specified organ or tissue transplants must be performed in a Contract Hospital or Facility that is designated as a “Center of Medical Excellence” under the Anthem Blue Cross PPO or a “Blue Distinction Center” in the PPO network administered by the Blue Cross and Blue Shield Association. The Professional Review Organization will determine, prior to surgery, if the organ or tissue transplant is one that is subject this limitation.
  - (3) The services provided are pre-approved by the Professional Review Organization.
  - (4) The recipient of the organ is an Eligible Individual;
  - (5) Benefits payable for an organ donor who is not an Eligible Individual will be reduced by any benefits paid or payable by the donor’s own health coverage; and
  - (6) Transplant travel expense for an authorized, specified transplant at a CME or Blue Distinction Center for the organ recipient and companion and/or donor transportation is limited to \$10,000 per transplant. Benefits for unrelated donor search are limited to \$30,000 per transplant. The following expenses are not covered under the transplant travel expense benefit: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation expenses, alcohol/tobacco, souvenirs and expenses for persons other than the Patient and his/her designated companion or donor.
- m. Dental treatment or services provided by a Dentist, but only when the treatment or services are necessary to:
- (1) repair or alleviate damage to teeth resulting from an accident; or
  - (2) repair or alleviate damage resulting from radiation treatment for cancer.
- n. Diabetes Education Program. The Plan will cover a formal diabetes education course/program taught by a Certified Diabetes Educator and recognized as an acceptable program by the American Diabetes Association, and/or nutritional counseling services provided by a Registered Dietician to an Eligible Individual with diabetes.
- (1) A diabetes education program is payable when a person is initially diagnosed with diabetes. A refresher course is payable once each year for up to 5 times.

- o. Hospice Care. Benefits are payable for inpatient Hospice care and outpatient home Hospice care provided to patients who meet the criteria outlined in the definition of Hospice in paragraph (1) below.
  - (1) For purposes of this benefit, “Hospice” means an agency or organization that provides a program of medical, psychological, social and spiritual care and may provide room and board for terminally ill persons assessed to have a life expectancy of 6 months or less. The Hospice agency must meet all of the following tests:
    - (a) It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located;
    - (b) It provides service 24 hours a day, 7 days a week.
    - (c) It is under the direct supervision of a physician.
    - (d) It has a nurse coordinator who is a registered nurse (R.N.).
  - (2) Covered Hospice Services include:
    - (a) Room and board for confinement in a hospice.
    - (b) Services and supplies furnished by the hospice.
    - (c) Home hospice care, including part-time nursing care by or under the supervision of a registered nurse (R.N.).
    - (d) Home health aide services.
    - (e) Special meals.
    - (f) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for immediate family members of the Eligible Individual who were covered by this Plan at the time of the Eligible Individual’s death, for up to 15 sessions during the 6-month period following the Eligible Individual’s death.

**Section 3.14. Exclusions.** Benefits will not be payable for the following:

- a. Services furnished by a naturopath or any other provider not meeting the definition of Physician, except as may be specifically provided in the Plan. Charges made by a nurse practitioner or operating room technician.
- b. Outpatient psychotherapy and psychological testing except as specifically provided in the Plan.
- c. Professional services received from a provider who lives in the Eligible Individual’s home.
- d. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Custodial Hospital care.
- e. Educational services: Such as applied behavioral analysis, applied behavioral therapy or training, auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aides, vision therapy, synthesizers, auxiliary aids such as communication boards, and listening systems), auditory perception or listening/learning skills and/or programs and services to remedy or enhance concentration, memory, motivation, reading or self esteem.



- f. Hospital confinements of less than 24 hours for a condition of mental or nervous disorders. Confinements for treatment of mental and nervous disorders of 24 hours or more are limited to a maximum of 30 inpatient Hospital days per calendar year.
- g. Dental plates, bridges, crowns, caps or other dental prostheses, extraction of teeth, or any other dental services or treatment to the teeth or gums, except for the following:
  - (1) treatment or services necessary to repair or alleviate damage to natural teeth resulting from an accident; or
  - (2) treatment or services necessary to repair or alleviate damage resulting from radiation treatment for cancer.
- h. Eye surgery to correct myopia, or any other refractive eye surgery. Optometric services, vision therapy including orthoptics, routine eye exams, eyeglasses or contact lenses.
- i. Cosmetic surgery or services, except as specifically provided in Subsection 3.07.d.(8).
- j. Orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification; wigs except as provided under Subsection 3.13.j.
- k. A Dependent daughter's pregnancy, maternity care or abortion.
- l. Services for which benefits are payable under any other programs provided by the Fund.
- m. Nutritional counseling or food supplements or substitutes.
- n. Services to reverse voluntary surgically induced infertility.
- o. Expenses for the treatment of infertility along with services to induce pregnancy and complications resulting from those services, including, but not limited to: services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of egg/sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization (except as specifically provided in Section 3.07.d.(5)).
- p. Hypnotism, stress management, massage therapy and any goal oriented behavior modification therapy, such as to quit smoking, lose weight, or control pain.
- q. Treatment of sexual dysfunction (except when caused by a medical condition, as certified by the Eligible Individual's Physician).
- r. Sex changes, care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change.
- s. Services or programs which are primarily for weight loss (except for covered bariatric surgery as described in Section 3.07.d.(9)), health club memberships, exercise and physical fitness programs and equipment, spas.

- t. Any course of treatment, whether or not prescribed by a Physician, for which charges incurred are not the direct result of an Injury or Illness, except as specifically provided in Section 3.10. Preventive Care Benefits.
- u. Chemical dependency except while Hospital confined for acute care of detoxification only and as provided in Article 6.
- v. More than one home or office “visit” charge per day by any one Physician. The term “visit” means a personal interview between the Eligible Individual and the Physician and does not include telephone calls or other situations where you are not personally examined by a Physician.
- w. Expenses for transportation of surgeons or family members.
- x. Charges for telephone calls between a Physician or other health care provider and a Patient, other health care provider, utilization management company, or representative of the Plan for any purpose. Charges for preparing medical reports, bills or claim forms. Charges for broken appointments.
- y. Any service or supply that is excluded under Article 11. *Exclusions, Limitations and Reductions*.
- z. Expenses related to the maternity care and delivery associated with a surrogate mother’s pregnancy.
- aa. Bariatric surgery or any specified organ or tissue transplant that is performed in a Hospital or Facility that is not designated as a “Center of Medical Excellence” under the Anthem Blue Cross PPO or as a “Blue Distinction Center” under the PPO network administered by the Blue Cross and Blue Shield Association. The Professional Review Organization will determine, prior to surgery, if the organ or tissue transplant is one that is subject this limitation.

**Section 3.15. Extended Benefits Due to Disability.**

- a. If an Eligible Employee or Dependent is Disabled, as certified by a Physician, when eligibility terminates for any reason, he will remain eligible for Comprehensive Health Plan Benefits for that Disability **only** for up to 12 consecutive months following the date eligibility terminated. However, the extended benefit will terminate upon the earliest of:
  - (1) The expiration of 12 continuous months following termination of eligibility;
  - (2) The date the individual becomes eligible under another Group Plan, another plan’s COBRA continuation coverage or any conversion policy; or
  - (3) The date the individual is no longer Disabled.
  - (4) An individual receiving benefits under this provision will not be eligible to elect the continuation coverage described in Article 9, *Continuation Coverage (COBRA)*.

- b. For purposes of this Section, the terms “Disabled” and “Disability” mean that due to Illness or Injury, the Eligible Individual is:
- (1) Under a Physician’s care,
  - (2) Not able to perform substantially all the normal activities of a person of the same age and sex who is in good health, and
  - (3) Unable to engage in any occupation or business for income or profit.

## ARTICLE 4. PRESCRIPTION DRUG BENEFITS

**Section 4.01. Benefits.** The benefits described in this Article are payable for outpatient Drugs that require a prescription, or insulin or other covered diabetic supplies that are administered or prescribed by a Physician or Dentist for treatment of an Illness or Injury.

a. **For Drugs Obtained from a Retail Participating Pharmacy.** (These benefits do not apply to proton pump inhibitor medications prescribed to treat stomach acid-related disorders.) The Plan will pay the charges incurred after the Eligible Individual pays the deductible described in Subsection (1) for Brand Name Drugs and the applicable Copayment specified in Subsection (2) for each prescription or refill.

(1) **Calendar Year Deductible for Brand-Name Drugs.** All Brand Name Drugs obtained from a retail pharmacy are subject to a \$100 deductible per calendar year for each Eligible Individual. This deductible applies in addition to the Copayments shown below for Preferred and Non-Preferred Brand Name Drugs.

(2) **Copayments:**

(a) Generic Drugs – \$5 Copayment

(b) Preferred Brand Name Drugs – \$25 Copayment. If a Brand Name Drug is dispensed when a Generic Drug is available, the Eligible Individual will be responsible for paying the cost difference between the Generic and Brand Name Drugs in addition to the \$25 Copayment, unless the prescribing Physician has indicated “dispense as written” on the prescription.

(c) Non-Preferred Brand Name Drugs – \$40 Copayment. If a Brand Name Drug is dispensed when a Generic Drug is available, the Eligible Individual will be responsible for paying the cost difference between the Generic and Brand Name Drugs in addition to the \$40 Copayment, unless the prescribing Physician has indicated “dispense as written” on the prescription.

(3) **Day Supply Limit.** Up to a 34-day supply of the medication is provided for each Copayment.

b. **For Drugs Obtained from the Mail Service Participating Pharmacy.** (These benefits do not apply to proton pump inhibitor medications prescribed to treat stomach acid-related disorders.) The Plan will pay the charges incurred after the Eligible Individual pays the applicable Copayment specified in Subsection (1) for each prescription or refill.

