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PENSIONED OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND

Summary Plan Description

ENROLL IN MEDICARE

It is very important that you are enrolled in both Parts A and B of Medicare in order to prevent a reduction in Plan benefits. If you or your Spouse is eligible for Medicare, benefits available under Parts A and B of Medicare will be deducted from the benefits payable under the Plan's comprehensive medical benefits, **regardless of whether or not you have actually enrolled for Medicare and regardless of whether or not your doctor or other medical provider has chosen to participate in Medicare.**

This Plan will estimate that Medicare Part A paid everything except the deductible and that Medicare Part B paid 80% of Medicare Part B charges and cover only the remaining 20%, even if you have not actually enrolled in Medicare. See "If You Are Eligible for Medicare" on page 66 for more information.

2023

PENSIONED OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND

Summary Plan Description and Rules and Regulations

April 1, 2023

Prepared by the Segal Company

ENROLL IN MEDICARE

It is very important that you are enrolled in both Parts A and B of Medicare in order to prevent a reduction in Plan benefits. If you or your Spouse is eligible for Medicare, benefits available under Parts A and B of Medicare will be deducted from the benefits payable under the Plan's comprehensive medical benefits, **regardless of whether or not you have actually enrolled for Medicare and regardless of whether or not your doctor or other medical Provider has chosen to participate in Medicare**.

This Plan will estimate that Medicare Part A paid the claim except the deductible and that Medicare Part B paid 80% of Medicare Part B charges. The Plan's payment will be based on the remaining 20% of the claim only, even if you have not actually enrolled in Medicare. See "If You Are Eligible for Medicare" on page 66 for more information.

PENSIONED OPERATING ENGINEERS
HEALTH AND WELFARE TRUST FUND

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PENSIONED OPERATING ENGINEERS
HEALTH AND WELFARE TRUST FUND

TO ALL PENSIONED OPERATING ENGINEERS:

We are pleased to provide you and your eligible Dependents with this booklet describing your health care benefits under the Pensioned Operating Engineers Health and Welfare Trust Fund effective April 1, 2023 (except for those provisions that specifically indicate other effective dates). This document replaces all other Summary Plan Descriptions (SPD) previously provided to you. This booklet also includes the Rules and Regulations of the Pensioned Operating Engineers Health and Welfare Trust Fund.

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), and
- Other important Plan information.

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 Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó 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 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

TRUST FUND OFFICE	
• **Eligibility information and Enrollment forms** • **COBRA administrator** • **Cost of COBRA continuation coverage** • **COBRA premium payments** • **HIPAA Privacy Notice** • **Medicare Part D Notice of Creditable Coverage** • **Summary of Benefits and Coverage (SBC)**	**(800) 251-5014 or (510) 433-4422 or (510) 271-0222** **www.oe3trustfunds.org**
• **Claims information and Contract Provider updates**	**(800) 251-5014 or (510) 433-4422**

FRINGE BENEFITS SERVICE CENTER	
Benefits questions	**(800) 532-2105 or (510) 748-7450**

ANTHEM BLUE CROSS (For Comprehensive Medical Plan participants in California)	
• **Help finding Contract Providers** • **Help finding Centers of Excellence and Value Based Facilities**	**Use the provider finder feature on www.anthem.com/ca** **Call Anthem: 800-888-8288** **(or call the Trust Fund Office)**
• **Required Pre-Authorizations for Hospital admissions, surgery, or organ or tissue transplants** • **Recommended Pre-Authorizations for medical equipment costing over $500**	**Have your doctor call the Pre-Authorization Number: (800) 274-7767**
Note: Pre-Authorization required only if you are not Medicare eligible.	

BLUE CARD (For Comprehensive Medical Plan participants outside of California)	
• **Help finding Contract Providers**	**www.bluecares.com or call (800) 810-2583**
• **Required Pre-Authorizations for Hospital admissions, surgery, and organ or tissue transplants**	**Have your doctor call (800) 274-7767**
Note: Pre-Authorization required only if you are not Medicare eligible.	

AMERICAN IMAGING MANAGEMENT (For Comprehensive Medical Plan participants not eligible for Medicare)	
• **Required Pre-Authorizations for outpatient diagnostic imaging procedures**	**Have your doctor call (877) 291-0360**

ASSISTANCE AND RECOVERY PROGRAM (ARP) (For Comprehensive Medical Plan and HMO participants)	
Referrals and required Pre-Authorizations for chemical dependency (substance abuse) treatment	**(800) 562-3277**

OPTUMRX	
• **Prescription drug benefits if you're in the Comprehensive Medical Pan** • **Retail, mail order and Specialty Pharmacy Services**	**(855) 672-3644 or www.optumrx.com** **TDD assistance: (855) 672-3644 (TTY 711)** **Mail order:** **For physicians to call in prescriptions: 800-791-7658** **For participants: (855) 672-3644** **Specialty Pharmacy Services, call (855) 672-3644**
If you are in an HMO, call the HMO about prescription drugs instead of OptumRx	

DELTA DENTAL PLAN OF CALIFORNIA (Dental benefits available to participants in the continental U.S.)	
• **Help finding Delta PPO Dentists** • **Questions or complaints regarding denial of dental services or claims**	**(800) 765-6003 or www.deltadentalins.com**

PREPAID DENTAL PLANS (Dental benefits available to participants who live in the service area)	
• **MetLife Dental Plan** (if you live in the service area)	**(800) 880-1800**
• **Hawaii Dental Service** (for Hawaii residents)	**From Oahu: 529-9248** **Toll Free: (800) 232-2533, ext. 248** **www.deltadentalhi.com**

HMSA (Hawaii Medical Service Association) (A Medicare and Non-Medicare HMO plan option for those living in Hawaii)	
• **Non-Medicare Plan** • **Akamai Advantage (Medicare Advantage) Plan**	**(800) 776-4672** **www.hmsa.com**

HEALTHNET SENIORITY PLUS HMO PLAN (a Medicare Advantage plan for those who are Medicare eligible)	
HealthNet Member Services	**(800) 275-4737** **TTY 800-995-0852**

HEARING AID VENDOR	
Hear USA	**(800) 442-8231** **www.hearusa.com**

KAISER HMO PLANS	
• **Kaiser Northern California**	**(800) 464-4000**
• **Kaiser Hawaii**	**(800) 966-5955**

SMOKING CESSATION ASSISTANCE (California only)	
Smokers' Helpline	**(800) 662-8887 (English)** **(800) 456-6386 (Spanish)**

UNITED HEALTHCARE SECURE HORIZONS HMO PLAN (a Medicare Advantage HMO plan for those who are Medicare eligible)	
Secure Horizons Customer Service	**(866) 622-8055**

VISION SERVICE PLAN	(800) 877-7195
Vision care benefits	**www.vsp.com**

CONTENTS

Chapter 1: Overview

In this chapter you will find:
- ✓ An overview of your benefits
- ✓ Privacy of health information
- ✓ Information on filing claims
- ✓ Role of Medicare

OVERVIEW OF BENEFITS AVAILABLE	
Benefit	**Description**
Medical	A Contract Provider feature allows you to keep your share of the costs down. NOTE: You have the option of enrolling in an HMO instead if you live in one of the HMO service areas.
Hearing Aids	The Plan pays up to $2,025 per ear, once every 48-months
Prescription Drugs	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. The Plan also offers a mail order service for medications you take on a long-term basis. NOTE: If you enroll in Kaiser, HealthNet, United HealthCare, or HMSA in Hawaii, you will have prescription drug coverage through the HMO.
Dental The Dental plan requires a separate enrollment decision and payment of premiums for coverage. You can enroll in the benefits listed above without enrolling in dental coverage.	The Delta Dental Plan described in this booklet offers a High Option plan and a Low Option plan and is available if you do not live in Hawaii. You also have the option of enrolling in a prepaid dental plan instead if one is available in the area where you live. Hawaii residents may enroll in the Hawaii Dental Service (HDS) plan that is described in a separate booklet.
Vision Care	The Plan pays benefits for eye exams and glasses or contact lenses. The Vision Service Plan Contract Provider feature allows you to keep your share of the costs down.

More detailed information on your benefits, including charts showing specific benefits, can be found in the chapters describing the individual benefits. Also, see Chapter 10, "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 1 of the Rules and Regulations that follow the SPD. It contains definitions of the words and terms used in the SPD.

However, because the following terms are so important, we are providing the definitions here so that you understand the meaning of these terms when you see them in the SPD. For the complete legal definition of these and other terms, please refer to Article 1 of the Rules and Regulations.

Allowed Charge means the lesser of:

- For Emergency Services provided by Non-Contract Providers, for Non-Emergency Services provided by a Non-Contract Provider at a Contract Health Facility, and for Air Ambulance Services, the Out-of-Network Rate, as defined below**.**

- For all other services, the lesser of:

  - ✓ 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. 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 Provider's billed rate. When a 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 organization to assist the Plan in determining the Allowed Charge for the submitted claim. This review by an independent medical review firm is separate and apart from any independent dispute resolution process that is facilitated pursuant to the No Surprises Act.

  - ✓ The Non-Contract Provider's actual billed charge.

- When using Non-Contract Providers, except for No Surprises Act Services, the Eligible Individual is responsible for any difference between the actual billed charge and the Plan's Allowed Charge (a practice called "balance billing"), in addition to any Copayment and percentage coinsurance required by the Plan. The term "No Surprises Act Services" means the following, to the extent covered under the Plan:

  - ✓ Out-of-network Emergency Services,
  - ✓ Out-of-network Air Ambulance Services;
  - ✓ Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a Non-Contract Provider at a Contract Facility; and
  - ✓ Other non-emergency services performed by a Non-Contract Provider at a Contract Facility with respect to which the provider does not comply with written federal notice and consent requirements.

Experimental or **Investigational** means a drug, device, medical treatment or procedure if:

- 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
- 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

- Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing 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
- 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.
- 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 procedures; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

The medical plan will cover routine costs when associated with certain approved clinical trials related to cancer or other life-threatening illnesses. This means that for individuals who participate in an approved clinical trial, routine costs, services and supplies will be payable during the time the Eligible Individual is participating in the clinical trial.

- "Routine costs" means services and supplies incurred by an Eligible Individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- An "approved clinical trial" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded (like a trial funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS); (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Medically Necessary with respect to services and supplies received for treatment of an Illness or Injury means those services or supplies determined to be:

- appropriate and necessary for the symptoms, diagnosis or treatment of the Illness or Injury, and
- provided for the diagnosis or direct care and treatment of the Illness or Injury, and
- within standards of good medical practice within the organized medical community, and

- not primarily for the convenience of the patient, the patient's Physician or another provider, and

- 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.

- The Plan will apply Medicare's determination of Medical Necessity for individuals who are eligible for Medicare.

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" (PHI). 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 HIPAA 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 about your claim, see "Claims and Appeals Procedures" in Chapter 9.

ROLE OF MEDICARE

Many retirees and Spouses are eligible for Medicare. In fact, as you will see in Chapter 2, eligibility for Medicare is a precondition for enrolling in some of the HMOs. For retired Owner-Operators, it is a requirement for eligibility to participate in the Plan.

IMPORTANT

It is very important that you are enrolled in both Parts A and B of Medicare. If you or your Spouse[1] are eligible for Hospital and medical benefits under Medicare, benefits available under Parts A and B of Medicare will be deducted from the benefits payable under the Plan's comprehensive medical benefits, **regardless of whether or not you have actually enrolled for Medicare and regardless of whether or not your doctor or other medical provider has chosen to participate in Medicare**.

This Plan will estimate that Medicare Part A pays the claim except the deductible and that Medicare Part B paid 80% of Medicare Part B charges. The Plan's payment will be based on the remaining 20% of the claim only, even if you have not actually enrolled in Medicare. See "If You Are Eligible for Medicare" on page 66 for more information.

You also have the option of enrolling in a Medicare Advantage HMO.

Dependent Social Security Numbers Needed for Coordination of Benefits with Medicare

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Trust Fund Office the Medicare Number or Social Security Number (SSN) of your eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such Dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date. Failure to provide the Medicare Number or SSN or complete the CMS model form (form is available from the Trust Fund Office or online at www.cms.gov) means that claims for Eligible Individuals cannot be processed.

Enrolling In Medicare

If you receive Social Security benefits or railroad retirement checks you will automatically be enrolled in Medicare Parts A and B (unless you opt-out of Part B). You will not have to pay a premium for Part A, but you will have to pay a monthly premium for Part B. **You and your Spouse[2] should not opt-out of Part B or your medical benefits from the Trust Fund will be reduced.** Medicare will mail you a Medicare card and general information before the date you become eligible.

If you are not receiving Social Security benefits or railroad retirement checks, you will need to sign up for Medicare in the **3 months** before you turn **age 65**. If you or your Spouse receive Social Security Disability benefits, you also may be eligible for Medicare (after a waiting period). By enrolling promptly, you will avoid a possible delay in the start of your coverage and a possible increase in the premiums you will have to pay for Part B. Call Social Security at (800) 772-1213 to sign up. TTY users should call (800) 325-0778.

This also applies to your Spouse as he or she nears age 65.

For information about Medicare, visit the website at www.medicare.gov or call 1-800-Medicare (1-800-633-4227) or 1-877-486-2048 for TTY users.

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[1] If you have an Eligible Dependent that is eligible for Medicare, they must also enroll in both Parts A and B of Medicare.

[2] If you have an Eligible Dependent that is eligible for Medicare, they must also enroll in both Parts A and B of Medicare.

Chapter 2: Eligibility and Enrollment

In this chapter you will find:

- ✓ Retiree and Dependent eligibility
- ✓ Schedule of Benefits that applies to you
- ✓ Enrolling in the Plan
- ✓ Special late enrollment provisions
- ✓ Continuation of eligibility by surviving Dependents
- ✓ Keeping the Trust Fund informed of changes

RETIREE ELIGIBILITY

Two types of retirees are potentially eligible for the benefits described in this booklet:

- Retired employees other than Owner-Operators, and
- Retired Owner-Operators.

Eligibility rules for each are described below.

Note that **you must enroll in the Plan within 60 days of first becoming eligible**. Otherwise, you will be able to enroll only under particular circumstances. See "Special Late Enrollment Provisions" later in this chapter for eligibility dates and other information.

Eligibility Rules for Retired Employees (Other Than Owner-Operators)

You are eligible for health care benefits under this Plan if you meet **all** of the following requirements:

- You are receiving a pension from the Pension Trust Fund for Operating Engineers that is based on 10 or more years of credited service earned while employed in covered employment under that Fund's Plan. Credit earned under another fund's pension plan will not be counted toward these 10 years of credited service;
- You are a dues-paying member of Operating Engineers Local No. 3 (the "Union") or you pay a service fee to the Union equal to the amount of dues required of retired members;
- You meet the applicable work-hour requirement (described immediately below); AND
- You make the required payments for coverage through authorized deductions from your pension checks. (The amount of such payments is set by the Board of Trustees.)

In addition to the above eligibility requirements, you must meet the following work-hour requirement:

Work-Hour Requirements for Benefits Eligibility
Beginning for retirements occurring on or after September 1, 2015, you must have worked at least 2,000 hours for one or more contributing employers and had contributions paid to the Fund for those hours during the 24-months immediately preceding your pension effective date; **or have worked 10,000 hours since January 1, 2005, for which contributions have been made to the Fund on their behalf.** This change also applies to participants with 25 or more years of credited service.
Grace periods will be granted for those months during which you either performed work for the International Union of Operating Engineers or the International Training Fund or were unable to work in covered employment due to a certified disability. A grace period will also be granted for moratorium years under the job placement regulations of a collective bargaining agreement.

A grace period is a period which is disregarded when counting the months immediately preceding your pension effective date.

As of January 1, 2022, the required monthly payments for coverage are as follows:

Coverage	Retiree not Medicare Eligible	Retiree Medicare Eligible
Participant + Spouse	$500.00	$250.00
Other Eligible Dependents	$179.00 per dependent	$179.00 per dependent
Surviving Spouse Coverage	$290.00	$225.00

These rates are subject to change and set by the Board of Trustees.

If the highest employer contribution rate for the last 12-months of employer contributions received by this Fund on your behalf, does not equal the target employer contribution rate[3] as determined by the Board of Trustees, or your employer did not make an additional allocation to the Fund, you can choose to either pay an increased monthly self-pay contribution **or** receive reduced Comprehensive Medical Plan benefits as shown below:

[3] As of January 1, 2022, the target employer contribution rates per State are as follows:

- CA – 2.54
- NV – 2.38
- HI – 2.39
- UT – 1.87

These rates are subject to change.

Employer Contribution Rate as % of Target Rate	Percent of Normal Schedule I Comprehensive Medical Benefits	Monthly Self-Pay Contribution	
		Retiree not eligible for Medicare	Medicare eligible Retiree
95% - 100%	100%	$500.00	$250.00
90% - 95%	95%	525.00	262.50
85% - 90%	90%	500.00	275.00
80% - 85%	85%	575.00	287.50
75% - 80%	80%	600.00	300.00
70% - 75%	75%	625.00	312.50
65% - 70%	70%	650.00	325.00
60% - 65%	65%	675.00	337.50
55% - 60%	60%	700.00	350.00
50% - 55%	55%	725.00	362.50
45% - 50%	50%	750.00	375.00
40% - 45%	45%	775.00	387.50
35% - 40%	40%	800.00	400.00
30% - 35%	35%	825.00	412.50
25% - 30%	25%	850.00	425.00
0 - 25%	NA	1,100.00	500.00

Retirees Who Return to Work That is Not Covered Under the Retiree Work Addendum

If you return to work with a contributing employer in the Operating Engineers Health and Welfare Trust Fund, you may continue your coverage under the Pensioned Operating Engineers Trust Fund until you establish your eligibility for benefits as an Active Employee. To do so, you will need to make the required monthly payments for coverage.

Eligibility Rules for Retired Owner-Operators

If you are a retired Owner-Operator who does not meet the eligibility requirements stated above for regular Retired Employees, you are eligible for health care benefits under this Plan if you meet **all** of the following requirements:

- You are eligible for Medicare benefits;
- You provide satisfactory proof of your retirement to the Board;

- You were covered under one of the Operating Engineers Local No. 3 active Health and Welfare plans for at least the 48 months immediately preceding your retirement;
- You are a dues-paying member of Operating Engineers Local No. 3 ("the Union") or you pay a service fee to the Union equal to the amount of dues required of retired Owner-Operators; and
- You pay the required contributions. (You will receive a bill for the required contributions you must pay. The amount of the contributions is determined by the Board of Trustees.)

DEPENDENT ELIGIBILITY

If you are eligible for the benefits described in this booklet, you may also cover your eligible Dependents for these benefits. Your eligible Dependents are:

- Your legal Spouse.
- Your children under **age 26** whether married or unmarried if you pay the cost of coverage. These can be your natural children, stepchildren, legally adopted children or a child required to be covered under a Qualified Medical Child Support Order. Legally adopted children become eligible when they are placed with you for adoption. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.
- An 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 and you pay the cost of coverage.

You must pay the full cost of coverage for any children you cover.

Note: A Spouse or child of your Dependent child is not eligible for coverage under the Plan.

Extended Eligibility for Disabled Children

You may continue coverage for your unmarried child beyond **age 26** if the child is incapable of self-sustaining employment because of a mental or physical disability. To qualify for the extended coverage, the following conditions must be met:

- The child must be considered your dependent for federal income tax purposes;
- The child must have been eligible as your Dependent under this Plan (or under the active Operating Engineers Health and Welfare Trust Fund or another other active 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.

Qualified Medical Child Support Orders

The Plan will recognize a Qualified Medical Child Support Order (QMCSO) and enroll a Dependent child specified by the Order. A QMCSO is any judgment, decree, or order (including a National Medical 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 who is not in your custody 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.

If You Have Coverage Elsewhere

If you or your Dependents have health care coverage elsewhere, 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 covered expenses. See "Coordination of Benefits with Other Plans" in Chapter 10 for more information.

SCHEDULE OF BENEFITS THAT APPLIES TO YOU

For Retirees Who Retired Before January 1, 2007

If you retired before January 1, 2007, there are two schedules of benefits under the Plan, Schedule I and Schedule II. You will see references to these two schedules in the chapters on the individual benefits. Some benefits (such as vision care) are available only to Retired Employees who qualify for Schedule I. For other benefits, the level of coverage depends on whether you qualify for Schedule I or Schedule II.

Schedule I

Schedule I applies to you if one of the following descriptions applies to you:

If you retired before January 1, 2007, call the Trust Fund Office to find out which Schedule of Benefits applies to you.

- You meet the Owner-Operator requirements for eligibility under this Plan.
- You became eligible for benefits under this Plan before January 1, 1981.
- You meet the applicable hours and contribution requirements for the work years during which you earned pension credit before your pension award date.

Schedule II

Schedule II applies if you are eligible for benefits under the Plan but do not meet the criteria for Schedule I—i.e., you worked for contributing employers but your hours or their contributions to the Fund fall short of those required for Schedule I, you do not meet the Owner-Operator eligibility requirements, or you did not become eligible for Plan benefits before January 1, 1981.

For Retirees Who Retired On or After January 1, 2007

If you retired on or after January 1, 2007, you will be eligible for full Schedule I benefits **if**:

- The highest contribution paid by your former employer during the last 12 months of contributions paid for pensioned health and welfare benefits equaled at least the target contribution as determined by the Board of Trustees; **or**
- Your bargaining unit made an additional allocation to this Plan that is at least 20% of the difference between the highest employer contribution rate paid on the Retirees behalf during the last 12 months of employer contributions received by the Plan and the target employer contribution rate..

Contact the Trust Fund office if you are not sure if you qualify for full Schedule I benefits.

If either of the above conditions were not met, you will have the option of **either**

- Paying a higher self-payment for benefits, or
- Receiving a reduced level of Schedule I benefits.

You will not have the opportunity to switch between full Schedule I benefits and the reduced level of comprehensive medical benefits after your date of retirement. See Chapter 4 (pg. 67) for the benefit reduction schedule if it applies to you.

ENROLLING IN THE PLAN

Deadline for Enrolling

- You must enroll yourself and your eligible dependents in the Plan **within 60 days of your eligibility date—the date you first become eligible**.
- If you get married after you are in the Plan, you must enroll your new Spouse (and any eligible children of that Spouse) **within 180 days of the date of your marriage**.
- Any other newly acquired Dependents you wish to enroll must be enrolled within **60 days** of when they first become eligible. Their eligibility will be effective the month following receipt of payment and all requested documentation (enrollment form, birth certificates, etc.). The actual birth certificate from the state or the birth document that the Hospital provides will be required to enroll a newborn child.
- You will not be eligible to enroll at a later date, except as described below under "Special Late Enrollment Provisions" or unless a good cause is approved by the Board.

Eligibility Dates

Eligibility Dates are shown below.

- **Retired employees other than Owner-Operators:** Provided you meet the eligibility requirements listed earlier in this chapter and pay the required contribution, you will first become eligible for the Plan on the later of the following dates:
  - ✓ the first day of the month for which a pension is payable to you from the Pension Trust Fund for Operating Engineers, or
  - ✓ the date on which your eligibility as an Active Employee terminates.

- **Retired Owner-Operators:** Provided you meet the eligibility requirements listed earlier in this chapter and pay the required contributions, you will first become eligible for benefits under this Plan on the first day of the calendar month in which you retire.
- **Dependents:** Your Spouse and eligible Dependent children at the time you become eligible have the same eligibility date you do and must be enrolled within **60 days** of that date.

  If you marry or add children after your eligibility date, the deadlines for enrolling the new Dependents are as follows:

  - ✓ **Spouse:** You must enroll your new Spouse (and any children of that Spouse) within **180 days** of the date of his or her marriage to you or as permitted in the Special Late Enrollment Provisions section.
  - ✓ **Children:** You must enroll a new child within **60 days** of the date of the child's birth or adoption, or the date you become legal guardian. A new stepchild must be enrolled within 180 days of the date you marry the child's parent.

How to Enroll

To enroll in Retired Employee health care benefits, you must complete and sign an Election and Authorization form authorizing the necessary monthly deduction from your pension check (or a Pensioned Operating Engineers Health & Welfare form, if you are a retired Owner-Operator) and return it to the Trust Fund Office. Note that you must pay an additional premium for each child you enroll.

(**EXCEPTION**: The premium for family dental coverage is the same no matter how many children you enroll.)

To enroll new Dependents after your eligibility date, contact the Trust Fund Office for the appropriate enrollment form and information about any additional contributions you must pay to start coverage.

Enrollment Options

Medical Plan Choices

When you enroll for benefits, you will have your choice of two options for medical and drug coverage:

1. Direct Pay Option--comprehensive medical benefits provided directly by the Fund; or
2. HMO Option--coverage offered by the Fund through an HMO.

The HMOs currently being offered (as of the printing of this booklet) and their requirements for eligibility are as follows:

- **Kaiser Northern California and Kaiser Hawaii:** You must live in the Kaiser service area. If you are age 65 or over, the Senior Advantage plan (Kaiser's Medicare Advantage program) is your only Kaiser option. To enroll in Senior Advantage, you must also be enrolled in Medicare Parts A and B and assign your Medicare benefits to Kaiser. If you do not have both parts of Medicare and do not assign your Medicare benefits to Kaiser, you will be moved to the comprehensive medical benefit plan provided directly by the Fund.
- **Health Net Seniority Plus (a Medicare Advantage plan):** You must live in the Health Net service area, and you must be enrolled in Medicare Parts A and B and assign your Medicare benefits to Health Net. If you do not have both parts of Medicare and do not assign your

Medicare benefits to Health Net, you will be moved to the comprehensive medical benefit plan provided directly by the Fund.

- **United HealthCare Secure Horizons (a Medicare Advantage plan**): You must live in the Secure Horizons service area, and you must be eligible for Medicare and enrolled in Medicare Parts A and B. If you do not have both parts of Medicare and do not assign your Medicare benefits to United HealthCare, you will be moved to the comprehensive medical benefit plan provided directly by the Fund.
- **Hawaii Medical Service Association (HMSA):** Available for Medicare and Non-Medicare participants. You must live in the HMSA service area. If you are age 65 or over, the Akamai Advantage Group Medicare Plan is your only HMSA option and you must be enrolled in Medicare Parts A and B to enroll in this plan. If you do not have both parts of Medicare and do not assign your Medicare benefits to HMSA, you will be moved to the comprehensive medical benefit plan provided directly by the Fund.

Plan Options for Your Dependents

Medical plan options for your Dependents will depend on your and your Spouse's eligibility for Medicare and what option you choose for yourself:

- If neither you nor your Spouse is eligible for Medicare, your Spouse and eligible enrolled children will be covered under whichever medical plan option you choose for yourself (the comprehensive medical benefits provided by the Fund, Kaiser, or HMSA).
- If you are eligible for Medicare but your Spouse is not, your Spouse and eligible enrolled children will be covered under the comprehensive medical benefits provided by the Fund if you have chosen that option for yourself. If you have chosen a Medicare Advantage program offered by Kaiser, Health Net, United HealthCare or HMSA, your Spouse and eligible enrolled children can be covered under either the comprehensive medical benefits, the Kaiser Non-Medicare plan or the HMSA Non-Medicare plan.
- If you and your Spouse are both eligible for Medicare, your Spouse may choose independently whether he or she wants to be covered by the comprehensive benefits provided by the Fund or the Medicare Advantage program offered by Kaiser, Health Net, United HealthCare or HMSA. Your eligible enrolled children will be covered under the comprehensive medical benefits if you have chosen that option for yourself; if you have chosen an HMO Medicare Advantage program, your eligible enrolled children can be covered under either the comprehensive medical benefits, Kaiser Non-Medicare plan or the HMSA Non-Medicare plan.

Other Plan Coverage When You Choose an HMO

If you elect coverage under an HMO, benefits for the following will be provided to you by the Comprehensive Medical Plan:

- Hearing aids,
- Additional chemical dependency treatment, and
- Vision care (if you qualify for Schedule I benefits).

Dental Benefits

Enrollment in dental benefits is completely separate from enrollment in other benefits, and enrollees in dental benefits pay additional, separate, premiums covering the full cost of dental coverage. If you wish to enroll in dental coverage, the plan options are:

- The Delta Dental Plan of California (if you live in the continental United States),
- MetLife Dental Plan, a dental HMO plan (if available in your area), or
- Hawaii Dental Service (if you live in Hawaii).

If you enroll in family dental coverage, your Dependents will all be in the same dental plan you are in.

Changing the Plan Option You've Elected

Once you elect a medical plan option, you must remain in that option for at least 12 months. An exception will be made only if you elected an HMO and you move out of its service area or it ceases to be available where you live, if you have a Special Late Enrollment Event (described on the next page), or if the Board approves a change.

Once you elect a dental plan option, you must remain in that plan for at least 12 months unless you are in a prepaid dental plan and you move out of its service area. An exception to the 12-month rule will be allowed once during a Retired Employee's period of eligibility under the Plan.

Once you have satisfied the 12-month requirement, you may change your medical or dental plan option. If you change options, you must remain in your new option for at least 12 months before you can change again (subject to the exceptions mentioned above). The timing of any change in medical plans is also subject to applicable Medicare rules for enrollment.

To make a change, contact the Trust Fund Office for an enrollment form. Any change in medical or dental 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. (EXCEPTION: If you are changing plans because you moved out of the HMO or prepaid dental plan service area, your change will be effective on the first day of the month following your change of address.)

Continuous Enrollment Only

Enrollment in benefits must be continuous. If you elect to discontinue coverage at any point, for your Dependents or for yourself and your Dependents, you may not re-elect coverage at a later date for anyone for whom coverage was stopped unless you have a Special Enrollment Event. Coverage must be continuous with no gap in coverage. See "Special Late Enrollment Provisions" on the next page.

SPECIAL LATE ENROLLMENT PROVISIONS

If you miss your original enrollment deadline (**60 days** from the time you first become eligible unless otherwise noted below), you may request enrollment in the Plan late if one of the

following events occurs. Coverage will be effective on the first day of the month following the date the Trust Fund Office receives your required documentation and enrollment form.

Marriage

If you did not enroll in the Plan when you were first eligible and you subsequently marry, you may request enrollment of yourself and/or your new Spouse and other eligible Dependents in the Plan no later than **180 days** after the date of marriage.

Addition of Children to Your Family:

If you did not enroll in the Plan when you were first eligible and you subsequently add a new child to your family, you may request enrollment of yourself and your new child in the Plan no later than **60 days** after the date of the child's birth or adoption, or the date you become legal guardian.

Please note: The Fund will accept the birth certificate from the state or the birth document that the hospital provides for the initial enrollment of a newborn baby.

Reaching Age 65

If you are under age 65 at the time of retirement, you may enroll in the Plan when you reach age 65, provided you enroll within **31 days** after your 65th birthday. *(Applies only to Retired Employees whose pensions were effective on or after January 1, 1999)*

Reaching Age 62

If your pension was effective before January 1, 1999, and you were under age 62 when you retired, you may enroll in the Plan when you reach age 62, provided you enroll within **31 days** after your 62nd birthday.

Becoming Entitled to Medicare

If you were not entitled to Medicare when you first became eligible for the Plan, you may enroll in the Plan within **31 days** of the date you become entitled to Medicare. (Does not apply to retired Owner-Operators)

Termination of Other Continuous Coverage

If you chose not to enroll in the Plan when first eligible (or if you discontinued plan coverage) because you had continuous health coverage under another insurance policy or program (including COBRA continuation coverage or individual insurance **but not Medicare coverage**) and that other coverage terminates, you may request enrollment in this Plan **within 31 days after it terminates**, provided:

- The other coverage was continuous from the time you became eligible under this Plan and
- You provide the Fund with proof of the continuity and the termination of the other coverage if that other coverage terminated because of:
  - ✓ Loss of eligibility for that coverage including loss resulting from legal separation (if applicable), divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause);
  - ✓ Termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right);

- ✓ The health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was "exhausted";
- ✓ Moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;
- ✓ The other plan ceasing to offer coverage to a group of similarly situated individuals;
- ✓ The loss of Dependent status under the other plan's terms; or
- ✓ The termination of a benefit package option under the other plan unless substitute coverage offered.

COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual;
- Because the 18-month, 29-month or 36-month (as applicable) period of COBRA Continuation Coverage has expired; or
- When your Spouse becomes entitled to Medicare.

If your Spouse or Dependent child chose not to enroll when first eligible or if they discontinued coverage because they had other coverage of this type, they will have this same late-enrollment opportunity.

Medicaid or Children's Health Insurance Program

If you or your Dependent did not enroll in the Plan when first eligible, you or your Dependent will have the opportunity to request enrollment in the Plan **within 60 days** of either of the following events:

- The date you or your Dependent loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP); or
- The date you or your Dependent becomes eligible to participate in a premium assistance program under Medicaid or the Children's Health Insurance Program (CHIP).

Individuals enrolled during Special Late Enrollment have the same benefit plan options at the same cost and the same enrollment requirements as other similarly situated eligible participants.