(1) **Copayments:**

(a) Generic Drugs – \$10 Copayment

(b) Preferred Brand Name Drugs – \$50 Copayment

(c) Non-Preferred Brand Name Drugs – \$80 Copayment

- (2) **Day Supply Limit.** Up to a 90-day supply of the medication is provided for each Copayment.
- c. **Exceptions to Day Supply Limits.**
- (1) Instead of the quantity limits described in Subsections a. and b. above, the Plan will provide up to 100 tablets of the following Drugs for the applicable Copayment: nitroglycerine, oral anti-diabetic medications, phenobarbital and thyroid U.S.P.
  - (2) Certain Drugs will have day supply limits per prescription that are less than the 34-day or 90-day limits specified above, as determined by Caremark.
- d. **Specialty Drugs.** Specialty Drugs are certain pharmaceutical and/or biotech or biological Drugs, including injectable, infused or oral medications, that are included on the pharmacy benefit manager's (Caremark) Specialty Drug List. The Specialty Drug List is subject to change by Caremark from time to time.
- (1) Any Drugs included on the Caremark Specialty Drug list must be obtained through the Caremark Specialty Pharmacy and are not available from retail Participating Pharmacies. The retail Participating Pharmacy Copayments described in Section 4.01.a. will apply to Drugs obtained from the Caremark Specialty Pharmacy and each prescription is limited to a 34-day supply.
  - (2) No benefits will be payable for paper claims submitted by Eligible Individuals for Specialty Drugs purchased from a pharmacy other than the Caremark Specialty Pharmacy. A one-time exception will apply to the first purchase of a Specialty Drug which will be covered in accordance with Subsection 4.01.e.
- e. **Benefits for Proton Pump Inhibitor Medications Prescribed to Treat Stomach Acid-Related Disorders.**
- (1) Retail Pharmacy: The Plan will pay up to a maximum of \$30 for each prescription up to a 34-day supply.
  - (2) Mail Service Pharmacy: The Plan will pay up to a maximum of \$90 for each prescription up to a 90-day supply.
  - (3) This benefit will cover PPI products available over the counter with a Physician's written prescription.
- f. **Step Therapy.** Certain Drugs may not be covered until an alternative Drug within the same class of Drugs has been tried. If an Eligible Individual receives a prescription for a Drug that requires step therapy, Caremark will ask the Physician to provide additional clinical information to the Caremark Prior Authorization department to support the necessity of the Drug before it will be covered by the Plan. If an Eligible Individual does not receive prior authorization from Caremark for a Drug requiring step therapy, no benefits will be payable for the Drug. (Exception: Eligible Individuals who received a Drug subject to step therapy prior to July 1, 2011 may continue to receive Plan benefits for the Drug for 12 months. At the end of the 12-month period, the step therapy requirements will apply.) The following classes of drugs are subject to step therapy:
- (1) Cholesterol medications

- (2) Pain medications
- (3) Sleep aids
- (4) Blood pressure medications
- (5) Antihistamines/combinations for allergies
- (6) Nasal steroids for allergies
- (7) Urinary antispasmodics for overactive bladder/incontinence
- (8) Bisphosphonates for osteoporosis
- (9) SSRIs for depression
- (10) Selective serotonin agonists/combinations for migraines
- (11) Short acting beta agonists inhalers

- g. **Benefits for Drugs Obtained from a Non-Participating Pharmacy.** The Copayments, Deductible and benefits described in Subsection 4.01.a. apply to Drugs purchased from a Non-Participating Pharmacy. However, the benefit payable by the Plan after subtracting the applicable Copayment and Brand-Name Drug deductible will be limited to the contract amount the Plan would have paid if the Drug had been purchased from a Participating Pharmacy.

**Section 4.02. Definitions.** For purposes of this Article, the following definitions will apply:

- a. “Copayment” means the amount the Eligible Individual is required to pay for a Drug before Plan benefits are payable.
- b. “Participating Pharmacy” means a pharmacy that has elected to participate in an agreement with the pharmacy benefit manager contracted by the Fund to provide services to Eligible Individuals at negotiated contract charges.
- c. “Non-Participating Pharmacy” means a pharmacy that has not elected to participate in an agreement with the pharmacy benefit manager contracted by the Fund.
- d. “Preferred Brand Name Drug” means a Drug sold under a trademark name or by a manufacturer who holds a patent on the Drug which is on the pharmacy benefit manager’s preferred drug list.
- e. “Non-Preferred Brand Name Drug” means a Drug that is sold under a trademark name or by a manufacturer who holds a patent on the Drug which is not on the pharmacy benefit manager’s preferred drug list.
- f. “Generic Drug” means a prescription Drug that is chemically the same (has the same active ingredients) as the Brand Name Drug and is usually referred to by its chemical name. A Generic Drug can be produced and sold after the patent has expired on a Brand Name Drug. A Generic Drug must meet the same FDA standard as its brand name counterpart.

**Section 4.03. Covered Expenses.** Covered Expenses include the following Drugs or supplies:

- a. Drugs that legally require the written prescription of a Physician or Dentist.
- b. Insulin and diabetic supplies.
- c. Drugs, insulin and diabetic supplies which are furnished by a Hospital for use outside the Hospital in connection with treatment received while the Patient was a bed patient in the Hospital.
- d. Drugs, insulin and diabetic supplies which are supplied by a Physician or Dentist in his or her office and for which a charge is made separately from the charge for any other service.
- e. Charges made by a Licensed Pharmacist for compounding a dermatological preparation prescribed by a Physician.
- f. Charges made by a Licensed Pharmacist for therapeutic vitamins, cough mixtures, antacids, eye and ear medications prescribed in writing by a Physician for the treatment of a specified Illness.
- g. Injectable Drugs and syringes.
- h. Charges for nicotine gum, patches or other prescription or non-prescription smoking cessation medications are limited to a maximum benefit of \$175 in any 12-month period, not to exceed a lifetime maximum of \$525 per Eligible Individual. However, non-prescription smoking cessation products are covered only with a Physician's written prescription.
- i. Contraceptives for Employees and Dependent Spouses only, including oral contraceptives, injectables and devices which legally require the written prescription of a Physician.

**Section 4.04. Required Prior Authorizations.** The following Drugs require prior authorization from CVS Caremark before Plan benefits are payable:

- a. Topical acne medications for a person over age 26
- b. Growth hormones
- c. Drugs or devices for treatment of sexual dysfunction
- d. Oral contraceptives prescribed for Dependent daughters for purposes other than contraception
- e. Certain contraceptive devices and injectables, all transdermal contraceptives (patches)
- f. Oral Fentanyl products
- g. Oxycontin for supplies exceeding the quantity limits established by Caremark
- h. Anti-narcolepsy agents
- i. Any Drug subject to step therapy

**Section 4.05. Exclusions. No benefits will** be provided for:

- a. Drugs taken or administered while the Patient is Hospital confined.
- b. Medications that do not require a prescription, except insulin and except as specifically provided in Sections 4.01.e. and 4.03.h.
- c. Appliances, devices, bandages, and any other supplies or equipment, except diabetic supplies.
- d. Contraceptives for Dependent daughters.
- e. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids.
- f. Immunization agents.
- g. Appetite suppressants or any other weight loss medications.
- h. Infertility medications.
- i. Medications with no federal Food and Drug Administration indications.
- j. Drugs not Medically Necessary for the treatment of an Illness or Injury. Medications used for Experimental indications, and/or dosage regimens determined to be Experimental or Investigational; any Investigational or unproven Drugs or therapies.
- k. Medications prescribed for cosmetic purposes only.
- l. Charges for prescriptions in excess of a 34-day supply (or 60-day supply for mail order drugs), except that reimbursement will be made for charges for up to 100 tablets of any of the following drugs: nitroglycerine, oral anti-diabetic drugs, phenobarbital or thyroid U.S.P.
- m. Replacement prescriptions resulting from loss, theft or breakage.
- n. Drugs or devices prescribed for treatment of sexual dysfunction (except when caused by a medical condition, as certified by the Eligible Individual's Physician).
- o. Any expenses excluded under Article 11. *Exclusions, Limitations and Reductions.*



## **ARTICLE 5. PHYSICAL EXAMINATION BENEFIT FOR EMPLOYEES AND SPOUSES**

**Section 5.01. Eligibility.** Only Employees and Spouses are eligible for benefits under this Article 5.

**Section 5.02. Benefits.** If an Employee or Spouse (but not a Dependent child over age 21) receives a routine physical examination performed by a Physician, including a Certified Driver's License Exam, the Plan will pay 100% of Covered Expenses incurred for the Physician charge and any related x-rays and laboratory tests, limited to one physical examination in a 12-month period.

**Section 5.03. Exclusions.** No benefits are payable for:

- a. Eye examinations.
- b. Any examination required by an employer as a condition of employment except for a Certified Driver's License Exam.
- c. More than one physical examination in a 12-month period.

## **ARTICLE 6. CHEMICAL DEPENDENCY TREATMENT BENEFITS**

### **Section 6.01. Benefits.**

If an Eligible Employee or Dependent Spouse receives treatment for alcoholism or other chemical dependency under the Operating Engineers Assistance Recovery Program (ARP), the Plan will pay the benefits described below, based on the setting in which treatment is provided.

Employees and Spouses who have elected health coverage under the Fund's alternative prepaid medical plan are also eligible for the benefits of this Article 6.

- a. **Residential Treatment.** Coverage is provided for up to 3 admissions, not to exceed 30 days per treatment in an ARP approved residential chemical dependency program. Plan benefits are payable according to the following schedule:
  - (1) First admission: 100% of negotiated charges.
  - (2) Second admission: 85% of negotiated charges.
  - (3) Third admission: 75% of negotiated charges.
- b. **Outpatient Treatment.** The Plan will cover rehabilitation, treatment and counseling received on an outpatient basis, as specified in Subsections (1), (2) and (3) below.