CONTINUATION OF ELIGIBILITY BY SURVIVING DEPENDENTS

If you die while covered by this Plan, your surviving Dependents may continue their eligibility for benefits. The specific benefits involved and the payments due will depend on the situation:

- If you were a Retired Employee other than an Owner-Operator who was receiving a husband-and-wife pension that had been awarded before November 30, 1976, your Spouse's benefits will continue, unchanged by your death. Your Spouse will not need to make any monthly payments toward the cost of his or her coverage. If your Spouse wants to continue coverage for your Dependent children, however, he or she will need to make monthly payments for their coverage.
- In any other case (including all cases involving Owner-Operators) your Spouse will be able to continue eligibility for all benefits except chemical dependency treatment by making monthly payments in an amount determined by the Board for surviving Spouses. Your Spouse can continue benefits for your children until they cease to be eligible Dependent children by paying the applicable premiums for them.
- If the surviving spouse or any Dependent children remaining on the Plan elect COBRA coverage, they can continue the same benefits as the retired member for a period not to exceed **36 months**.

Any required payments must be received by the Trust Fund Office by the **15th of each month prior to the month for which coverage is intended**. Your surviving Spouse must make the first required payment the month after you die, and payments must be continuous—if there is any lapse, coverage will terminate and your Spouse will not be able to reinstate it.

If a surviving Spouse remarries, coverage for the Spouse and any of the Spouse's covered Dependent children will terminate on the date the Spouse remarries.

Special Provision for Surviving Dependents of Active Operating Engineers

If an active Operating Engineer should die after becoming eligible for a pension but before his or her pension effective date, the surviving Spouse will be eligible for benefits under the Pensioned Operating Engineers Health and Welfare Trust Fund after the active hour bank is exhausted. To begin and maintain coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund, the Spouse will need to make the required monthly payments. The Spouse will also need to pay the required premiums for any eligible Dependent children he or she wants to cover.

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.

Chapter 3: When Eligibility Ends

In this chapter you will find:
- ✓ Termination of eligibility
- ✓ COBRA continuation coverage

TERMINATION OF ELIGIBILITY

Termination of Your Eligibility

Retired Employees Other Than Owner-Operators

If you are a Retired Employee other than an Owner-Operator, your eligibility will terminate on the earliest of the following dates:

- when you stop paying the required Union dues or service fee (your eligibility would end the last day of the last month for which you have paid the required dues or service fee) or
- when you stop making the required payment for the cost of coverage (your eligibility would end the last day of the month for which the last required pension check deduction or payment has been made) or
- when you cease to be eligible for a pension (your eligibility would end the last day of the last month for which a benefit was payable to you from the Pension Trust Fund for Operating Engineers) or
- the date on which this Plan is terminated by the Board.

Retired Owner-Operators

If you are a retired Owner-Operator, your eligibility will terminate on the earliest of the following dates:

- when you stop paying the cost of coverage or the required Union dues or service fee (your eligibility would end the last day of the last month for which you made the last required payment) or
- the date you are no longer retired or
- the date on which this Plan is terminated by the Board.

Retroactive Termination of Coverage

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact. You will be given a **30 day** notice of termination except for non-payment of your self-pay contributions.

Termination of Your Dependents' Eligibility

Your Dependents' eligibility will terminate on the earlier of the following dates:

- the date your eligibility terminates (unless your eligibility is terminating because of your death and your surviving Dependents decide to make the required payments to continue eligibility—see "Continuation of Eligibility by Surviving Dependents" in Chapter 2) or
- the last day of the month in which your Spouse ceases to be your Spouse or your children cease to meet the definition of eligible Dependents.

When coverage under this Plan terminates you may have the option to buy temporary continuation of this group health plan coverage by electing COBRA, or convert your coverage to an individual insurance policy (if you are covered under an HMO option) or you can look into your options to buy an individual insurance policy for health care coverage from the Health Insurance Marketplace **(if you are not eligible for Medicare).**

Termination of Eligibility for a Surviving Spouse and/or Dependents

Eligibility for a Surviving Spouse and Dependents will terminate on the earlier of the following dates:

- For lack of any required premium payment;
- A Dependent Child attains age 26, unless a documented disability eligibility is satisfied;
- The date the surviving Spouse remarries;
- Death of Spouse;
- Spouse becomes enrolled in other group health coverage;
- The date any QMCSO terminates and the Dependent is not otherwise eligible for coverage;
- Dependent spouse enters full-time military;
- Death of Dependent;
- Plan discontinues Dependent or Spousal coverage; or
- Plan is discontinued/terminated.

Once a surviving Spouse or Dependent is disenrolled for one of the foregoing reasons, he or she will be ineligible to re-enroll in the Plan.

Conversion of HMO Coverage

If you or your Spouse or Dependent children are enrolled in an HMO plan, you may be able to convert to individual coverage when your eligibility for benefits under this Plan ends. Check the materials you have received from the HMO or call the HMO's customer service number for more information.

COBRA CONTINUATION OF HEALTH CARE COVERAGE

Federal law has special provisions regarding health care coverage when people lose eligibility for benefits coverage. If your Spouse's or children's coverage under the Pensioned Operating

Engineers Health and Welfare Trust Fund ends due to a "qualifying event" (see below), the Consolidated Omnibus Budget Reconciliation Act (commonly known as COBRA) allows them to continue their coverage at their own expense for up to **36 months**. As a Retiree, you generally do not have COBRA Continuation rights after your Retiree coverage terminates as you were offered a choice between COBRA Continuation and Retiree coverage at the time of your retirement.

Alternatives to COBRA: Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace **(if you are not eligible for Medicare)**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov (for California residents, see: www.coveredca.com). Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Qualifying Events

For your Dependents to be eligible for COBRA continuation coverage, the loss of coverage must be due to one of the qualifying events shown in the chart below.

Qualifying Event	Who May Continue Coverage	Maximum Period of Continuation Coverage
You die	Your Spouse and/or your Dependent children covered under the Plan	36 months
You and your Spouse divorce	Your former Spouse and/or former stepchildren covered under the Plan	36 months
Your child ceases to meet the Plan's definition of an eligible Dependent (for example, a change in age)	The affected Dependent child who was covered under the Plan	36 months

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 qualifying event by virtue of being on that day the Spouse or Dependent child of a Retired Employee.

A child who becomes a Dependent child by birth, adoption, or placement for adoption with your Spouse during a period of COBRA continuation coverage is also a Qualified Beneficiary.

A new Spouse of an existing COBRA participant may be added to the COBRA participant's coverage for the balance of the continuation coverage period. (See "Special COBRA Enrollment Rights" later in this section.) However, the new Spouse would not be a Qualified Beneficiary.

Notification Responsibilities

You or your Dependents are responsible for providing the Trust Fund Office with timely written notice of any of the qualifying events listed above.

You must make sure that the Trust Fund Office is notified of any of the qualifying events listed in the above chart. Failure to provide this notice within the form and timeframes described below may prevent your Dependents from obtaining or extending COBRA coverage.

How to Provide Notice of a Qualifying Event to the Trust Fund Office

Notice of any of the three qualifying events listed in the chart above must be provided in writing. Send a letter to the Trust Fund Office containing the following information:

- The name of the individual(s) affected by the qualifying event and their relationship to the Retired Employee
- The Retired Employee's name and Social Security number
- The event for which you are providing notice
- The date of the event (for example the end of the month after a Dependent child's **26th birthday**)
- A copy of the final marriage dissolution if the event is a divorce
- A current address, phone number and email address (if applicable) for the affected individual(s).

Where to Send the Notice

Notice of a qualifying event must be sent by U.S. mail to the following address:

COBRA Administrator
Pensioned 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

You or your Dependent must send the notice no later than 60 days after the date of the qualifying event (death, divorce, or loss of Dependent child status).

Notice Requirements for Disability Events

A Qualified Beneficiary (e.g., a Spouse or Dependent child) who is entitled to continuation coverage who becomes disabled during the first 60 days of continuation coverage may qualify for an extension of continuation coverage. Notice of such a disability must be provided as follows:

- 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. Furthermore, the Plan Administrator will not consider a notice of a disability determination for an extension of continuation coverage if it is furnished after the end of the first 18 months of continuation coverage.
- If you are providing notice of a Social Security Administration determination that 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 your dependent is no longer disabled.

Who Can Provide Notice

Notice may be provided by you (the Retired Employee), your Dependent, or by any representative acting on behalf of your Dependent.

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 Retired 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.

How to Elect COBRA Continuation Coverage

When the Trust Fund Office receives notice of the qualifying event, it will notify your Spouse (former Spouse) and/or Dependent children (former stepchildren) of their right to choose continuation coverage within **14 days** of receiving notification of the qualifying event. The notice will include the necessary COBRA election forms and cost of coverage. A notice sent to your Spouse will be deemed to have also been sent to any Dependent children residing with your Spouse at the time.

Your covered Dependents have ***60 days*** to make their election from the later of:

- The date they would have lost coverage because of the qualifying event; or
- The date the COBRA Notice is mailed from the Trust Fund Office.

If any of your covered Dependents do not elect COBRA within the 60-day period allowed, their group health coverage will end and the Plan will not pay claims for services provided after the date their coverage terminates.

Independent Elections

Each Qualified Beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, one child may elect to continue coverage under COBRA while another child decides not to.

A parent or legal guardian may elect COBRA continuation coverage for a minor child. If your Spouse elects COBRA continuation coverage, she or he will be deemed to be electing it for your Dependent children as well, unless your Spouse specifies otherwise in the election. If your Spouse does not elect COBRA continuation coverage, your Dependent children will be able to elect it or reject it independently of your Spouse's rejection.

In considering whether to elect COBRA continuation coverage, your Dependents should take into account that a failure to continue their group health coverage may affect their future rights under federal law.

Your eligible Dependents have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your Spouse's employer). Special enrollment under this provision is allowed within **31 days** after their group health coverage ends because of the qualifying events listed above or at the end of COBRA continuation coverage if they get COBRA continuation coverage for the maximum time available to them.

Coverage Options

Any participant electing COBRA continuation coverage may choose one of the following coverage packages:

- Medical and prescription drug benefits; or
- Medical, prescription drug, vision care, and dental benefits.

Your Dependents may not elect any coverage they did not have immediately before the qualifying event.

The 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.

Paying for COBRA Continuation Coverage

Your Dependents are responsible for the entire cost of COBRA continuation coverage. Premiums for COBRA continuation coverage are payable monthly, in amounts established by the Board of Trustees.

Your Dependents have a maximum of **45 days** from the date they mail their COBRA election form to the Trust Fund Office in which to submit the first payment. This first payment must cover all months from the date coverage terminated through the month in which you make payment.

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. **You may not receive a bill for either the first payment or subsequent monthly payments.**

Payment of Partial COBRA Premium Payment

If the Trust Fund Office receives a COBRA premium payment that is not for the full amount due, the Trust Fund Office will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Trust Fund Office will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

Special COBRA Enrollment Rights

If a Qualified Beneficiary marries or has a child, adopts a child, or has a child placed with him or her for adoption while he or she is enrolled in COBRA, he or she may enroll the new Spouse or child for coverage for the balance of the period of COBRA continuation coverage. The new

Dependent must be enrolled within **30 days** of the marriage, birth, adoption, or placement for adoption.

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

- The 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,
- The Dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it, and
- The Dependent must enroll within **31 days** after the termination of the other coverage or contributions.

Adding a Spouse or Dependent child may cause an increase in the premium for COBRA continuation coverage.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the last day of the maximum period of coverage (**36 months**) unless it ends earlier for any of the following reasons:

- Your Dependents fail to make the monthly payments on time (they will be allowed a **30-day** grace period from the premium due date)
- The person receiving the coverage becomes covered by another group health plan.
- The person receiving the coverage becomes covered under Part A or Part B of Medicare
- The Plan stops providing group health coverage to any Retired Employees and/or Dependents.

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.

Conversion to Individual Coverage for HMO Members

At the end of the COBRA continuation coverage period, your eligible Dependents may be eligible to enroll in any individual conversion plan offered by your HMO, provided they were enrolled in the HMO before their continuation coverage ended.

Check your HMO Evidence of Coverage for more information on whether conversion coverage is available and how to enroll in a conversion plan. You can also call the applicable HMO.

Questions or Changes

If you have any questions regarding COBRA continuation coverage, please contact the COBRA Administrator at the Pensioned Operating Engineers Health and Welfare Trust Fund, P.O. Box 23190, Oakland, CA 94623-0190; Telephone: **(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 changes COBRA provisions in existence at the time this Summary Plan Description was printed, you will be advised of any such change as required.

Chapter 4: Comprehensive Medical Benefits

In this chapter you will find:

- ✓ A quick-reference schedule of benefits
- ✓ How to find Contract Providers
- ✓ Annual limit on out of pocket expenses
- ✓ Required Pre-Authorizations
- ✓ What the Plan covers
- ✓ Hearing aid benefit
- ✓ Chemical dependency benefits
- ✓ Exclusions from coverage
- ✓ If you are eligible for Medicare
- ✓ Information on filing claims

This chapter applies to individuals enrolled in the **comprehensive medical benefits** provided directly by the Fund (except for chemical dependency and hearing aid benefits, which apply to all eligible retirees and Spouses only).

If you chose one of the HMO options, ONLY the benefits and procedures described for hearing aids and chemical dependency treatment apply to you; see the materials provided by your HMO for information on your other medical benefits.

If You or Your Spouse Are Eligible for Medicare

If you or your Spouse are age 65 or over or otherwise eligible for Medicare benefits, see "If You Are Eligible for Medicare" on Page 66 for information on how benefits will be paid for you under the Plan. **You must enroll in both Parts A and B of Medicare in order to maximize your benefit coverage under the Plan.**

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, and treatment for mental illness or chemical dependency, among other medical services.

The Schedule of Benefits charts starting on the next page are intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the charts.

Note: Reduced Benefits May Apply if Your Former Employer Paid a Sub-Standard Contribution to the Pensioned Operating Engineers Health and Welfare Trust Fund. Your comprehensive medical benefit will be reduced if your former employer's contribution to the Fund was less than the minimum required contribution and you did not elect to pay a higher self-pay contribution. See the description of these reduced benefit levels on Page 67.

SCHEDULE OF MEDICAL BENEFITS

Two Schedules

Your benefits coverage will depend on which schedule of benefits you qualify for, Schedule I or Schedule II. See "Schedule of Benefits That Applies to You" in Chapter 2 for more information.

COMPREHENSIVE MEDICAL BENEFITS

Schedule II is not available if you retired after January 1, 2007. Unless noted otherwise, benefits shown for Schedule II are payable after the annual deductible has been met.

General Plan Features		
	Schedule I	**Schedule II**
Calendar-year Deductible	None	$200 per individual
Calendar-year Out-of-Pocket Limit on Deductibles, Coinsurance and Copays (except for prescription drugs)	$5,000/person, $11,000/family	$5,000/person, $11,000/family
Calendar-year Overall ACA Out-of-Pocket Limit **(This limit applies only to the Reduced Comprehensive Medical benefits only.)**	$9,100/person; $18,200/family	$9,100/person; $18,200/family
Calendar year Out-of-Pocket on Prescription Drugs	$1,600/person, $2,200/family	$1,600/person, $2,200/family
Calendar year Out-of-Pocket Limit on Non-Contract Providers	$10,000/person	$10,000/person
What is not included in the Out-of-Pocket limit for Contract Providers?	The Out-of-Pocket Limit does not include premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums and allowed charges, dental and vision plan expenses, amounts over the reference based price for certain surgeries, amounts for certain treatment at a Non-CME facility and out-of-network copays and coinsurance. Note: In general, No Surprises Act Services (Emergency Services provided by Non-Contract Providers, Non-Emergency Services provided by a Non-Contract Provider at a Contract Health Facility, and Air Ambulance Services by a Non-Contract Provider) may not be balance billed.	

Benefits for Covered Services				
	Contract Provider		**Non-Contract Provider**	
Inpatient Hospital, Long Term Acute Care Facility, Skilled Nursing Facility **(Pre-Authorization required for admissions)**				
• Accommodations, including CCU and ICU • Ancillary services and supplies • Skilled nursing facility (up to 100 days per calendar year)	**Schedule I** Plan pays 80% of contract rate	**Schedule II** Plan pays 75% of contract rate	**Schedule I** Plan pays 80% of Allowed Charge	**Schedule II** Plan pays 75% of Allowed Charge

Benefits for Covered Services (continued)				
Physician Services				
• Office visits • Home visits • Visits while you are in the Hospital (excluding Emergency Room Services)	**Schedule I**	**Schedule II**	**Schedule I**	**Schedule II**
	Plan pays 80% of contract rate	Plan pays 75% of contract rate	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge
Outpatient Hospital, Ambulatory Surgery Facility (See page 36 for Pre-Authorization requirements)				
• Outpatient Hospital charges • Ambulatory Surgery Facility	**Schedule I**	**Schedule II**	**Schedule I**	**Schedule II**
	Plan pays 80% of contract rate	Plan pays 75% of contract rate	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge
• **Emergency Services**	Plan pays 80% of contract rate	Plan pays 75% of contract rate	Plan pays the Allowed Charge less cost-sharing of 20% based on the Recognized Amount[4]	Plan pays the Allowed Charge less cost-sharing of 25% based on the Recognized Amount
Surgery (not including surgery related to an Emergency Service)	**Contract Provider**		**Non-Contract Provider**	
• Surgery • Organ or tissue transplants • Anesthesia and its administration • Second surgical opinion	**Schedule I**	**Schedule II**	**Schedule I**	**Schedule II**
	Plan pays 80% of contract rate	Plan pays 75% of contract rate	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge
See page 36 for Pre-Authorization requirements. Use of Anthem Blue Cross Centers of Medical Excellence (CME) required for bariatric surgery and organ or tissue transplants.				
Preventive Care Required by Health Care Reform	**Contract Provider**		**Non-Contract Provider**	
• Immunizations – for adults and children (CDC recommended immunizations)	**Schedule I**	**Schedule II**	**Schedule I**	**Schedule II**
	Plan pays 100% of contract rate (Schedule II deductible does not apply)		Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge
• Preventive Care for Men (See page 53 for covered services)	Plan pays 100% of contract rate (Schedule II deductible does not apply)		Not covered	Not Covered

[4] The Plan pays a Non-Contract Provider a portion of the Allowed Charge for most services. If the Plan pays 80% of the Allowed Charge for a non-emergency service, your cost-sharing responsibility is the remaining 20%, subject to annual out-of-pocket limits. Under the No Surprises Act, if you receive Emergency Services from a Non-Contract Provider, your cost-sharing component will be calculated as a percentage of a Recognized Amount, a rate calculated as if you received the Emergency Service at a Contract Facility. You may not be balance billed for Emergency Services.

Preventive Care Required by Health Care Reform (continued)	**Contract Provider**	**Non-Contract Provider**	
• Preventive Care for Women including pregnant women (See page 53 for covered services)	Plan pays 100% of contract rate (Schedule II deductible does not apply)	Not covered	Not Covered
• Preventive Care for Children (See page 52 for covered services)	Play pays 100% of contract rate (Schedule II deductible does not apply)	Not covered	Not Covered
• Colorectal cancer screening, including colonoscopy	Plan pays 100% of contract rate (Schedule II deductible does not apply)	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge

Additional Preventive Care - Not Required by Health Care Reform	**Contract Provider**		**Non-Contract Provider**	
	Schedule I	**Schedule II**	**Schedule I**	**Schedule II**
• Physical examination — for Retired Employee and Spouse only (limited to one in exam in any calendar year)	Plan pays 100% of contract rate (Schedule II deductible does not apply)		Plan pays 100% of Allowed Charge	Plan pays 100% of Allowed Charge (no deductible)

Mental Health Treatment	**Contract Provider**		**Non-Contract Provider**	
Inpatient treatment (covered the same as any other Illness)	**Schedule I**	**Schedule II**	**Schedule I**	**Schedule II**
	Plan pays 80% of contract rate	Plan pays 75% of contract rate	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge
Outpatient treatment	Plan pays 80% of contract rate	Plan pays 75% of contract rate	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge

Physical Therapy/ Chiropractic	**Contract Provider**		**Non-Contract Provider**	
• Physical and occupational therapy • Chiropractic services	**Schedule I**	**Schedule II**	**Schedule I**	**Schedule II**
Up to 40 visits total per calendar year—combined maximum (Visit limits for physical and occupational therapy will not apply to diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice)	Plan pays 80% of contract rate	Plan pays 75% of contract rate	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge

Additional Services and Supplies	Contract Provider		Non-Contract Provider	
	Schedule I	**Schedule II**	**Schedule I**	**Schedule II**
• Ambulance service (Air Ambulance paid at contract rate with no Balance Billing) • Outpatient diagnostic laboratory and radiology services (Pre-Authorization required for certain diagnostic imaging procedures) • Medical equipment and supplies (Pre-Authorization recommended) • Prosthetic devices • Foot orthotics (limited to $500 for both feet) • Acupuncture (up to 16 visits per calendar year) • Speech therapy • Chemotherapy, radiation therapy • Home health care • Hospice care • Blood transfusions • Oxygen and rental of equipment for its administration • Medically Necessary Services provided by an Emergency Medical Technician (EMT) or registered Paramedic (even without ground transportation)	Plan pays 80% of contract rate (Exception: laboratory services billed by a free-standing contract laboratory are paid at 100% of contract rate)	Plan pays 75% of contract rate (Exception: laboratory services billed by a free-standing contract laboratory are paid at 100% of contract rate)	Plan pays 80% of Allowed Charge	Plan pays 75% of Allowed Charge

Benefits for Covered Chemical Dependency Treatment **REFERRAL THROUGH ASSISTANCE AND RECOVERY PROGRAM (ARP) REQUIRED FOR INPATIENT TREATMENT** **Not available for Dependent children**	
Enrolled in the Comprehensive Medical Plan Benefits	
Inpatient Residential Treatment Referral and Pre-Authorization by ARP is recommended so that you can be directed to a Contract Provider. The Plan will not cover services that are determined by ARP to be not Medically Necessary.	Paid the same as Inpatient Hospital for Contract and Non-Contract Providers.
Outpatient Treatment Referral and Pre-Authorization by ARP is recommended so that you can be directed to a Contract Provider. The Plan will not cover services that are determined by ARP to be not Medically Necessary.	Professional charges: Paid the same as Physician Visits under the medical plan for Contract and Non-Contract Providers. Facility Charges: Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers.

Enrolled in the Kaiser Medical Plan Benefits	
Inpatient Residential Treatment	100%, no deductible **(You must use either your HMO's chemical dependency benefit or ARP Contract Providers. No benefits will be paid for Non-Contract Providers.)**
Outpatient Treatment Referral and Pre-Authorization by ARP is recommended so that you can be directed to a Contract Provider. The Plan will not cover services that are determined by ARP to be not Medically Necessary.	100%, no deductible **(You must use either your HMO's chemical dependency benefit or ARP Contract Providers. No benefits will be paid for Non-Contract Providers.)**

Hearing Aid Benefit **Not subject to out-of-pocket limit**	
Examination and device (limit of one per ear in any 48-month period)	Plan pays 100% of Allowed Charge, up to a maximum benefit of $2,025 per ear (no deductible)

If you are eligible for Medicare, you can use Contract and Non-Contract Providers.

CONTRACT PROVIDERS

The medical Plan includes a 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 to provide services at contract rates.

In California, the Preferred Provider Organization is *Anthem Blue Cross*. Outside of California, it is called *Blue Card*.

- If you use a Contract Provider, you pay only your percentage of the negotiated fee. The Provider cannot bill you for any amount over this contract rate.
- If you use Non-Contract Providers, covered charges are limited to the Plan's Allowed Charges (as defined at the beginning of this SPD and 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.

Emergency Services

In accordance with the federal No Surprises Act, the Plan will cover Emergency Services provided by a Non-Contract Provider at a Non-Contract facility (regardless of the department of the facility in which the items or services are furnished) until the Provider or facility determines that you or your Eligible Dependent are able to travel using nonmedical transportation or nonemergency medical transportation to a Contract facility. In this case, Emergency Services include post-stabilization services and services provided as part of outpatient observation or an inpatient or outpatient stay related to an Emergency Medical Condition.

Cost-sharing for Emergency Services received at a Non-Contract facility will not be greater than the requirement that would apply if those services were provided by a Contract Provider at a

Contract facility and will be based on the Recognized Amount for those services. You cannot be billed for charges beyond your cost-sharing by the Non-Contract Provider for these services.

Your cost-sharing payments for Emergency Services performed by a Non-Contract Provider will count toward your Contract Provider deductible and out-of-pocket maximum.

In general, you cannot be balance billed for these items or services.

Non-Emergency Services Performed by Non-Contract Providers at a Contract Facility

Unless appropriate notice is provided by the Non-Contract Provider and consent obtained from your or your Eligible Dependent (see below), the Plan will cover non-emergency services performed by a Non-Contract Provider at a Contract facility and the cost-sharing requirement for such services or items will be calculated as if provided by a Contract Provider at the Recognized Amount.

Your cost-sharing payments for Non-Emergency Services performed by a Non-Contract Provider at a Contract Health Care Facility will count toward your Contract Provider deductible and Contract Provider out-of-pocket maximum.

In general, you cannot be balance billed for these items or services.

Notice and Consent Exception

Non-emergency items or services performed by a Non-Contract Provider at a Contract Facility will be covered based on the Plan's definition of Allowed Charge and you will forgo the financial protections of the No Surprises Act **if**:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the Provider is a Non-Contract Provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any Contract Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract Providers listed; and

- You give written informed consent to continued treatment by the Non-Contract Provider, acknowledging that you understand that continued treatment by the Non-Contract Provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Contract Provider satisfied the notice and consent criteria.

Ancillary Services

Written consent cannot be given if the health care Provider is an Ancillary Services Provider. Ancillary Services include:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,

- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by a nonparticipating Provider if there is no participating Provider who can furnish such item or service at such facility.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a Non-Contract Provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-Contract Provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a Contract Provider.
- Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a Contract Provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Contract out-of-pocket maximum in the same manner as those received from a Contract Provider.
- In general, you cannot be Balance Billed for these items or services.

How to Find Contract Providers

You should 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.

If you live outside of California, you can find Blue Card Providers online at 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 must call the Assistance and Recovery Program at (800) 562-3277 instead of the contacts above. You will be referred to a contract chemical dependency treatment Provider.

For hearing aids, the most favorable benefit coverage depends on your using the Hear USA network for hearing aids, (888) 432-7464.

Special Rule with respect to Provider Directories

A list of Contract Providers is available to you without charge by visiting the websites noted on the Quick Reference Chart or by calling the phone number on your ID card. If you obtain and rely upon incorrect information about whether a Provider is a Contract Provider from a current Plan Provider Directory, the Plan will apply Contract cost-sharing to your claim, even if the Provider was a Non-Contract Provider.

Continuing Care Patient

If you are a Continuing Care Patient and the Plan terminates its PPO contract with a Contract Provider or Contact Facility or Hospital, or your benefits are terminated because of a change in terms of the Providers' and/or Facilities' participation in the Plan, the Plan will do the following:

- Notify you in a timely manner of the Plan's termination of its contracts with the Contract Provider or Facility and inform you or your representative of your right to elect continued transitional care from the Provider or facility; and

- Allow you ninety (90) days of continued coverage at the in-network cost-sharing to allow for a transition of care to a Contract Provider or Facility.

A "Continuing Care Patient" means an individual who is:

- Undergoing a course of treatment for a serious and complex condition from the Provider or facility;

- Undergoing a course of institutional or inpatient care from the Provider or facility;

- Scheduled to undergo non-elective surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a surgery;

- Pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or

- Determined to be terminally ill and receiving treatment for such illness from such Provider or facility.

Note: The directory of Contract Providers is used for a large number of groups. It may include some Providers whose services may not be covered by the Plan. 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.

ANNUAL OUT-OF-POCKET LIMITS

Your annual out-of-pocket expenses include the deductible (under Schedule II), copays and/or coinsurance for In-Network prescription drugs, and the percentage of the Contract Provider negotiated rates or Non-Contract Provider Allowed Charge that you have to pay. For example, if you're under Schedule I and you visit a doctor who is a Contract Physician, the Plan would pay 80% of the contract rate and you would pay the other 20%. That 20% would be your out-of-pocket expense.

The Out-of-Pocket Limits are the most you pay during the calendar year before your plan starts to pay 100% for covered essential health benefits received from Contract Providers (or In-Network pharmacies). **This Plan has two separate Out-of-Pocket Limits on Contract Providers (one for medical deductible (for Schedule II) and medical coinsurance and a separate Out-of-Pocket limit for In-Network outpatient Prescription Drugs).**

- **Out-of-Pocket Limit on Deductible and Coinsurance from Contract Providers:** $5,000 per person per calendar year, and $11,000 per family per calendar year.

- **Out-of-Pocket Limit on Outpatient In-Network Prescription Drugs (Retail, Mail Order and Specialty Pharmacy):** $1,600 per person per calendar year, and $2,200 per family per calendar year. The Out-of-Pocket Limit on prescription drugs is explained in more detail in the Prescription Drug Chapter of this SPD.

These amounts may be adjusted annually in accordance with ACA regulations. In addition, there is a **separate Out-of-Pocket limit for Non-Contract Providers** ($10,000 per person per calendar year, no family limit).

- The Out-of-Pocket Limit is accumulated on a calendar year basis.
- The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.
- Out-of-Pocket Limits are NOT interchangeable, meaning you may not use a portion of a Contract Out-of-Pocket Limit to meet a Non-Contract Out-of-Pocket Limit and vice versa, except that Emergency Services performed in an Out-of-Network Emergency Room will apply to meet the in-network Out-of-Pocket Limit.
- Covered emergency services performed in an Out-of-Network Emergency Room will apply to meet the medical Contract Provider Out-of-Pocket Limit.
- The family Out-of-Pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual Out-of-Pocket limit.

Reduced Comprehensive Medical Benefits

There is a separate Out-of-Pocket limit for the Reduced Comprehensive Medical benefits. For a description of how the Out-of-Pocket limit applies to the Reduced Comprehensive Medical Benefit see page 67.

Expenses Not Counted Toward the Out-of-Pocket Limit on Deductible and Coinsurance

The Out-of-Pocket Limit on medical deductible and coinsurance does not include or accumulate:

- Any covered expenses that the Plan normally pays at 100%,
- Contributions for coverage (including COBRA premiums),
- Expenses for medical services or supplies that are not covered by the Plan,
- Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for Non-Contract Providers,
- Expenses for the use of **Non-Contract Providers**, except Emergency Services performed in a Non-Contract Emergency Room, for certain non-emergency services provided by a Non-Contract Provider at a Contract health facility, and for air ambulance services,
- Charges in excess of the Plan's maximum benefits (including benefit-specific limits),
- Cost sharing for expenses that are not considered to be essential health benefits, such as hearing aids.
- Copays for prescription drugs;
- Expenses for dental plan and vision plan services; and
- Amounts that exceed any reference based pricing maximums paid by the Plan.

In addition, there may be benefits that are denied if you do not follow Pre-Authorization requirements. These excluded amounts do not accumulate to the Out-of-Pocket Limit.

ANNUAL DEDUCTIBLE – SCHEDULE II ONLY

If you are under Schedule I, you do not have to meet an annual deductible before the Plan starts paying medical benefits.

If you are under Schedule II (could only apply if you retired before January 1, 2007), you are responsible for paying the first $200 in covered expenses each calendar year for each individual covered under the Plan. The Plan does not start paying its share of covered expenses until after this deductible has been met.

The deductible does not apply to routine physical exams or covered preventive care, chemical dependency treatment or hearing aids.

REQUIRED PRE-AUTHORIZATIONS

If you are not yet eligible for Medicare and you want to maximize your benefit coverage for a Hospital stay or Skilled Nursing Facility, outpatient surgery, organ or tissue transplant, bariatric surgery, gene therapy, or routine care associated with a clinical trial, you must obtain prior approval (Pre-Authorization) of the Hospital stay, outpatient surgery, transplant, bariatric surgery or routine care associated with a clinical trial from Anthem Blue Cross ("Anthem"), which is the Professional Review Organization (PRO) under contract with the Fund. It is also recommended that you obtain prior approval from Anthem for medical equipment if it will cost more than $500.

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

Certain outpatient diagnostic imaging procedures require Pre-Authorization from American Imaging Management (only if you are not eligible for Medicare).

All participants (including those eligible for Medicare) should contact Operating Engineers Assistance and Recovery Program (ARP) prior to receiving treatment for chemical dependency so you can be directed to a Contract Provider. In addition, for inpatient treatment, you must obtain a referral from the ARP to receive maximum benefit coverage.

These Pre-Authorization requirements are summarized in the chart below.

Plan Requirements for Pre-Authorization – Participants Not Yet Eligible for Medicare	
Situation	**Pre-Authorization Requirement**
Elective, non-emergency hospitalization at an acute-care Hospital, Long Term Acute Care Facility or Skilled Nursing Facility	Anthem Blue Cross must approve the Hospital stay **before the admission**.
Hospitalization as a result of an Emergency Medical Condition	You or someone acting on your behalf must contact Anthem Blue Cross **within 24 hours of admission** 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.