- (1) No more than 3 outpatient Treatment Series will be covered in an Eligible Individual's lifetime. Benefits are payable in accordance with the following schedule:
    - (a) First Treatment Series: 100% of negotiated charges
    - (b) Second Treatment Series: 85% of negotiated charges
    - (c) Third Treatment Series: 75% of negotiated charges.
  - (2) A "Treatment Series" is defined as all outpatient visits and/or services received in a Benefit Year. For any one treatment series, a "Benefit Year" is the 12 consecutive month period beginning with the first outpatient treatment visit.
  - (3) No more than 50 outpatient visits will be covered in a Benefit Year.
- c. **Recovery Home Treatment.** The Plan will pay the 100% of the Allowed Charge for residential treatment in an ARP approved recovery home, which immediately follows a period of confinement in a covered ARP approved residential program, as described in Section 6.01.a. above. Benefits are limited to a maximum of 30 days per calendar year.
- d. **Chemical Dependency Diversion Program.** The Plan will pay 100% of the Allowed Charge for one chemical dependency diversion program for an Eligible Employee who has tested positive in a drug or alcohol test but who does not require residential or outpatient chemical dependency treatment. Services of a chemical dependency diversion program include evaluation by a substance abuse professional and any prescribed educational diversion program.

**Section 6.02. Exclusions.** No benefits are payable for:

- a. Inpatient or outpatient care in an acute care Hospital.
- b. Any treatment or service that has not been approved by the Operating Engineers Assistance Recovery Program.
- c. Services provided to a Dependent child.
- d. Any expenses excluded under Article 11. *Exclusions, Limitations and Reductions.*

## ARTICLE 7. VISION COVERAGE

**Section 7.01. Eligibility.** Plan A Employees and their Dependents are eligible for the vision benefits under this Article 7.

**Section 7.02. Benefits.** Vision care benefits are provided as specified in the agreement between Vision Service Plan (VSP) and the Fund and are described in the Summary Plan Description that is provided to Participants. Any frequency limitations on services specified in the Vision Service Plan agreement do not apply to Dependent children under 18 years of age.

## ARTICLE 8. DENTAL BENEFITS

Effective January 1, 2008 dental and orthodontic benefits are provided through an insured contract with Delta Dental Plan of California under a Preferred Provider (PPO) program. Eligible Individuals may use any licensed Dentist.

### Section 8.01. Definitions.

- a. "Covered Dental Expense" means services provided by a Dentist that are necessary and customary as determined by the standards of generally accepted dental practice. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is provided.
- b. "Delta Dental PPO Dentist" means a Dentist with whom Delta Dental has a written agreement to provide services at the in-network level for Eligible Individuals enrolled in this Delta Dental PPO Plan.
- c. "Delta Dental PPO Dentist's Fee" means the fee that a Delta Dental PPO Dentist has contractually agreed with Delta Dental to accept for treating Eligible Individuals under this Plan, or the Fee Actually Charged, whichever is less.
- d. "Fee Actually Charged" means the fee for a particular dental service or procedure which a Dentist submits to Delta Dental on a claim, less any portion of such fee which is discounted, waived or rebated, or which the Dentist does not use good faith efforts to collect.
- e. "Usual, Customary and Reasonable" means for a Dentist who has signed a Delta Dental Dentist Agreement, the fee that the Dentist has filed with Delta Dental and which Delta Dental has accepted. For Dentists who have not signed a Delta Dental Dentist Agreement, a fee is Usual, Customary and Reasonable if it satisfies a majority of Delta Dental's Dentists.

**Section 8.02. Benefits.** If an Eligible Individual incurs a Covered Dental Expense, the Plan will pay, subject to the limitations and exclusions stated in the Plan, the applicable percentage (shown under Section 8.03) of Delta Dental's Usual, Customary and Reasonable fee or the Fee Actually Charged, whichever is less, or the applicable percentage of the Delta Dental PPO Dentist's Fee, up to the following maximum benefit payments.

- a. Maximum Calendar Year Benefit for Dental Services: \$2,500 per person, per calendar year. Diagnostic and Preventive benefits are not counted toward this maximum.
- b. Maximum Lifetime Benefit for Orthodontic Services: \$2,500 per Dependent child age 18 and younger.

**Section 8.03. Schedule of Services.** Subject to the Limitations and Exclusions contained in Sections 8.04 and 8.07, the following services are Covered Dental Expenses provided they are necessary and customary, as determined by the standard of generally accepted dental practice:

- a. **Diagnostic and Preventive Services.** Payable at 100% of the Dentist's Usual, Customary and Reasonable fees, or the Fee Actually Charged, whichever is less, or 100% of the Delta Dental PPO Dentist's Fee, for the following services.
  - (1) Diagnostic. Procedures to assist the Dentist in evaluating existing conditions to determine the required dental treatment, including oral examination, bite-wing x-rays, examination of biopsied tissue, emergency palliative treatment of dental pain, specialist consultation.
  - (2) Preventive. Prophylaxis, fluoride treatment and sealants.
- b. **Basic Benefits.** Payable at 85% of the Dentist's Usual, Customary and Reasonable fees, or the Fee Actually Charged, whichever is less, or 85% of the Delta Dental PPO Dentist's Fee, for the following services.
  - (1) Full-mouth x-rays and other x-rays, space maintainers.
  - (2) Oral surgery. Extractions and certain other surgical procedures, including pre- and postoperative care.
  - (3) Restorative. Amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).
  - (4) Endodontic. Treatment of the tooth pulp.
  - (5) Periodontic. Treatment of gums and bones supporting teeth.
  - (6) Occlusal Guards. Covered only when prescribed for treatment of bruxism.
  - (7) Diagnostic casts/study models.
  - (8) Adjunctive General Services. General anesthesia, IV sedation, office visit for observation or after regularly scheduled hours, therapeutic drug injection, treatment

of post-surgical complications (unusual circumstances), and occlusal adjustment, limited.

- c. **Crowns, Inlays, Onlays and Cast Restoration Benefits.** Payable at 85% of the Dentist's Usual, Customary and Reasonable fees, or the Fee Actually Charged, whichever is less, or 85% of the Delta Dental PPO Dentist's Fee, for the following services.
  - (1) Crowns, inlays, onlays and cast restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) which cannot be restored with amalgam, silicate or direct composite (resin) restorations.
- d. **Prosthodontic Benefits.** Payable at 60% of the Dentist's Usual, Customary and Reasonable fees, or the Fee Actually Charged, whichever is less, or 60% of the Delta Dental PPO Dentist's Fee, for the following services.
  - (1) Construction or repair of fixed bridges, partial or complete dentures.
  - (2) Implant surgical placement and removal, and implant supported prosthetics, including implant repair and recementation.
- e. **Orthodontic Benefits.** The following benefits are payable for procedures performed by a licensed Dentist, involving surgical repositioning of the teeth or jaws in whole or in part and/or the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their function.
  - (1) Provided for Dependent children through age 18 only. Payable at 80% of the Usual, Customary and Reasonable fees or the Fee Actually Charged, whichever is less, or 80% of the Delta Dental PPO Dentist's fee, up to the lifetime maximum amount shown below.
  - (2) Lifetime Maximum Orthodontic Benefit: \$2,500 per eligible Dependent child.
  - (3) Benefits will not be paid for any month in which the child was not eligible under the Plan as a Dependent.
- f. **Note on Additional Benefits During Pregnancy.** When an Eligible Individual is pregnant, the Plan will pay for additional services to help improve her oral health during pregnancy. The additional services each calendar year while the individual is eligible under this Plan include: one additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant. Written confirmation of the pregnancy must be provided by the Eligible Individual or her Dentist when the claim is submitted.

**Section 8.04. Limitations.** The benefits described in Section 8.03 are subject to the following limitations:

- a. Benefits payable for oral examinations are limited to one examination every 6 months. (See note on additional benefits during pregnancy.) Specialist consultations are not subject to the once every six months limitation.)

- b. Benefits payable for prophylaxis (cleaning) and fluoride treatment are limited to 2 treatments in any calendar year. (See note on additional benefits during pregnancy.) Periodontal prophylaxes are not subject to the two cleanings per calendar year limitation.

Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit.

- c. Full mouth x-rays are covered only after 3 years have elapsed since any prior set of full-mouth was provided under any Delta Dental plan or the prior Trust Fund Plan. Intraoral/periapical x-rays amounting to 14 or more for any age are considered full-mouth x-rays. Bitewing x-rays are covered once in any 6-month period. A panoramic x-ray provided as an individual service is limited to once every 3 years.
- d. Crowns, inlays, onlays or cast restorations are covered benefits on the same tooth only once every five years while enrolled under any Delta Dental plan as well as the prior Trust Fund Plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration. (This limitation will not apply if the previous crown was a temporary stainless steel crown provided to a child under 19 years of age.)
- e. Direct composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspid. Any other posterior direct composite (resin) restorations are optional services and Delta Dental's payment is limited to the cost of the equivalent amalgam restorations.
- f. Benefits will not be payable for the replacement of an existing prosthodontic appliance or implant that were provided under any Delta Dental plan or the Trust Fund's prior dental plan, unless:
  - (1) the existing appliance is at least 5 years old; or
  - (2) Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing fixed bridge, partial denture or complete denture cannot be made satisfactory. Replacement of a Prosthodontic appliance or implant supported prosthesis that was not provided under a Delta Dental plan or the prior Trust Fund plan will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to once for each tooth during the Eligible Individual's lifetime.
- g. Delta Dental will pay the applicable percentage of the Dentist's allowable fee for a standard cast chrome or acrylic partial denture or a standard complete denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.)
- h. If an Eligible Individual selects a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee and the Eligible Individual is responsible for the remainder of the Dentist's fee. For example: a crown where an amalgam filling would restore the tooth, or a precision denture where a standard denture would suffice.

- i. Benefits for sealants are provided only for children under 14 years of age and only for permanent posterior molars that are without caries (decay) or restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant within 3 years of its application.
- j. Diagnostic casts are covered only when made in connection with subsequent orthodontic treatment covered under this Plan.
- k. Periodontal scaling and root planning is covered once for each quadrant each 24-month period. (See note on additional benefits during pregnancy.)

**Section 8.05. Pre-determination of Dental Services.** If a proposed dental treatment is extensive and involves crowns or bridges, or if the service will cost more than \$300, it is recommended that the Dentist request a predetermination of benefits from Delta Dental before treatment begins.

- a. To receive a predetermination, the Dentist must send a claim form listing the proposed treatment. Delta Dental will send the Dentist a Notice of Predetermination which estimates how much the Eligible Individual will have to pay.
- b. A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if the Patient meets all requirement of the Plan at the time the planned treatment is completed. Payment will depend on the individual's eligibility under the Trust Fund and remaining annual maximum when completed services are submitted to Delta Dental.

**Section 8.06. Extension of Dental Benefits.** In the event of termination of eligibility, the Plan will pay normal dental benefits for the following crowns and prosthetic devices only, when the crown or prosthetic device is furnished within 30 days following the date eligibility terminated:

- a. Delivery or placement of full or partial dentures, providing the final impression is taken on a date when the Employee or Dependent was eligible.
- b. Delivery or placement of fixed bridgework or crowns providing the teeth were first prepared on a date when the Employee or Dependent was eligible for dental benefits.

Examinations, x-rays or other services in connection with delivery and placement of prosthetic devices or crowns are not covered services under this Extension of Benefits provision.

**Section 8.07. Exclusions.** The following services are not covered Benefits:

- a. Dental expense incurred prior to the date the Patient became an Eligible Individual.
- b. Services for injuries or conditions that are covered under Workers' Compensation or Employer's Liability Laws.
- c. Experimental procedures or any procedures that are not within the standards of generally accepted dental practice.

- d. Services which are provided by any Federal or State Government Agency or are provided without cost to the Eligible Individual by any municipality, county or other political subdivision, except as provided in California Health and Safety Code Section 1373(a).
- e. Services related to congenital (hereditary) or developmental (following birth) malformations, or cosmetic surgery or dentistry performed for purely cosmetic reasons, including but not limited to: cleft palate, upper or lower jaw malformations, enamel hypoplasia (lack of development) and fluorosis (a type of discoloration of the teeth).
- f. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
- g. Prosthodontic services or any Single Procedure started prior to the date the Eligible Individual became eligible under this Plan. A Single Procedure is a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).
- h. Prescribed or applied therapeutic drugs, premedication or analgesia.
- i. All Hospital costs and any additional fees charged by the Dentist for Hospital treatment.
- j. Charges for anesthesia, other than general anesthesia or IV sedation administered by a licensed Dentist in connection with covered oral surgery services or select Endodontic and Periodontic procedures.
- k. Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- l. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
- m. Replacements of existing restorations for any purpose other than active tooth decay.
- n. Intravenous sedation.
- o. Complete occlusal adjustment.
- p. The replacement of a lost, misplaced or stolen appliance.
- q. Expense incurred as a result of broken appointments.
- r. Orthodontic services, other than as specifically provided in Subsection 9.03.e.
- s. Any expenses excluded under Article 11. *Exclusions, Limitations and Reductions.*



## ARTICLE 9. CONTINUATION COVERAGE (COBRA)

### Section 9.01. General.

Eligible Individuals who lose eligibility under the Plan due to one of the Qualifying Events described in Subsection 9.02.b., may continue Fund coverage for a limited period of time subject to the terms described in this Article.

**Section 9.02. Continuation Coverage under COBRA.** The health care continuation coverage provisions of the Employee Retirement Income Security Act, Sections 601 et seq., as amended (COBRA) require that under specific circumstances when coverage terminates, certain health plan benefits available to Eligible Individuals must be offered for extension through self payment. To the extent that COBRA applies to any Eligible Individual under this Plan, these required benefits will be offered in accordance with this Section.

a. **General.** Employees or their Dependents who lose eligibility under the Plan may continue Plan coverage subject to the terms of this Section. This Section is intended to comply with the health care continuation provisions of COBRA, which are incorporated into the Plan and are controlling in the event of any conflict between its provisions and the terms of this Section.

(1) Any Eligible Individual who is Totally Disabled and elects coverage under the Extended Benefits Due to Disability provision described in Section 3.16 is not eligible for the COBRA continuation coverage described in this Article 9.

b. **Continuation Coverage.** Employees and/or their Dependents whose eligibility terminates may continue coverage (except Life Insurance, Accidental Death and Dismemberment benefits and Burial Expense benefits) under COBRA upon the occurrence of a “Qualifying Event.”

A “Qualifying Event” is defined as any of the following:

(1) Termination of employment (for reasons other than gross misconduct);

(2) Reduction in the Employee’s Hour Bank below 120 hours;

(3) The Employee’s death;

(4) Divorce of the Employee from his Dependent Spouse;

(5) Cessation of a Dependent child’s Dependent status under the Plan.

c. **Qualified Beneficiary.** A Qualified Beneficiary as defined under COBRA is any individual who on the day before a Qualifying Event was covered under the Plan by virtue of being on that day either an Employee, the Spouse of an Employee, or a Dependent child of an Employee. A child born to or placed for adoption with an Employee during a period of COBRA continuation coverage is also a Qualified Beneficiary.

d. **Duration of Coverage.**

- (1) A Qualified Beneficiary whose eligibility would otherwise terminate because of a Qualifying Event described in paragraphs (1) or (2) of Subsection 10.02.b. may elect continuation coverage for up to 18 months from the date of the Qualifying Event. The 18-month period will expand to a maximum of 36 months from the date of the Qualifying Event for a Dependent if a second Qualifying Event (other than a termination of employment or reduction in work hours) occurs with respect to that Dependent during the original 18-month period and while the Dependent is covered under the Plan.
- (2) A Qualified Beneficiary whose eligibility would otherwise terminate because of a Qualifying Event other than one described in paragraphs (1) or (2) of Section 9.02.b., may elect continuation coverage for up to 36 months from the date of the Qualifying Event.
- (3) A Qualified Beneficiary who is determined by Social Security to be totally disabled at any time before, or during, the first 60 days after, a Qualifying Event described in Subsections 9.02.b.(1) or (2) may extend coverage beyond the original 18 months up to a total of 29 months. Other Qualified Beneficiaries in the disabled Qualified Beneficiary's family are also eligible for the 29 month extended coverage period. To qualify for the additional 11 months of coverage, the Qualified Beneficiary must report the Social Security disability determination to the Fund Office in writing before the original 18 month period expires and within 60 days after the Social Security determination.
- (4) If an Employee became covered under Medicare before losing eligibility due to a Qualifying Event described in Subsections 9.02.b.(1) or (2), Dependents of that Employee may elect continuation coverage until the later of
  - (a) 18 months from the date of the Qualifying Event; or
  - (b) 36 months from the date the Employee became entitled to Medicare.
- (5) If an Employee becomes covered under Medicare within 18 months after losing eligibility due to a Qualifying Event described in Subsections 9.02.b.(1) or (2), COBRA continuation coverage for the Employee will end when he becomes covered by Medicare; however, the Dependents of the Employee may elect to receive continuation coverage for a total of 36 months from the date of the Qualifying Event.
- (6) Any month of self-payment as provided in Section 2.02.e. will be used to offset the 18, 29 or 36 months of available COBRA continuation coverage described above.

e. **Termination of COBRA Continuation Coverage.** Notwithstanding the maximum duration of coverage described in the Subsection 9.02.d., a Qualified Beneficiary's continuation coverage will end on the earliest of the date on which:

- (1) The Employer of the Employee ceases to provide group health coverage to any of its employees;

- (2) The premium described in Subsection 9.02.h. is not timely paid. A payment is considered timely if it is received by the Fund Office within 30 days of the due date described in Subsection 9.02.h.;
  - (3) The Qualified Beneficiary becomes covered, after the Qualifying Event, under any other Group Plan (as an employee or otherwise), provided the other Group Plan may no longer limit or exclude coverage for the Qualified Beneficiary's pre-existing medical condition; or
  - (4) The Qualified Beneficiary becomes covered, after the Qualifying Event, under Part A or Part B of Medicare.
- f. **Election Procedure.** A Qualified Beneficiary must elect continuation coverage within 60 days after the later of: (1) the date of the Qualifying Event; or (2) the date on which the Qualified Beneficiary receives notice of COBRA continuation coverage from the Fund Office.
- Except as otherwise specified in the election, any election by a Qualified Beneficiary who is an Employee or Dependent Spouse will be deemed to include an election for any other Qualified Beneficiary who would lose coverage under the terms of the Plan as a result of a Qualifying Event. However, the failure to elect continuation coverage by an Employee or Dependent Spouse will result in any other Qualified Beneficiary being given a 60-day period to elect or reject coverage independently of the Employee's or Spouse's rejection.
- g. **Types of Benefits Provided.** A Qualified Beneficiary will be provided health coverage under the Plan which is identical to the health coverage that is provided to other Eligible Individuals who have not experienced a Qualifying Event. A Qualified Beneficiary has the option of continuing "core coverage" only. "Core coverage" means the health benefits the Qualified Beneficiary was receiving immediately before the Qualifying Event, except vision and dental benefits. Life insurance, burial expense benefits and accidental death and dismemberment benefits may not be continued under COBRA.
- h. **Premiums.** Premiums for continuation coverage will be charged to Qualified Beneficiaries in amounts established by the Board. Premiums are payable in monthly installments.
- (1) Any premium due for coverage during the coverage period before the election was made must be paid within 45 days of the date the Qualified Beneficiary elects continuation coverage.
  - (2) Thereafter, monthly premium payments are due on the 15th day of the month prior to the month for which continuation coverage is elected. A 30 day grace period for premium payment will be allowed before coverage is terminated. Notwithstanding the provisions of this Subsection, the Board may extend the premium payment due date.
- i. **Notice Requirement.** If the Qualifying Event is a divorce or a child losing Dependent status, the Qualified Beneficiary must notify the Fund Office in writing of the Qualifying Event no later than 60 days after the date of the Qualifying Event. If the Qualifying Event is the reduction of the Employee's Hour Bank below 110 hours, the determination that a

reduction has occurred will be made by the Fund Office. No later than 14 days after the date on which the Fund Office receives written notification from a Qualified Beneficiary or an Employer, the Fund Office will notify the Qualified Beneficiary in writing of his or her right to continuation coverage.

The Fund Office's written notification to a Qualified Beneficiary who is a Dependent Spouse will be treated as notification to all other Qualified Beneficiaries residing with that person at the time the notification is made.