Plan Requirements for Pre-Authorization – Participants Not Yet Eligible for Medicare	
Situation	**Pre-Authorization Requirement**
Surgical procedure scheduled for a Hospital outpatient department or free-standing Ambulatory Surgery Facility	The procedure must be approved by Anthem Blue Cross **before it is performed**.
Outpatient Diagnostic Imaging Procedures, including: • CT/ CTA • MRI/ MRA • Nuclear Cardiology • PET • Echocardiography	Your Physician must contact American Imaging Management for approval of these imaging procedures **before you have the test or service**.
Organ or tissue transplant	All planned services must be approved by Anthem Blue Cross **before services begin**.
Bariatric surgery for weight loss	All planned services must be approved by Anthem Blue Cross **before services begin**.
Gene Therapy	All planned inpatient services must be approved by Anthem Blue Cross **before services begin**.
Durable Medical Equipment	It is recommended that equipment costing more than $500 be approved by Anthem Blue Cross **before buying or renting**.
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 **within 24 hours of admission**.
For Participants who participate in a clinical trial	Precertification by Anthem Blue Cross is required in order to notify the Fund that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.

Plan Requirements for Pre-Authorization – All Participants (Regardless of Whether You Are Eligible for Medicare)	
Treatment for inpatient chemical dependency	You are strongly encouraged to contact the ARP office prior to receiving outpatient treatment for chemical dependency so you can be directed to a Contract Provider. For maximum inpatient benefits, you must contact the ARP office and be referred to an appropriate authorized treatment program before seeking treatment.
If you are eligible for Medicare you will need to follow any Medicare Pre-Authorization requirements. Your Providers are familiar with these procedures.	

How the Process Works for Hospital Stays

(Does not apply if you are eligible for Medicare; see any applicable Medicare procedures in the Federal Medicare Handbook.)

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 to maximize your 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 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 or ARP 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 (or ARP) 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 if your Physician obtains approval of your admission to the Non-Contract Hospital from Anthem Blue Cross (or ARP) 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

(Does not apply if you are eligible for Medicare; see any applicable Medicare procedures in the Federal Medicare Handbook.)

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 begins.

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

(Does not apply if you are eligible for Medicare; see any applicable Medicare procedures in the Federal Medicare Handbook.)

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 37. 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

(Does not apply if you are eligible for Medicare; see any applicable Medicare procedures in the Federal Medicare Handbook.)

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 your Physician has done so and that Pre-Authorization has been obtained before services begin. Anthem will advise your doctor if the surgery must be performed at a *Center of Medical Excellence* facility and will provide a list of those facilities in your area.

- If you proceed with the bariatric surgery or 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 an organ or tissue transplant at a facility that is not a *Center of Medical Excellence* without Pre-Authorization, **no benefits will be payable** for the procedures.
- 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 Routine Care Associated with Clinical Trials

(Does not apply if you are eligible for Medicare; see any applicable Medicare procedures in the Federal Medicare Handbook.)

Your Physician must call Anthem Blue Cross to provide necessary information and apply for Pre-Authorization of the routine care associated with a clinical trial. **You are responsible** for seeing that your Physician has done so and that Pre-Authorization has been obtained before services begin.

The plan may require that an Eligible Individual use a Contract Provider as long as the Provider will accept the patient. This plan is only required to cover Non-Contract costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

How the Process Works for Chemical Dependency Treatment

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

To receive maximum benefits, you must contact the ARP office before seeking inpatient treatment. In addition, you are strongly encouraged to contact the ARP office prior to receiving outpatient treatment so you can be directed to a contract

You can contact the ARP office at (800) 562-3277.

Provider. The ARP coordinator will assist in making a referral to an appropriate authorized treatment program. All communication with the ARP will be strictly confidential.

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 to request Pre-Authorization.

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 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.)

Intent of Required Pre-Authorizations

The Pre-Authorizations required under the Utilization Review Program work to control your costs by, for example, 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 the quality of health care services actually provided. These entities are also not responsible for the results if an Eligible Individual 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 9.

EMERGENCIES

In the case of an Emergency Medical Condition, you should seek the necessary treatment immediately.

The term "Emergency Medical Condition" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such 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 impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

The Fund will cover Emergency Services without the need for any Pre-Authorization determination, even if the services are provided at a Non-Contract Facility, such as an out-of-network Hospital emergency department or an Independent Freestanding Emergency Department, and without regard to whether the health care Provider furnishing the Emergency Services is a Contract Provider or a Contract Facility. Furthermore, the Fund will not impose any administrative requirements or limitations on Emergency Services received from a Non-Contract Provider or Facility that are more restrictive than the requirements or limitations that apply to Emergency Services received from a Contract Provider or Facility.

The cost-sharing for Emergency Services performed by a Non-Contract Provider or Facility will be the same as the cost sharing for Emergency Services performed by a Contract Provider or Facility and will be based on the Recognized Amount payable for these services. Your cost sharing payments for Emergency Services performed by a Non-Contract Provider or facility count toward your deductible and out-of-pocket maximum as if the services were received from a Contract Provider.

In general, you cannot be balance billed for Emergency Services.

If you are admitted to a Hospital as an inpatient for an Emergency Medical Condition, you (or someone acting on 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.

See "Additional Covered Services and Supplies" for information on benefits for ambulance service later in this Chapter.

WHAT THE PLAN COVERS

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.

See the Schedule of Medical Benefits starting on page 27 for cost sharing details related to covered services.

See "If You Are Eligible for Medicare" on page 66 for information on how benefits will be paid for you if you are Medicare eligible. You must be enrolled in both Part A and Part B of Medicare to prevent a reduction in Plan benefits.

Special Provisions Regarding Women's Health Care

Federal law guarantees certain rights to women (Also see Preventive Care for Women on page 54):

- 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 36 for information on approvals necessary for maximum benefits for Hospital admissions if you are not eligible for Medicare.

Covered

- 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; and

- 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; and
- Personal items (telephone, television, etc.).

Cash Incentive for Recovering Overcharges by Non-Contract Hospitals

(Does not apply if you are eligible for Medicare.)

If you discover an overcharge on your bill from a Non-Contract **Hospital** and negotiate with the Hospital to have it corrected, the Plan will pay you 25% of the amount recovered (subject to the deductible if you are under Schedule II).

You will receive 25% of the amount recovered from the Hospital as a result of direct negotiations between you and the Hospital, up to a maximum of $1,000 in any calendar year. For you to be eligible, your Hospital overcharges must total $25 or more in a calendar year.

The overcharge program does not apply to Contract Hospitals, which have per diem rates that are all-inclusive and are not subject to negotiation.

Among typical Hospital overcharges are those involving the number of days of hospitalization, the room rate, double billing for x-rays or other diagnostic services, charges for tests you never had, overbilling for surgical or anesthesia procedures and supplies, and incorrect pharmacy charges (the incorrect number of pills or injections).

Only Hospital expenses covered under the Plan will be considered. Expenses such as telephone bills, television rental, newspapers, etc., that are not covered expenses under the Plan will not be considered**.**

If you are covered by more than one health plan, you are eligible only if the Pensioned Operating Engineers Health and Welfare Trust Fund is the primary plan (see "Coordination of Benefits" in Chapter 10 for a discussion of which plan is primary).

To claim your cash incentive, send the Trust Fund Office the following documents within 45 days of the date of discharge from the Hospital:

- A copy of the initial itemized Hospital bill with the overcharges circled; and
- A copy of the adjusted bill showing that the Hospital agreed to reduce its billing by the amount of the overcharges.

Outpatient Hospital or Ambulatory Surgery Facility

See "Required Pre-Authorizations" on page 36 for information on approvals necessary for outpatient surgical procedures if you are not eligible for Medicare. See "Surgery" below for benefits payable for the surgeon and anesthesiologist charges.

The Plan pays benefits in accordance with the Schedule of Benefits for outpatient services and supplies at a Hospital or Ambulatory Surgery Facility. Please note: **There is a daily maximum benefit of $500 for all services received at a Non-Contract Ambulatory Surgery Facility (this $500 maximum does not apply to individuals who are eligible for Medicare).**

Covered

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

Maximum Allowable Charges Apply for Certain Surgical Procedures

(Does not apply if you are eligible for Medicare.)

Charges for surgical procedures can vary greatly among hospitals and facilities. For example, at in-network facilities within 50 miles of San Jose, the costs for knee replacement surgery can range from $19,000 to over $75,000. Yet, there is little evidence of a higher quality of care at a higher cost facility.

The Plan will allow a Maximum Allowable Charge (MAC) for the following five surgical procedures in the state of California **if you are not eligible for Medicare**:

1. Single hip replacement;
2. Single knee replacement;
3. Arthroscopic surgery at an outpatient Hospital;
4. Cataract surgery at an outpatient Hospital; and
5. Colonoscopy at an outpatient Hospital.

The MAC is the highest amount your plan will pay for these procedures (in the state of California). Any amount over the MAC will be your responsibility. This benefit design applies ONLY to routine total hip or knee replacements, arthroscopies, cataract surgery and colonoscopies **in the state of California**.

Procedure	Maximum Allowable Charge per Surgery
At an Inpatient Hospital	
Routine Total Hip Replacement Surgery	$34,000
Routine Total Knee Replacement Surgery	$34,000
At an Outpatient Hospital (instead of an ambulatory surgical center)	
Single Hip Replacement Surgery	$34,000
Single Knee Replacement Surgery	$34,000
Arthroscopy	$6,000
Cataract Surgery	$2,000
Colonoscopy	$1,500

* These maximums do not apply to Medicare eligible Participants. The maximums include hospital charges and the charge for any device; it does not include the professional fees such as anesthesiologist or surgeon fees.

* Maximums do not apply to individuals who are eligible for Medicare or to surgeries performed outside the state California.

* **Please note:** Amounts denied as over the MAC for a procedure will not accumulate toward your Out-of-Pocket Maximum.

Value Based Site

For hip and knee replacements, there are many California hospitals that will hold costs under the MAC. We call these facilities "Value-Based Sites." For surgeries done outside the state of California, normal surgery benefits will apply.

You can find a Value-Based Site, by calling Anthem Blue Cross at the Pre-Authorization phone number listed in the Contact at the beginning of this booklet.

How can I make sure my costs are under the MAC?

Clearly, it makes sense to have your inpatient procedure done at a Value-Based Facility and your outpatient procedure done at an Ambulatory Surgery Facility. You'll receive quality care at an affordable price for you and your Benefit Trust Fund. To make sure you keep your costs under the MAC (or at a price you can afford if you decide not to go to a Value-Based Site for your care), take these actions BEFORE you receive your care:

To receive the highest level of benefits, have the service preauthorized by Anthem Blue Cross and plan to have your inpatient procedure at a Value-Based Facility and your outpatient procedure at an Ambulatory Surgery Facility.

Exceptions Process

The inpatient and outpatient services provided by a Provider, hospital, or outpatient surgery center that has not agreed to accept the MAC may be treated as a MAC Provider, hospital, or outpatient surgery center if:

- Your access to a MAC Provider, hospital, or outpatient surgery center is unavailable or the service cannot be obtained within a reasonable wait time or travel distance; OR
- Your or your Dependent's Provider certifies that the quality of services for you or your Dependent could be compromised with the MAC Provider, hospital, or outpatient surgery center (e.g., if comorbidities present complications or patient safety issues).

Information About MAC

Upon request, Anthem will provide you with:

- A list of Providers, hospitals, and outpatient surgery centers that accept the MAC for a particular inpatient or outpatient service;
- A list or Providers, hospitals, and outpatient surgery centers that will accept a negotiated price above the MAC; and
- Information on the process and underlying data used to ensure that an adequate number of Providers, hospitals, and outpatient surgery centers that accept the MAC meet reasonable quality standards.

Skilled Nursing Facility

See "Required Pre-Authorizations" on page 36 for information on approvals necessary for maximum benefits if you are not eligible for Medicare.

Benefits are provided in accordance with the Schedule of Benefits for a maximum of 100 days per calendar year. 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 determined to be Medically Necessary. Benefits are provided only for the number of days required to treat the Illness or Injury.
  - ✓ For **Retirees and/or Eligible Dependents who are not eligible for Medicare**, Pre-Authorization by the Utilization Review Program is required in order to determine the care is Medically Necessary.
  - ✓ For **Retirees and/or Eligible Dependents who are eligible for Medicare,** the Fund will use Medicare's determination of Medical Necessity. This means that if Medicare determines the skilled nursing is not Medically Necessary, the Fund will not consider the services to be Medically Necessary.
- You must remain under the active medical supervision of a Physician.

Covered

- 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;
- Special treatment rooms;
- Laboratory tests;
- Physical, occupational, and speech therapy, oxygen;
- Drugs and medicines that are used in the facility; and
- Blood transfusions, blood products, and blood processing.

Not Covered

- Skilled nursing facility services for any days beyond 100 days per calendar year.

Care in a Long Term Acute Care (LTAC) Facility

See "Required Pre-Authorizations" on page 36 for information on approvals necessary for maximum benefits if you are not eligible for Medicare.

Benefits may be provided for a limited period of time in a Long Term Acute Care (LTAC) facility if a patient is receiving continued rehabilitation therapy immediately after, or instead of, acute inpatient hospitalization, and only to the extent the patient is continuing to progress.

- ✓ ***For Retirees and/or Eligible Dependents who are not eligible for Medicare***, Pre-Authorization by the Utilization Review Program is required in order to determine the care is Medically Necessary (Medical Necessity must be re-established by the Utilization Review Program every two months).
- ✓ ***For Retirees and/or Eligible Dependents who are eligible for Medicare,*** the Fund will use Medicare's determination of medical necessity. This means that if Medicare determines the care in a LTAC facility is not Medically Necessary, the Fund will not consider the services to be Medically Necessary.

Not Covered

- Custodial Care

Surgery

See "Required Pre-Authorizations" on page 36 for information on approvals necessary for maximum benefits if you are not Medicare eligible.

The Plan pays benefits for the surgeon, assistant surgeon, and anesthesiologist in accordance with the Schedule of Benefits.

Covered Expenses for the services of a licensed Physician Assistant (P.A.) 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: reconstruction of the breast on which a 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; and
- A second surgical opinion for the purpose of determining the necessity for prescribed surgery (this is covered only if it is obtained from a Physician who does not perform the surgery, is Board-Certified in the field of medical specialization related to the proposed surgery, and has no financial interest in the outcome of his or her recommendation).

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; and
- Expenses for transportation of surgeons.

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

(Does not apply if you are eligible for Medicare.)

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 or a Blue Distinction Center* (including an Anthem PPO facility that is not an Anthem Blue Cross Center of 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

(Does not apply if you are eligible for Medicare.)

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) or Blue Distinction Center.

Travel Benefit for Bariatric Surgery

(Does not apply if you are eligible for Medicare.)

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

- The patient's transportation to and from the CME, limited to actual and documented expenses up to $130 per roundtrip for up to 3 roundtrips (pre-surgical visit, initial surgery and one follow-up visit);
- One companion's transportation to and from the CME, limited to actual and documented expenses up to $130 per roundtrip for up to 2 roundtrips (initial surgery and one follow-up visit);
- Lodging while away from home for the patient is limited to actual and documented expenses up to $50 per day for up to 2 days (pre-surgical visit and one follow-up visit);
- Lodging (limited to one room, double occupancy) for the Patient and one companion while away from home is limited to actual and documented expenses up to $100 per day for up to 2 days (or as Medically Necessary) for one pre-surgical visit, 4 days for the initial surgery, and 2 days (or as Medically necessary) for one follow-up visit;
- Other reasonable and direct travel expenses related to bariatric surgery are limited to actual and documented medical care expenses up to $25 per day each up to 4 days per roundtrip for the patient and one companion whose presence is necessary for the receipt of the medical care by the patient. Such medical care expenses shall not include meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs, and any expense 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 and Tissue Transplant

(Does not apply if you are eligible for Medicare.)

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). 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. See the applicable sections of this chapter for benefit payment information.

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

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

- 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 (as determined by the Fund or its designated review organization).
- The transplant must be pre-authorized by Anthem Blue Cross. Specified transplant procedures, including kidney transplants, must be performed in a Hospital or facility that is designated as a *Center of Medical Excellence* by Anthem or a "Blue Distinction Center" by the Blue Cross and Blue Shield Association 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 (*applies only if you are not eligible for Medicare*).

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.

Travel Benefit for Organ or Tissue Transplants

(Does not apply if you are eligible for Medicare.)

The Fund will reimburse reasonable and direct transplant travel expenses for a pre-authorized, specified transplant at a *Center of Medical Excellence* or *Blue Distinction Center* subject to the following conditions:

- Benefits for unrelated donor search are limited to a maximum of $30,000 per transplant;
- Travel expenses for the organ recipient, one companion, and the organ or tissue donor for the specified transplant at a *Center of Medical Excellence* is limited to $10,000 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.

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.

If you are anticipating needing an organ or tissue transplant, bariatric surgery, cardiac care, spinal surgery or treatment for a complex and rare cancer, please have your doctor contact Anthem Blue Cross at (800) 274-7767 for pre-approval and referral to a Center of Medical Excellence contract facility. You can also visit the Blue Cross websites at www.anthem.com/ca for a list of CME facilities and www.bcbs.com for a list of nationwide Blue Distinction Centers.

Physician Services

Covered

- Visits to a Physician's office (including a specialist) for diagnosis or treatment of an Illness or Injury;
- Visits by a Physician while you are in the Hospital; and

- Visits by a Physician to your home for diagnosis or treatment of an Illness.

Not Covered

The term "visit" means a personal interview between you and the Physician or other covered Health Care Provider and does not include telephone calls or other situations where you are not personally examined by the Health Care Provider.

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.

- 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).

Laboratory and Radiology Services

Certain outpatient diagnostic imaging procedures require Pre-Authorization from American Imaging Management (only if you are not eligible for Medicare).

See "Required Pre-Authorizations" on page 36 for information on approvals necessary for certain diagnostic imaging procedures if you are not eligible for Medicare.

If you use a free-standing contract laboratory, the Plan will pay 100% of the negotiated contract rate under either Schedule I or Schedule II. (The 100% benefit does not apply to lab charges billed by a Hospital.)

If you use a Non-Contract laboratory or laboratory services billed by a Hospital, the Plan will pay the benefits shown in the Schedule of Medical Benefits beginning on page 27.

Radiology services are paid as shown in the Schedule of Medical Benefits on page 27.

Covered

- Outpatient diagnostic laboratory tests and diagnostic imaging procedures including ultrasound and nuclear medicine
- Outpatient diagnostic x-rays
- Radiation therapy

Gene Therapy

The Plan covers Medically Necessary and Non-Experimental Gene Therapies that are FDA-approved. Gene Therapies are covered subject to any plan deductible, coinsurance, and/or copay.

Gene Therapy seeks to modify or introduce genes into a patient's body with the goal of treating, preventing, or potentially curing a disease. Examples of Gene Therapy approaches include replacing a mutated gene that causes disease with a functional copy; introducing a new, correct copy of a gene into the body; or turning off genes that cause medical problems. Contact Anthem Blue Cross to

determine whether a particular Gene Therapy is FDA approved, Non-Experimental, and Medically Necessary..

For Participants who are not yet eligible for Medicare: Any Gene Therapy treatment that requires confinement in a Hospital, Skilled Nursing Facility, or chemical dependency treatment facility must be preauthorized by Anthem Blue Cross ("Anthem"). If services are subsequently determined to be not Medically Necessary, or is Experimental or not approved by the FDA, there will be no benefits available. Anthem will determine whether the patient meets the indications for use of the therapy. Where possible, the patient will be directed to a Contract Provider.

Acupuncture

Covered

Acupuncture treatment by a licensed acupuncturist for **up to 16 visits** per calendar year.

Physical or Occupational Therapy and Chiropractic Services

The Plan covers physical or occupational therapy and chiropractic services provided by a registered physical therapist, chiropractor, or Physician.

Benefits are **limited to a maximum of 40 visits per calendar year.** (This limit applies to all visits for physical therapy, occupational therapy, and chiropractic services combined.) Visit limits will not apply to diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.

Maternity and Infertility/Family Planning Services

Maternity services are covered the same as other medical expenses and 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 information. Covered infertility services are limited to the initial consultation only.

Covered

- Hospital and Physician services for pregnancy and childbirth.
- Services of a stand-by pediatric Physician at a cesarean section or other at-risk delivery, but only when the stand-by Physician is actually present in the delivery room.
- 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 abortion (except when the life of the mother would be in danger if the fetus were carried to term or where medical complications arise from an 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 non-Spouse, non-member, or non-Dependent surrogate mother's pregnancy.
- Adoption expenses.
- Reversal of sterilization.

See Chapter 5, "Prescription Drug Benefits," for information on benefits for contraceptives.

Preventive Care Benefits Required by Health Care Reform

Contract Providers Only

The following preventive care services that are required by the Affordable Care Act (Health Care Reform) will be payable at 100%, with no cost sharing, **only when they are received from a Contract Provider**. The Schedule II deductible does not apply. The covered services may change over time. Please refer to the websites below for a list of up-to-date Covered Services.

The wellness/preventive services payable by this Plan are designed to comply with ACA regulations and the current recommendations of the United States Preventive Services Task Force (Grade A and B) (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control and Prevention (CDC). The following websites list the types of payable preventive services, including immunizations:

https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.hrsa.gov/womensguidelines/.

Preventive Care for Children

Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required. Covered Services include but are not limited to:

- Childhood immunizations that are FDA approved and in accordance with the CDC recommendations for children in the U.S.
- Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
- Developmental screening for children under age 3, and surveillance throughout childhood
- Behavioral assessments for children of all ages
- Medical history
- Blood pressure screening
- Depression screening for adolescents ages 11 and older
- Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors
- Hearing screening
- Height, Weight and Body Mass Index measurements for children
- Autism screening for children at 18 and 24 months
- Alcohol and Drug Use assessments for adolescents

- Critical congenital heart defect screening in newborns
- Hematocrit or Hemoglobin screening for children
- Lead screening for children at risk of exposure
- Tuberculin testing for children at higher risk of tuberculosis
- Dyslipidemia screening for children at higher risk of lipid disorders
- Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents
- Cervical Dysplasia screening at age 21
- Oral Health risk assessment
- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
- Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- Screening for hepatitis B virus infection in adolescents at high risk for infection.
- Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.
- Syphilis screening for adolescents who are at increased risk for infection.
- For adolescents, screening and counseling for interpersonal and domestic violence.

Preventive Care for Adults

Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required. Covered Services include but are not limited to:

- Routine adult immunizations for men who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.
- Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
- Alcohol Misuse screening and counseling: screening and behavioral counseling interventions to reduce alcohol misuse by adults ages 18 and older in primary care settings.

- Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older and women aged 45 and older; men aged 20 to 35 if they are at increased risk for coronary heart disease; and women aged 20 to 45 if they are at increased risk for coronary heart disease.
- Colorectal Cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 45 and continuing until age 75. The test methodology must be medically appropriate for the patient. The plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending Provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
- Depression screening for adults.
- Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- Tobacco Use screening for all adults and cessation interventions for tobacco users.
- Syphilis screening for all adults at increased risk of infection.
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
- Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.
- Screening for hepatitis B virus infection in adults at high risk for infection.
- Screening for latent tuberculosis infection in populations at increased risk.

Preventive Care for Women (including pregnant women)

Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required. Covered Services include but are not limited to:

- Routine adult immunizations for women who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.
- Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.
- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care Provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
- Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.
- Comprehensive lactation support and counseling by a trained Provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the plan administrator.
- Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.
- Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
- FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.
- Gonorrhea screening for sexually active women age 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.

- Counseling for sexually transmitted infections, once per year as part of a well woman visit.
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool will be eligible for screening. The Plan will pay for the most cost-effective test methodology only.
- Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
- Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.
- Depression screening for pregnant and postpartum women.

Additional Preventive Care Benefits Not Required By Health Care Reform

The Plan covers the following additional preventive care services that were benefits of the Plan prior to Health Care Reform.

Retiree / Spouse Physical Examination

Available from Contract Providers and Non-Contract Providers.

This benefit is available only for you and your Spouse, not for your Dependent children, and only once per calendar year.

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.

Not Covered

- More than one physical examination in any calendar year
- Eye examinations
- Any examination required by an employer as a condition of employment

Immunizations

The Plan covers immunizations for adults and children, including but not limited to the vaccines for hepatitis, influenza (flu), pneumonia, herpes zoster, and HPV.

Benefits for Non-Contract Providers are payable in accordance with the Schedule of Benefits. (*If you use a Contract Provider, benefits are payable at 100% of the Allowed Charge with no cost sharing.*)

Colorectal Cancer Screening Including Colonoscopy

The Plan will pay benefits in accordance with the Schedule of Benefits for the following services for individuals age 45 and over. (*If you use a Contract Provider, benefits are payable at 100% of the Allowed Charge with no cost sharing.*)

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.
- Follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization test.

If recommended by a Physician, the Plan will cover screening before age 45 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)

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 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 [(800) 662-8887] and mention that you are a participant in the Pensioned 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 Dependents under prescription drug benefits (*see Chapter 5*).

Mental Health

Inpatient

Benefits for inpatient mental health treatment are paid the same as any other medical condition, as applicable for the type of service (Hospital charges, charges for inpatient doctor visits, etc.). See the applicable sections in this chapter for benefit payment information.

Outpatient

For outpatient mental health care, the Plan will pay the same as physician services for any other medical condition and the same as diagnostic lab and x-ray services for psychological testing and lab tests.

Covered

- Inpatient mental health treatment
- Outpatient treatment of mental or nervous disorders provided by a licensed Provider who is practicing within the scope of his or her license/
- Outpatient diagnostic lab and x-ray tests related to treatment of mental illness

Not Covered

- Educational services, as described under "Exclusions from Coverage" later in this chapter

Medical Equipment, Prosthetic Appliances and Orthotics

Pre-Authorization is recommended for medical equipment costing more than $500; see page 36.

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 an organ or body part, or that improves the function of an impaired organ or body part;
- Diabetic shoes; and
- Foot Orthotics, limited to a maximum benefit of $500 for both feet.

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 reasonable purchase price of the equipment;
- Dental prosthetic devices (see Chapter 6 for dental benefits);
- Expenses for foot orthotics beyond the maximum stated under "Covered" immediately above; or
- Orthopedic shoes (except when joined to braces) or shoe inserts (except foot orthotics as provided above).

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; and
- 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 (R.N.);
- Home health aide services;
- Special meals; and
- Bereavement counseling services by a licensed mental health Provider (e.g., social worker) or pastoral counselor for immediate family members of the patient who were covered by this Plan at the time of the patient's death.

Anthem SilverSneakers

Medicare eligible Retirees and Spouses have access to a FREE gym benefit. SilverSneakers is more than a fitness program. It's an opportunity to improve your health, gain confidence and connect with your community. This fitness program for Medicare Eligible Individuals gives you unlimited access to thousands of fitness locations across the country.

Please go to SilverSneakers.com/StartHere to get started. If you do not have access to a computer or you are in need assistance with this important step, call customer service at 866-584-7389, Monday through Friday, 8 a.m. – 8 p.m. for assistance.

With SilverSneakers, you're free to move in the ways that work for you.

- Membership to thousands of fitness locations nationwide
- - Signature SilverSneakers group fitness classes
- - Group activities and classes offered outside the gym in your community
- - Access to SilverSneakers LIVE virtual classes
- - Hundreds of On-Demand workout videos available

- - SilverSneakers GO app with fitness programs that can be tailored to your fitness level

To get started go to SilverSneakers.com/StartHere or to find a location near you, go to SilverSneakers.com/Locations

SilverSneakers offers several exclusive classes for all ability levels and interests, including:

- **SILVERSNEAKERS CLASSIC:** a variety of exercises designed to increase muscular strength, range of movement and activities for daily living. Hand-held weights, elastic tubing with handles and a SilverSneakers ball are offered for resistance. A chair is available if needed for seated or standing support. Not all locations offer classes. The most up to date benefit information, including locations and online options, can be found on our website at www.silversneakers.com.

- **SILVERSNEAKERS CIRCUIT:** Upper-body strength work with hand-held weights, elastic tubing with handles, and a SilverSneakers ball is alternated with low-impact aerobic choreography. A chair is used for standing support, stretching and relaxation exercises.

- **SILVERSNEAKERS CARDIOFIT:** This workout includes easy-to-follow low-impact movement and upper-body strength, abdominal conditioning, stretching and relaxation exercises designed to energize your active lifestyle.

- **SILVERSNEAKERS YOGA:** This class will move your whole body through a complete series of seated and standing yoga poses. Chair support is offered to safely perform a variety of seated and standing postures designed to increase flexibility, balance and range of movement.

- **SILVERSNEAKERS SPLASH:** Splash offers fun, shallow-water movement to improve agility and flexibility while addressing cardiovascular, strength and endurance conditioning. No swimming ability is required, and a SilverSneakers kickboard or other aquatic equipment is used to improve strength, balance and coordination.

- **BOOM CLASSES:** The BOOM series offers three distinct, 30-minute group exercise classes designed for Baby Boomers and active older adults looking to take their fitness to the next level. Classes include: yoga, Pilates and stretching, a unique blend of cardio and strength-based athletic exercises, a dance workout class that improves cardio endurance.

- **FLEX CLASSES:** Offered at recreation centers, older-adult living communities, local parks and more, FLEX features more than 50 unique classes, like: dancing, boot camp walking groups and more.

All SilverSneakers classes are designed by experts in older adult fitness and taught by credentialed fitness professionals. SilverSneakers classes are created for adults of all fitness levels and abilities. Modifications are offered and chairs are available in certain classes. If you're new to fitness, recovering from an injury or want to know which exercises are right for you, talk to your doctor. Most locations are wheelchair accessible, but we cannot guarantee full accessibility. Call the participating location you're interested in prior to your first visit. If you are in need of an at-home kit, please call the SilverSneakers Customer Service phone number at 866-584-7389. These kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.

In addition, after you enroll in Kaiser, you are automatically eligible to enroll in the Silver&Fit program (either at a fitness center or at home). Call (877) 427-4788 for more information on how to utilize these benefits.

Additional Covered Services and Supplies

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 make air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life.

- ***Services of a registered nurse, licensed nurse practitioner, registered nurse first assistant and other licensed Providers*** when performing services within the scope of their license.

- ***Home health care,*** including IV drugs and their administration when furnished by a home health care agency.

- ***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. In addition, certain dietary counseling may be payable as a preventive care service in accordance with ACA requirements.

  A diabetes education program is covered when you are first diagnosed with diabetes. A refresher course may be covered once a year, 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). This exclusion will not be applied for treatment of developmental delays.

  Benefits are payable until understandable speech is attained or until a determination is made that understandable speech cannot be attained.

- ***Blood transfusions***, including blood processing and the cost of un-replaced blood and blood products.

- ***Oxygen and the rental of equipment for its administration.***

- ***Purchase of a wig*** when hair loss is the direct result of chemotherapy treatment.

- ***Dialysis*** treatment.

- ***Cardiac and pulmonary rehabilitation programs*** when recommended by your Physician.

HEARING AID BENEFIT

*Available to enrollees in the comprehensive medical benefits **and** HMO enrollees. The annual deductible for Schedule II does not apply.*

The Plan will pay 100% of covered expenses, up to a maximum of $2,025 per ear. Hearing aid expenses do not apply to the Plan's annual out-of-pocket limit.

Covered

- A hearing examination; and
- Hearing aid device (limited to one device per ear during any 48-month 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 48-month period;
- Batteries or any other ancillary equipment other than that obtained when the hearing aid was purchased and which can be covered within the $2,025 maximum benefit; or
- 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 Hear USA, a national network of hearing aid Providers that offer discounted rates for the fitting and dispensing of hearing aids.

- To contact Hear USA, call (800) 442-8231 or go to www.hearusa.com.

CHEMICAL DEPENDENCY TREATMENT

Available to enrollees in the comprehensive medical benefits ***and*** *HMO enrollees.* ***Note that all HMO enrollees must use either the HMO's chemical dependency benefits or ARP Contract Providers. No chemical dependency benefits will be paid by this Plan for services received from a Non-Contract Provider for any individual who is enrolled in an HMO offered by the Fund.*** *The annual deductible for Schedule II does not apply.*

The Plan pays benefits described below for covered services received through the Operating Engineers Assistance and Recovery Program (ARP).

Note: Benefits for treatment of alcoholism or other chemical dependency are available **only to you and your Spouse**, not to Dependent children.

See "Required Pre-Authorizations" earlier in this chapter for information on referrals necessary for benefits.

Covered

Residential treatment: The Plan will pay 100% of the Allowed Charge, Deductible does not apply, with Pre-Authorization by ARP required.

Recovery home treatment in an ARP-approved recovery home: The Plan will pay 100% of the Allowed Charge, Deductible does not apply, for recovery home treatment in an ARP approved recovery home.

Outpatient treatment: The Plan will pay 100% of the Allowed Charge, Deductible does not apply, for treatment received through the ARP. Referral and Pre-Authorization by ARP is recommended so that you can be directed to a Contract Provider.

Not Covered

- Any treatment or service that is determined by the Operating Engineers Assistance and Recovery Program to be not Medically Necessary;
- Services provided to a Dependent child; or
- Services provided by Non-Contract Providers to Retired Employees or Spouses who are enrolled in an HMO.