## ARTICLE 10. COORDINATION OF BENEFITS

**Section 10.01.** If an Eligible Individual is entitled to benefits from another Group Plan, for which benefits are also due from this Fund, then the benefits provided by this Fund will be paid in accordance with the following provisions, not to exceed the total amount of benefits which would have been paid for the calendar year in the absence of other group coverage, or 100% of Covered Expenses incurred.

- a. If the Eligible Individual is the Employee, Fund benefits will be provided for Covered Expenses without reduction by this Plan.
- b. The benefits of a Group Plan which covers the Eligible Individual other than as a Dependent will be determined before the benefits of a Group Plan which covers the person as a Dependent.
- c. If the Eligible Individual for whom claim is made is a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan which covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, will be determined before the benefits of the Group Plan which covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year. If either Group Plan does not have the provisions of this rule c. regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule will not apply, and the rule set forth in the Plan which does not have the provisions of this rule c. will determine the order of benefits.
- d. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Group Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Group Plan which covers the child as a dependent of the parent without custody.
- e. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Group Plan which covers the child as a dependent of the natural parent with custody will be determined before the benefits of a Group Plan which covers that child as a dependent of the stepparent, and the benefits of a Group Plan which covers the child as a dependent of the stepparent will be determined before the benefits of a Group Plan which covers the child as a dependent of the natural parent without custody.
- f. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d. and e. above, the benefits of a Group Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other Group Plan which covers the child as a dependent child.

- f. When rules a., b., c., d., e., or f. do not establish an order of benefit determination, Fund benefits will be provided without reduction if the Eligible Individual has been eligible continuously for benefits from this Fund for a longer period of time than he or she has been continuously eligible for benefits from the other Group Plan, provided that:
- (1) The benefits of a Group Plan covering the Eligible Individual as a laid-off or retired employee will be determined after the benefits of any other Group Plan covering the person as an active employee.
  - (2) If either Group Plan does not have a provision regarding laid off or retired employees, which results in each Group Plan determining its benefits after the other, then the provision of Subsection (1) above will not apply.

**Section 10.02. Coordination with Preferred Provider Agreements.** In no event will a Covered Expense exceed the lesser of: (1) the normal charge billed by the provider for the expense, (2) the contractual rate for the expense under a preferred provider agreement between the provider and the other Group Plan with which this Plan is coordinating, or (3) this Plan's contractual rate if the provider is a Contract Provider under this Plan.

**Section 10.03. Coordination with Prepaid Plans.** In the event an Eligible Individual (i) has coverage under the indemnity portion of this Plan, and (ii) has coverage under a prepaid program under another Group Plan (regardless of whether the Eligible Individual must pay a portion of the premium for that plan), and (iii) uses the prepaid program for services covered by this Plan, then this Plan will only reimburse the copayments required of the Eligible Individual under the prepaid plan, and only if those copayments are required of every person covered by that program. For purposes of this Plan, the term "prepaid program" will include health maintenance organizations, individual practice associations, and any other programs that the Board in its sole discretion deems to be essentially similar to prepaid arrangements. However, normal coordination of benefits rules apply with regard to the order of benefit determination.

**Section 10.04. Coordination With Medicare.** Notwithstanding any other provision of this Article, if the Eligible Individual is the Employee or a Dependent and is eligible for Medicare either because of age or because he is entitled to a disability pension from Social Security, Fund benefits will be provided without reduction to the extent required by Section 9319 of the Omnibus Reconciliation Act of 1986.

**Section 10.05. Coordination with Medicaid.** Payments by this Plan for benefits with respect to an Eligible Individual will be made in compliance with any assignment of rights made by or on behalf of the Eligible Individual as required by California's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

Where payment has been made by the State under Medicaid for medical assistance in any case where this Plan has a legal liability to make payment for that assistance, payment for the benefits will be made in accordance with any State law which provides that the State has acquired the rights with respect to an Eligible Individual to the payment for that assistance. In no event will payment be made by this Plan, under this provision, for claims submitted more than one year from the date expenses were incurred. Reimbursement to the State, like any other entity which has made payment for medical assistance where this Plan has a legal liability to make payment, will be equal to Plan benefits or the amount actually paid, whichever is less.

## ARTICLE 11. EXCLUSIONS, LIMITATIONS, AND REDUCTIONS

**Section 11.01. Exclusions.** The Fund will not provide benefits for:

- a. Any amounts in excess of Allowed Charges or any services not considered to be customary and reasonable.
- b. Services not specifically listed in this Plan as Covered Services or those services which are not Medically Necessary.
- c. Services for which the Eligible Individual is not legally obligated to pay. Services for which no charge is made to the Eligible Individual. Services for which no charge would be made to the Eligible Individual in the absence of insurance or other indemnity coverage, except services received at a non-governmental charitable research Hospital which meets the following guidelines:
  - (1) It must be internationally known as being devoted mainly to medical research, and
  - (2) At least 10% of its yearly budget must be spent on research not directly related to Patient care, and
  - (3) At least one-third of its gross income must come from donations or grants other than gifts or payments for Patient care, and
  - (4) It must accept Patients who are unable to pay, and
  - (5) Two-thirds of its Patients must have conditions directly related to the Hospital's research.
- d. Any work related Injury or Illness. The Plan will however pay benefits on behalf of an Eligible who has incurred an occupational Injury or Illness 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; and
  - (2) The Eligible Individual agrees to reimburse the Fund for any benefits paid by the Fund 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.
- e. Conditions caused by or arising out of an act of war, armed invasion or aggression.
- f. Conditions caused by or arising out of involvement in the commission of a felony.

- g. Except to the extent benefits are required by federal law to be provided by the Fund, any services provided by a local, state or federal government agency or Hospital, or any services for which payment may be obtained from any such agency (except Medi-Cal or Medicaid).
- h. Any services and supplies in connection with Experimental or Investigational Procedures. For purposes of this Exclusion, the term Experimental or Investigational Procedures means a drug or device, medical treatment or procedure if:
  - (1) The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
  - (2) The drug, device, medical treatment or procedure, or the Patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
  - (3) Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
  - (4) Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
  - (5) For purposes of this Exclusion, "Reliable Evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.
- i. Any services or supplies excluded under any other Articles of the Plan.



## **ARTICLE 12. THIRD PARTY LIABILITY**

If an Eligible Individual is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

**Section 12.01.** Such Eligible Individual, or anyone receiving any Plan benefits as a result of the injury to the Eligible Individual, shall be required to pay to the Plan any and all proceeds whatsoever, including but not limited to proceeds designated as being for pain and suffering, received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage) arising out of any claims for money or other damages by the Eligible Individual or his or her heirs, parents, or legal guardians, or anyone else acting on his or her behalf, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. The assets so recovered shall be considered Plan assets and the recipient shall be under a fiduciary duty to pay them over to the Plan. In addition to any other remedy provided hereunder, the Plan shall be entitled to enforce this requirement by way of restitution or constructive trust, equitable lien by agreement or any other remedy permitted by law.

**Section 12.02.** Any Eligible Individual, or anyone acting on his or her behalf, who accepts payments from the Plan, or authorizes Plan payments to be made to anyone else, or on whose behalf any benefits are paid with respect to the Eligible Individual's injuries, agrees that a present assignment of the Eligible Individual's rights against such third party is automatically made to the extent of the payments made by the Plan.

**Section 12.03.** These rules are automatic, but the Plan may require that any Eligible Individual or his or her representative sign an Agreement to Reimburse or Assignment of Recovery in such form or on such forms as the Plan may require. If an Eligible Individual, or his or her representative, refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan, the Eligible Individual shall not be eligible for Plan benefit payments related to the injury involved. This remedy is in addition to all other remedies the Plan may have.

**Section 12.04.** If Plan benefits are paid on behalf of an Eligible Individual and upon recovery of any proceeds from or on behalf of the third party such benefits are not reimbursed to the Plan as set forth above, then the Eligible Individual will be ineligible for any future Plan benefit payment until the Plan has withheld an amount equal to the amount which has not been reimbursed. This remedy is in addition to all other remedies the Plan may have.

**Section 12.05.** Any Eligible Individual on whose behalf the Plan pays benefits agrees that the Plan may intervene in any legal action brought against a third party or any insurance company, including the Eligible Individual's own carrier for uninsured motorists coverage.

**Section 12.06.** An equitable lien by agreement shall exist in favor of the Plan upon all sums of money recovered by the Eligible Individual against any third party responsible for the injuries to the eligible employee. The lien may, but is not required to, be filed with the third party, the third party's agents, or the court. The Eligible Individual, and those acting on his or her behalf, shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

**Section 12.07.** If an Eligible Individual settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then the Eligible Individual shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim, unless the Plan or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.

**Section 12.08.** In addition to all other remedies the Plan may have, the Plan shall be subrogated to the rights of the Eligible Individual against the responsible third party.

**Section 12.09.** By accepting benefits under the Plan, a Participant and any Eligible Individual on whose behalf benefits are paid, agrees as a contractual matter enforceable under state or federal law, that upon receipt of recovery from the responsible third party, the person receiving the payment shall reimburse the Plan the amount of benefits it has paid to the Eligible Individual caused by the responsible third party.

## **ARTICLE 13. INTERNAL CLAIMS AND APPEALS PROCEDURES**

### **Section 13.01.**

All benefits will be paid by the Plan to the Employee, or to the provider if the Eligible Individual has assigned benefits to the provider, following the receipt of written proof, satisfactory to the Plan, covering the occurrence, character and extent of the charges for which the claim is made. The Plan's financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the Eligible Individual. Therefore, Plan benefits for a Hospital or Health Care Facility will generally be paid directly to the facility and Plan benefits for surgery will generally be paid directly to the provider of the services.

### **Section 13.02.**

- a. Except to the extent otherwise specifically provided in Subsections b. and c. of this Section or elsewhere in the Plan, every Eligible Individual is forbidden to sell, transfer, assign or dispose of any right to benefits under the Plan, and the Plan will not be required to recognize any such sale, transfer, assignment, or disposition. Any right to benefits under the Plan, is not subject in any manner to voluntary transfer or transfer by operation of law or otherwise, and is exempt from the claims of creditors or other such Claimants and from all orders, decrees, garnishments, executions or other legal process or proceedings not expressly authorized by federal law.
- b. Any Eligible Individual may direct that payment for benefits be paid to any provider of hospital, medical or other health services or supplies for providing such services or supplies to the Eligible Individual, or to any other agency that may have provided or paid for, or agreed to provide or pay for, any services or supplies for which benefits are payable by the Plan.
- c. In the event that through mistake or any other circumstance, an Eligible Individual has been paid or credited more than he is entitled to under the Plan or under the law, or has become obligated to the Plan under an indemnity agreement or a third party liability agreement or in any other way, the Plan may set off, recoup and recover the amount of the overpayment, excess credit or obligation from benefits accrued or thereafter accruing to the Employee, Dependent or beneficiary and not yet distributed, through the Plan's collection procedures, in any installments and to the extent determined by the Board.

### **Section 13.03. Facility of Payment**

In the event it is determined that the Employee is incompetent or incapable of handling his own affairs and no guardian has been appointed, or in the event the Employee has not provided the Trust Fund Office with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Trust Fund Office to be equitably entitled to payment. In the case of the death of the Employee before all amounts have been paid, the Plan may pay any of those amount to one or more of the following surviving relatives of the Employee: lawful Spouse, child or children, mother, father, brothers, or sisters or to the Employee's estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

### **Section 13.04. Definitions.**

- a. Adverse Benefit Determination. An “Adverse Benefit Determination” for health care claims 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:
- (1) 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);
  - (2) 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;
  - (3) a failure to cover an item or service because the Plan considers it to be experimental, investigational, not medically necessary or not medically appropriate;
  - (4) a decision that denies a benefit based on a determination that a Claimant is not eligible to participate in the Plan;
  - (5) A Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time is considered an Adverse Benefit Determination.
- b. Claim. The term “Claim” means a request for a benefit made by a Eligible Individual (hereinafter Claimant) in accordance with the Plan’s reasonable procedures.
- (1) 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 Claimant 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.
  - (2) 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 Claimant pays the entire cost, the Claimant should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.
  - (3) 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 Care Claims, if applicable), as described under Claim Procedures, below.

#### Claims are Categorized as Follows:

- c. Urgent Care Claim. The term “Urgent Care Claim” means a Claim for medical care or treatment that if normal Pre-Service or Concurrent Care 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.

- d. 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.
- e. Concurrent Care Claim. The term “Concurrent Care 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. A Concurrent Care Claim also refers to a request by a participant or beneficiary to extend a pre-approved course of treatment.
- f. Post-Service Claim. The term “Post-Service Claim” means a Claim for benefits that is not a Pre- Service, Urgent Care or Concurrent Care Claim. This will generally be a claim for reimbursement for services already rendered. A claim involving a rescission will be treated as a Post-Service Claim.
- g. 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.
- h. Rescission. “Rescission” means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind coverage of an Eligible Individual if he/she performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

**Section 13.05. Claim Procedures.**

- a. Urgent Care Claims. The Trust Fund Office or the Plan’s designated Review Organization for medical claims, Caremark for prescription drug claims or Operating Engineers Assistance Recovery Program (ARP) for chemical dependency claims, will determine whether a Claim is an Urgent Care 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 Care Claim, and notifies the Plan of such, it will be treated as an Urgent Care Claim.
  - (1) Urgent Care Claims, which may include requests for Precertification of Hospital admissions and Prior Authorization of services, may be requested orally or in writing to the Trust Fund Office or the Plan’s designated Review Organization for medical claims, Caremark for prescription drug claims or Operating Engineers Assistance Recovery Program (ARP) for chemical dependency claims.
  - (2) For properly filed Urgent Care Claims, the Trust Fund Office or the Plan’s designated Review Organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims, will respond to the Claimant and provider with a determination by telephone 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.
  - (3) If an Urgent Care Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Trust Fund Office or the Plan’s designated Review Organization for medical claims, Caremark for

prescription drug claims or ARP for chemical dependency claims, will notify the Claimant 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 Claimant 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.

- (4) During the period in which the Claimant 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 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.
  - (5) If a Claimant improperly files an Urgent Care Claim, the Trust Fund Office or the Plan's designated Review Organization, or Caremark or ARP will notify the Claimant as soon as possible but not later than *24 hours* after receipt of the Claim of the proper procedures required to file an Urgent Care 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 Claimant or authorized representative requests written notification. Unless re-filed properly, an improperly filed claim will not constitute a Claim.
- b. Pre-Service Claims. Under the terms of this Plan, Claimants are required to obtain Precertification (also called Pre-authorization or Prior Authorization) for: admission to a Hospital or Skilled Nursing Facility, out-patient surgery at a Hospital outpatient department or free standing Ambulatory Surgery Facility, bariatric surgery for weight loss, organ or tissue transplants, and chemical dependency services in order to receive maximum benefits. Precertification is also required for certain outpatient diagnostic imaging procedures, as described in Section 3.05, and for certain prescription drugs as described in Section 4.04.
- (1) Pre-Service Claim Urgent Care claims may be requested orally to the Plan's designated Review Organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims. All other Pre-Service Claim must be requested in writing to the Plan's designated Review Organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims. Any Pre-Service Claim Urgent Care claim requested in writing should prominently designate on its cover that it is an "Urgent Care claim" requiring immediate attention.
  - (2) The designated Review Organization, Caremark or ARP shall notify the Claimant of an improperly filed Pre-Service Claim and of the proper procedures to be followed in filing a claim, including additional information needed to make the claim complete, as soon as possible, taking into account the medical exigencies, but no later than: (i) *72 hours* after receipt of the claim in the case of Pre-Service Urgent Care, or (2) *5 days* after receipt of the claim in the case of Pre-Service claims.
  - (3) For properly filed Pre-Service Claims, designated Review Organization, Caremark or ARP shall notify, in writing, Claimant and, if requested, Claimant's doctor or other provider 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, Caremark or ARP. If an extension is necessary, the designated Review Organization, Caremark or ARP shall notify, in writing, Claimant of the need to extend the initial *15 day* period

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.

- (4) 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. Claimant has *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* from receipt of the request for additional information; or (ii) the date the participant responds to the request. The Review Organization, Caremark or ARP shall notify, in writing, the Claimant and, if requested, the Claimant's doctor or other provider of a decision within *15 days* after receipt of any additional information.
- c. Concurrent Care Claims. A claim involving concurrent care may be filed orally or in writing to the Trust Fund Office or the Plan's designated Review Organization for medical claims, Caremark for prescription drug claims or ARP for chemical dependency claims,
- (1) If a decision is made to reduce or terminate an approved course of treatment, the participant will be notified sufficiently in advance of the reduction or termination to allow the Participant or Beneficiary to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.
  - (2) Concurrent Care Claims that are an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Section for Urgent Care Claims. Concurrent Care Claims that are not an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Section for Pre-Service and Post-Service Claims.
  - (3) If the Concurrent Care Claim is approved, the participant will be notified orally followed by written notice provided no later than *3 days* after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, the participant will be notified orally followed by written notice.
- d. Post-Service Claims. A Post-Service Claim must be submitted in writing to Anthem Blue Cross for medical claims in California, the local Blue Cross Blue Shield plan for medical claims outside California (hereafter referred to as Blue Cross), Caremark for prescription drug claims or ARP for chemical dependency claims, in writing, using an appropriate claim form or appropriate electronic claims procedure, within one (1) year after expenses are incurred. (This does not apply to dental or vision claims, which must be submitted to Delta Dental Plan or Vision Service Plan, respectively, under the terms and timeframes established by those Plans.) 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.
- (1) 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. Claimants do not have to submit an additional claim form if the bill(s) are for a continuing illness and Claimant 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 all required information for the request to be considered a Claim and for the Plan to be able to decide the claim.

- (2) In the event of death, the Participant's or Beneficiary's estate must obtain a claim form and submit the written claim form and a certified copy of the death certificate to the Trust Fund Office.
  - (3) A Post-Service Claim is considered to have been filed upon receipt of the Claim by Blue Cross, Caremark or ARP. The Trust Fund Office or Caremark shall notify, in writing, Claimants of decisions on Post-Service Claims within *30 days* of receipt of the Claim by Blue Cross, Caremark or ARP. The Trust Fund Office, Blue Cross, Caremark or ARP 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 Trust Fund Office or Caremark shall notify Claimants, in writing, of the need to extend the initial *30-day* period prior to the expiration of the initial *30 day* period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered.
  - (4) If an extension is required because the Plan needs additional information from the participant, the Trust Fund Office, Blue Cross, Caremark or ARP shall request additional information from provider and/or Claimant via fax, telephone, Explanation of Benefits (EOB) or letter within *30 days* of the receipt of the Claim or within *45 days* if a *15 day* extension is taken. The request for additional information shall specify the information needed. Claimant has *45 days* from receipt of the request for additional information 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* from receipt of the request for additional information; or (ii) the date the participant responds to the request. The Trust Fund Office or Caremark shall notify, in writing, the Claimant and, if requested, the Claimant's doctor or other provider of a decision within *15 days* after receipt of any additional information.
- e. New or Additional Rationale or Evidence. If the Plan bases an adverse benefit decision on new or additional rationale or evidence, Claimant must be provided:
    - (1) the new rationale or evidence as soon as possible, and
    - (2) reasonable opportunity to respond prior to the due date for the initial benefit decision.
  - f. Expiration of Time Periods. If a claim is not acted upon within the time periods prescribed herein, the Claimant may proceed to the appeal procedure as if the claim were denied.
  - g. Right to Continued Coverage. If the Claimant initiates an internal appeal in compliance with the internal appeals process set forth herein and if the appeal concerns a previously approved ongoing course of treatments to be provided over a period of time or number of treatments, the Plan shall continue to provide such coverage pending the outcome of the internal appeal.
  - h. Life Insurance Claims. For Life Insurance and Accidental Death and Dismemberment Claims, including burial expense benefits, the insurance company will make a decision on the claim and notify the Claimant of the decision within *90 days* of receipt of the claim. If the insurance company 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*.