EXCLUSIONS FROM COVERAGE

Comprehensive medical benefits are not payable for the following:

1. Any expenses that:
   - Exceed Allowed Charges,
   - Are for services and supplies that are deemed not Medically Necessary,
   - Are for services or supplies that are deemed Experimental or Investigational, 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(s)," "Experimental or Investigational" and other terms used in this chapter can be found in the definitions section of the Rules and Regulations at the end of this SPD.
2. Any services or supplies listed as "Not Covered" in relation to specific benefits earlier in this chapter.
3. Services for which benefits are payable under any other programs provided by the Fund.
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"*). This exclusion does not include a licensed Provider that is practicing within the scope of his or her license and providing covered Medically Necessary services.
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 services, treatment of the temporomandibular joint (TMJ treatment), extraction of teeth, or treatment of 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 resulting from radiation treatment for cancer.

9. Optometric services; vision therapy, including orthoptics; routine eye exams and routine eye refractions; or eyeglasses or contact lenses (*see Chapter 7 for information about available vision care benefits*).

10. Eye surgery for correction of myopia, or any other refractive eye surgery.

11. Nutritional counseling (*except for covered diabetes education programs or under the preventive care benefits)* or food supplements or substitutes.

12. Educational services: such as auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, 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 61*).

13. Hypnotism, massage therapy, stress management, or any goal-oriented behavior modification therapy (e.g., to quit smoking, lose weight, or control pain). *See page 57 for information on assistance with smoking cessation and Chapter 5 for information on coverage of smoking cessation products.*

14. Services for cosmetic purposes (except as specifically noted earlier under "Surgery" in "Covered Expenses").

15. Services or programs that are primarily for weight loss (except for covered bariatric surgery or as required to be covered under the Affordable Care Act), health club memberships, exercise and physical fitness programs or equipment, or spas.

16. Routine physical examinations, except as provided under "Preventive Care" earlier in this chapter.

17. Charges due to occupational Injuries or Illnesses (except as provided under "General Exclusions, Limits, and Reductions" in Chapter 10).

18. Covered expenses for Hospital care or medical services or supplies that are covered by Medicare for Retired Employees and Dependents who are eligible for Medicare (whether or not the individual has actually enrolled in Medicare).

19. Any service or supply that is excluded under "General Exclusions, Limits, and Reductions" in Chapter 10.

20. Non-emergency services provided outside the United States (expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency).

21. Military service related Injury/Illness: If an Eligible Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan. See Coordination With Other Government Programs in Chapter 10.

22. Habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development, even if the delay in development is a direct result of an Injury, surgery or as a result of a treatment that is the type that is covered by this Plan. This exclusion does apply to treatment of diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.

23. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or occurring in an institution which is primarily a place for the treatment of chronic or long-term Injuries or Illnesses. This exclusion does not include Medically Necessary care in a Long-Term Acute Care (LTAC) facility where a patient is receiving continued rehabilitation therapy immediately after, or instead of, acute inpatient hospitalization, and only to the extent the patient is continuing to progress.

   - ✓ ***For Retirees and/or dependents who are not eligible for Medicare***, Pre-Authorization by the Utilization Review Program is required in order to determine the care is medically necessary (medical necessity must be re-established by the Utilization Review Program every two months).
   - ✓ ***For Retirees and/or Eligible Dependents who are eligible for Medicare,*** the Fund will use Medicare's determination of medical necessity. This means that if Medicare determines the care in a LTAC facility is not medically necessary, the Fund will not consider the services to be medically necessary.

24. A Dependent daughter's abortion (except when the life of the mother would be in danger if the fetus were carried to term or where medical complications arise from an abortion).

IF YOU ARE ELIGIBLE FOR MEDICARE

If you or your Spouse are eligible for Hospital and medical benefits under Medicare, benefits available under Parts A and B of Medicare will be deducted from the benefits payable under the Plan.

This deduction will happen regardless of whether or not you have actually enrolled for Medicare and regardless of whether the Provider of medical services has chosen to participate in Medicare. It is very important that you and your Spouse enroll in both Part A and Part B of Medicare as soon as you become eligible.

You are eligible for Medicare Parts A and B when you attain age 65. In addition, if you receive a Social Security Disability Award, you may be eligible for Medicare Parts A and B before age 65.

This Plan will estimate that Medicare Part B paid 80% of charges and that Medicare Part A paid hospital charges in full, less the inpatient Medicare deductible. This means that if you do not enroll in Medicare Parts A and B, you will incur significant out-of-pocket medical expenses.

If you are eligible for Medicare, the Plan will pay benefits as follows:

- If you are under Schedule I, the Plan will pay 80% of the covered expenses remaining after Medicare has paid its amount (provided you have not reached the Plan's calendar year maximum).
- If you are under Schedule II, the Plan will pay 75% of covered expenses remaining after Medicare has paid its amount (provided you have met the Plan's annual deductible and you have not reached the calendar year maximum).

"Covered expenses" 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. **The Plan will apply Medicare's determination of medical necessity.**

If You Have Coverage Elsewhere

If you or your Dependents have Medicare or other group medical care 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 "If You Are Eligible for Medicare" above and "Coordination of Benefits with Other Plans" in Chapter 10.

REDUCED COMPREHENSIVE MEDICAL BENEFITS

If the highest contribution paid by your former employer for the last 12 months of contributions paid to the Trust Fund did not equal the target employer contribution rate as determined by the Board of Trustees and your bargaining unit did not make an additional allocation, you can choose to either pay a higher monthly self-pay contribution OR receive a reduced level of comprehensive medical benefits as shown in the following chart.

If you leave employment with a Contributing Employer due to a disability (for which you receive an SSDI award), AND retire within three years from the time you become eligible for benefits, the target rate for determining the Retired Employee's payment will be determined based on the last contribution rate your Contributing Employer made while you were actively working.

Reduced Comprehensive Medical Benefits Payable If Employer Contribution was Less than the Target Contribution Rate	
If Employer Contribution was:	**You will receive the following percentage of normal Schedule I benefits:**
between 95% and 100% of target contribution rate	**100%**
between 90% and 95% of target contribution rate	**95%**
between 85% and 90% of target contribution rate	**90%**
between 80% and 85% of target contribution rate	**85%**
between 75% and 80% of target contribution rate	**80%**
between 70% and 75% of target contribution rate	**75%**
between 65% and 70% of target contribution rate	**70%**
between 60% and 65% of target contribution rate	**65%**
between 55% and 60% of target contribution rate	**60%**
between 50% and 55% of target contribution rate	**55%**
between 45% and 50% of target contribution rate	**50%**
between 40% and 45% of target contribution rate	**45%**
between 35% and 40% of target contribution rate	**40%**
between 30% and 35% of target contribution rate	**35%**
between 25% and 30% of target contribution rate	**25%**
Between 0% and 25% of target contribution rate	**N/A. Monthly self-pay contribution required: $1,100 for Non-Medicare Retirees $550 for Medicare Retirees**

- The reduced benefit levels apply to all comprehensive medical benefits, except chemical dependency benefits and preventive care services mandated by the Affordable Care Act.
- **Out-of-pocket limit**. The reduced benefit percentages will continue to apply after you reach the medical out of pocket limit, until you reach the overall ACA out-of-pocket limit. For example, if you are subject to a 35% reduced benefit percentage, after you reach the medical out-of-pocket limit, your claims will be reimbursed at 35% of covered expenses, instead of

100%, until you reach the overall ACA out-of-pocket limit. Once you reach the overall ACA out-of-pocket limit, your Contract Provider claims will be reimbursed at 100%. There is no overall out-of-pocket limit on Non-Contract Provider claims, and these will continue to be reimbursed at 35% of Covered Non-Contract Provider Expenses for the balance of the calendar year. The medical out of pocket limit and the ACA out-of-pocket limit are listed on page 27.

- You will not have the opportunity to switch between full Schedule I medical benefits and the reduced level of benefits after your date of retirement.

HOW TO FILE A CLAIM FOR MEDICAL BENEFITS

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 36 and "Claims and Appeals Procedures" in Chapter 9 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 when you seek medical care. 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 in that state.

Chemical Dependency Claims

Chemical Dependency claims should be sent to the Operating Engineers Assistance and Recovery Program (ARP), 3000 Clayton Road, Concord, CA 94519.

Deadline for Claims Submission

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

If You Are Eligible for Medicare

Medicare "Cross-Over" Claim Filing with Anthem Blue Cross

Because Medicare is the primary payer of medical expenses for Medicare-eligible Retirees and their Medicare eligible Dependents, your medical Providers must submit your expenses to Medicare *first*.

Anthem Blue Cross has made special arrangements with Medicare that permits your medical claim and Medicare's Explanation of Benefits on each claim to be electronically submitted to their office. This allows claims to be filed under the Pensioned Operating Engineers Health and Welfare

Plan ***automatically*** without added claim submission by you or your Provider. This process is called "Medicare Cross-Over."

All that is required to start this process is for you and your Medicare-eligible Dependent to send a ***copy*** of your Medicare Identification Card to the Trust Fund Office.

Questions?

If you have any questions about submitting your claim, contact the Trust Fund Office at (800) 251-5014. 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 9.

Chapter 5: Prescription Drug Benefits

In this chapter you will find:
- ✓ A note about PPI drugs
- ✓ A schedule of benefits
- ✓ Retail pharmacy program
- ✓ Mail service program
- ✓ Specialty pharmacy services
- ✓ Plan maximums
- ✓ What the Plan covers
- ✓ Step therapy and quantity limits
- ✓ Required Pre-Authorizations
- ✓ Exclusions from coverage
- ✓ Information on filing claims

Note: 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. If you elected coverage under any of the HMO plans, you will receive prescription drug coverage through the HMO.

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 is 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 OptumRx to provide you with prescription drugs at contract rates when you use an OptumRx participating retail pharmacy or the OptumRx mail service. When you are eligible, you will receive an OptumRx ID card.

Generic Versus Brand Name Medications

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. **Choosing generic medications can be a significant source of savings for both you and the Trust Fund.**

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.

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 maximum Plan payment 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.

SCHEDULE OF BENEFITS

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

General Plan Features	
Calendar-year deductible	None
Calendar-year limit on your In-Network copayments	$1,600 Individual/$2,200 Family

Note: Your prescription drug copayments do not accumulate to the separate Comprehensive Medical Plan out-of-pocket limit.

Your Copayment for Each Prescription or Refill	
Note: *The copayments in this chart* ***do not apply to PPI drugs*** *for ulcers or other acid-related stomach disorders. See the following chart for PPI drugs.*	
Prescription filled at a participating retail pharmacy	You pay the following copayment for up to a 34-day supply (or 100 tablets or capsules, whichever is greater): • Generic drug: **$10*** • Brand-name drug if no generic is available: **$15** • Brand-name drug if a generic is available: **$35** plus the difference in price between the generic and the brand name (If your doctor specifies that no generic substitution may be made, you will not be charged the difference in price between the generic and brand-name drugs.) The Plan covers the remaining cost. **Compound drugs** are subject to the Brand Name copay of **$35** *Generic contraceptives are covered with no copayment. A brand name contraceptive will be covered with no copayment if the prescribing doctor states that the generic will not work.
Prescription filled at a non-participating retail pharmacy	You must pay the full cost of the drug at the pharmacy and send a claim to OptumRx. Your reimbursement will be limited to the contract amount a participating pharmacy would have charged less the copayments shown above for generic and brand name drugs.
Prescription ordered through the Plan's mail order service	You pay the following copayment for up to a 100-day supply: • Generic drug: **$0** (no charge to you) • Brand-name drug if no generic is available: **$10** • Brand-name drug if a generic is available: **$40** The Plan covers the remaining cost.
Specialty pharmacy drug copays effective January 1, 2015 * All Specialty Drugs must be purchased from an OptumRx Specialty Pharmacy in order to be covered.	• Specialty Generic Formulary: **20% of cost, up to a $50 maximum copay** • Specialty Brand Preferred: **20% of cost, up to a $100 maximum copay** • Specialty Non-Preferred: **20% of cost, up to a $200 maximum copay** The Plan covers the remaining cost.

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

Preventive Care Drugs

In accordance with Health Care Reform, certain preventive care drugs are at no charge when prescribed by your doctor and purchased at an OptumRx retail pharmacy. For a preventive drug to be covered with no Copay, the drug must be:

- a generic drug that is obtained at an OptumRx participating retail pharmacy, and
- presented to the pharmacist with a prescription for the preventive care drug from your physician.

The following chart outlines the preventive care drugs currently payable by the Fund at no charge when purchased from a network retail pharmacy. Where the information in this notice conflicts with any newly released ACA regulations affecting the coverage of preventive care drugs, the Fund will comply with the new requirements on the date required.

Coverage Details for Preventive Care Drugs	
Aspirin	Generic OTC aspirin (1 bottle of 100 tablets every 3 months) for the preventive of cardiovascular disease or for: • Preeclampsia prevention for pregnant women after 12 weeks gestation who are at high risk (as determined by your Health Care Provider) for preeclampsia (a pregnancy complication). • Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk (as determined by your Health Care Provider) for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
Fluoride	Generic oral fluoride supplements
Folic Acid	Generic folic acid supplements, including prenatal vitamins, for women during pregnancy
Preparation ("prep") products for a colon cancer screening test	Generic for adults over age 45 for preparation before a colonoscopy
Smoking Cessation Drugs	Two 90-day regimens per calendar year (including both prescription and over the counter medications)

Coverage Details for Preventive Care Drugs	
FDA contraceptives for women	Generic FDA approved contraceptives for females (or brand drug if generic is medically inappropriate)
Preparation products for colon cancer screening test	Covered with a prescription
Tobacco cessation products	All FDA-approved generic tobacco cessation medications (including both prescription and over-the-counter medications) for two 90-day treatment regimens annually.
Breast Cancer preventive medication (e.g. Tamoxifen, Raloxifene or aromatase inhibitors)	For women at increased risk (as determined by your Health Care Provider) for breast cancer and at low risk (as determined by your Health Care Provider) for adverse medication effects.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater. (Brand statins payable only if a generic alternative is medically inappropriate.)
Pre-exposure Prophylaxis (PrEP)	Offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons at increased risk of HIV acquisition.

Compound Drugs

A **Compound Drug** is any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order. Pharmacy compounding is a practice in which a pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Each Compound Drug prescription that is filled is subject to the brand name drug copay.

Non-FDA approved bulk chemicals used in compound drugs are not covered.

Compounded medications with a cost greater than $150 are subject to review. Your pharmacist can initiate this process by calling the dedicated Operating Engineers help desk at 1-855-OPA-ENGI (1-855-672-3644).

Out-of-Pocket Limit on In-Network Outpatient Prescription Drugs

Your annual out-of-pocket expenses for copays and/or coinsurance for In-Network outpatient prescription drugs is $1,600 per person per calendar year and $2,200 per family per calendar year. There is also a separate Out-of-Pocket Limit on medical deductible (for Schedule II) and coinsurance that is explained in Chapter 4 of this SPD (Comprehensive Medical Benefits).

The Out-of-Pocket Limit is the most you pay during the calendar year before your plan starts to pay 100% for covered In-Network outpatient prescription drugs. This amount may be adjusted annually in accordance with ACA regulations. In addition, there is no **Out-of-Pocket limit for covered outpatient prescription drugs purchased at a Non-Network pharmacy.**

- The Out-of-Pocket Limit is accumulated on a calendar year basis.
- The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.

- The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.

Expenses Not Counted Toward the Out-of-Pocket Limit on In-Network Outpatient Prescription Drugs

The annual Out-of-Pocket Limit on In-Network outpatient prescription drugs does not include or accumulate:

- Expenses for drugs purchased at a Non-Participating Pharmacy.
- Charges in excess of the Plan benefit maximums for PPI drugs and compound drugs.
- Non-covered expenses or balance-billed charges.
- Premiums or self-pay contributions.

If You Are Eligible for Medicare

Note about Medicare Part D Prescription Drug Coverage

The Trust Fund has determined that the prescription drug coverage described in this chapter is "creditable" for purposes of Medicare Part D. "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all Plan participants, expected to pay out as much as or more than, the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (generally October 15th through December 7th).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If you do enroll in a Medicare prescription drug plan, you will need to pay the Medicare Part D premium out of your own pocket. There will be no reduction in your premium for this Plan's medical and prescription drug coverage. If you keep this Plan coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare.

Important Note: You may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical Plan. If you drop medical and drug coverage, you can never come back into this Plan unless you qualify under the Special Late Enrollment provisions.

Medicare Eligible Individuals can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- when the Eligible Individual becomes eligible for a Special Enrollment Period, such as when the individual involuntarily loses drug coverage when he or she leaves union group health coverage.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare prescription drug plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage see the Notice of Creditable Coverage (a copy is available from Trust Fund Office or contact the Trust Fund at the number located on the Contact Chart in the front of this document). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

RETAIL PHARMACY PROGRAM

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 OptumRx to provide you with prescription drugs at contract rates. When you have a prescription filled at an OptumRx participating pharmacy:

- Except for PPI drugs, your payments are limited to the copayments shown in the Schedule of Benefits chart. You do not have to submit a claim. Simply give the pharmacist your prescription, show your OptumRx ID card, and pay your copayment. 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 (retail) or $90 (mail order) maximum Plan benefit.

If you do not show the pharmacy your ID card, you must pay 100% of the pharmacy's price for the drug. If the drug is covered by the Plan, you can be reimbursed by sending OptumRx a Direct Member Reimbursement Form with the pharmacy receipt. For a copy of the form, contact OptumRx Customer Service and request for the form to be mailed to you or the form is also available and accessible on www.optumrx.com.

To contact OptumRx: call (855) 672-3644 (TTY 711)

Finding a Participating Pharmacy

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

- visit the OptumRx website www.optumrx.com and use the "Locate a Pharmacy" tool, or
- call OptumRx at the number shown in the box above, or
- ask the pharmacist if they participate in the OptumRx network

Benefits for Drugs Purchased from a Retail Pharmacy

For Other Than PPI Drugs

- a generic drug — you pay $10

Exception: Generic contraceptives are covered with no copayment. Normal copayments will apply to brand name contraceptives unless the prescribing doctor states that the generic will not work

- a brand-name drug if a generic is not available — you pay $15
- a brand-name drug if a generic is available — you pay $35 plus the difference in cost between the brand name and generic drug

Specialty drugs may not be obtained from a retail pharmacy. See "Specialty Pharmacy Services" on page 79 for information on how to obtain specialty drugs.

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 maximum Plan payment.

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

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.

Please note: The Fund will limit coverage of erectile dysfunction drugs approved by the Food and Drug Administration for use in treating male impotence to 6 doses per month from a retail pharmacy (and 18 doses for 90 days through the mail order program). Coverage will be subject to the same copay as any other covered prescription drug.

Non-Participating Retail Pharmacy

If you purchase your drugs from a non-participating pharmacy, you will need to pay 100% of the pharmacy's price for the drug at the time of purchase and submit a Direct Member Reimbursement Form to OptumRx. If the drug is covered by the Plan, OptumRx will reimburse you for the covered amount, based on the contract amount that would be payable to a participating pharmacy, less the applicable copayment. For a copy of the form, go to www.optumrx.com, or call the customer service number.

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.

MAIL SERVICE PROGRAM

The OptumRx 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 100-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:

Note: By law, OptumRx must fill your prescription for the exact quantity of medicine prescribed by your doctor, up to the 100-day limit.

- a generic drug or a preventive care drug as required by the Affordable Care Act — you pay nothing
- a brand-name drug if no generic is available — you pay $10
- a brand-name drug if a generic is available — you pay $40

Exception: If the prescribing doctor states that a generic contraceptive will not work, there will be no copayment for the brand-name contraceptive.

For PPI Drugs

- The Plan will pay up to a maximum of $90 for each 90-day supply.
- You will be responsible for paying the difference between the cost of the drug and the maximum Plan payment. Charges in excess of the Plan Payment do not accumulate to the Out-of-Pocket maximum on prescription drugs.

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

How to Use the Mail Service

Ask your doctor for a prescription for up to a 100-day supply, with three refills if appropriate. Then choose one of these easy options to place your order.

Option 1: Call OptumRx at (855) 672-3644. They will contact your doctor and help you get started with mail service. Be sure to provide your doctor with the ID number from your OptumRx ID card and your mailing address.

Option 2: Pre-addressed order forms are available at the Trust Fund Office and the Fringe Benefits Service Center. You can also request them by calling OptumRx at the number shown above. Complete the form and mail it to OptumRx with your original prescriptions.

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.

You can also have your doctor call in the prescription to OptumRx. If your doctor prefers to be contacted directly, you can call OptumRx and ask a representative to contact your doctor.

OptumRx number for doctors to call in prescriptions: (800) 791-7658

First-Time Prescriptions

If you need to start a long-term medication right away, ask your doctor to write two prescriptions: one 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.optumrx.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 OptumRx 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.

SPECIALTY PHARMACY SERVICES

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 OptumRx's Specialty Drug list. This list is subject to change from time to time. You or your doctor should call OptumRx 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 OptumRx Specialty Pharmacy 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 OptumRx Specialty Pharmacy
- Delivery of your prescriptions directly to you or to your doctor's office

You must use the OptumRx Specialty Pharmacy 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**.

How to Use Specialty Pharmacy Services

You can obtain up to a 34-day supply of your specialty medications.

For Specialty Pharmacy Services, or if you have questions regarding your specialty pharmacy prescription, call OptumRx at (855) 672-3644 and you will be transferred to the specialty pharmacy or you may call direct at (855) 672-3644. Representatives are available 24 hours a day, 7 days a week.

PLAN MAXIMUMS

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.

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.

WHAT THE PLAN COVERS

- 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 80 for benefit limits for PPI drugs*).
- Drugs 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 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). The Compound Drug is subject to the brand name $35 copayment.
- 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 OptumRx's Specialty Drug List. Specialty drugs are only available through the OptumRx Specialty Pharmacy; they are not available from participating retail pharmacies.
- Charges for nicotine gum, patches, or other smoking cessation medications.

  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.

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 OptumRx 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 Pre-Authorization from OptumRx 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:

1. Cholesterol medications
2. Pain medications
3. Sleep aids
4. Blood pressure medications

Exception: If you had a prescription for a drug in classes #1 through # 4 above before July 1, 2011, step therapy will not apply to that prescription.

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

Exception: If you had a prescription for a drug in classes #5 through #11 above before January 1, 2012, step therapy will not apply to that prescription.

Quantity Limits

Certain medications have quantity limits less than regular 34-day retail supply or 100-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, intra-nasal corticosteroids, oxycontin and extended release morphine products.

Contact OptumRx for specific quantity limits as they are subject to change.

Preferred Alternative Drugs

Within each drug category, there are many therapeutic alternative drugs available. If you are taking a prescription drug for one of the Therapeutic Categories for certain medications, the Fund will only provide coverage for the Preferred Alternative. Please contact OptumRx for a list of impacted medications. If you attempt to fill a prescription for one of the "Excluded Medications," there will be no payment by the Fund. This does not mean you should stop taking your medication, we recommend that you talk to your doctor to discuss alternative covered medication options.

However, if you are taking Betaseron, Extavia, or Rebif for treatment of multiple sclerosis as of 7/1/16, you may continue to take that medication and the Fund will continue to provide coverage (it will not be considered an excluded medication).

You can search for medications and confirm coverage using the "price a medication" tool at www.optumrx.com or by calling the dedicated Operating Engineers help desk at 1-855-opa-engi (1-855-672-3644).

Required Pre-Authorizations

Some medications require Pre-Authorization before they will be covered. Prior approval from OptumRx is required for the following:

Your doctor may obtain Pre-Authorization by calling OptumRx at (800) 791-7658.

- Topical acne medications for a person over age 26
- Growth hormones
- Drugs or devices for treatment of sexual dysfunction (6 doses per month at a retail pharmacy, 18 doses for a 90-day supply through the mail order program)
- Certain contraceptive devices and injectables, all transdermal contraceptives (patches)
- Oral Fentanyl products
- Oxycontin for supplies exceeding the Plan's quantity limits
- Narcolepsy drugs
- Any drug subject to step therapy
- Appetite suppressants or any other weight loss medications.

EXCLUSIONS FROM COVERAGE

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, smoking cessation products provided with a doctor's written prescription, and certain generic over-the-counter preventive care drugs in accordance with ACA).* No Copayment will apply to these preventive drugs if they are obtained from a retail Participating Pharmacy and you present the pharmacist with a Physician's prescription for the drug.

3. Appliances, devices, bandages, and any other supplies or equipment, except diabetic supplies.
4. Multiple and non-therapeutic vitamins, cosmetics, nutritional and dietary supplements (except as otherwise required under ACA), and health and beauty aids.
5. Immunization agents (except for Zostavax and Flu vaccines), and allergy serums.
6. Infertility medications.
7. Medications with no Federal Food and Drug Administration indications. This includes any non-FDA approved bulk chemicals used in Compound Drugs.
8. 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.
9. Drugs or devices for treatment of sexual dysfunction (*except when caused by a medical or mental health condition as certified by your doctor; requires prior approval by OptumRx*).
10. Medications prescribed for cosmetic purposes only, hair growth stimulants, and hair removal agents.
11. Charges for any single prescription filling or refilling in excess of the 34-day, 100-day, or 100-tablet limits mentioned earlier in this chapter or for any quantity exceeding other quantity limits of the Plan.
12. Any specialty drug on the OptumRx Specialty Drug list that is obtained from a non-participating pharmacy or from any source other than the OptumRx Specialty Pharmacy.
13. Charges in excess of any Plan maximums.
14. Replacement prescriptions resulting from loss, theft, or breakage.
15. Expenses for or related to gene therapy. Please refer to page 50 for benefits that may be available under the comprehensive medical benefits.
16. Any expenses excluded under "General Exclusions, Limits, and Reductions" in Chapter 10.

HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS

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 file 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 Direct Member Reimbursement Form from OptumRx, the Trust Fund Office, or the Fringe Benefits Service Center. (You can also download and print a claim form from the OptumRx 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

If you have any questions about submitting your claim, contact OptumRx at (855) 672-3644.

For the reimbursement form, you may contact OptumRx Customer Service and request that the form to be mailed to you. The reimbursement form is also available and accessible on the OptumRx website. Mail the completed claim form with your original prescription receipt(s) to:

OptumRx
P.O. Box 29077
Hot Springs, AR 71903

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

Chapter 6:
Dental Benefits

Please note that this insured dental coverage is not subject to the requirements of Health Care Reform. This means that calendar year maximums will apply to all Eligible Individuals; however, dependent children may be covered for dental benefits up to age 26.

In this chapter you will find:

- ✓ Information on two Plan options
- ✓ A schedule of benefits
- ✓ PPO network Dentists
- ✓ Covered dental services
- ✓ Limitations and Exclusions from coverage
- ✓ Information on filing claims

NOTE: Dental coverage is an optional addition to the other benefits described in this SPD. If you enroll in dental coverage you must pay the full cost of the coverage through separate monthly payments.

The benefits described in this chapter apply ONLY to individuals enrolled in the Delta Dental Plan of California. If you chose a prepaid dental plan, see the materials provided for that plan for information on your dental benefits.

This chapter provides a brief summary of the Delta Dental insured benefits. Please see the separate Delta Dental Evidence of Coverage brochure for complete information. If there is any conflict between this chapter and the Delta Dental Evidence of Coverage, Delta Dental's Evidence of Coverage will prevail.

Note to Hawaii Residents

The Delta Dental benefits described in this chapter don't apply to you. Your dental option is the ***Hawaii Dental Service*** plan, which is a separate Delta Dental plan. See the ***Hawaii Dental Service*** Evidence of Coverage brochure (available at the Trust Fund Office) for information on your dental coverage.

Dental Benefits cover 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 generally accepted standards of dental practice.

TWO PLAN OPTIONS

There are two Delta Dental Plan of California plans available to you with different premium costs. You have the option to choose either the **High Option** plan or the **Low Option** plan.

Please note that:

- You must remain in the dental plan you select for at least 12 months before changing to another plan.
- You and your Dependents must be in the same dental plan.
- The benefits of the two plans are linked. This means that if you move from one plan to another, any plan maximums and benefits under the original plan will carry over to the new plan.

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	Low Option Plan	High Option Plan	
	PPO and Non-PPO	PPO	Non-PPO
Deductible	None	None	None
Calendar Year Maximum *	$2,750	$2,500	
Diagnostic and Preventive Benefits	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Benefits	Plan pays 50%	Plan pays 85%	Plan pays 60%
Crowns, Inlays, Onlays and Cast Restorations	Plan pays 50%	Plan pays 85%	Plan pays 60%
Prosthodontic Benefits	Plan pays 50%	Plan pays 70%	Plan pays 50%

* Diagnostic and Preventive Services are exempt from maximum.

Delta will pay the applicable percentage of the covered Dentist's fees up to the calendar year maximum for each covered person. You are responsible for paying any remaining charges, known as your "copayment".

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

CHOICE OF DENTISTS / PPO NETWORK DENTISTS

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. About 16,500 of these Delta Dental Dentists are also **Delta Dental PPO Dentists**.

Visit a Delta PPO Dentist for the lowest out of pocket costs

Note: The PPO benefits shown in the Schedule of Benefits chart for the High Option plan **apply only to Delta Dental PPO Dentists**, not to all Delta Dental Dentists.

Advantages to Using a Delta Dental PPO Dentist

There are advantages to visiting a Delta Dental PPO Dentist, including lower out of pocket costs.

- You will usually pay the lowest out of pocket amount when you visit a Delta Dental PPO Dentist because PPO Dentists agree to accept a reduced fee for patients covered under the PPO plan. If you are in the High Option plan, the plan pays a higher benefit percentage of fees for most services when you use a PPO Dentist.

- PPO Dentists charge you only the patient's share at the time of treatment. (The patient's share is your copayment, any amount over the calendar year maximum and any services the Plan does not cover.) Delta Dental pays its portion directly to the Dentist. PPO Dentists will complete claim forms and submit them for you at no charge.
- If you use a Non-Delta Dental Dentist, 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.

How to Find a Delta Dentist

Call (800) 765-6003 for a list of Delta Dental PPO Dentists.

You can also log on to the Delta Dental website at www.deltadentalins.com for a current listing of dental offices that are part of Delta Dental's PPO network.

- Click on "Find a Dentist"
- Go to "Select your Program and State or Territory"
- Select "Delta Dental PPO" and your state, then click "Continue"

Covered Dentist Fees

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 who is Not a PPO 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

A. Diagnostic and Preventive Benefits

- Diagnostic procedures to assist the Dentist in evaluating existing conditions, including oral examination, bite-wing x-rays, examination of biopsied tissue, palliative (emergency) treatment of dental pain, specialist consultation.
- Preventive procedures – prophylaxis (cleaning), fluoride treatment.
- Sealants – topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.

B. Basic Benefits

- 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.
- Full mouth x-rays, panoramic x-rays and all other x-rays other than bitewing x-rays.
- Space maintainers.
- Diagnostic casts /study models.
- 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.

C. 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.

D. Prosthodontic Benefits

- Construction or repair of fixed bridges, partial dentures and complete dentures if provided to replace missing natural teeth or 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 when the claim is submitted.

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.

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.

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.

LIMITATIONS

Dental and Orthodontic benefits are limited for the following services:

1. Bitewing x-rays are covered twice in a calendar year while you are covered under any Delta Dental plan. 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. The Plan covers a panoramic x-ray provided as an individual service once every 3 years.

2. Prophylaxis (cleaning), or a procedure that includes a cleaning, is limited to two treatments in a calendar year while you are covered under any Delta Dental plan. *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 while you are covered under any Delta Dental plan.

4. An oral examination is covered twice in a calendar year while you are covered under any Delta Dental plan. *See note on additional benefits during pregnanc*y.

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. 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 5 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.

   This 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 5 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 appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan or the prior Trust Fund Plan will be made if it is unsatisfactory and cannot be made satisfactory.

    Delta Dental will replace an implant, a prosthodontic appliance or an implant supported prosthesis you received under another dental plan if they determine 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 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, 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 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.

EXCLUSIONS

In addition to any general Plan exclusions, limits, and reductions (see page 132), Delta Dental does not provide benefits for:

1. Experimental procedures.
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 treatment are equilibration and periodontal splinting.
4. Any single procedure, bridge, denture or other prosthodontic service which was started before the date you 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).
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 I.V. 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) joints or associated muscles, nerves, or tissues.
10. Replacement of an existing restoration for any purpose other than active tooth decay.
11. Occlusal guards and complete occlusal adjustment.
12. Orthodontic services (treatment of malalignment of teeth and/or jaws).
13. Any general Plan exclusions, limits or reductions, as listed beginning on page 132.

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

- Delta PPO Dentist and Delta 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 of California
  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) 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 (Pensioned Operating Engineers Health and Welfare Trust Fund) and number (9576), 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

Please note that this vision coverage is not subject to the requirements of Health Care Reform. This means that calendar year maximums will apply to all Eligible Individuals; however, dependent children may be covered for dental benefits up to age 26.

In this chapter you will find:
- ✓ A schedule of vision benefits
- ✓ How the Plan works
- ✓ What the Plan covers
- ✓ Low vision benefit
- ✓ Limitations and exclusions
- ✓ Information on filing claims and appealing denied claims

You are eligible to enroll in the vision care benefits described in this chapter **only if you are under Schedule I**. See "Schedule of Benefits That Applies to You" in Chapter 2 or call the Trust Fund Office if you don't know if you are in Schedule 1 or Schedule 2.

The Fund has contracted with Vision Service Plan (VSP) and the VSP *Choice Plan* network of vision care Providers, to provide covered vision expenses at contract rates. Your Plan benefits will go farther when you use VSP *Choice Plan* Providers (also known as VSP Member Doctors).

Note to Hawaii Residents

In Hawaii, the following benefits will be different from those shown in this chapter:

- Your VSP Provider network is the Signature Network
- Reimbursements when you use non-VSP Providers
- Lens option benefits for ant-reflective coating and progressive lenses
- Benefits for elective contact lenses

See the separate VSP brochure for information on these benefits in Hawaii.

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 Choice Plan Doctor	Non-VSP Provider
Copayment	$7.50	$7.50
Vision Exam – Limited to once every 12 months	Plan pays 100%	Plan pays up to $45 per exam

Vision Benefits	VSP Choice Plan Doctor	Non-VSP Provider
Lenses – Limited to once every 12 months	Plan pays 100% up to member doctor scheduled allowances	Plan pays up to:
Single Vision		$34
Bifocal		$51
Trifocal		$68
Lenticular		$100
Lens Options		
Tints/Photochromic	Covered in Full	$5
Anti-reflective Coating	Plan pays up to $8	Not Covered
Progressive Lenses	Plan pays up to $15	Not Covered
Benefits for lenses are per complete set, not per lens.		
Frames – Limited to once every 24 months	Covered up to Plan allowance	Plan pays up to $70
Visually Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Covered in Full	Plan pays up to $210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to $100 for contact lenses and fitting (exam covered at 100% of scheduled allowances	Plan pays up to $100 for exam, lenses and fitting

HOW THE PLAN WORKS

Steps for using a VSP Choice Plan Provider:

Call any VSP Choice Plan doctor to make an appointment. Identify yourself as a VSP *Choice Plan* member and provide your VSP member identification number and the name of the group plan ("Pensioned Operating Engineers Health and Welfare Trust Fund").

If you need assistance locating a VSP Choice Plan doctor, call VSP at (800) 877-7195 or log on to the VSP website at www.vsp.com and use the "Find a doctor" feature.

After you have scheduled an appointment, the VSP Choice Plan doctor will contact VSP to verify your eligibility and Plan coverage. The doctor will also obtain benefit authorization from VSP for services and materials.

When you go for your visit, pay the VSP Choice Plan doctor your $7.50 copayment and charges for any costs not covered. VSP will pay the doctor directly for the balance of the charges.

When you use a VSP *Choice Plan* Doctor, 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 should pay the Provider their full fee and submit a claim for reimbursement. You will be reimbursed the 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 from a Non-VSP Provider are in lieu of obtaining services from a VSP Choice Plan 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 *Choice 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).

WHAT THE PLAN COVERS

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.
  - ✓ 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.
  - ✓ Elective Contact Lenses. If you choose contact lenses for other than the visually necessary circumstances described above, they are considered Elective contact lenses.

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

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 Choice Plan Doctor	Non-Member Provider
Supplemental testing	Covered in full	Plan pays up to $125
Supplemental Care Aids	75% of cost	Plan pays up to 75% of amount it would pay to a VSP Choice Plan Doctor
Maximum Benefit	$1,000 per person, every two (2) years	

LIMITATIONS AND EXCLUSIONS

In addition to any general Plan exclusions and limitations (see page 132), 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 (except for the allowance shown in the Schedule of Benefits for VSP Choice Plan Doctors)
    - ✓ Color coating, mirror coating or scratch coating
    - ✓ Blended lenses
    - ✓ Laminated lenses
    - ✓ Cosmetic lenses
    - ✓ Oversize lenses
    - ✓ Polycarbonate lenses (Exception: polycarbonate lenses are covered in full for children under age 18 – VSP Choice Plan Doctors only)
    - ✓ Progressive multifocal lenses (except for the allowance shown in the Schedule of Benefits for VSP Choice Plan Doctors)
    - ✓ UV (ultraviolet) protected lenses
    - ✓ A frame that costs more than the Plan allowance
    - ✓ Certain limitations on low vision care

Please note that the Plan is designed to cover visual needs rather than cosmetic materials.

2. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±0.50 diopter power); or two pair of glasses in lieu of bifocals.
3. Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
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 in the Schedule of Benefits.
7. Services or materials not shown as covered in the Schedule of Benefits.

HOW TO FILE A VISION CLAIM

When you use a VSP Choice Plan Doctor, you do not need to file a claim for reimbursement. If you use a non-VSP Provider, call VSP to have a VSP Member Reimbursement Form mailed or faxed to you. (You can also fill out the form online at www.vsp.com and print it).

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

If you have any questions about submitting your claim, contact VSP at (800) 877-7195.

Vision Service Plan
Attn: Claims Services
PO Box 385018
Birmingham, AL 35238-5018

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.

If You Have Other Vision Coverage

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.

Chapter 8: Retired Employee Death Benefit

In this chapter, you will find:

- ✓ Benefit Amount
- ✓ Your beneficiary
- ✓ How to file a death benefit claim

The benefit described in this chapter is available whether you are enrolled in the Plan's comprehensive medical benefits or an HMO offered by the Plan. It applies to the Retired Employee only, not to any Dependents.

BENEFIT AMOUNT

A **$2,500 lump sum benefit** will be paid to your beneficiary in the event of your death from any cause while eligible under the Plan.

Note: The benefit may be taxable to your beneficiary. Beneficiaries should consult their tax advisors.

YOUR BENEFICIARY

Your beneficiary may be any person or persons you name on your beneficiary form on file at the Trust Fund Office. You may also designate the benefit to be paid to a trust.

If you did not name a beneficiary or trust, or if the named beneficiary is not living or cannot be found, the benefit will be paid to the surviving person or persons in the following order:

- Spouse or domestic partner
- Natural or adopted children
- Parents
- Brothers and sisters
- Nieces and nephews
- Estate

Change of Beneficiary

You may request a change of beneficiary at any time by submitting a new beneficiary form to the Trust Fund office. A change of beneficiary will take effect as of the date you signed the new beneficiary form but will not affect any payment the Trust Fund made before receiving your new beneficiary form.

HOW TO FILE A DEATH BENEFIT CLAIM

To file a claim for the death benefit, your beneficiary should contact the Trust Fund Office for a death benefit claim form. 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:

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

Claims and all required documentation must be submitted to the Trust Fund Office **within 1 year** from the date of death.

Appeals of Denied Death Benefit Claims

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she may request a review of the decision by sending a written request for reconsideration to the Trust Fund Office at the address shown above. The written request for reconsideration must be submitted within 180 days from the date the beneficiary received the payment decision. Any request for reconsideration should include documents or records in support of the appeal.

Chapter 9: Claims and Appeals Procedures

In this chapter, you will find:
- ✓ Claims Procedures
- ✓ Internal Appeals Procedures
- ✓ Legal proceedings
- ✓ External Review of Claims

CLAIMS PROCEDURES

If you elected HMO 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 your HMO for information on procedures applicable to your HMO medical and prescription drug benefits. An exception is made for eligibility questions, which requires 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 six types of claims applicable to the benefits described in this SPD.

- **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:

  - Elective, non-Emergency Medical Condition Hospital admissions at an acute-care Hospital, Long Term Acute Care Facility or Skilled Nursing Facility (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 With Other Plans" in Chapter 10);
  - Outpatient surgery at a Hospital or an Ambulatory Surgery Facility;
  - Hospitalization as a result of an Emergency Medical Condition (within 24 hours of admission) including admission to an acute-care Hospital for detoxification on an emergency basis;
  - Surgical procedure scheduled for a Hospital outpatient department or free-standing Ambulatory Surgery Facility;
  - Outpatient Diagnostic Imaging Procedures, including: CT/ CTA, MRI/ MRA, Nuclear Cardiology, PET and Echocardiography;
  - Organ or tissue transplant;

Note: If you are eligible for Medicare, the only prior approvals that apply to you are for chemical dependency and certain prescription drugs.

- Bariatric surgery for weight loss;
- Gene Therapy;
- Durable Medical Equipment;
- Services for Participants who participate in a clinical trial;
- Inpatient chemical dependency treatment, and
- Certain prescription drugs.

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, OptumRx for prescription drug claims or Operating Engineers Assistance and 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 claim:** 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.

- **Death benefit claim:** A death benefit claim is a claim for the benefit payable upon the death of a Retired Employee. The Plan will treat a death benefit claim or appeal in a manner similar to a post-service claim.

- **Disability claim:** A disability claim is a claim for which the Plan must make a determination of disability in order for the participant to receive the benefit (for example, the Plan's determination of disability related eligibility for a disabled child age 26 and older or grace periods for eligibility purposes for periods of disability.)

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 Pre-Authorization of a benefit that does not require precertification or Pre-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 Pre-Authorization of a benefit where the Plan does require precertification or Pre-Authorization should be submitted as pre-service claims (or Urgent Care Claims, if applicable) as described under "How to File 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 in this SPD. 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.

If you are eligible for Medicare, prior approval is required only for chemical dependency and certain prescription drugs.

For outpatient diagnostic imaging procedures that require Pre-Authorization (CT/CTA, MRI/MRA, Nuclear Cardiology, PET, Echocardiography), your Physician must call American Imaging Management at (877) 291-0360.

For chemical dependency treatment, call the Assistance and 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 must call OptumRx at (855) 672-3644.

- **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. Your Provider should know the address of the Blue Cross Blue Shield Plan in your area.

If You Are Eligible for Medicare

Medicare "Cross-Over" Claim Filing with Anthem Blue Cross

Because Medicare is the primary payer of medical expenses for Retirees and their Medicare eligible Dependents, your medical Providers must submit your expenses to Medicare *first*.

Anthem Blue Cross has made special arrangements with Medicare that permits your medical claim and Medicare's Explanation of Benefits on each claim to be electronically submitted to their office. This allows claims to be filed under the Pensioned Operating Engineers Health and Welfare Plan ***automatically*** without added claim submission by you or your Provider. This process is called "Medicare Cross-Over."

All that is required to start this process is for you and your Medicare-eligible Dependent to send a ***copy*** of your Medicare Identification Card to the Trust Fund Office. If you have any questions on this process, call the Trust Fund Office at (800) 251-5014.

- **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 OptumRx at the following address: OptumRx Claims Department, PO Box 650334, Dallas, TX 75265-0334.
- **Post-service claims for chemical dependency benefits:** Claims must be sent to the Operating Engineers Assistance and Recovery Program at 3000 Clayton Road, Concord, CA 94519.
- **Post-service claims for dental benefits** *(if you are in the Delta Dental of California plan)*: 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*): To request reimbursement, member should complete and print the VSP Member Reimbursement Form (available at www.vsp.com or (800) 877-7195) form, enclose a legible copy of itemized receipt(s), and send it to the following address (keeping a copy for your records: VSP, PO Box 385018, Birmingham, AL 35238-5018.

- **Retired Employee death benefit claims.** The Retired Employee's beneficiary should contact the Trust Fund Office for a death benefit claim form and submit the completed claim form and a certified copy of the death certificate to the Trust Fund Office at 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

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. (***Note***, *American Imaging Management and Anthem Blue Cross prior approval requirements do not apply to you if you are Medicare eligible*)

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 Pre-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, OptumRx for prescription drug claims or Operating Engineers Assistance and 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, OptumRx 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, OptumRx 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, OptumRx 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 Urgent Care claims may be requested orally to the Plan's designated review organization for medical claims, OptumRx for prescription drug claims or ARP for chemical dependency claims. All other Pre-Service Claims must be requested in writing to the Plan's designated review organization for medical claims, OptumRx for prescription drug claims or ARP for chemical dependency claims. Any Pre-Service 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, OptumRx 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 (ii) ***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, OptumRx 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, OptumRx or ARP. If an extension is necessary, the designated review organization, OptumRx or ARP will notify the claimant, in writing, 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. The 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, OptumRx 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, OptumRx 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), OptumRx 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) is for a continuing Illness and claimant filed a signed claim form within the past calendar year. 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.

Note, if you are Medicare eligible, see "Medicare Cross Over Claim Filing with Anthem Blue Cross" on page 102.

- 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, OptumRx or ARP. The Trust Fund Office or OptumRx will notify claimants of decisions on Post-Service Claims in writing within ***30 days*** of receipt of the claim by Blue Cross, OptumRx or ARP. The Trust Fund Office, Blue Cross, OptumRx 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, Blue Cross, ARP or OptumRx 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, OptumRx or ARP shall request additional information from the 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, Blue Cross, ARP or OptumRx 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.

Disability Claims

A Disability Claim must be submitted in writing to the Trust Fund Office using an appropriate claim form, within one (1) year after expenses are 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 written claim must be completed in full and requested documentation must be attached to the written claim in order for the request for benefits to be considered a claim. The written claim must include all required information for the request to be considered a claim and for the Plan to be able to decide the claim.

- A Disability Claim is considered to have been filed upon receipt of the claim by the Trust Fund Office. The Trust Fund Office will notify you of decisions on Disability Claims in writing within 45 days of receipt of the claim. The Trust Fund Office may extend this period for up to 30 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Trust Fund Office will notify you, in writing, of the need to extend the initial 45 day period prior to the expiration of the initial 45 day period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. If, prior to the end of this first 30-day extension, the Trust Fund Office determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date 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 shall request additional information from the Provider and/or claimant via fax, telephone, or letter within 45 days of the receipt of the claim or within 75 days if a 30 day extension is taken. The request for additional information shall specify the information needed. You have 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 you are 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 you respond to the request. The Trust Fund Office shall notify you, in writing, of a decision within 15 days after receipt of any additional information.

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 (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.

For disability claims, the notice will also include a discussion of the decision, including the basis for disagreeing with or not following:

1. The views of a treating physician or vocational professional who evaluated the claimant;
2. The views of medical or vocational experts obtained by the plan, and
3. Any disability determination by the Social Security Administration.

INTERNAL APPEALS PROCEDURES

Note: *If you have a vision claim that is denied by VSP, a prescription drug claim that is denied by OptumRx, or a dental claim that is denied by Delta Dental, you must exhaust the appeals processes of VSP, OptumRx 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.

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. Appeals of Adverse Benefit Determinations regarding Disability Claims must be submitted in writing to the Trust Fund Office via mail, email or fax.

Your request for appeals of Adverse Benefit Determinations must include:

1. The patient's name and address
2. The Participant's (Employee's) name and address, if different;
3. A statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
4. The date of the Adverse Benefit Determination; and
5. 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 methods, 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, fax, e-mail or other available similarly expeditious method, with written notice to follow within ***48 hours***.

  The Plan's designated review organization is American Imaging Management for outpatient diagnostic imaging procedures requiring prior approval and Anthem Blue Cross for all other medical claims (applies only if you are not Medicare eligible).

- **Concurrent Care Claims**

  Appeals of Adverse Benefit Determinations regarding Concurrent Care Claims may be made in the same manner as 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 fax. 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, OptumRx, the HMO, 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 111. If your eligibility dispute cannot be resolved by the Trust Fund office, you may file an appeal with the Board of Trustees. 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:
    - o For urgent care appeals the notification period is based on the current urgency of the claim;
    - o For non-urgent pre-service and post-service concurrent appeals the time periods set forth under each standard.
- **Post-Service Claims and Disability 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 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. You will be advised in writing in advance of this extension. Once a decision on review of your claim has been reached, you will be notified as soon as possible, but no later than *5 days* after the date of the decision.

- 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 (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 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.

LEGAL PROCEEDINGS

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

The Board or its designated Appeals Committee is the named fiduciary for appeals.

- 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.

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 section and current federal external review regulations.

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 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.
- The denial involves surprise billing or cost-sharing issues that are protected under the No Surprises Act for Emergency Services, Air Ambulance Services, and non-emergency services provided by a Non-Contract Provider at a Contract Facility.

Generally, an External Review may be requested only after the claimant has exhausted the internal claims and appeals process described 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 incomplete, the notice will describe the information or materials needed to complete the request, and allow the claimant to 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, the Plan Sponsor shall monitor that the third-party administrator (TPA) refers the request for external review as soon as practicable to one of the IROs with whom the Trust Fund has contracted to perform external review services. Each contracted IRO is selected on a rotating basis. 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 (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 benefit 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
- OptumRx 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 Anthem Blue Cross and OptumRx 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 OptumRx 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 OptumRx will immediately notify the claimant (e.g. via telephone or fax) as to whether their 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 OptumRx determines that a request is eligible for expedited External Review, Anthem Blue Cross or OptumRx 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 OptumRx 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.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination, or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or proves that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, appropriate Claims Administrator, nor any other designee of the Plan Administrator will be required to see to the application of the money by the Health Care Professional(s) so paid.

Chapter 10: Other Important Plan Information

In this chapter, you will find:

- ✓ 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

COORDINATION OF BENEFITS WITH OTHER PLANS

NOTE: This section deals only with health care benefits paid directly by the Fund. If you elected coverage through an HMO instead of the Plan's comprehensive medical benefits, see the materials provided by your HMO 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 and annual maximum, 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 contract rate (if the Provider is a Contract Provider under this Plan), the contract 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.

This Plan does not coordinate benefits with individual (non-group) plans. This means that when a Plan participant is covered by this Plan and also covered by an individual (non-group) plan/policy, including a policy through the Health Insurance Marketplace, this Plan will not pay benefits toward the unpaid amount related to claims covered by the individual plan/policy.

The provisions for coordination with Medicare, Medicaid, and HMO plans are different and are explained below. Otherwise, primary and secondary payers are as follows:

- **Retired Employees:** If you are covered under another plan as an active employee, that plan is primary and this Plan, which covers you as a Retired Employee, is secondary for both you and your eligible Dependents, provided the other plan has this same Coordination of Benefits rule. Otherwise, this Plan will be primary.

- **Spouses:** The plan covering the Spouse directly, as a nondependent rather than as 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.

  For a Dependent child who has coverage under either or both parents' plans and also has his/her own coverage as a Dependent under a Spouse's plan, the order of benefits is determined based on who has the longer/shorter length of coverage and if the length of coverage is the same. The "birthday rule" applies in selecting the dependent child's parent's coverage or the dependent spouse's coverage. For example, if a married Dependent child on this Plan is also covered by the group plan of their Spouse and the two plans have covered the Dependent child the same length of time, then the Plan looks to the sponsor (i.e., employee-parent or employee-spouse) who has the earlier birthday in the year.

If none of the rules outlined here apply, the Plan that has covered someone for a longer period will pay first.

COORDINATION WITH PREFERRED PROVIDER AGREEMENTS

The Allowed Charge for purposes of Coordination of Benefits will be the lesser of:

- The normal charge billed by the Provider for the expense;

- 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

- This Plan's contractual rate if the Provider is a Contract Provider under this Plan.

The Board of Trustees has absolute discretion to make a determination as to the Covered Expense for claims involving coordination with preferred Provider agreements.

COORDINATION WITH MEDICARE

Generally, most people who are age 65 or older are entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).

Medicare Participants May Retain or Cancel Coverage Under the Retiree Plan: If an Eligible Individual under the Retiree Plan becomes covered by Medicare, whether because of End Stage Renal Disease (ESRD), disability, or age, that individual may either retain or cancel coverage under the Retiree Plan. The choice of retaining or canceling coverage under this Plan of a Medicare Eligible Individual is the responsibility of the participant. Neither this Plan nor any prior employer will provide any consideration, incentive, or benefits to encourage cancellation of coverage under this Plan.

If an eligible Retiree or Dependent is Medicare eligible because of age or disability and also covered under the Retiree Plan, Medicare pays first and the Retiree Plan pays second. If an eligible Retiree or Dependent initially becomes eligible for Medicare due to End Stage Renal Disease (ESRD), and subsequently becomes eligible for Medicare due to age, this Plan will pay primary for the first 30 months.

If you or your Spouse is eligible for Medicare, the Plan will pay benefits as described in Chapter 4 of this SPD. See "If You Are Eligible for Medicare" on page 66. Note that the Plan will apply Medicare's determination of medical necessity. **You and your Spouse must enroll in both Parts A and B of Medicare in order to receive maximum Plan benefits.**

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 OTHER GOVERNMENT PROGRAMS

TRICARE

If a Dependent is covered by both this Plan and the TRICARE Program (formerly known as the Civilian Health and Medical Program of the Uniformed Service) that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For a Retired Employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for

active members of the armed services only. If an Eligible Individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related Illness or Injury, benefits are not payable by this Plan.

Veterans Affairs/Military Medical Facility Services

If an Eligible Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan. If an Eligible Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or Injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.

Motor Vehicle Coverage Required by Law:

If an Eligible Individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

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.

THIRD PARTY LIABILITY

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 to complete an explanation of Accident/Injury Questionnaire and 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 complete such Questionnaire and sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan within 1 year after the expense is incurred, the Eligible individual shall not be eligible for Plan benefit payment related to the injury involved. This remedy is in addition to all other remedies the Plan may have. 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.

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 motorist 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 Individual. 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.

FACTORS THAT COULD AFFECT YOUR RECEIPT OF BENEFITS

NOTE: If you are enrolled in an HMO, see also your Evidence of Coverage from the HMO 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 enroll in both Part A and Part B of Medicare** if you or your Spouse are eligible for Medicare.
- **Failure to follow the Plan's provisions for Pre-Authorization or prior approval, and utilization review.** The Plan's comprehensive medical benefits and prescription drug benefits require that you follow the procedures described in Chapters 4 and 5 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 payable if you submit your claim more than 1 year after the date on which covered expenses were incurred.
- **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.
- **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, family status, or other 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 (e.g., divorce). 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.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Trust Fund Office at (800) 251-5014.

See also Chapters 2 and 3 for information on eligibility and termination of eligibility.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective September 23, 2013

Section 1. General Policy.

The Trust Fund will use protected health information to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and regulations issued thereunder by the Department of Health and Human Services (HHS). The Trust Fund will use and disclose protected health information for:

(A) purposes related to health care treatment, payment for health care and health care operations;

(B) when authorized by a participant or a participant's personal representative; and

(C) when required by law.

Section 2. Definitions.

A. *Breach* shall have the meaning set forth under 45 CFR §164.402 and means, the acquisition, access, Use, or Disclosure of Protected Health Information in a manner not permitted under the 1-IIPAA Privacy Rule which compromises the security or privacy of the Protected Health Information. Breach excludes:

2) any unintentional acquisition, access, or Use of Protected Health Information by a Workforce member or person acting under the authority of a Covered Entity or Business Associate if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in fu1ther Use or Disclosure in a manner not permitted by the HIPAA Privacy Rule;

3) any inadvertent Disclosure by a person who is authorized to access Protected Health Information at a Covered Entity or Business Associate to another person authorized to access Protected Health Information at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted by the HIPAA Privacy Rule; and

4) a Disclosure of Protected Health Information where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.

B. *Business Associate* is defined in 45 CFR §160.103 and means,

1) with respect to a Covered Entity a person who:

a) on behalf of such Covered Entity or of an organized health care arrangement in which the Covered Entity participates, but other than in the capacity of a member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits Protected Health Information for a function or activity

regulated by HIPAA, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management, and repricing; or

b) provides, other than in the capacity of a member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of Protected Health Information from such Covered Entity or arrangement, or from another Business Associate of such person.

2) Covered Entity may be a Business Associate of another Covered Entity.

3) Business Associate includes:

a) a Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to Protected Health Information to a Covered Entity and that requires access on a routine basis to such Protected Health Information;

b) a person that offers a Personal Health Record to one or more Individuals on behalf of a Covered Entity; and

c) a Subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the Business Associate.

(C) *Covered Entity* shall have the meaning set forth in 45 CFR §160.103, and means a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction governed by HIPAA.

(D) *Disclosure* shall have the meaning set forth in 45 CFR §160.103 and means the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

(E) *Electronic Health Record* shall have the meaning set forth under 42 U.S.C. 17921, and means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

(F) *Health Care Operations* shall have the meaning set forth under 45 CFR §164.501, and include, but are not limited to, the following activities:

1) quality assessment and improvement activities;

2) population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

3) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

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

5) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

7) business management and general administrative activities of the Plan, including, but not limited to:

   a) management activities relating to the implementations of and compliance with HIPAA's administrative simplification requirements, or

   b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

   c) resolution of grievances;

8) the sale, transfer, merger, or consolidation of all or part of the Covered Entity with another Covered Entity, or an entity that following such activity will become a Covered Entity and due diligence related to such activity; and

9) consistent with the applicable requirements of 45 CFR §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity.

(G) *individually Identifiable Health Information* shall have the meaning set forth under 45 CFR §160.l 03 and is health information created or received by the Plan which relates to the (a) past, present or future physical or mental health or condition of an individual, (b) provision of health care to an individual, or (c) past, present or future payment for the provision of health care to an individual that either identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(H) *Payment* shall have the meaning set fo1th under 45 CFR §164.50 I, which 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:

   1) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);

2) coordination of benefits;

3) adjudication of health benefit claims (including appeals and other payment disputes)

4) subrogation of health benefit claims and application of third party lien and workers compensation rules;

5) establishing employee contributions;

6) billing, collection activities and related health care data processing;

7) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

8) obtaining payment under a contract for reinsurance (including stop-loss insurance);

9) medical necessity reviews or reviews of appropriateness of care or justification of charges;

10) utilization review, including precertification, preauthorization, concurrent review and retrospective review;

11) reimbursement to the Trust Fund;

12) administration of reciprocity with other trusts and/or plans; and

13) communication with a pension plan concerning payment of retiree health premiums.

(I) *Personal Health Record* ("PHR") shall have the meaning set forth under 42U.S.C. §17921, and means an electronic record of PHR identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or primarily for the individual.

(J) *PHR Identifiable Health Information* shall have the meaning set fo1th under 42U.S.C. §l 7937(f)(2), and means individually identifiable health information, and includes information (a) that is provided by or on behalf of the individual, and (b) that identifies the individual or with respect to which there is a reasonable basis to believe that the information can be Used to identify the individual.

(K) *Protected Health Information* shall have the meaning set forth under 45 CFR §160.l 03, and is individually identifiable health information that is transmitted or maintained in any form or medium.

(L) *Subcontractor* shall have the meaning set forth under 45 CFR §160.103, and is a person to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the Workforce.

(M) *Treatment* shall have the meaning set fo1th under 45 CFR §164.501, and includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

(N) *Use* shall have the meaning set forth under 45 CFR §160.103, and means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis at such information within an entity that maintains such information.

(O) Workforce is defined in 45 CFR §160.103 and means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such entity, whether or not they are paid by the Covered Entity or Business Entity.

Section 3. Uses and Disclosures Not Requiring Authorizations.

The Trust Fund may without authorization Use and disclose Protected Health Information:

(A) for Treatment, Payment and Health Care Operations;

(B) to the individual, or his or her duly authorized personal representative;'

(C) where permitted by law after providing a participant notice and an opportunity to object to Disclosure (unless notice is not possible) and no objection has been received, such as, depending on the circumstances, to some or all of the following persons: the spouse, domestic partner, relatives, close friend or other person designated in writing by the participant and involved in the care of the participant or involved in payment related to the participant's health care; and

(D) where required by law or for purposes of public health activities; or judicial and administrative hearings.

Section 4. Consent.

The Trust Fund may, but need not, utilize and request the consent of a participant before disclosing protected health information even where an authorization is not required by law.

Section 5. Authorization of the Participant or Beneficiary.

In general, with an authorization which complies with both federal and any applicable state privacy laws, the Trust Fund may disclose Protected Health Information for the additional purposes permitted by law and by the authorization.

Section 6. Minimum Necessary Use and Disclosure.

In those situations, in which it is required, the Trust Fund will make reasonable efforts to limit Use and Disclosure of Protected Health Information to the minimum necessary to accomplish the intended purpose. Per the requirements of 42 U.S.C. §I7935(b), "minimum necessary" shall mean that the Trust Fund will, to the extent practicable, limit such Disclosure to a "limited data set" as such term is defined under 45 CFR §164.514(e) or, if needed, to the minimum necessary to accomplish the intended purpose of such Use, Disclosure, or request. If the Trust Fund finds it

necessary to use more than the "limited data set," it will be prepared to justify why use of the limited data set is not practicable.

The Trust Fund shall comply with "minimum necessary" standard set forth 42 U.S.C.§l7935(b) until such date that the Secretary of the Department of Health and Human Services issues final guidance regarding the "minimum necessary" standard. At such time that the Secretary issues such guidance, the guidance shall be incorporated herein by reference until such time as this Trust Fund is amended, and the Trust Fund will comply with the new minimum necessary guidance.

Section 7. Compliance with Breach Notification Requirements.

The Trust Fund agrees, per the requirements of 45 CFR §164.400, et al., and 42 U.S.C.§17932, that notice will be provided to individuals, to the media (if required), and/or to HHS (if required), in the event that the Trust Fund discovers a Breach of unsecured Protected Health Information. Such notice of a Breach of unsecured Protected Health information may be provided by either the Plan or assigned to a responsible Business Associate. Such notice will not be required if it can be demonstrated that there is a low probability that the Protected Health Information has been compromised based on a risk assessment of HIPAA statutory factors.

Section 8. Compliance with the Security Rule.

The Trust Fund agrees, per the requirements of 45 CFR §§164.302-318, with respect to Electronic Protected Health Information to:

(A) ensure the confidentiality, integrity, and availability of all Electronic Protected Health Information the plan creates, receives, maintains, or transmits;

(B) protect against any reasonably anticipated threats or hazards to the security or integrity of such information;

(C) protect against any reasonably anticipated Uses or Disclosures of such information that are not permitted or required under the regulations; and

(D) ensure compliance with the regulations by its Workforce.

In addition, the Trust Fund agrees to comply with the Administrative Safeguards required by 45 CFR §164.308, the Physical Safeguards required by 45 CFR §164.310, the Technical Safeguards required by 45 CFR §164.312, and the documentation requirements required by 45 CFR §164.316.

Section 9. The Joint Board Agrees to Certain Conditions.

The Joint Board, as Plan sponsor under ERISA, agrees to:

(A) not Use or further disclose Protected Health Information other than as permitted or required by the Plan's rules or as required by law;

(B) ensure that any Business Associate to whom the Plan provides Protected Health Information received from the Plan agrees to the same restrictions and conditions that apply to the Plan with respect to such Protected Health Information;

(C) make Protected Health Information available to a participant or beneficiary in accordance with HIPAA's access requirements;

(D) make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with HIPAA;

(E) make available the information required to provide an accounting of Disclosures; and

(F) make internal practices, books and records relating to the Use and Disclosure of protected health information received from the Plan available to the HHS Secretary for the purposes of determining the Trust Fund's compliance with HIPAA."

GENERAL EXCLUSIONS, LIMITS, AND REDUCTIONS

The Fund will not provide benefits for the following:

1. Any services or amounts in excess of Allowed Charges.
2. Services not specifically listed in the Plan's Rules and Regulations as covered services or any services that are not Medically Necessary (For a definition of "Medically Necessary," see the definitions section in 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.
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 unless such condition is the result of domestic violence or the involvement in the commission of a felony is the direct result of an underlying health factor.

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. (For a definition of "Experimental or Investigational," see the definitions section in the Rules and Regulations following this SPD.)

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 SPD.

GENERAL PLAN INFORMATION

Patient Protection Rights of the Affordable Care Act (For Kaiser and Health Net)

Kaiser and Health Net generally allow the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, contact the insurance company at the telephone number listed on the Contact Chart.

For children, you may designate a pediatrician as the primary care Provider.

You do not need Pre-Authorization from Kaiser or Health Net or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Pre-Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance company at the number listed on the Contact Chart.

Patient Protection Rights of the Affordable Care Act (For the Self-funded Plan)

The self-funded plan does not require the selection or designation of a primary care Provider (PCP). You have the ability to visit any Contract or Non-Contract Health Care Provider; however, payment by the Plan may be less for the use of a Non-Contract Provider.

You also do not need Pre-Authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Pre-Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PPO network at their website listed on the Quick Reference Chart.

Nondiscrimination in Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any Health Care Provider who is acting within the scope of that Provider's license or certification under applicable State law. The Plan is not required to contract with any Health Care Provider willing to abide by the terms and conditions for participation established by the Plan . The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Assignment of Benefits

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a Health Care Provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying Health Care Provider invoices that are balance billed to a Plan Participant.

Right to Examinations

The Trust 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 Trust 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.

INFORMATION REQUIRED BY ERISA

Plan Facts

Name of Plan	Pensioned Operating Engineers Health and Welfare Trust Fund
Type of Plan	Employee welfare benefit plan maintained for the purpose of providing comprehensive medical, prescription drug and vision care benefits, to eligible Retired Employees and their eligible Dependents. Dental benefits are also available under a plan in which the participant pays the entire cost of the coverage.
Plan Sponsor	A joint labor-management Board of Trustees
IRS Employer Identification Number (EIN)	94-6096327
Plan Number	501
Plan Year	The date of the end of the Plan year is December 31.
Funding Medium	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. Health care benefits (other than HMO benefits) are paid directly from the Fund and are not insured by any contract of insurance. HMO benefits and dental benefits are provided through carriers and are fully insured or otherwise guaranteed. For more information, see "Organizations Through Which Benefits Are Provided or Administered" below.
Source of Contributions	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. Contributions are also made by participants in an amount determined by the Board of Trustees.
Plan Administrator	The Board of Trustees Pensioned Operating Engineers Health and Welfare Trust Fund 1141 Harbor Bay Parkway, Suite 100 Alameda, CA 94502 Names and addresses of the Trustees as of the date this booklet was issued are shown below.