- i. Dental and Vision Claims. Dental claims must be submitted to the dental insurance carrier, Delta Dental Plan. Vision claims must be submitted to the vision plan administrator, Vision Service Plan.

**Section 13.06. 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 in writing on a form available at the Trust 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 Trust Fund Office at least annually.

A health care professional with knowledge of the participant's medical condition may act as an authorized representative. The participant does not need to designate in writing that the Health Care Professional is his/her authorized representative for an Urgent Care Claim.

**Section 13.07. Written Notice of Initial Adverse Benefit Determination.** The participant will be provided with written notice of the initial benefit determination. The notice for Urgent Care Claims may be provided orally and followed with written notification. If the determination is an Adverse Benefit Determination, the written notice shall include:

- a. identification of the claim involved (e.g., date of service, health care provider, claim amount if applicable).
- b. the specific reason(s) for the determination, including the denial code, if any, and its corresponding meaning as well as any Plan standards used in denying the claim;
- c. reference to the specific Plan provision(s) on which the determination is based;
- d. a description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
- e. a description of the Plan's internal appeal procedures and external review processes along with time limits and information regarding how to initiate an internal appeal;
- f. a statement that, upon request and free of charge, any applicable diagnosis code and/or treatment code, and their corresponding meanings, will be provided, but that a request for this information will not be treated as a request for Internal Appeal;
- g. a statement of the Claimant's right to bring civil action under ERISA Section 502(a) after the internal appeal and, if applicable, the external review is completed;
- h. if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement that such rule, guideline, protocol or criteria that was relied upon will be provided to the participant upon request free of charge;
- i. if the denial was based on medical necessity, experimental or investigational treatment, or similar exclusion or limit, a statement that an explanation regarding the scientific or clinical judgment for the denial will, upon request, be provided to the participant free of charge;

- j. if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
  - (1) the Notice of Adverse Benefit Determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
  - (2) upon request the Plan shall provide a Notice of Adverse Benefit Determination in that non-English language;
  - (3) the Notice of Adverse Benefit Determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language;
  - (4) any customer assistance services provided by the Plan shall be provided in that non-English language;
- k. a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) Claimant's rights, (2) the notice, or (3) other assistance; and
- l. for Urgent Care Claims, a description of the expedited review process applicable to Urgent Care Claims.

**Section 13.08. Internal Appeal Procedures.**

- a. Appealing an Adverse Benefit Determination. If any Claim is denied in whole or in part, or if Claimant 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. The request for Appeals of Adverse Benefit Determinations must include
  - the Patient's name and address
  - the Employee's name and address, if different;
  - a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
  - the date of the Adverse Benefit Determination; and
  - the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.
- (1) Urgent Care Claims. Appeals of Adverse Benefit Determinations regarding Urgent Care Claims may be made either in writing to the Trust Fund Office or the Plan's designated Review Organization, or orally by calling the Trust Fund Office or the Plan's designated Review Organization or by other available similarly expeditious method, including electronic means. A written appeal should prominently designate on the cover that it is an Urgent Care claim requiring immediate attention. An appeal of an Urgent Care claim requiring immediate attention shall be reviewed on an expedited basis. All necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, e-mail or other available similarly expeditious method, with written notice to follow within *48 hours*.

- (2) Concurrent Care Claims. Appeals of Adverse Benefit Determinations regarding Concurrent Care Claims may be made in the same manner as an Urgent Care Claims if the timeframe for a decision 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. All other Concurrent Care Claims shall be filed in the same manner as a Pre-Service Claim.
  - (3) Pre-Service Claims. Appeals of Adverse Benefit Determinations regarding Pre-Service Claims must be submitted in writing to the Trust Fund Office or the Plan's Designated Review Organization 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 the Plan's designated Review Organization in accordance with Plan provisions will not be considered an appeal, but a new Pre-Service Claim.
  - (4) Post-Service Claims. Appeals of Adverse Benefit Determinations regarding Post-Service Claims must be submitted in writing to the Trust Fund Office or the Plan's Designated Review Organization via mail or facsimile.
  - (5) Dental and Vision Claims. Appeals of denied dental or vision claims must first be submitted to Delta Dental Plan or Vision Service Plan. After exhausting the appeals procedures of Delta Dental Plan or Vision Service plan, the Claimant may then submit an appeal in writing to the Trust Fund Office under the appeals process noted in this Section for Post-Service Claims.
- b. The Appeal Process. The Claimant 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 Claimant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to the Claim if the documents:
- (a) were relied upon in making the initial determination, (b) were submitted, considered or generated in the course of making the internal adverse benefit determination even if not relied upon, (c) demonstrate that the Plan provisions have been followed and applied consistently with respect to similarly situated individuals, or (d) constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, whether or not relied upon.
- (1) A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim or the subordinate of such person. 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 Claimant.
  - (2) 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 Claimant 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) Claimant shall have no right to personally appear before the named fiduciary for appeals unless the named fiduciary for appeals in its sole discretion concludes that such

an appearance would be of value in enabling it to review the adverse initial determination.

c. Timeframes for Sending Notices of Appeal Determinations.

- (1) Urgent Care Claims. Notice of the appeal determination for Urgent Care Claims will be provided as soon as possible, taking into account the medical exigencies, but not later than *72 hours* of receipt of the appeal by the Trust Fund Office or the Plan's designated Review Organization.
- (2) 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.
- (3) Concurrent Care Claims. Notice of the appeal determination for a Concurrent Care Claim will be sent by the Trust Fund Office or its designated Review Organization according to the following time periods:
  - (a) if the concurrent care claim concerns a reduction or termination of an initially approved course of treatment, before the proposed reduction or termination takes place; or
  - (b) for all other claims to extend a concurrent care treatment, the decision must be made in the time periods:
    - (i) for urgent care appeals the notification period is based on the current urgency of the claim;
    - (ii) for non-urgent pre-service and post-service concurrent appeals the time periods set forth under each standard.
- (4) Post-Service Claims. Ordinarily, decisions on appeals involving Post Service Claims will be made at the next regularly scheduled meeting of the appeals committee of the Board of Trustees following receipt of Claimant'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 Claimant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the Claimant's request for review may be necessary. The Claimant will be advised in writing in advance of this extension. Once a decision on review of Claimant's Claim has been reached, the Claimant will be notified as soon as possible, but no later than *5 days* after the date of the decision.
- (5) If the decision on review is not furnished to the Claimant within the time specified in this Section, the Claimant's Claim shall be deemed denied upon review. In such situation, Claimant may request an External Review for a claim that fits within the parameters for External Review.

**Section 13.09. Written Notice of Final Internal Benefit Determination.** The participant will be provided with written notice of the final internal benefit determination. The notice for Urgent Care Claims may be provided orally and followed with written notification. If the determination is a Final Internal Adverse Benefit Determination, the written notice shall include:

- a. information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable),
- b. a statement that, upon request and free of charge, any applicable diagnosis code and/or treatment code, and their corresponding meanings, will be provided, but that a request for this information will not be treated as a request for External Review;
- c. the specific reason(s) for the adverse appeal review determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the appeal, including a discussion on how the standard was applied;
- d. reference to the specific Plan provision(s) on which the determination is based;
- e. a statement that the Claimant is entitled to receive, upon written request and free of charge, reasonable access to and copies of all documents relevant to the Claim;
- f. if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement that such rule, guideline, protocol or criteria that was relied upon will be provided to the Claimant free of charge upon request;
- g. if the determination was based on medical necessity, experimental or investigational treatment, or other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge to the Claimant upon request;
- h. a statement of the Claimant's right to file a request for an External Review, or for an eligibility dispute, bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
- i. if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
  - (1) the Notice of Final Internal Adverse Benefit Determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
  - (2) upon request the Plan shall provide a Notice of Final Internal Adverse Benefit Determination in that non-English language;
  - (3) the Notice of Final Internal Adverse Benefit Determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language;
  - (4) any customer assistance services provided by the Plan shall be provided in that non-English language;
- j. a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) Claimant's rights, (2) the notice, or (3) other assistance;
- k. a statement of the Claimant's right to external review if the final adverse benefit determination involves either medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level

of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; or a rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time and, if applicable, a description of the external review process processes along with time limits and information regarding how to initiate an external review;

1. a statement of the Claimant's right for Urgent Care claims or when Claimant is receiving an ongoing course of treatment, that Claimant shall be allowed to proceed with expedited external review if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Claimant received emergency services, but has not been discharged from a facility; and a description of the expedited review process.

### **Section 13.10. Legal Proceedings.**

- a. Legal Actions. A Claimant may pursue their claim for benefits in court under ERISA §502(a) but only after they exhaust their internal appeal and external review remedies as provided in the claims procedures. Failure of a Claimant to exhaust his or her internal appeal and external review remedies will preclude judicial review.
- b. Legal Standards.
  - (1) Except in cases where federal law requires an external review upon request of a Claimant, the named fiduciary for appeals is given full discretionary authority (a) to finally determine all facts relevant to any claim, (b) to finally construe the terms of the Plan and all other documents relevant to the Plan, and (c) to finally determine what benefits are payable from the Plan.
  - (2) Any decision made by any named fiduciary for appeals shall be binding on all persons affected to the fullest extent permitted by law.
  - (3) No decision of a named fiduciary for appeals shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the named fiduciary for appeals was an abuse of discretion in light of the information actually available to it at the time of its decision.
  - (4) A decision of an IRO shall be final and binding unless a Court of competent jurisdiction determines otherwise.

## ARTICLE 14. EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the Affordable Care Act (ACA) External Review requirements. For purposes of this section, references to the “Claimant” include the Participant and any covered Dependent(s), and the Participant’s and covered Dependent(s)’ authorized representatives; and references to “Plan” include the Plan and its designee(s).

The term “Independent Review Organization or IRO” means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan’s External Review provisions outlined in this Article and current federal external review regulations.