Agent for Service of Legal Process	Greg Trento Pensioned Operating Engineers Health and Welfare Trust Fund 1141 Harbor Bay Parkway, Suite 100 Alameda, CA 94502 Telephone: (800) 251-5014 Service of legal process may also be made upon a Fund trustee or the Board of Trustees.
Discretionary Authority of the Board of Trustees	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.

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:

Zenith American Solutions, Inc.
Pensioned Operating Engineers Health and Welfare Trust Fund
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502
Telephone: (800) 251-5014

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 SPD are listed below:

Employee Trustees

Dan Reding
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

Brandon Dew
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

Justin Diston
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

David Harrison
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

Steve Ingersoll
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

Employer Trustees

James E. Murray
Ford Construction Co., Inc
2470 Robertson Bridge Road
Grants Pass, OR 97526

Kevin J. Albanese
1100 Lincoln Avenue, Suite 381
San Jose, CA 95125

Patty Dutra Bruce
The Dutra Group
2350 Kerner Blvd, #200
San Rafael, CA 94901

F.G. Crosthwaite
9580 Oak Avenue Parkway, Suite 7-113
Folsom, CA 95630-1888

Thomas Holsman
7205 Hollywood Blvd, #507
Los Angeles, CA 90046

Employee Trustees (continued)

Jim Jacobs
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

Charles Lavery
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

Bruce Noel
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

John Rector
Operating Engineers Local Union No. 3
3000 Clayton Road
Concord, CA 94519

Nate Tucker
Operating Engineers Local Union No. 3
1916 No. Broadway
Stockton, CA 95205

Employer Trustees (continued)

Lance Inouye
Ralph S. Inouye Company, Ltd.
500 Alakawa Street, Rm220E
Honolulu, HI 96817-5703

Tom Squeri
Granite Rock Company
350 Technology Drive
Watsonville, CA 95076

David R. Stanton
HMH Engineers
1570 Oakland Road
San Jose, CA 95131

Garrett Updike
W.W. Clyde & Co.
869 North 1500 West
Orem, UT 84057

Frank Williams
Goodfellow Brothers
50 Contractors Street
Livermore, CA 94551

Your Rights Under ERISA

As a participant in the Pensioned 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 claim appeal 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:

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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.

Organizations Through Which Benefits Are Provided or Administered

The complete terms of the benefits provided directly by the Fund are set forth in the Rules and Regulations at the end of this Summary Plan Description. The complete terms of the benefits provided through insurance companies or Health Maintenance Organizations (HMOs) are set forth in the contracts with those organizations.

Anthem Blue Cross 21555 Oxnard Street Woodland Hills, CA 91367 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.	**American Imaging Management, Inc.** 8600 West Bryn Mawr Ave. South Tower, Suite 800 Chicago, IL 60631 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.
Assistance and Recovery Program 3000 Clayton Road Concord, CA 94519 Administers the chemical dependency treatment benefits; does not guarantee payment of these benefits. Benefits are self-funded by the Trust Fund.	**OptumRx** 2300 Main Street Irvine, CA 92614 Administers the prescription drug plan; does not insure or guarantee payment of prescription drug benefits. Benefits are self-funded by the Trust Fund.
Delta Dental Plan of California 100 First Street San Francisco, CA 94105 Insures and administers dental benefits, with guaranteed payment of those benefits.	**Hawaii Dental Service (HDS)** 700 Bishop Street, Suite 700 Honolulu, HI 96813-4196 Insures and administers dental benefits with guaranteed payment of those benefits.

Hawaii Medical Service Association (HMSA) P.O. Box 860 Honolulu, HI 96808-0860 Insures and administers medical and prescription drug benefits with guaranteed payment of those benefits.	
Health Net Seniority Plus Plan (HMO) 21281 Burbank Boulevard Woodland Hills, CA 91377 Provides prepaid medical and prescription drug benefits, with guaranteed payment of those benefits.	**Hear USA** 100 East Corson Street, Suite 230 Pasadena, CA 91103 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.
Kaiser Foundation Health Plan (HMO) Northern California Region 1950 Franklin Street Oakland, CA 94612 Provides prepaid medical and prescription drug benefits, with guaranteed payment of those benefits.	**Kaiser Foundation Health Plan (HMO)** Hawaii Region 711 Kapiolani Boulevard Honolulu, HI 96813 Provides prepaid medical and prescription drug benefits with guaranteed payment of those benefits.
MetLife Dental Plan 425 Market Street, Suite 970 San Francisco, CA 94105 Provides prepaid dental benefits with guaranteed payment of those benefits.	**United HealthCare Secure Horizons Plan (HMO)** PO Box 29800 Hot Springs, AR 71903-0880 Provides prepaid medical and prescription drug benefits, with guaranteed payment of those benefits.
Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 Administers vision plan; does not guarantee payment of benefits. Benefits are self-funded by the Trust Fund.	

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 Plan 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.
- Legal 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" in Chapter 9 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 Operating Engineers Local Union No. 3 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 participants, 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 benefit and/or 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.

If you want to maximize your Pensioned Health & Welfare medical benefits, you must enroll in Medicare Part A and B when you are eligible for Medicare. Please call the Trust Fund Office at (800) 251-5014 if you have any questions.

PENSIONED OPERATING ENGINEERS
HEALTH AND WELFARE TRUST FUND

Rules and Regulations
of the
Direct Payment Plan

Restated Effective March 1, 2023

TABLE OF CONTENTS

ARTICLE 1. DEFINITIONS

Unless the context or subject matter otherwise requires, the following definitions will govern in these Rules and Regulations:

Section 1.01. The term "Active Employee" means each employee who has established eligibility in accordance with the rules provided in the Rules and Regulations for Active Employees in the area within the jurisdiction of the Union in which he was last employed.

Section 1.02. The term "Allowed Charge" means the lesser of:

a. For Emergency Services provided by Non-Contract Providers, for Non-Emergency Services provided by a Non-Contract Provider at a Contract Health Facility, and for Air Ambulance Services, the Out-of-Network Rate, as defined below**.**

b. For all other services, the lesser of:

   - 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. 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 Provider's billed rate. When a 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 organization to assist the Plan in determining the Allowed Charge for the submitted claim. This review by an independent medical review firm is separate and apart from any independent dispute resolution process that is facilitated pursuant to the No Surprises Act.
   - The Non-Contract Provider's actual billed charge.

c. When using Non-Contract Providers, except for No Surprises Act Services, the Eligible Individual is responsible for any difference between the actual billed charge and the Plan's Allowed Charge (a practice called "balance billing"), in addition to any Copayment and percentage coinsurance required by the Plan.

Section 1.03. The term "Ambulatory Surgery Facility" means a health facility that is accredited by the *Accreditation Association for Ambulatory Health Care*.

Section 1.04. Ancillary Services. Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by a Non-Contract Provider at a Contract Facility, the term **"**Ancillary Services**"** means the following**:**

a. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,

b. Items and services provided by assistant surgeons, hospitalists, and intensivists;

c. Diagnostic services, including radiology and laboratory services;

d. Items and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and

e. Items and services provided by a Non-Contract Provider if there is no Contract Provider who can furnish such item or service at such facility.

Section 1.05. The term "Assistance Recovery Program" (ARP) means that program adopted by the Fund which coordinates services for the treatment of substance abuse for Eligible Individuals.

Section 1.06. The term "Board" means the Board of Trustees of the Pensioned Operating Engineers Health and Welfare Trust Fund.

Section 1.07. The term "Concurrent Review" means the process whereby the Professional Review Organization (PRO) under contract to the Fund determines the number of authorized Hospital 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 1.08. The term "Continuing Care Patient" means an individual who is: (1) receiving a course of treatment for a "Serious and Complex Condition", (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

Section 1.09. The term "Contract Facility" means a health care or substance abuse treatment facility that has a contract in effect with the Fund under the Preferred Provider Organization.

Section 1.10. The term "Contract Hospital" means a Hospital that has a contract in effect with the Fund under the Preferred Provider Organization.

Section 1.11. The term "Contract Physician" means a Physician that has a contract in effect with the Fund under the Preferred Provider Organization.

Section 1.12. The term "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 1.13. The term "Contract Provider Service Area" means the geographic area that is within 30 miles of a Contract Provider.

Section 1.14. The term "Covered Expense(s)" means charges which do not exceed the Plan's Allowed Charge 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. The Plan will apply Medicare's determination of Medical Necessity for individuals who are eligible for Medicare.

Section 1.15. "Covid-19 Test" means diagnostic tests to detect the presence of, or antibodies against, the virus causing Covid-19 that are approved, cleared or authorized by the certain sections of the Federal Food, Drug and Cosmetic Act (the Drug Act); tests for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied); tests developed in and authorized by a State that has notified HHS of its intention to review tests to diagnose COVID-19; and other tests determined appropriate by HHS, including the administration of such tests.

Section 1.16. "Covid-19 Test Related Visit/Services" means items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the Covid-19 Test,

including the administration of such test, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

Section 1.17. The term "Dentist" means a dentist licensed to practice dentistry in the state in which he provides treatment.

Section 1.18. The term "Dependent" means the Retired Employee's Spouse and child as defined in Subsections 1.54 and 2.02.a.(4), respectively, provided the required contribution, as determined by the Board of Trustees, is paid to the Fund for the child's coverage.

Section 1.19. The term "Drugs" means any article that may be lawfully dispensed, as provided under the Federal Food, Drug, and Cosmetic Act including any amendments to the Act, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

Section 1.20. The term "Eligible Individual" means each Retired Employee, Dependent Spouse or Dependent child, if any.

Section 1.21. The term "Emergency Medical Condition" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such 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 impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Section 1.22. "Emergency Period" means any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), beginning on or after March 18, 2020, namely, the period during which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary pursuant to section 247d of the Social Security Act.

Section 1.23. The term "Emergency Services" means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Emergency services furnished by a Non-Contract Provider or at a Non-Contract Hospital (regardless of the department of the Hospital in which such items or services are furnished) or an Independent Freestanding Emergency Department also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:
    - The attending emergency physician or treating provider determines that the Patient is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and

- The Patient or their representative is supplied with a written notice, as required by federal law, that the provider is a Non-Contract Provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any Contract Providers at the facility who are able to treat the Patient, and that the Patient may elect to be referred to one of the Contract Providers listed; and
- The Patient or their representative gives informed voluntary consent to continued treatment by the Non-Contract Provider, acknowledging that the Patient understands that continued treatment by the Non-Contract Provider may result in greater costs to the Patient.

Section 1.24. The term "Experimental or Investigational Procedure" means a drug, device, medical treatment or procedure if:

a. 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

b. 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

c. 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

d. 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.

e. 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.

f. Under the Comprehensive Medical benefits of this Plan, Experimental or Investigational Procedures do not include **"routine costs" associated with a certain "approved clinical trial" related to cancer or other life-threatening Illnesses**. For individuals who will participate in a clinical trial, precertification is required in order to notify the Plan that routine costs, services and supplies may be incurred by the Eligible Individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

(1) "Routine costs" means services and supplies incurred by an Eligible Individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the Plan does not cover

non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the Patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a Patient's particular diagnosis.

(2) An "approved clinical trial" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

Section 1.25. The term "Fund" and "Plan" means the Pensioned Operating Engineers Health and Welfare Trust Fund.

Section 1.26. The term "Gene Therapy" means a technique that uses human genes to treat or prevent disease in humans. Gene therapy involves introducing human DNA into an individual to treat a genetic disease (genetically altering the patient's own cells to fight their disease). The new DNA usually contains a functioning gene to correct the effects of a disease-causing mutation. The technique can allow doctors to treat a disorder by inserting a gene into an individual's cells instead of using drugs or surgery. There are several approaches to gene therapy, including:

a. Replacing a mutated "faulty" gene that causes disease with a healthy copy of the gene.

b. Inactivating, or "knocking out," a mutated "faulty" gene that is not functioning properly.

c. Introducing a new gene into the body to help fight a disease or cure the disease.

Most often, human gene therapy works by introducing a healthy copy of a defective gene into the patient's cells. There have been rapid advancements in techniques that make it easier than ever to edit the human genome. Genome editing techniques, such as CRISPR/Cas9, allow editing of the genome, by removing, replacing, or adding to parts of the DNA sequence. The Plan covers medically necessary, non-experimental, FDA-approved gene therapy treatment.

Section 1.27. The term "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 1.28. The term "Health Care Facility" (for non-emergency services) means each of following:

a. A hospital (as defined in section 1861(e) of the Social Security Act);

b. A hospital outpatient department;

c. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

d. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Section 1.29. The term "Hospital" means an acute care hospital which is licensed under any applicable state statute and which provides: (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 health and/or substance use disorder 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 health and/or substance abuse treatment.

Section 1.30. The term "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.

Section 1.31. The term "Independent Freestanding Emergency Department" means a health-care facility that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Section 1.32. The term "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 1.33. The term "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 1.34. The term "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 convenience of the patient, the patient's Physician or another provider, 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.

The Plan will apply Medicare's determination of Medical Necessity for individuals who are eligible for Medicare.

Section 1.35. The term "Medicare" means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

Section 1.36. The term "Non-Contract Hospital" means a Hospital which does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.37. The term "Non-Contract Facility" means a health care facility or substance abuse treatment facility that does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.38. The term "Non-Contract Physician" means a Physician who does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.39. The term "Non-Contract Provider" means a Hospital, facility, Physician or other health care provider that does not have a contract if effect with the Fund's Preferred Provider Organization.

Section 1.40. The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 21, 2020. The term "No Surprises Act Services" means the following, to the extent covered under the Plan: (1) out-of-network Emergency Services, (2) out-of-network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a Non-Contract Provider at a Contract Facility; and (4) other out-of-network non-emergency services performed by a Non-Contract Provider at a Contract Facility with respect to which the provider does not comply with written federal notice and consent requirements.

Section 1.41. Out-of-Network (Non-Contract) Rate. With respect to 1) Emergency Services provided by a Non-Contract Hospital or Independent Freestanding Emergency Department, 2) non-emergency services furnished by a Non-Contract Provider at a Contract Facility, and 3) Air Ambulance Services by a Non-Contract Provider, the term "Out-of-Network Rate" means one of the following in order of priority:

- If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
- Applicable state law;
- The amount parties negotiate; or
- The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

Section 1.42. The term "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 1.43. The term "Patient" means the Eligible Individual who is receiving medical treatment, services, or supplies covered by the Plan.

Section 1.44. The term "Physician" means a physician (M.D.), an Osteopath (D.O.), or a Dentist (D.D.S. or D.M.D.) licensed to practice medicine or dentistry in the state in which he practices. The Plan also covers other licensed providers when they are performing covered services within the scope of their licenses and providing services that are Medically Necessary.

Section 1.45. The term "Plan" means the Rules and Regulations of the Pensioned Operating Engineers Health and Welfare Trust Fund, including any amendments.

Section 1.46. The term "Pre-admission Review" 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 1.47. The term "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 1.48. The term "Professional Review Organization" (PRO) means the organization(s), under contract to the Fund to determine:

a. whether the elective confinement of an Eligible Individual in a Hospital, Skilled Nursing Facility or chemical dependency treatment facility 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 1.49. The term "Qualifying Payment Amount" (QPA) means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the plan or issuer for the item or service in the area.

Section 1.50. The term "Recognized Amount" means (in order of priority), with respect to an item or service provided by a Non-Contract Provider, one of the following:

a) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

b) An amount determined by a specified state law; or

c) The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For Air Ambulance Services furnished by Non-Contract providers, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

Section 1.51. The terms "Retired Employee" and "Retiree" mean each person who meets the eligibility rules in either Subsection 2.02.a.(1) or Subsection 2.03.a.(1).

Section 1.52. The term "Serious and Complex Condition" means one of the following:

a. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b. In the case of a chronic illness or condition, a condition that is the following:

(1) Life-threatening, degenerative, potentially disabling, or congenital; and

(2) Requires specialized medical care over a prolonged period of time.

Section 1.53. The term "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 times 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, and (5) is not a place for rest, custodial care, for the aged, nor is a hotel or similar institution.

Section 1.54. The term "Spouse" means the legal spouse of the Retired Employee.

Section 1.55. The term "Trust Agreement" means the Trust Agreement establishing the Pensioned Operating Engineers Health and Welfare Trust Fund, including any amendment, extension or renewal.

Section 1.56. The term "Union" means the Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Section 1.57. The term "Utilization Review (UR) Program" means a program whereby an Eligible Individual who is scheduled for confinement in a Hospital, Skilled Nursing Facility or chemical dependency treatment facility on a non-emergency 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 benefits from the Plan. For Emergency confinements, the review must be obtained retrospectively.

ARTICLE 2. ELIGIBILITY FOR BENEFITS

Section 2.01. Definitions. The following definition will govern in this Article:

a. The term "Certified Disability" means an Illness or Injury which prevents an Active Employee from performing any and every duty of his regular occupation as an Operating Engineer, as certified by his Physician.

b. The term "Collective Bargaining Agreement" means any written agreement entered into by the Union with any employer as this term is defined in the Labor-Management Relations Act, 1947 (29 U.S.C. § 141 et seq.) covering wages, rates of pay, hours of labor or other conditions of employment of employees represented for the purposes of collective bargaining by the Union, and any extension or renewal of the agreement, or any substitute for or successor to the agreement, which agreement provides for payments by Individual Employers into the Fund.

c. The term "Contributing Employer" means any employer who is required by a collective bargaining agreement with the Union or any other written Contribution Agreement to make contributions to the Fund, subject to the minimum contribution requirements as may be established by the Board from time to time. The term "Contributing Employer" will also include the Union, if it makes contributions to the Fund on behalf of its Employees, provided the inclusion of the Union is not a violation of any existing law or regulation.

d. 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 Agreement with the Operating Engineers Local Union Number 3 requiring flat-rate contributions to this Fund, and is a dues-paying member of or service fees payor to the Union.

Section 2.02. Eligibility Rules

a. **Establishment and Maintenance of Eligibility**

(1) A person who receives a pension from the Pension Trust Fund for Operating Engineers based on 10 or more Years of Credited Service earned while employed in Covered Employment under that Fund's Plan will become eligible as a Retired Employee if he meets the following requirements:

(a) He makes the required self-payment for coverage through authorized deductions in an amount determined from time to time by the Board; and

(b) He is a dues paying member of the Union, or pays a service fee to the Union equal to the amount of dues required of retired members; and

(c) Beginning for retirements occurring on or after September 1, 2015: he has worked at least 1) 2,000 hours for one or more Contributing Employers during the 24-months immediately preceding the pension effective date for which contributions have been made to this Plan on his behalf, OR 2) 10,000 hours since January 1, 2005 for which contributions have been made to this Plan on his behalf.

For purposes of this subsection (c), all active participants who had a Pension Application on file before October 9, 2015, shall be given 72 months immediately preceding their date of retirement to meet the 2,000 Pensioned Health and Welfare hour requirement.

(d) **Grace Period.** For purpose of meeting the requirement of Subsection2.02 a. (1) (c) above, a grace period will be granted for those months during which either (i) work was performed for the International Union of Operating Engineers or the International Training Fund or (ii) a person was unable to work in covered employment due to a Certified Disability. A grace period will also be granted for moratorium years under the Job Placement regulations of a Collective Bargaining Agreement.

A grace period is a period that is to be disregarded when counting the months immediately preceding a person's pension effective date.

(e) **Exception for Retirees Who Return to Work Which is Not Covered Under the Retiree Work Addendum.** Notwithstanding the first paragraph of this Subsection 2.02.a.(1), a Retiree who returns to work with a Contributing Employer in the Operating Engineers Health and Welfare Trust Fund may continue coverage under this Trust Fund until he establishes initial eligibility as an active employee under the Operating Engineers Health and Welfare Trust Fund, provided the required self-payments are made.

(f) **Employees who Retire with Hours Remaining in Their Hour Bank under the Operating Engineers Health and Welfare Trust Fund (California Plan). This Section does <u>not</u> apply to participants who retire on or after January 1, 2015.** If a participant eligible under the Operating Engineers Health and Welfare Trust Fund (not including the Utah Plan) retires and becomes a Retired Employee, any hours remaining in his/her active hour bank on the date of retirement will be used to provide coverage under this Fund with no self-payment required from the Retired Employee for the months of coverage provided by the hour bank. After the hour bank is exhausted, the Retired Employee must make the required self-payments to continue eligibility under this Fund and the premium for the voluntary Retiree Dental Plan. The hour bank will be used to provide eligibility under this Fund as follows:

(i) Prior to July 1, 2010, 110 hours will be deducted from the hour bank for each month of eligibility under this Fund.

(ii) Effective July 1, 2010, 120 hours will be deducted from the hour bank for each month of eligibility under this Fund.

(iii) If an active participant elected to apply the hour bank hours toward the cost of COBRA Continuation Coverage under the Operating Engineers Health and Welfare Trust Fund, the hour bank will not be used to provide coverage under this Fund unless any hours are remaining after his/her active COBRA coverage is exhausted.

(2) **Eligibility Date.** A person who meets the eligibility requirements specified in Section 2.02.a.(1) will become eligible to enroll in the Plan as a Retired Employee on the later of the following dates:

(a) On the first day of the second month after a pension is payable to him from the Pension Trust Fund for Operating Engineers and from which the authorized self-payment deduction has been made; or

(b) The date on which his eligibility as an Active Employee terminates.

(3) **Spouse Eligibility.** A Retired Employee's Spouse becomes eligible to enroll in the Plan on the date the Retired Employee's eligibility is effective, or the date of marriage to the Retired Employee, whichever is later.

(4) **Dependent Children Eligibility**. A Retired Employee's child is eligible to enroll in the Plan as a Dependent provided the required self-pay contribution is paid to the Fund for the child's coverage, subject to the following requirements:

(a) Eligible Dependent children include the Retiree's natural child, stepchild or legally adopted child, or a child of the Retiree 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.

(b) An unmarried child younger than 26 years of age for whom the Retired Employee has been appointed legal guardian is eligible provided the child is considered the Retired Employee's dependent for federal income tax purposes.

(c) An unmarried child of the Retired Employee (or the Retired 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 is eligible, provided:

(i) The child is considered the Retired Employee's dependent for federal income tax purposes;

(ii) The child became disabled before reaching age 26 and while eligible as a Dependent under this Plan or under any active health and welfare plan maintained by Operating Engineers Local No. 3; and

(iii) Written evidence of the individual's incapacity is 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.

(d) A spouse or child of a Dependent child is not eligible for coverage under the Plan.

(e) **Enrollment Requirement for Children.** A Dependent child must be enrolled in the Plan when the Retired Employee enrolls. A Dependent child acquired after the Retired Employee' s eligibility date must be enrolled in the Plan within 60 days after the date of the child's birth, adoption or legal guardianship status. A new stepchild must be enrolled within 180 days of the date of the Retired Employee' s marriage to the child's parent. The actual birth certificate from the state or the birth document that the Hospital provides will be required to enroll a newborn child.

(f) In accordance with ERISA Section 609(a)(2)(A), the Plan will provide coverage for a Retired Employee's child under 26 years of age if required by a Qualified Medical Child Support Order, including a National Medical Support Order.

(5) **Enrollment Requirements**. A Retired Employee and Dependent must enroll in the Plan within 60 days of becoming eligible in accordance with Subsections 2.02.a. (2), (3) and (4) by completing the Election and Authorization form authorizing the required monthly deduction from his pension check and returning it to the Trust Fund office. Plan coverage is effective retroactive to the individual's Eligibility Date. Enrollment must be continuous with no gap in coverage. Any individual who does not enroll in the Plan within this time period will not be eligible to enroll at a later date, except as specifically provided in paragraphs (a) and (b) below, in the Special Late Enrollment Provisions outlined in Subsection (6) or for good cause shown as determined at the discretion of the Board or any committee which it has designed to make such determination.

(a) **Exception for a New Spouse**: A new Spouse (and any eligible children of that Spouse) must enroll in the Plan within 180 days of the date of marriage to the Retired Employee.

(b) **Exception for Retirees Who Receive the Election Form After Their Date of Retirement or After the Date Their Active Hour Bank Expired:** A Retiree who received the Election and Authorization Form after his date of retirement and/or after his active hour bank expired may have his enrollment effective on either of the following dates, provided coverage is accepted and the pension deduction is authorized:

(i) Retroactive to the date of retirement or the date the active hour bank expired, whichever is later; or

(ii) On the first day of the month following the date the Trust Fund office receives the completed Election and Authorization form from the participant, provided the form is postmarked within 30 days of the date it was mailed by the Trust Fund office. If this option is chosen, a gap in coverage is allowed.

(6) **Special Late Enrollment Provisions.** An Eligible Individual may enroll in the Plan later than the dates specified above only upon the occurrence of any of the following events, provided the required self-payments are made. Coverage will be effective on the first of the month in which date the Trust Fund Office receives the required documentation.

(a) **Loss of Other Coverage.** If an Eligible Individual did not enroll in the Plan when first eligible (or if he/she discontinued Plan coverage) because he/she had continuous health coverage under another insurance policy or program (including coverage through the hour bank of the active Operating Engineers plan, COBRA Continuation Coverage or individual insurance and that other health coverage terminates, the Eligible Individual may enroll in this Plan within 31 days after termination of the other coverage, provided:

(i) The other coverage was continuous from the time the individual became eligible under this Plan, and

(ii) The individual provides the Fund with proof of the continuity and cessation of the other coverage; and

(iii) The other continuous coverage is NOT Medicare coverage.

(b) The other coverage must have terminated due to any of the following reasons:

(i) Loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause);

(ii) Termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right);

(iii) The health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was "exhausted;"

(iv) Moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;

(v) The other plan ceasing to offer coverage to a group of similarly situated individuals;

(vi) The loss of Dependent status under the other plan's terms; or

(vii) The termination of a benefit package option under the other plan, unless substitute coverage offered.

(c) COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;

(iii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or

(iv) Because the 18-month, 29-month or 36-month (as applicable) period of COBRA Continuation Coverage has expired.

(d) **Medicaid or Children's Health Insurance Program.** A Retiree or Dependent who did not enroll in the Plan on the date the Retiree or Dependent first became eligible will have the opportunity to request enrollment in the Plan within 60 days of either of the following events:

(i) The date the Retiree and/or Dependent loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP); or

(ii) The date the Retiree and/or Dependent becomes eligible to participate in a premium assistance program under Medicaid or the Children's Health Insurance Program (CHIP).

(e) **Age 65.** A Retired Employee whose pension was effective on or after January 1, 1999, and who was under age 65 at the time of retirement may enroll in the Plan when he reaches age 65, provided he enrolls within 31 days after his 65th birthday.

(f) **Age 62.** A Retired Employee whose pension was effective before January 1, 1999, and who was under age 62 when he retired may enroll in the Plan when he reaches age 62, provided he enrolls within 31 days after his 62nd birthday.

(g) **Medicare.** If the Retired Employee was not entitled to Medicare at the time he became eligible under the Fund, he may enroll in the Plan within 31 days of the date he became entitled to Medicare.

(h) **New Dependent**. If a Retired Employee who did not enroll in the Plan when first eligible subsequently acquires a new Dependent child by birth, adoption or legal guardianship, the Retired Employee may enroll himself and his new Dependent child no later than **60 days** after the date of the birth, adoption or legal guardianship status of the child. If a Retired Employee who did not enroll in the Plan when first eligible subsequently marries, the Retired Employee may enroll himself and his new Spouse, and any Dependent children of that Spouse, no later than **180 days** after the date of marriage to the new Spouse.

b. **Determination of Applicable Schedule of Benefits for Retired Employees Who Retired Prior to January 1, 2007**.

If a Retired Employee meets the eligibility requirements set forth in this Article, a further determination will be made as to whether he is entitled to the benefits of Schedule I or Schedule II (as described in ARTICLE 4).

(1) Schedule I applies to:

(a) A Retired Employee who worked a majority of hours for Contributing Employers who contributed to the Fund at a rate equal to 70% or more of the hourly construction rate specified in the Collective Bargaining Agreement in the state in which the work was performed during each of the last 3 calendar work years in which he earned pension credit prior to his pension award date; or

(b) A Retired Employee whose total employer contributions for each year of the last 3 calendar work years in which he earned pension credit prior to his pension award date were equal to or greater than 70% of the total contributions required during the same 3 calendar work years for an employee working at the construction rate for 1,200 hours under the Collective Bargaining Agreement in the state in which the work was performed; or

(c) A Retired Employee whose total employer contributions for the last 10 calendar work years in which he earned pension credit prior to his pension award date were equal to or greater than 70% of the total contributions required during the same 10 calendar work years for an employee working at

the construction rate for 1,200 hours under the Collective Bargaining Agreement in the state in which the work was performed; or

(d) A Retired Employee whose total employer contributions for all the calendar work years in which he earned pension credit prior to his pension award date were equal to or greater than 70% of the total contributions required during the same calendar work years for an employee working at the construction rate for 1,200 hours under the Collective Bargaining Agreement in the state in which the work was performed.

(e) Any Retired Employee who became eligible for Plan benefits prior to January 1, 1981.

(2) Schedule II applies to:

(a) A Retired Employee who worked for Contributing Employers who contributed to the Fund, but whose hours or whose contributions were insufficient to allow the Retired Employee to qualify for Schedule I as specified in Subsection (a) above.

c. **Determination of Applicable Schedule of Benefits for Retired Employees who Retired After January 1, 2007.**

(1) Schedule II will no longer be provided. All Retired Employees will receive Schedule I comprehensive medical benefits (as described in ARTICLE 4), provided:

(a) The highest contribution paid by the Retired Employee's former employer(s) during the last 12-months of employer contributions received by this Fund, equals the target employer contribution rate as determined by the Board of Trustees, OR

(b) The Retired Employer's bargaining unit makes an additional allocation to the Pensioned Operating Engineers Health and Welfare Trust Fund. The additional required allocation is at least 20% of the difference between the highest employer contribution rate paid on the Retired Employee's behalf during the last 12 months of employer contributions received by this Fund and the target employer contribution rate. The target employer contribution rates by state are listed below. The target employer contribution rate will be the (1) Master Agreement allocation and (2) if no Master Agreement exists in a state, the target employer contribution rate will be the highest allocation rate in that state.

The 2022 target employer contribution rates by state are as follows:

- California $2.54
- Nevada $2.38
- Hawaii $2.39
- Utah $1.87

Example: If a Retired Employee worked in California and the highest employer contribution rate paid during the last twelve months of contributions received by this Fund is $1.75, the bargaining unit will need to allocate an additional $0.16 to the Pensioned Operating Engineers Health and Welfare Fund:

$2.54 - $1.75 = $0.79;

$0.79 x 20% = $0.16.

(2) If the highest employer contribution rate for the last 12-months of employer contributions received by this Fund does not equal the target employer contribution rate as determined by the Board of Trustees, and the bargaining unit does not make an additional allocation as outlined in (1)(b) above, the Retired Employee can choose to either pay an increased monthly self-pay contribution or receive reduced comprehensive medical plan benefits as shown below:

Employer Contribution Rate as % of Target Rate	**Percent of Normal. Schedule I Comprehensive Medical Benefits**	**Monthly Self-Pay Contribution**	
		Retiree not eligible for Medicare	**Medicare eligible Retiree**
95% - 100%	100%	$500.00	$250.00
90% - 95%	95%	525.00	262.50
85% - 90%	90%	550.00	275.00
80% - 85%	85%	575.00	287.50
75% - 80%	80%	600.00	300.00
70% - 75%	75%	625.00	312.50
65% - 70%	70%	650.00	325.00
60% - 65%	65%	675.00	337.50
55% -60%	60%	700.00	350.00
50% - 55%	55%	725.00	362.50
45% - 50%	50%	750.00	375.00
40% - 45%	45%	775.00	387.50
35% - 40%	40%	800.00	400.00
30% - 35%	35%	825.00	412.50
25% - 30%	25%	850.00	425.00
0 – 25%	NA	1,100.00	550.00

The reduced comprehensive medical plan benefits will be subject to the ACA Out of Pocket Limit specified in Section 4.02.b. 3.

(3) The level of comprehensive medical plan benefits applicable to the Retiree will also apply to his Dependents.

(4) Retirees will not have the opportunity to switch between full Schedule I comprehensive medical plan benefits and the reduced level of comprehensive medical benefits after their date of retirement.

(5) If a person who worked for a Contributing Employer leaves employment due to a disability (for which he or she receives an SSDI award), AND retires within three years from the time he becomes eligible for benefits, the target rate for determining the Retired Employee's payment will be determined based on the last contribution rate their Contributing Employer made while they were actively working.

d. **Termination of Eligibility**

(1) A Retired Employee's eligibility will terminate on the earliest of the following dates:

(a) The last day of the last month for which the required dues or service fee has been paid; or

(b) The last day of the month for which the last required pension check deduction or self-payment has been made; or

(c) The last day of the last month for which a benefit was payable to the Retired Employee from the Pension Trust Fund for Operating Engineers; or

(d) The date on which this Plan is terminated by the Board.

(2) The eligibility of a Spouse will terminate on the date the Retired Employee's eligibility terminates, except as set forth in Section 2.02.e., or the date the Spouse no longer qualifies as a Dependent as defined in Section 1.18 and 1.54, whichever is sooner.

(3) The eligibility of a Dependent child will terminate on the date the Retired Employee's eligibility terminates, on the date the child no longer qualifies as a Dependent or on the last day of the month for which the last contribution has been paid to the Fund for the child's coverage, whichever occurs first. A Dependent child whose coverage has terminated due to non-payment of the contribution will not be eligible to re-enroll in the Plan at a later date.

e. **Surviving Spouses Continuation of Eligibility by Self-Payment**

(1) If a Retired Employee elected the Husband-and-Wife Pension and was awarded a pension prior to November 30, 1976, benefits for his surviving Spouse will continue until the last day of the month preceding the month for which no monthly benefit is payable from the Pension Trust Fund for Operating Engineers to the spouse. No self-payment is required for this continuation of coverage.

(2) A deceased Retired Employee's surviving Spouse who does not qualify under Paragraph (1) above may continue Plan benefits by making the required monthly self-payments to the Fund in the amount determined by the Board for surviving Spouses. Plan benefits for a surviving Spouse are the same as received when the Retired Employee was living, except that chemical dependency treatment benefits are not included.

(3) If applicable, monthly payments in an amount determined by the Board and as amended from time to time must be received at the Fund Office by the 15th day of the month for which coverage is desired. The first self-payment must be made the month following the month in which the Retired Employee died.

(4) Self-payments must be continuous. If a self-payment is not received for any month, coverage will terminate and may not be reinstated at a later date.

(5) Surviving Spouses of Active Operating Engineers. A surviving spouse of an active Operating Engineer, who is otherwise eligible for a pension from the Pension Trust Fund for Operating Engineers but who dies before his pension effective date, will be eligible under this Subsection as if the Operating Engineer had retired and was receiving a pension on his date of death. Eligibility will begin under this Plan on the date eligibility provided by the hour bank of the Operating Engineers Health and Welfare Trust Fund has terminated, provided the required self-payments are made.

(6) Termination of Surviving Spouse Eligibility Upon Remarriage. Eligibility for a surviving Spouse and any Dependent children of a surviving Spouse will terminate on the date the surviving Spouse remarries. See 2.03d below for additional termination reasons.

Section 2.03. Eligibility Rules for Retired Owner-Operators

a. **Establishment and Maintenance of Eligibility**

(1) An Owner-Operator, who does not meet the eligibility requirements of Section 2.02 of the Plan, will become eligible to enroll in the Plan on the first day of the calendar month of his retirement, provided the required self-pay contribution is made and subject to the following requirements:

(a) The Owner-Operator must be eligible for Medicare benefits; and

(b) Must provide satisfactory proof of his retirement to the Board; and

(c) Must have been covered under one of the Operating Engineers Local Number 3 active health and welfare plans for at least the 48 months immediately preceding his retirement; and

(d) Must be a dues-paying member of Operating Engineers Local No. 3 (the "Union") or pay a service fee to the Union equal to the amount of dues required of retired Owner-Operators.

(2) Subject to the requirements outlined in Subsection (1) above, an Owner-Operator's Spouse will become eligible to enroll in the Plan on the date the Owner-Operator's eligibility is effective, or the date of the marriage, whichever is later.

(3) **Enrollment Requirements**. The Enrollment Requirements set forth in Section 2.02.a.(5) also apply to Retired Owner-Operators and their Dependent Spouses and children.

(4) **Dependent Children Eligibility**. The Dependent children eligibility provisions set forth in Section 2.02.a.(4) also apply to Dependent children of Retired Owner-Operators

(5) **Special Late Enrollment Provisions**. The Special Late Enrollment provisions set forth in Section 2.02.a.(6) also apply to Retired Owner Operators and their Dependents, except for Subsections (e), (f) and (g).

(6) If an Owner-Operator meets the eligibility requirements set forth in this Section, he will be entitled to the benefits of Schedule I (as described in ARTICLE 4).

b. **Termination of Eligibility**

(1) An Owner-Operator's eligibility will terminate on the earliest of the following dates:

(a) The last day of the last month for which the last required self-payment, Union dues, or service fee payment was made; or

(b) The date the Owner-Operator is no longer retired; or

(c) The date on which this Plan is terminated by the Board.

(2) The eligibility of a Spouse will terminate on the date the Retired Employee's eligibility terminates, except as set forth in Section 2.03.c., or the date the Spouse no longer qualifies as a Dependent as defined in Section 2.02 (a) 4, whichever is sooner.

(3) The eligibility of a Dependent child will terminate on the date the Retired Owner-Operator's eligibility terminates, on the date the child no longer qualifies as a Dependent or on the last day of the month for which the last contribution has been paid to the Fund for the child's coverage, whichever occurs first. A Dependent child whose coverage has terminated due to non-payment of the contribution will not be eligible to re-enroll in the Plan at a later date.

c. **Surviving Spouses Continuation of Eligibility by Self-Payment**

(1) If applicable, monthly payments in an amount determined by the Board and as amended from time to time must be received at the Fund Office by the 15th day of the month preceding the month for which coverage is desired. The first self-payment must be made the month following the month in which the Owner-Operator died.

(2) Self-Payments must be continuous. If a self-payment is not received for any month, coverage will terminate and may not be reinstated at a later date.

(3) Plan benefits for a surviving Spouse are the same as when the Retired Employee was living, except that chemical dependency treatment benefits are not included.

d. **Termination of Eligibility for a Surviving Spouse and/or Dependents**

(1) Eligibility for a Surviving Spouse and Dependents will terminate on the earlier of the following dates:

(a) For lack of any required premium payment;

(b) A Dependent Child attains age 26, unless a documented disability eligibility is satisfied;

(c) The date the surviving Spouse remarries;

(d) Death of Spouse;

(e) Spouse becomes enrolled in other group health coverage;

(f) The date any QMCSO terminates and the Dependent is not otherwise eligible for coverage;

(g) Dependent spouse enters full-time military;

(h) Death of Dependent;

(i) Plan discontinues Dependent or Spousal coverage; or

(j) Plan is discontinued/terminated.

Once a surviving Spouse or Dependent is disenrolled for one of the foregoing reasons, he or she will be ineligible to re-enroll in the Plan.

ARTICLE 3. ELECTION OF COVERAGE

Section 3.01. Election of Medical Coverage. Each Retired Employee will be given the opportunity to elect the comprehensive medical benefits provided by the Fund's Direct Payment Plan, as described in these Rules and Regulations, or the coverage then being provided by the Fund through a prepaid health plan (HMO).

a. If neither the Retired Employee nor Spouse is eligible for Medicare, the coverage elected by the Retired Employee will also apply to the Spouse and any enrolled Dependent children.

b. If the Retired Employee and Spouse are both eligible for Medicare, the Retired Employee and Spouse may each make individual plan elections. Any enrolled Dependent children will be covered under the comprehensive medical benefits provided by the Fund if the Retired Employee has chosen that option for himself. If the Retired Employee has chosen an HMO plan, any enrolled Dependent children may be covered under either the comprehensive medical benefits or under an HMO plan that provides non-Medicare benefits.

c. If the Retired Employee is eligible for Medicare but the Spouse is not, the Spouse and any enrolled Dependent children will be covered under the comprehensive medical benefits if the Retired Employee has chosen that option for himself. If the Retired Employee has chosen a Medicare HMO plan, the Spouse and any enrolled Dependent children may be covered under either the comprehensive medical benefits or an HMO plan that provides non-Medicare benefits.

d. Changes in Coverage. Each Eligible Individual must remain in the health plan selected for a minimum of 12 months, unless he or she moves out of the prepaid plan's service area, the prepaid plan is no longer available in the area where the Eligible Individual resides or a change is approved by the Board of Trustees. Each Eligible Individual may change health plans one time in any 12-month period, subject to Medicare's rules for the timing of plan changes if applicable. 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.

e. If the Eligible Individual elects medical coverage under an HMO plan, he will not be entitled to any benefits under this Direct Payment Plan, except for the following benefits:

   (1) Hearing aid,

   (2) Vision care,

   (3) Chemical dependency treatment,

   (4) Dental benefits if the Retired Employee elects these benefits and pays the required self-payment.

Section 3.02. Election of Dental Coverage. A Retired Employee who elects dental coverage will be given the opportunity to elect the dental benefits provided by the Fund, as described in these Rules and Regulations or the coverage then being offered by the Fund through a prepaid dental

plan. The dental coverage selected by the Retired Employee will also apply to any Dependent of the Retired Employee if Dependent coverage has been elected.

a. Changes in Coverage. Eligible Individuals must remain in the dental plan selected for a minimum of 12 months, unless they move out of the prepaid plan's service area, the prepaid plan is no longer available in the area where the individual resides or a change is approved by the Board of Trustees. A Retired Employee may change dental plans one time in any 12-month period; however, an exception to this rule will be granted once during the Retired Employee's period of eligibility under this Trust Fund. The change in plan will be effective on the first day of the second calendar month following the date the enrollment form is received by the Fund.

ARTICLE 4. COMPREHENSIVE MEDICAL BENEFITS

The benefits described in this Article are provided for Covered Expenses incurred for Medically Necessary treatment of an 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 under this Article are subject to all of the provisions of the Plan, which may limit benefits or result in benefits not being payable.

All benefits payable for Eligible Individuals who are eligible for Medicare will be payable in accordance with ARTICLE 5.

Section 4.01. Deductible Amount for Schedule II Only. Each Eligible Individual entitled to Schedule II benefits is responsible for the first $200 of Covered Expenses per calendar year. This deductible is the amount of Covered Expenses which an Eligible Individual must incur in a calendar year before Plan benefits are paid, except that the deductible is waived for the hearing aid benefit described in Section 4.04.h. Covid-19 Test and Covid-19 Related Visit/Services, from March 18, 2020 through May 11, 2023 (the end of the Emergency Period in which the federal government has announced a Public Health Emergency Period ~~National Emergency)~~ and the Online Physician Consultation benefit described in Subsection 4.04.c.(6).

Section 4.02. Payment

a. Except as stated in Section 4.08 for No Surprises Act Services, payment is provided at the applicable percentage of Covered Expenses incurred as specified in Section 4.04.

b. **Calendar Year 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, the Plan will pay 100% of Covered Expenses incurred during the remainder of that calendar year. Plan deductibles, coinsurance and Copayments are counted toward the Calendar Year Out of Pocket Limit.

(1) Contract Providers Out of Pocket Limit: $5,000 per Eligible Individual, maximum of $11,000 per family

(2) Non-Contract Providers Out of Pocket Limit: $10,000 per Eligible Individual, no family limit

(3) ACA Overall Out-of-Pocket Limit. This limit only applies to the reduced comprehensive medical plan benefits outlined in Section 2.02 c(2).

(a) Contract Providers: This is the Calendar Year's annual indexed ACA maximum out-of-pocket limit amount for an individual and for families, released by the Department of Health and Human Services, less the respective Calendar Year Out-of-Pocket Limit on Prescription Drugs;

(b) Non-Contract Providers: No limit.

(4) The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.

(5) Exceptions to Calendar Year Out of Pocket Limit: The following expenses are not counted toward the Out of Pocket Limit and are not payable at 100% after the limit is reached:

(a) Self-pay contributions, including COBRA premiums

(b) Balance-billed charges in excess of Allowed Charges or the negotiated contract rates for Contract Providers

(c) Penalties for failure to obtain precertification

(d) Non-covered expenses, amounts over the Plan maximum amounts for certain surgeries; charges in excess of any specific benefit maximums

(e) Charges for certain specified treatment at a facility that is not a Center of Medical Excellence

(f) For the Contract Provider Out of Pocket Limit, any Non-Contract Provider Copayments and coinsurance, except that covered emergency services performed in a Non-Contract Provider emergency room will apply to meet the Contract Provider Out of Pocket Limit

(g) Outpatient prescription drug expenses (included in a separate Out-of-Pocket Limit described in Article 6, Prescription Drug Benefits)

(h) Dental and vision plan expenses

Section 4.03. Maximum Benefits. Effective January 1, 2014, there is no calendar year maximum benefit for Comprehensive Medical and Prescription Drug benefits.

Section 4.04. Covered Expenses

a. **Hospital and Ambulatory Surgery Facility Benefits**. The following benefits are payable for Covered Expenses billed by a Hospital or accredited Ambulatory Surgery Facility:

(1) Contract Hospital or Facility. The Fund will pay 80% (Schedule I), or 75% (Schedule II) of the negotiated contract rate.

(2) Non-Contract Hospital or Facility. The Fund will pay the 80% (Schedule I), or 75% (Schedule II) of Covered Expenses incurred.

(3) Utilization Review. If an Eligible Individual is to be confined in a Hospital, Long Term Acute Care Facility, or Skilled Nursing Facility on a Non-Emergency basis, the Physician should obtain Pre-admission Review by the Professional Review Organization (PRO) to determine prior to admission, the Medical Necessity of the 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. In the case of an Emergency Medical Condition, Utilization Review must be obtained within 24 hours of admission to the Hospital when reasonably possible. No benefits will be payable for any days of Hospital confinement determined not Medically Necessary by the PRO.

(4) Preferred Provider Organization (PPO) Centers of Excellence. The following services and procedures will only be covered 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:

(a) Specified organ and tissue transplants

(b) Bariatric surgery

No Plan benefits will be payable for these 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 Subsection 4.04.a.(3). The Professional Review Organization will determine, prior to the service being provided, if the procedure or treatment is subject to this limitation. The provisions of this Subsection do not apply to individuals who are eligible for Medicare.

(5) Inpatient Hospital.

(a) Maximum Benefit for Single Hip Replacement or Single Knee Replacement Surgery. A maximum benefit of $34,000 is payable for Hospital inpatient facility services associated with a single hip joint replacement or a single knee joint replacement surgery. This maximum includes all of the Hospital charges and the charge for the device; it does not include the professional fees such as anesthesiologist or surgeon fees. (This maximum does not apply to individuals who are eligible for Medicare or to surgeries performed outside the state California.)

(b) Covered Inpatient Hospital Services:

(i) Accommodations in a semi-private room, including cardiac care units and intensive care units.

(ii) Operating, delivery and cystoscopic rooms.

(iii) Supplies and oxygen.

(iv) Ancillary services including laboratory, radiology, cardiology, anesthesia, and physical therapy. Any professional component of these services.

(v) Drugs and medicines that are supplied by the Hospital for the Illness or Injury for which the Eligible Individual is hospitalized, including take-home Drugs when supplied by a Contract Hospital only.

(vi) Blood transfusions including the cost of un-replaced blood, blood products and blood processing.

(6) (a) Outpatient Hospital Services. Benefits are payable for Covered Expenses incurred for outpatient services billed by a Hospital, including emergency room, outpatient treatment and surgery rooms, supplies, ancillary services, laboratory and radiology services, Drugs and medicines. The maximum benefit payable listed below will apply to facility and, when applicable, device fees for the following procedures when received in an outpatient Hospital setting, unless the surgeon certifies that it is Medically Necessary to have the procedure performed in an outpatient Hospital setting:

- Colonoscopy - $1,500
- Arthroscopy - $6,000
- Cataract surgery - $2,000
- Single Hip Replacement Surgery - $34,000

- Single Knee Replacement Surgery - $34,000

(The above maximums do not apply to individuals who are eligible for Medicare or to procedures performed outside the state of California.)

For emergency room visits, the deductible and coinsurance are waived if it is a Covid-19 Related Visit/Services, from March 18, 2020, through May 11, 2023 (the end of the Emergency Period in which the federal government has announced a Public Health Emergency Period).

(b) Ambulatory Surgery Facility. Benefits are payable for Covered Expenses incurred for outpatient services billed by an Ambulatory Surgery Facility. There is a daily maximum benefit of $500 for all services received at a Non-Contract Ambulatory Surgery Facility. (This $500 maximum does not apply to individuals who are eligible for Medicare.)

b. **Skilled Nursing Facility and Long Term Acute Care Facility**. Benefits are provided according to the following:

(1) Payment. Payment is provided at 80% (Schedule I), or 75% (Schedule II) of the Covered Expenses incurred, as described in Section 4.04.a. for Contract and Non-Contract Hospitals.

(2) Utilization Review. As described in Section 4.04a, Pre-admission Review by the Professional Review Organization (PRO) is required in advance of admission, except in the case of an Emergency Medical Condition, to determine the Medical Necessity of the confinement and the number of pre-authorized days for the confinement.

(3) Days Covered. Medically Necessary Skilled Nursing Facility services benefits are provided to a maximum of 100 days per calendar year. Benefits may be provided for a limited period of time in a Long Term Acute Care facility if a patient is receiving continued rehabilitation therapy immediately after, or instead of, acute inpatient hospitalization, and only to the extent the patient is continuing to progress.

(a) For Retirees and/or dependents who are not eligible for Medicare, preauthorization by the Utilization Review Program is required in order to determine the care is Medically Necessary.

(i) Long Term Acute Care Facility. The Medical Necessity for Long Term Acute Care Facility services must be re-established by the Utilization Review Program every two months.

(b) For Retirees and/or-dependents who are eligible for Medicare, the Fund will use Medicare's determination of medical necessity. This means that if Medicare determines the skilled nursing or long term acute care is not medically necessary, the Fund will not consider the services to be Medically Necessary.

(4) Covered Services for Skilled Nursing Facility.

(a) Accommodations in a room of 2 or more beds, or the prevailing charge for a 2-bedroom in that facility if a private room is used.

(b) Special treatment rooms.

(c) Laboratory tests.

(d) Physical, occupational and speech therapy, oxygen.

(e) Drugs and medicines which are used in the facility.

(f) Blood transfusions, blood products and blood processing.

(5) Conditions of Service.

(a) The Eligible Individual must be referred to the Skilled Nursing Facility by a Physician.

(b) Services must be those which are regularly provided and billed by a Skilled Nursing Facility.

(c) 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.

(d) The Eligible Individual must remain under the active medical supervision of a Physician.

c. **Medical and Surgical Services of a Physician**

(1) Contract Physicians. The Fund will pay 80% (Schedule I), or 75% (Schedule II) of the Contract Provider's negotiated contract fees.

(2) Non-Contract Physicians. The Fund will pay 80% (Schedule I), or 75% (Schedule II) of Covered Expenses incurred.

(3) Reconstructive Surgery. Benefits are payable in accordance with Subsections (1) and (2) above for the following reconstructive surgery:

(a) Surgery to correct functional disorders or surgery performed as a result of Injury.

(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.

(4) Second Surgical Opinion. Benefits are payable in accordance with Subsections (1) and (2) above for a second surgical opinion consultation obtained for the purpose of determining the necessity for prescribed surgery, provided the second surgical opinion is obtained from a Physician who does not perform the surgery and:

(a) is Board Certified in the field of medical specialization related to the proposed surgery, and

(b) has no financial interest in the outcome of his recommendation.

(5) 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. Reasonable and direct travel expenses related to bariatric surgery are 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 bariatric travel expense benefit does not apply to individuals who are eligible for Medicare.

(b) 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);

(c) 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);

(d) 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.

(e) 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.

(6) Online Physician Consultation. For services through May 11, 2023, benefits are payable for online interactive video Physician consultation through the Anthem Blue Cross LiveHealth Online Services with no cost sharing. The calendar year deductible does not apply. LiveHealth Online is the Plan's only provider for telehealth services where all cost sharing will be waived for Non-Covid-19 Related Visit/Services. Charges for any/all phone calls or online interactive video with another provider (Contract or Non-Contract) will be covered at normal plan benefits (deductible, coinsurance), except as specifically provided in subsection (7) below.

(7) Covid-19 Related Visit/Services, from March 18, 2020 through May 11, 2023 (the end of the Emergency Period in which the federal government has announced a Public Health Emergency Period): The Plan will pay 100% of the negotiated contract rates, the Allowed Charge, or for Covid-19 Test only, the cash price as listed by the provider on a public website, as applicable.

d. **Laboratory Services**

(1) Contract Laboratory. The Fund will pay 100% (Schedules I and II) of the negotiated contract charge for outpatient diagnostic laboratory services provided by a free-standing laboratory. The Fund will pay 80% (Schedule I), or 75% (Schedule II) of the negotiated contract charge for outpatient diagnostic laboratory services billed by a Hospital.

(2) Non-Contract Laboratory. The Fund will pay 80% (Schedule I), or 75% (Schedule II) of Covered Expenses incurred for outpatient diagnostic laboratory services.

(3) Covid-19 Test and Covid-19 Related Visit/Services, from March 18, 2020 through May 11, 2023 (the end of the Emergency Period in which the federal government has announced a Public Health Emergency Period): The Plan will pay 100% of the negotiated contract rates or the Allowed Charge as applicable, or for Covid-19 Test only, the cash price as listed by the provider on a public website, as applicable.

e. **Radiology Services**

(1) Contract Provider. The Fund will pay 80% (Schedule I) or 75% (Schedule II) of the negotiated contract charge for outpatient diagnostic radiology services and for radiation therapy.

(2) Non-Contract Provider. The Fund will pay 80% (Schedule I) or 75% (Schedule II) of Covered Expenses incurred for outpatient diagnostic radiology and for radiation therapy.

(3) Prior Authorization. Prior authorization by the Professional Review Organization (American Imaging Management) is required for certain diagnostic imaging procedures in accordance with Section 4.05.

f. **Additional Covered Services and Supplies**. The Fund will pay 80% (Schedule I), or 75% (Schedule II) of the Covered Expenses incurred for the following services, subject to any limitations specified in this Subsection:

(1) Services of a licensed ambulance for the ground transportation of an Eligible Individual to or from a Hospital or other medical facility for medical care. In addition, services provided by an Emergency Medical Technician (EMT) or registered paramedic are payable if Medically Necessary even without ground transportation. 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.

(2) Anesthesia and its administration.

(3) Services of a registered nurse.

(4) Physical Therapy and Chiropractic Services provided by a registered physical therapist, chiropractor or Physician, limited to a maximum of 40 visits per calendar year. Visit limits for physical and occupational therapy will not apply to diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.

(5) Speech therapy provided by a licensed speech therapist, only when the Eligible Individual had normal speech at one time and lost it due to an Illness or Injury. This limitation will not be applied treatment of diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.

(6) Acupuncture treatment by a licensed acupuncturist, limited to a maximum of 16 visits per calendar year.

(7) Services of a licensed Physician Assistant, provided they are performed under the supervision of a Physician and subject to the following conditions:

(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) Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

(9) Orthotics, limited to a maximum benefit of $500 for each pair of foot orthotics.

(10) Oxygen and the rental of equipment necessary for its administration.

(11) Artificial limbs and eyes and other prosthetic devices, crutches, splints, casts, and braces.

(12) Rental or purchase of other medical equipment and supplies, provided the rental cost does not exceed the purchase price, and provided the equipment or supplies are:

(a) Ordered by a Physician;

(b) Of no further use when medical need ends;

(c) Usable only by the Patient;

(d) Not primarily for the comfort or hygiene of the Eligible Individual;

(e) Not for environmental control;

(f) Not for exercise;

(g) Manufactured specifically for medical use;

(h) Approved as effective and usual and customary treatment of a condition as determined by the Fund, and

(i) Not for prevention purposes.

(13) Purchase of a wig when hair loss is the direct result of chemotherapy treatment.

(14) Immunizations for Eligible Individuals including but not limited to the vaccines for hepatitis, influenza, pneumonia, herpes zoster and the HPV vaccine.

(15) Smoking Cessation Program. The benefits described in this Subsection will be provided for all participants who access a telephone based counseling program for

smoking cessation that is sponsored by the Fund in partnership with the State Building & Construction Trades Councils BUILT project.

(a) In California, Eligible Individuals may access the telephone counseling services of the "California Smokers' Helpline," which are provided without charge to the individual or the Fund.

(b) Benefits for smoking cessation medications are payable in accordance with Article 6, Subsection 6.01.a.(6).

(16) Travel Benefit for Cardiac Care, Spinal Surgery and Treatment for Complex and Rare Cancers. (This benefit does not apply to individuals who are eligible for Medicare.) Reimbursement for travel expenses for authorized cardiac care, spinal surgery and treatment for complex and rare cancers received at an Anthem Blue Cross Center of Medical Excellence (CME) or Blue Distinction Center subject to the following limitations:

(a) The Patient lives more than 50 miles away from a CME or Blue Distinction Center and confined as an inpatient for more than 3 days.

(b) Reimbursement for transportation expenses is limited to the lesser of actual transportation costs to and from a CME or Blue Distinction Center for the patient and one companion or $130 per trip per confinement.

(c) Hotel expenses for one companion are limited to actual costs up to $100 per day for the duration of the Patient's confinement, up to 4 days.

Cardiac care, spinal surgery and treatment for complex and rare cancers are not required to be performed at a Center of Medical Excellence or Blue Distinction Center in order to be covered. While it is not a requirement to use a Center of Medical Excellence or Blue Distinction Center, it is encouraged that an Anthem Blue Cross Center of Medical Excellence or Blue Distinction Center be considered for cardiac care, spinal surgery and treatment for complex and rare cancers. The travel benefit described in this section only applies to authorized cardiac care, spinal surgery and treatment for complex and rare cancers received at an Anthem Blue Cross Center of Medical Excellence or Blue Distinction Center.

g. **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;

(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) Reasonable and direct 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.

h. **Hearing Aids**

1) If an Eligible Individual has a hearing loss that may be lessened by the use of a hearing aid, the Fund will pay 100% of the Covered Expenses incurred for the examination and a hearing aid, up to a maximum payment of $2,025 per ear.

2) Exclusions. No benefits will be provided for:

a) More than one hearing aid for each ear;

b) The replacement of a hearing aid for any reason more often than once during any 48-month period;

c) Batteries or any other ancillary equipment other than that obtained when the hearing aid was purchased and which can be covered within the $2,025 maximum benefit; or

d) Servicing or alterations of the hearing aid.

i. **Outpatient Mental Health Benefits.** Outpatient treatment of mental health or substance use disorders provided by a licensed provider (e.g., psychiatrist, psychologist, licensed clinical social worker or marriage, family and child counselor) is payable on the same basis as the Physician office visit benefit for any other medical treatment.

j. **Preventive Care Services**

(1) **Preventive Care Services From a Contract Provider**. In addition to the Physical Examination benefit for Retired Employees and Spouses described Article 9, the preventive care services that are required to be covered under Health Care Reform will be payable at 100% of Covered Expenses with no copayment or deductible **when received from a Contract Provider**. This benefit includes a Contract Physician's charge for an office visit if the primary purpose of the office visit is the delivery of the preventive care item or service.

(a) Preventive Care for Children – Contract Providers Only. Covered Services include services as recommended by the "Bright Futures /American Academy of Pediatrics. The following list of Covered Services is subject to change over time (see the latest Periodicity Schedule online at https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/):

✓ Childhood immunizations that are FDA approved and in accordance with the CDC recommendations for children in the U.S.

- ✓ Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
- ✓ Developmental screening for children under age 3, and surveillance throughout childhood
- ✓ Behavioral assessments for children of all ages
- ✓ Medical history
- ✓ Blood pressure screening
- ✓ Depression screening for adolescents ages 11 and older
- ✓ Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors
- ✓ Hearing screening
- ✓ Height, Weight and Body Mass Index measurements for children
- ✓ Autism screening for children at 18 and 24 months
- ✓ Alcohol and Drug Use assessments for adolescents
- ✓ Critical congenital heart defect screening in newborns
- ✓ Hematocrit or Hemoglobin screening for children
- ✓ Lead screening for children at risk of exposure
- ✓ Tuberculin testing for children at higher risk of tuberculosis
- ✓ Dyslipidemia screening for children at higher risk of lipid disorders
- ✓ Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents
- ✓ Cervical Dysplasia screening at age 21
- ✓ Oral Health risk assessment
- ✓ Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
- ✓ Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
- ✓ Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
- ✓ Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- ✓ HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
- ✓ Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

- ✓ Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- ✓ Screening for hepatitis B virus infection in adolescents at high risk for infection.
- ✓ Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.
- ✓ Syphilis screening for adolescents who are at increased risk for infection.
- ✓ For adolescents, screening and counseling for interpersonal and domestic violence.

(c) Preventive Care for Men – Contract Providers Only. Covered Services include the services (Grade A and B) as required by the United States Preventive Care Task Force and/or the Advisory Committee on Immunization Practices of the CDC. A searchable list of the latest Final Recommendations (A and B) may be found online at https://uspreventiveservicestaskforce.org/uspstf/topic_search_results. The following list of Covered Services is subject to change over time:

- ✓ Routine adult immunizations for men who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.
- ✓ Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
- ✓ Alcohol Misuse screening and counseling: screening and behavioral counseling interventions to reduce alcohol misuse by adults ages 18 and older in primary care settings.
- ✓ Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- ✓ Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older and women aged 45 and older; men aged 20 to 35 if they are at increased risk for coronary heart disease; and women aged 20 to 45 if they are at increased risk for coronary heart disease.
- ✓ Colorectal Cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 45 and continuing until age 75. The test methodology must be medically appropriate for the patient. The plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending Provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
- ✓ Depression screening for adults.

- ✓ Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
- ✓ Diet counseling for adults at higher risk for chronic disease.
- ✓ HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
- ✓ Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.
- ✓ Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- ✓ Tobacco Use screening for all adults and cessation interventions for tobacco users.
- ✓ Syphilis screening for all adults at increased risk of infection.
- ✓ Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- ✓ Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- ✓ Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
- ✓ Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.
- ✓ Screening for hepatitis B virus infection in adults at high risk for infection.
- ✓ Screening for latent tuberculosis infection in populations at increased risk.

(c) Preventive Care for Women Including Pregnant Women – Contract Providers Only). Covered Services include services as required by the United States Preventive Care Task Force and/or the Advisory Committee on Immunization Practices of the CDC. A searchable list of the latest Final Recommendations (A and B) may be found online at https://uspreventiveservicestaskforce.org/uspstf/topic_search_results. The following list of Covered Services is subject to change over time:

- ✓ Routine adult immunizations for women who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.
- ✓ Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.
- ✓ Anemia screening on a routine basis for pregnant women.
- ✓ Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

- ✓ Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- ✓ BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care Provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.
- ✓ Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
- ✓ Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.
- ✓ Comprehensive lactation support and counseling by a trained Provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the plan administrator.
- ✓ Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.
- ✓ Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
- ✓ FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.
- ✓ Gonorrhea screening for sexually active women age 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.
- ✓ Counseling for sexually transmitted infections, once per year as part of a well woman visit.
- ✓ Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.

- ✓ Hepatitis B screening for pregnant women at their first prenatal visit.
- ✓ Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool will be eligible for screening. The Plan will pay for the most cost-effective test methodology only.
- ✓ Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- ✓ Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
- ✓ Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.
- ✓ Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
- ✓ Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.
- ✓ Depression screening for pregnant and postpartum women.

(2) **Preventive Care Services From a Non-Contract Provider**. In addition to the Physical Examination benefit for Retired Employees and Spouses described Article 9, the Plan will cover the following Preventive Care Services from a Non-Contract Provider.

Colorectal Cancer Screening. The Plan will pay 80% (Schedule I) or 75% (Schedule II) of Covered Expenses for colorectal cancer screening, including colonoscopy, in accordance with American Cancer Society guidelines.

k. **Diabetes Education Program.** The Plan will pay 80% (for Schedule I) and 75% (for Schedule II) of Covered Expenses incurred for 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. In addition, certain dietary counseling may be payable as a Wellness service in accordance with Health Reform requirements.

(1) A diabetes education program is covered when a person is initially diagnosed with diabetes. A refresher course is covered once each year for up to 5 times.

l. Hospice Care. The Plan will pay 80% (for Schedule I) and 75% (for Schedule II) of Covered Expenses incurred for inpatient Hospice care and outpatient home Hospice care provided to patients who meet the criteria outlined in the definition of Hospice in Subsection (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 mental health provider (e.g., 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.

m. Gene Therapy. The Plan covers Medically Necessary, non-Experimental, FDA-approved gene therapy treatment. Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

(1) Gene therapy products and their administration are covered at the applicable regular plan cost-sharing, and limitations, depending on the type of service and provider, as outlined above.

(2) All Gene Therapy services and products require preauthorization by the Professional Review Organization before services begin.

n. Covid-19 Test and Covid-19 Related Visit/Services, from March 18, 2020 through May 11, 2023 (the end of the Public Health Emergency Period). The Plan will pay 100% of the negotiated contract rates, the Allowed Charge, or for Covid-19 Test only, the cash price as listed by the provider on a public website, as applicable.