The Plan shall either:

- (1) contract with at least two IROs by January 1, 2012 to perform external review services and contract with at least three IROs by July 1, 2012 to perform external review services; or
- (2) contract with a third party administrator who contracts with at least two IROs by January 1, 2012 to perform external review services and contract with at least three IROs by July 1, 2012 to perform external review services, but only if the Plan Sponsor monitors the review process in order to confirm compliance.

**Section 14.01.** If an appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied, the Claimant may request further external review by an independent review organization (“IRO”) if the denial fits within the parameters described in paragraphs a. and b. below:

- a. The denial involves medical judgment, including but not limited to, those based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or
- b. The denial is due to a Rescission of coverage (i.e., any cancellation or discontinuance of coverage that has a retroactive effect), regardless of whether the rescission has any effect on any particular benefit at that time.

**Section 14.02.** Generally, an External Review may be requested only after the Claimant has exhausted the internal claims and appeals process described in Article 13. This means that, in the normal course, a Claimant may only seek External Review after a final Adverse Determination has been made on an appeal.

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

**Section 14.03. External Review of Standard (Non-Urgent Care) Claims.** A request for External Review of a non-urgent claim must be made, in writing, within *four (4) months* of the date that the Claimant receives notice of a denial of an internal appeal. An internal appeal denial is referred to below as an “Adverse Determination.” An External Review request on a non-urgent care claim should be made to the Trust Fund Office.

**a. Preliminary Review of Standard (Non-Urgent Care) Claims**

- (1) Within *five (5) business days* of the Trust Fund Office's receipt of a request for an External Review of a non-urgent care claim, the Trust Fund Office will complete a preliminary review of the request to determine whether:
  - (a) the Claimant is/was covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
  - (b) the Adverse Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan, or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;
  - (c) the Claimant has exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the Claimant is not required to do so); and
  - (d) the Claimant has provided all of the information and forms required to process an External Review.
- (2) The preliminary review by the Trust Fund Office shall take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination or internal appeal.
- (3) Within *one (1) business day* of completing its preliminary review, the Trust Fund Office will notify the Claimant in writing as to whether Claimant's request for External Review meets the above requirements for External Review. This notification will inform the Claimant:
  - (a) If Claimant's request is complete and eligible for External Review; or
  - (b) If the request is complete but not eligible for External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
  - (c) If the request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow the Claimant to perfect (complete) the request for External Review within the *four (4) month* filing period, or within a *48-hour* period following receipt of the notification, whichever is later.

**b. Review of Standard (Non-Urgent Care) Claims by an Independent Review Organization (IRO)**

If the request for external review is complete and eligible for an external review, Trust Fund Office shall as soon as practicable refer, on a rotating basis, a proper request for external review to an accredited Independent Review Organization (IRO) with whom the Trust Fund Office has contracted to perform external review services or the Trust Fund Office shall monitor that the third party administrator (TPA) referred as soon as practicable, on a rotating basis, the request for external review to one of the IROs with whom the third party administrator has contracted to perform external review services. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. Once the claim is assigned to an IRO, the



following procedure will apply to the IRO and will be monitored by the Trust Fund Office or TPA:

- (1) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review, including directions about how the Claimant may submit additional information regarding Claimant's claim within *ten (10) business days* following the date of receipt of the notice. The Trust Fund Office shall monitor to assure that IRO notifies Claimant of IRO's acceptance of claim for review and Claimant's right to submit additional information to IRO within *ten (10) business days* from receipt of notice.
- (2) Within *five (5) business days* after the External Review is assigned to the IRO, the Trust Fund Office shall provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
- (3) If the Claimant submits additional information related to the claim to the IRO, the assigned IRO shall, within *one (1) business day*, forward that information to the Trust Fund Office. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the External Review. If, upon reconsideration, the Plan reverses its Adverse Determination, the Trust Fund Office shall provide written notice of the Plan's decision to the Claimant and the IRO within *one (1) business day* after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- (4) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- (5) In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including: information from the Claimant's medical records; recommendations or other information from the treating (attending) health care providers; other information from the Claimant or the Plan; reports from appropriate health care professionals; appropriate practice guidelines and applicable evidence-based standards; the Plan's applicable clinical review criteria unless the criteria are inconsistent with the Plan or applicable law; and/or the opinion of the IRO's clinical reviewer(s).
- (6) The assigned IRO will provide written notice of its final External Review decision to the Claimant and the Trust Fund Office within *forty-five (45) days* after the IRO receives the request for the External Review.
- (7) The decision of the IRO is binding except to the extent that other remedies may be available under state or federal law to the Plan or Claimant. If the IRO's final external review decision reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan shall immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

- (8) The assigned IRO's decision notice will contain:
- (a) a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code(s) and the corresponding meaning(s), treatment code(s) and the corresponding meaning(s), reason for the previous denial and denial code(s) and the corresponding meaning(s));
  - (b) the date that the IRO received the request to conduct the External Review and the date of the IRO decision;
  - (c) references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
  - (d) a discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
  - (e) a statement that the IRO's determination is binding on the Plan (unless other remedies may be available to the Claimant or the Plan under applicable State or Federal law);
  - (f) a statement that judicial review may be available to the Claimant; and
  - (g) if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
    - (1) the Notice of Final External Review Decision must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
    - (2) upon request the Plan shall provide a Notice of Final External Review Decision in that non-English language;
    - (3) the Notice of Final External Review Decision must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language;
    - (4) any customer assistance services provided by the Plan shall be provided in that non-English language;
  - (h) a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) Claimant's rights, (2) the notice, or (3) other assistance.

#### **Section 14.04. External Review of Expedited Urgent Care Claims**

- a. A Claimant may request an expedited External Review if:
- (1) The Claimant receives an initial adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize Claimant's life or health, or would jeopardize Claimant's

ability to regain maximum function, and Claimant has filed a request for an expedited internal appeal; or

- (2) The Claimant receives a final adverse determination of an appeal that involves a medical condition for which the timeframe for completion of a non-urgent external review would seriously jeopardize Claimant's life or health or would jeopardize Claimant's ability to regain maximum function; or, the Claimant receives a final adverse determination that concerns an admission, availability of care, continued stay, or health care item or service for which Claimant received services for an emergency, but Claimant has not yet been discharged from a facility.
- b. Requests for external review of expedited urgent care claims should be made to the following Plan designee:
- (1) Anthem Blue Cross with respect to a denied urgent care claim not involving retail or mail order prescription drug expenses; or
  - (2) Caremark with respect to a denied urgent care claim involving retail or mail order prescription drug expenses.

Claimants may submit written comments, documents, records or other information relating to the claim.

- c. **Preliminary Review of an Expedited Urgent Care Claim.** Immediately upon receipt of the request for expedited External Review, Anthem Blue Cross or Caremark shall complete a preliminary review of the request for an expedited external review to determine whether the requirements for preliminary review are met (as described under Standard Non-Urgent Care claims above).

Anthem Blue Cross or Caremark shall immediately notify the Claimant (e.g. telephonically, via fax) as to whether Claimant's request for review meets the preliminary review requirements, and if not, will provide or seek the information needed to complete the request as described under Standard Claims above.

- d. **Review of Expedited Claim by an Independent Review Organization (IRO)**

If Anthem Blue Cross or Caremark determines that a request is eligible for expedited External Review, Anthem Blue Cross or Caremark shall refer, on a rotating basis, a proper request for external review to an accredited Independent Review Organization (IRO) with whom they have contracted to perform external review services. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. Anthem Blue Cross or Caremark will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its initial adverse benefit determination or final adverse determination. Once the claim is assigned to an IRO, the following procedure will apply:

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

- (2) The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- (3) The IRO will provide notice of their final expedited External Review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than *seventy-two (72) hours* after the IRO receives the request for an expedited External Review. If the notice of the IRO's decision is not in writing, within *forty-eight (48) hours* after the date of providing that notice, the IRO must provide written confirmation of the decision to the Claimant and the Plan.
- (4) The decision of the IRO is binding except to the extent that other remedies may be available under state or federal law to the Plan or Claimant. If the IRO's final External Review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

## ARTICLE 15. GENERAL PROVISIONS

**Section 15.01.** The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of the Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement will prevail.

**Section 15.02.** The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

**Section 15.03.** The Fund, at its own expense, has the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

### **Section 15.04. 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.

- (1) Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SARs, 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 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.
- e. 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
- f. 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.
- g. 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.
- h. 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.
- i. The Board of Trustees of the Operating Engineers 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.



## ARTICLE 16. RECIPROCITY

**Section 16.01.** Eligibility for benefits is provided under this Article for Employees who would otherwise be ineligible for health and welfare benefits because their hours of employment have been divided between different health and welfare trust funds. The provisions of this Article are operative only if the Operating Engineers Local Union No. 3 Reciprocity Agreement has been adopted by each of the funds in whose jurisdiction the Employee works.

**Section 16.02.** The responsibility for coverage of an employee who is available for work but ineligible for coverage because his hours were worked under two or more of the funds signatory to the Reciprocity Agreement will be determined in accordance with the administrative procedures outlined in the Reciprocity Agreement.

## ARTICLE 17. AMENDMENT AND TERMINATION

**Section 17.01.** The Board has determined that each of the conditions, limitations and other terms of this Plan are essential to carry out the obligation of the Fund to provide benefits to all Employees. In furtherance of that obligation, the Board expressly reserves the right, in its sole discretion at any time, upon a non-discriminatory basis:

- a. To terminate or amend either the amount or condition with respect to any benefit even though the termination or amendment affects claims which have already accrued; and
- b. To alter or postpone the method or payment of any benefit; and
- c. To amend or rescind any other provisions of the Plan.

## ARTICLE 18. DISCLAIMER

**Section 18.01.** A certain portion of the benefits described in this plan are paid directly from the assets of the Fund, and there is no liability on the Board or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for that purpose. Any benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for payment.

**Section 18.02.** The Fund has no control over any diagnosis, treatment, care or other services delivered to an Eligible Individual by a health care provider, whether the provider is a Contract Provider or a Non-Contract Provider, and disclaims liability for any loss or injury caused to the Eligible Individual by any provider by reason of negligence, failure to provide treatment or otherwise.

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