Section 4.05. No Surprises Act Requirements.

a. Air Ambulance Services. Air Ambulance Services are medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605. The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

(1) The Air Ambulance Services from a Non-Contract Provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a Contract Provider;

(2) The cost-sharing amount will be calculated as if the total amount that would have been charged for the services by a Contract Provider of Air Ambulance Services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services;

(3) Any cost-sharing payments the Eligible Individual makes with respect to covered Air Ambulance services will count toward the in-network deductible and in-network out-of-pocket maximum in the same manner as those received from a Contract Provider; and

(4) In general, Eligible Individuals cannot be balance billed for these Air Ambulance Services.

b. Continuing Care Patients. If an Eligible Individual is a Continuing Care Patient and the Plan terminates its contract with the Eligible Individual's Contract Provider or Facility, or an Eligible Individual's benefits are terminated because of a change in the terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

(1) Notify the Eligible Individual in a timely manner of the Plan's termination of its contracts with the in-network provider or facility and inform them of their right to elect continued transitional care from the provider or facility; and

(2) Allow the Eligible Individual ninety (90) days of continued coverage at the in-network cost sharing to allow for a transition of care to a Contract Provider.

c. Emergency Services. The No Surprises Act requires Emergency Services to be covered as follows:

(1) Without the need for any prior authorization determination, even if the services are provided on a Non-Contract basis;

(2) Without regard to whether the health care provider furnishing the Emergency Services is a Contract Provider or a Contract Facility, as applicable, with respect to the services;

(3) Without imposing any administrative requirement or limitation on Non-Contract Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Contract Providers and Contract Facilities;

(4) Without imposing cost-sharing requirements on Non-Contract Emergency Services that are greater than the requirements that would apply if the services were provided by a Contract Provider or a Contract Facility;

(5) By calculating the cost-sharing requirement for Non-Contract Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services;

(6) By counting cost-sharing payments you make with respect to Non-Contract Emergency Services toward your Contract Provider deductible and Contract Provider out-of-pocket maximum in the same manner as those received from a Contract Provider; and

(7) In general, Eligible Individuals cannot be balance billed for these Emergency Services.

d. Non-Emergency Services. The No Surprises Act requires non-emergency services performed by Non-Contract Provider at a Contract Facility to be covered as follows:

(1) With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a Contract Provider;

(2) By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Contract Provider were equal to the Recognized Amount for the items and services;

(3) By counting any cost-sharing payments made toward any Contract Provider deductible and Contract Provider out-of-pocket maximums applied under the plan (and the Contract Provider deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a Contract Provider; and

(4) In general, Eligible Individuals cannot be balance billed for these items or services.

(5) ***Notice and Consent Exception:*** Non-emergency items or services performed by a Non-Contract Provider at a Contract Facility will be covered based on the Plan's definition of Allowed Charge and forgo the financial protections of the No Surprises Act if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the Patient (or their representative) is provided with a written notice, as required by federal law, that the provider is a Non-Contract Provider with respect to the Plan, the estimated charges for the treatment and any advance limitations that the Plan may put on the treatment, the names of any Contract Providers at the facility who are able to provide treatment, and that the Patient may elect to be referred to one of the Contract Providers listed; and
- The Patient (or their representative) gives written informed consent to continued treatment by the Non-Contract Provider, acknowledging that the Patient understands that continued treatment by the Non-Provider may result in greater costs.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Contract Provider satisfied the notice and consent criteria, and, therefore, these services are covered as follows:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a Contract Provider;
- With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services;
- By counting any Contract Provider deductible and Contract Provider out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a Contract Provider; and

- In general, Eligible Individuals cannot be balance billed for these items or services.

e. Provider Directory. The Provider Directory will be updated at least every ninety (90) days. If an Eligible Individual is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic Provider Directory that a provider is a Contract Provider, but, in fact, the provider is a Non-Contract Provider and services are furnished by that Non-Contract Provider, the Plan will:

(1) Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was a Contract Provider, and

(2) Apply the out-of-pocket limit, if any, as if the services were provided by a Contract Provider.

Section 4.06 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 Professional Review Organization before the surgery is performed.

b. Outpatient Diagnostic Imaging Services. The Physician must also obtain preauthorization from the Professional 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. Clinical Trials. The Physician must obtain preauthorization from the Professional Review Organization for any routine care associated with a clinical trial.

d. If an Eligible Individual receives an outpatient service noted above without preauthorization, the service is subject to retrospective review by the Professional Review Organization and no benefits will be payable for any service deemed not Medically Necessary.

Section 4.07 Exclusions. Benefits will not be payable under this Article 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. This exclusion does not include a licensed Provider that is practicing within the scope of his or her license and providing covered Medically Necessary services.

b. Professional services received from a provider who lives in the Eligible Individual's home.

c. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.

d. Dental plates, bridges, crowns, caps or other dental services, treatment of the temporomandibular joint (TMJ treatment), extraction of teeth or treatment to the teeth or gums, except for the following:

   (1) treatment or services necessary to repair or alleviate damage to teeth resulting from an accident; or

   (2) treatment or services necessary to repair or alleviate damage resulting from radiation treatment for cancer.

e. Optometric services, vision therapy including orthoptics, routine eye exams and routine eye refractions, eyeglasses or contact lenses.

f. Eye surgery for correction of myopia, or any other refractive eye surgery.

g. Cosmetic surgery or other services for beautification, except as specifically provided.

h. Orthopedic shoes (except for diabetic shoes and shoes joined to braces) or shoe inserts (except as provided in Subsection 4.04.f.(9)), air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification.

i. Services for which benefits are payable under any other programs provided by the Fund.

j. Educational services: Such as auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, 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.

k. Nutritional counseling (except for certain preventive care counseling that is required to be covered under Health Reform) or food supplements or substitutes

l. Hypnotism, stress management, massage therapy or any goal-oriented behavior modification therapy, such as to quit smoking, lose weight, or control pain.

m. Services which are primarily for weight loss; health club memberships; exercise and physical fitness programs or equipment; spas.

n. Routine physical examination except as provided in Article 9.

o. A Dependent daughter's abortion (except when the life of the mother would be in danger if the fetus were carried to term or where medical complications arise from an abortion).

p. 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.

q. Treatment of sexual dysfunction, except when caused by a medical or mental condition as certified by a Physician.

r. 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 Subsections 4.04.f.(14) and 4.04.j.

s. Covered expenses for Hospital care, medical services or supplies, which are payable by Medicare for Retired Employees and Dependents who are eligible for Medicare (whether or not the individual has actually enrolled in Medicare).

t. Any service or supply that is excluded under Article 13.

u. Expenses related to the maternity care and delivery associated with a non-Spouse, non-member, or non-Dependent surrogate mother's pregnancy.

v. Bariatric surgery and 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 services being provided, if the procedure or treatment is subject to this limitation. (This exclusion does not apply to individuals who are eligible for Medicare.)

w. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or occurring in an institution that is primarily a place for the treatment of chronic or long-term Injuries or Illnesses. This exclusion does not include Medically Necessary care in a Long-Term Acute Care (LTAC) facility where a patient is receiving continued rehabilitation therapy immediately after, or instead of, acute inpatient hospitalization, and only to the extent the patient is continuing to progress.

   - ***For Retirees and/or Dependents who are not eligible for Medicare***, preauthorization by the Utilization Review Program is required in order to determine the care is medically necessary (medical necessity must be re-established by the Utilization Review Program every two months).

   - ***For Retirees and/or Dependents who are eligible for Medicare,*** the Fund will use Medicare's determination of medical necessity. This means that if Medicare determines the care in a LTAC facility is not medically necessary, the Fund will not consider the services to be medically necessary.

x. Habilitation services. This exclusion does apply to treatment of diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice".

y. Non-emergency services provided outside the United States (expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency).

Section 5.08 Hospital Self Audit Benefit (Non-Contract Hospitals Only). If an Eligible Individual discovers and arranges for the recovery or elimination of overcharges in excess of $25 made on that Eligible Individual's own bill from a Non-Contract Hospital, the Fund will pay the Retired Employee 25% of the amount determined to be an overcharge, subject to the Deductible for Schedule II and subject to the following provisions:

a. Cash Incentive. The cash incentive paid on behalf of an Eligible Individual for eliminating or recovering an amount that was initially overcharged on a Non-Contract Hospital bill for that Eligible Individual will be 25% of the actual amount of the overcharge that the Hospital agrees is invalid as a result of direct negotiations between the Eligible Individual and the Hospital.

b. Maximum. The Maximum paid by the Fund in any calendar year on behalf of an Eligible Individual under this Benefit will not exceed $1,000.

c. Covered Expenses. For purposes of the cash incentive, only expenses that are incurred for covered Non-Contract Hospital services will be considered in determining the amount payable under this program. Claims for Medicare eligible individuals are not eligible for this program. Claims involving coordination of benefits will be eligible only if this Fund is the primary payer.

d. Proof of Eligibility. Proof of eligibility for a cash incentive must be submitted to the Fund in the form of a copy of the initial Non-Contract Hospital bill with the overcharges circled, and a copy of the adjusted bill showing that the Hospital dropped the discrepancy. The proof must be submitted to the Fund within 45 days following the date of discharge from the Hospital. Within 30 days after receipt of proof and verification that the overcharge has been eliminated or recovered, the Fund will disburse to the Retired Employee a check in the amount of the cash incentive.

ARTICLE 5. BENEFITS FOR INDIVIDUALS ELIGIBLE FOR MEDICARE

Section 5.01. Eligible Individuals who are Medicare eligible must enroll in Medicare Parts A and B. If an Eligible Individual does not enroll in both Parts A and B, benefits under this Plan will be estimated as if Medicare had paid as primary. Failure to enroll in Medicare Parts A and B will lead to significant out-of-pocket expenses.

Section 5.02. If an Eligible Individual incurs Covered Expenses as a result of a Hospital confinement or medical services or supplies for which he is also entitled to benefits under Medicare, the Fund will pay, after satisfaction of the Schedule II deductible, 80% (Schedule 1) or 75% (Schedule 2) of Covered Expenses remaining after the amount payable by Medicare for the expenses has been deducted. Covered Expenses are based on Medicare's determination of Medical Necessity.

Section 5.03. Benefits available under both Parts A and B of Medicare will be deducted from the benefits payable under the Plan regardless of whether or not:

a. The Eligible Individual has actually enrolled for Medicare, or

b. The provider of medical services has chosen to participate in Medicare.

ARTICLE 6. PRESCRIPTION DRUG BENEFITS

Section 6.01. Benefits. If Drugs that require a prescription, or insulin or other covered diabetic supplies, are prescribed or administered by a Physician or Dentist for treatment of an Eligible Individual, the Plan will pay the following benefits.

a. **Benefits 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.)

(1) For Generic Drugs – The charge incurred after a $10 Copayment is applied.

(2) For Brand Name Drugs When a Generic Equivalent is **Not** Available – The charge incurred after a $15 Copayment is applied.

(3) For Brand Name Drugs When a Generic Equivalent **Is** Available – The cost of the equivalent generic Drug after a $35 Copayment is applied. However, if the prescribing Physician specified that no substitution may be made, the benefit payable is the charge incurred after the $35 Copayment is applied.

(4) Day Supply Limit. The benefits specified in Subsections (1), (2) and (3) above apply to each 34-day supply of a prescription or refill.

(5) Exception for Contraceptives. No Copayment will apply to Generic contraceptive medications. The normal Brand Name Copayment described above will apply to Brand Name contraceptives unless the prescribing Physician states that the Generic product will not work, in which case no Copayment will apply. Non-prescription contraceptives are not covered.

(6) Exception for Certain Preventive Care Drugs. Certain over-the-counter preventive care drugs are covered by the Plan in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. No Copayment will apply to these preventive drugs if they are obtained from a retail Participating Pharmacy and the Eligible Individual presents the pharmacist with a Physician's prescription for the drug. Only generic over-the-counter drugs will be covered at no cost under this provision and they may be subject to age and frequency guidelines. Smoking cessation products, which are covered under this provision, are limited to two 90-day regimens per calendar year.

b. **Benefits for Drugs Obtained from the Mail Service Participating Pharmacy.**

(1) For Generic Drugs – The charge incurred.

(2) For Brand Name Drugs When a Generic Equivalent is **Not** Available – The charge incurred after a $10 Copayment is applied.

(3) For Brand Name Drugs When a Generic Equivalent **Is** Available – The charge incurred after a $40 Copayment is applied.

(4) Day Supply Limit. The benefits specified in Subsections (1), (2) and (3) above apply to each 100-day supply of a prescription or refill.

(5) The Copayment specified in Subsection (2) above will not apply to brand name diabetic test strips and diabetic supplies when a Generic equivalent is not available.

(6) Exception for Contraceptives. If the prescribing Physician states that a Generic contraceptive will not work, the Plan will pay the full cost of the charge incurred for

the Brand Name medication and the Copayments described in Subsections (2) and (3) above will not apply. Non-prescription contraceptives are not covered.

c. **Exception 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: 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 100-day limits specified above, as determined by OptumRx.

(3) The Fund will limit coverage of sexual dysfunction drugs to 6 doses per month from a retail pharmacy (and 18 doses for 90 days through the mail order program). Coverage will be subject to the same Copayment as any other covered prescription drug.

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 (OptumRx) Specialty Drug List. The Specialty Drug List is subject to change by OptumRx from time to time. Any Drugs included on the OptumRx Specialty Drug list must be obtained through the OptumRx Specialty Pharmacy and are not available from Participating retail Pharmacies.

(1) Copayments: The following participant Copayments will apply to Specialty Drugs obtained from the OptumRx Specialty Pharmacy and each prescription is limited to a 34-day supply.

Specialty Generic Formulary: 20% of cost, up to a $50 maximum Copayment

Specialty Brand Preferred: 20% of cost, up to a $100 maximum Copayment

Specialty Non-Preferred: 20% of cost, up to a $200 maximum Copayment

(2) No benefits will be payable for paper claims submitted by Eligible Individuals for Specialty Drugs purchased from a pharmacy other than the OptumRx Specialty Pharmacy.

e. **Benefits for Drugs obtained from a Non-Participating Pharmacy**

The Copayments and benefits described in Section 6.01.a. will apply to Drugs purchased from a Non-Participating Pharmacy. However, the benefit payable by the Plan after deducting the Copayment will be limited to the amount the Plan would have paid if the Drug had been purchased from a Participating Pharmacy.

f. **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 products available over the counter with a Physician's written prescription.

g. **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, OptumRx will ask the Physician to provide additional clinical information to the OptumRx 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 OptumRx for a Drug requiring step therapy, no benefits will be payable for the Drug. (Exception: Eligible Individuals who received a Drug in one of the following Drug classes listed in paragraphs (1) through (4) prior to July 1, 2011 may continue to receive Plan benefits for the Drug.)

(1) Cholesterol medications

(2) Pain medications

(3) Sleep aids

(4) Blood pressure medications

Exception: Eligible Individuals who received a Drug in one of the following Drug classes listed in paragraphs (5) through (11) prior to January 1, 2012 may continue to receive Plan benefits for the Drug.

(1) Antihistamines/combinations for allergies

(2) Nasal steroids for allergies

(3) Urinary antispasmodics for overactive bladder/incontinence

(4) Bisphosphonates for osteoporosis

(5) SSRIs for depression

(6) Selective serotonin agonists/combinations for migraines

(7) Short acting beta agonists inhalers

h. **Step Therapy for Specialty Drugs.** Certain Non-Preferred Specialty Drugs may not be covered until an alternative Preferred Specialty Drug within the same class of Specialty Drugs has been tried. If an Eligible Individual receives a prescription for a Specialty Drug that requires step therapy, OptumRx will ask the Physician to provide additional clinical information to the OptumRx Prior Authorization department to support the necessity of the Specialty Drug before it will be covered by the Plan. If an Eligible Individual does not receive prior authorization from OptumRx for a Specialty Drug requiring step therapy, no benefits will be payable for the Drug. The following Drug classes are subject to step therapy: Autoimmune, Multiple Sclerosis, and Growth Hormones.

(1) Exception Applicable to the Autoimmune and Multiple Sclerosis Drug Classes: Eligible Individuals who received a Non-Preferred Specialty Drug prior to October 1, 2012 may continue to receive Plan benefits for the Non-Preferred Specialty Drug.

(2) Exception Applicable to Growth Hormones: If an Eligible Individual received a Preferred growth hormone Drug for a 30-day supply in the 24 months prior to October 1, 2012 and it did not work, Plan benefits will be payable for the Non-Preferred growth hormone Drug.

i. **Benefit Maximums.** Benefits for proton pump inhibitor (PPI) drugs (i.e., ulcer and acid reflux medications) 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. Charges in excess of these maximums do not count toward the Prescription Drug Calendar Year Out-of-Pocket Limit.

j. **Calendar Year Out-of-Pocket Limit on Prescription Drugs – Participating Pharmacies Only**. Each calendar year, after an Eligible Individual or family incurs the maximum out of pocket cost specified below for covered prescription drug expenses, the Plan will pay 100% of Covered Expenses incurred during the remainder of that calendar year. Copayments, coinsurance and deductibles (if any) that the individual pays for covered medications purchased from a Participating Pharmacy (retail, mail order or Specialty pharmacy) are counted toward the Calendar Year Out-of-Pocket Limit. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.

(1) Out-of-Pocket Limit for Prescription Drugs: $1,600 per Eligible Individual, maximum of $2,200 per family.

(2) The family Out-of-Pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.

(3) Exceptions to Out-of-Pocket Limit. The following are not counted toward the Calendar Year Out-of-Pocket Limit and are not covered at 100% after the limit is reached:

(a) Expenses for drugs purchased at a Non-Participating Pharmacy;

(b) Charges in excess of the Plan benefit maximums for proton pump inhibitor (PPI) drugs;

(c) Non-covered expenses or balance-billed charges; and

(d) Premiums or self-pay contributions.

Section 6.02. Definitions. For purposes of this Article, the following definitions will apply:

a. "Compound Drug" means any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a Drug that requires a prescription under state law.

b. "Copayment" means the amount the Eligible Individual is required to pay for a Drug before Plan benefits are payable.

c. "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.

d. "Non-Participating Pharmacy" means a pharmacy that has not elected to participate in an agreement with the pharmacy benefit manager contracted by the Fund.

Section 6.03. Covered Expenses. Covered Expenses include the following Drugs and supplies:

a. Drugs prescribed by 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 Drugs prescribed by a Physician are covered at the Retail Pharmacy Copayment described in Section 6.01.a.(3), subject to review by OptumRx if the cost of the compounded medication exceeds $150. The pharmacist can initiate the review process by calling OptumRx. Select non-FDA-approved bulk chemicals used in Compound Drugs are not covered.

f. Charges made by a Licensed Pharmacist for therapeutic vitamins, cough mixtures, antacids, eye and ear medications prescribed by a Physician for the treatment of a specified Illness.

g. Charges for nicotine gum, patches or other prescription or non-prescription smoking cessation medications. However, non-prescription smoking cessation products are covered only with a Physician's written prescription.

h. Contraceptives that legally require a written prescription of a Physician, including oral contraceptives, injectables and devices.

Section 6.04. Required Prior Authorizations. The following Drugs require prior authorization from OptumRx 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 (6 doses per month at a retail pharmacy, 18 doses for a 90-day supply through the mail order program)

d. Certain contraceptive devices and injectables, all transdermal contraceptives (patches)

e. Oral Fentanyl products

f. Oxycontin for supplies exceeding the quantity limits established by OptumRx

g. Anti-narcolepsy agents

h. Any Drug subject to step therapy

i. Appetite suppressants or any other weight loss medications.

Section 6.05. 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 for insulin and diabetic supplies, and except as specifically provided in the Plan for over-the-counter proton pump inhibitor (PPI) medications, smoking cessation products and certain preventive drugs required under Health Reform.

c. Appliances, devices, bandages, and any other supplies or equipment, except diabetic supplies.

d. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids.

e. Immunization agents.

f. Drugs or devices prescribed for treatment of sexual dysfunction, except when caused by a medical or mental health condition, as certified by the Physician.

g. Infertility medications.

h. Medications with no federal Food and Drug Administration (FDA) indications including any non-FDA-approved bulk chemicals used in Compound Drugs.

i. Medications used for Experimental indications, and/or dosage regimens determined to be Experimental or Investigational; any Investigational or unproven Drugs or therapies.

j. Medications prescribed for cosmetic purposes only.

k. Charges for prescriptions in excess of a 34-day supply (or 100-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.

l. Replacement prescriptions resulting from loss, theft or breakage.

m. Any expenses excluded under ARTICLE 13.

n. Expenses for or related to gene therapy. Please refer to Section 4.04(m) for benefits available under the Comprehensive Health Plan Benefit.

ARTICLE 7. CHEMICAL DEPENDENCY TREATMENT BENEFIT

Section 7.01. Benefits for those Enrolled in the Direct Payment Plan. If an Eligible Retired Employee or Spouse receives treatment for alcoholism or other chemical dependency through the Operating Engineers Assistance Recovery Program (ARP), the Fund will pay the benefits described below, based on the setting in which treatment is provided.

a. **Residential Treatment**. Plan benefits are payable on the same basis as any other covered Hospital service in accordance with Subsection 4.04.a. with preauthorization by ARP required.

b. **Recovery Home Treatment**. The Plan will pay 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 7.01.a. above.

c. **Outpatient Treatment**. Plan benefits are payable on the same basis as the Physician office visit benefit in the case of professional services or on the same basis as any other outpatient Hospital benefit for services billed as a facility service in accordance with Subsections 4.04.c. and 4.04.a.(5)(b), respectively.

Section 7.02. Benefits for those Enrolled in a Prepaid Health Plan (HMO). If an Eligible Retired Employee or Spouse receives treatment for alcoholism or other chemical dependency through the Operating Engineers Assistance Recovery Program (ARP), the Fund will pay the benefits described below, based on the setting in which treatment is provided.

a. **Residential Treatment**. The Plan will pay 100% of the Allowed Charge, Deductible does not apply, with preauthorization by ARP required.

b. **Recovery Home Treatment**. The Plan will pay 100% of the Allowed Charge, Deductible does not apply, 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 7.02.a. above.

c. **Outpatient Treatment**. The Plan will pay 100% of the Allowed Charge, Deductible does not apply.

d. **Exception to Benefits for Retired Employees and Spouses Enrolled in a Prepaid Health Plan (HMO).** A Retired Employee or Spouse who is enrolled in a prepaid health plan (HMO) must use either the HMO's chemical dependency benefits or ARP contract providers. No chemical dependency benefits will be paid by this Plan for services received from a Non-Contract Provider for any individual who is enrolled in an HMO offered by the Fund

Section 7.03. Exclusions. No benefits are payable for:

a. Any expenses excluded under ARTICLE 13.

b. Services provided to a Dependent child.

c. Services provided by Non-Contract Providers to Retired Employees or Spouses who are enrolled in an HMO.

ARTICLE 8. VISION COVERAGE

Section 8.01. Eligibility. Schedule I Retired Employees, Dependents, and Surviving Spouses are eligible to receive benefits under this Article.

Section 8.02. 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.

ARTICLE 9. PHYSICAL EXAMINATION BENEFIT

Section 9.01. Eligibility. Schedule I and Schedule II Retired Employees and Spouses are eligible to receive benefits under this Article.

Section 9.02. Benefits. If a Retired Employee or Spouse receives a routine physical examination performed by a Physician, 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 calendar year.

Section 9.03. Exclusions: No benefits are payable for:

a. More than one physical examination in any calendar year.

b. Eye examinations.

c. Any examination required by an employer as a condition of employment.

ARTICLE 10. CONTINUATION COVERAGE (COBRA)

Section 10.01. A Qualified Beneficiary (e.g., a Dependent) who loses eligibility under the Plan due to one of the Qualifying Events described in Section 10.02.a. may continue Plan coverage for a limited period of time, subject to the terms of this Article. 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 continuation through self-payment.

Section 10.02. Continuation Coverage

a. **Qualifying Events**. A Qualified Beneficiary whose eligibility terminates may continue coverage under COBRA upon the occurrence of a "Qualifying Event. A "Qualifying Event" is defined as either of the following:

   (1) The Retired Employee's death;

   (2) Divorce of the Dependent from the Retired Employee.

   (3) A child's loss of Dependent status under the Plan.

b. **Qualified Beneficiary**. A Qualified Beneficiary as defined under COBRA is an individual who on the day before a Qualifying Event was covered under the Plan by virtue of being on that day an eligible Spouse or Dependent child of a Retired Employee.

c. **Duration of Coverage**. A Qualified Beneficiary whose Plan coverage terminates as a result of a Qualifying Event may elect Continuation Coverage for up to 36 months from the date of the Qualifying Event.

d. **Termination of Continuation Coverage**. Notwithstanding the maximum duration of coverage described above, a Qualified Beneficiary's Continuation Coverage will end on the earlier of the following dates:

   (1) The date the Plan ceases to provide group health coverage to any Retired Employees;

   (2) The date the premium described in Subsection g. is not timely paid;

   (3) The Qualified Beneficiary becomes covered, after the Qualifying Event, under another Group Plan which does not limit any pre-existing condition of the Qualified Beneficiary; or

   (4) The Qualified Beneficiary becomes covered, after the Qualifying Event, under Part A or Part B of Medicare.

e. **Election Procedure**. A Qualified Beneficiary must elect Continuation Coverage within 60 days after the later of:

   (1) The date on which the Qualified Beneficiary loses coverage under the Plan as a result of a Qualifying Event; or

   (2) The date on which the continuation notice is mailed by the Fund Office.

f. **Types of Benefits Provided**. A Qualified Beneficiary will be provided coverage under these Rules and Regulations, which, as of the time the coverage is being provided, is identical to the coverage that is provided to similarly situated Dependents with respect to whom a Qualifying Event has not occurred. A Qualified Beneficiary will have the option of taking "core coverage" (medical and prescription drug only) or "core plus coverage" (medical, prescription drug and vision benefits).

g. **Premium**. A premium 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 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 must be made no later than the 15th day of the month prior to the month for which Continuation Coverage is elected. A grace period of 30-days from the first day of the month for which coverage is intended will be allowed before coverage is terminated. Notwithstanding the previous sentence, the Board may extend the premium payment due date.

h. **Notice Requirement**. The Qualified Beneficiary must notify the Fund Office of the Qualifying Event no later than 60 days after the date of the Qualifying Event.

ARTICLE 11. COORDINATION OF BENEFITS

Section 11.01. If an Eligible Individual is entitled to benefits from another Group Plan for which benefits are also due from this Plan, then the benefits provided by this Plan will be paid in accordance with the provisions of this Article, not to exceed the total amount of benefits which would have been paid in the absence of other group coverage or 100% of Covered Expenses incurred.

Section 11.02. Order of Benefit Determination

a. If the Eligible Individual is the Retired Employee, Fund benefits will be provided without reduction, unless the Retired Employee is covered under another Group Plan as an active employee, in which case the benefits of the active employee plan will be payable before this Fund's benefits.

b. If the Eligible Individual is the Dependent Spouse of a Retired Employee, Fund benefits will be paid for eligible expenses not covered by the Spouses' Group Plan.

c. When the above paragraphs do not establish an order of benefit determination, the benefits of the Group Plan that has covered the person for the longer period of time will be determined before the benefits of a Group Plan that has covered the person for the shorter period of time. However, the benefits of a Group Plan that covers a person either as a retired employee or as that retired employee's dependent are determined after the Group Plan that covers the same person as an active employee, or as that active employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

d. If the Eligible Individual is eligible for Medicare coverage, Fund benefits will be provided in accordance with ARTICLE 5 for Covered Expenses not payable by Medicare.

Section 11.03. 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. Notwithstanding the above, the Board of Trustees has absolute discretion to make a determination as to the Covered Expense for claims involving coordination with preferred provider agreements.

Section 11.04. Coordination with Medicare. If an Eligible Individual is eligible for Medicare, Plan benefits will be provided in accordance with ARTICLE 5.

Section 11.05. Coordination with Prepaid Plans. Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, 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. Except for the copayments specified above, the Plan will not pay expenses of eligible participants or dependents covered by prepaid programs of other plans. 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.

Section 11.06. 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.

Section 11.07. Coordination with Other Government Programs.

a. **TRICARE.** If a Dependent is covered by both this Plan and the TRICARE Program (formerly known as the Civilian Health and Medical Program of the Uniformed Service) that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For a Retired Employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this plan is secondary for active members of the armed services only. If an Eligible Individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

b. **Veterans Affairs/Military Medical Facility Services.** If an Eligible Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are allowed charges.

c. **Motor Vehicle Coverage Required by Law:** If an Eligible Individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

Section 11.08. Coordination with Preferred Provider Agreements

a. The Allowed Charge for purposes of Coordination of Benefits will be the lesser of:

- The normal charge billed by the Provider for the expense;

- 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

- This Plan’s contractual rate if the Provider is a Contract Provider under this Plan.

The Board of Trustees has absolute discretion to make a determination as to the Covered Expense for claims involving coordination with preferred Provider agreements.

ARTICLE 12. THIRD PARTY LIABILITY

Section 12.01. 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 to complete an explanation of Accident/Injury Questionnaire and 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 complete such Questionnaire and sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan within 1 year after the expense is incurred, the Eligible individual shall not be eligible for Plan benefit payment related to the injury involved. This remedy is in addition to all other remedies the Plan may have. 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.

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. EXCLUSIONS, LIMITATIONS, AND REDUCTIONS

Section 13.01. The Fund will not provide benefits for:

a. Any amounts in excess of the Plan's Allowed Charge.

b. Services not specifically listed in the Plan as Covered Expenses, 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. The Hospital must meet 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 Individual 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

   (2) 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, including involvement in the commission of a felony, unless such condition is the result of domestic violence or the involvement in the commission of a felony is the direct result of an underlying health factor.

f. Except to the extent benefits are required by federal law to be paid by the Fund, any services provided by a local, state or federal government agency, or any services for which payment may be obtained from any local, state or federal government agency (except Medi-Cal or Medicaid).

g. Any services and supplies in connection with Experimental or Investigational Procedures.

h. Any services or supplies excluded under any other Articles of the Plan.

ARTICLE 14. INTERNAL CLAIMS AND APPEALS PROCEDURES

Section 14.01.

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan participant, a participant's dependent or creditor of the Plan participant without the express written permission of the Plan Sponsor; however, a Plan participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan participant.

Section 14.02. Facility of Payment

In the event it is determined that the Retired Employee is incompetent or incapable of handling his own affairs and no guardian has been appointed, or in the event the Retired 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 Retired Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Retired 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 Retired Employee: lawful Spouse, child or children, mother, father, brothers, or sisters or to the Retired 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 14.03. 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 Preauthorization of a benefit that does not require Preauthorization by the Plan as a condition for receiving maximum benefits is not considered a Claim. However, requests for Preauthorization of a benefit where the Plan does require Preauthorization 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. Disability Claim. A Disability Claim is a claim for which the plan must make a determination of disability in order for the participant to receive the benefit (for example, the Plan's determination of disability related eligibility for a disabled child age 26 and older (*see* Section 2.02(a)(4)(c)), or grace periods for eligibility purposes for periods of disability (*see* Section 2.02(a)(1)(d)).

h. 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.

i. 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 14.04. Claim Procedures

a. Urgent Care Claims. The Trust Fund Office or the Plan's designated Review Organization for medical claims, OptumRx 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, OptumRx 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, OptumRx 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, OptumRx 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 OptumRx 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 Preauthorization or Prior Authorization) for: admission to a Hospital, Long Term Acute Care Facility, 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 4.05, and for certain prescription drugs as described in Section 6.04.

(1) Pre-Service Claim Urgent Care claims may be requested orally to the Plan's designated Review Organization for medical claims, OptumRx 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, OptumRx 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, OptumRx 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, OptumRx 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, OptumRx

or ARP. If an extension is necessary, the designated Review Organization, OptumRx 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, OptumRx 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, OptumRx 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), OptumRx 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, OptumRx or ARP. The Trust Fund Office or OptumRx shall notify, in writing, Claimants of decisions on Post-Service Claims within *30 days* of receipt of the Claim by Blue Cross, OptumRx or ARP. The Trust Fund Office, Blue Cross, OptumRx 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 OptumRx 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, OptumRx 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 OptumRx 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. Disability Claims. A Disability Claim must be submitted in writing to the Trust Fund Office, in writing, using an appropriate claim form, within one (1) year after expenses are 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 written claim must be completed in full and requested documentation must be attached to the written claim in order for the request for benefits to be considered a claim. The written claim 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) A Disability Claim is considered to have been filed upon receipt of the claim by the Trust Fund Office. The Trust Fund Office will notify claimants of decisions on Disability Claims in writing within 45 days of receipt of the claim. The Trust Fund Office may extend this period for up to 30 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Trust Fund Office will notify claimants, in writing, of the need to extend the initial 45 day period prior to the expiration of the initial 45 day period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. If, prior to the end of this first 30-day extension, the Trust Fund Office determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

(3) If an extension is required because the Plan needs additional information from the participant, the Trust Fund Office shall request additional information from provider and/or claimant via fax, telephone, or letter within 45 days of the receipt of the claim or within 75 days if a 30 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 shall notify, in writing, the claimant of a decision within 15 days after receipt of any additional information.

f. 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.

g. 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.

h. 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.

i. Dental and Vision Claims. Dental claims must be submitted to the dental insurance carrier, Delta Dental Plan, Hawaii Dental Service or MetLife Dental. Vision claims must be submitted to the vision plan administrator, Vision Service Plan.

j. No Surprises Act Services Claims. The Non-Contract Provider will receive initial payment or notice of denial of payment from the Plan for No Surprises Act Services within 30 days receipt of all information necessary to adjudicate the claim.

- If a claim is subject to the No Surprises Act, the participant or Dependent cannot be required to pay more than the cost-sharing amount under the Plan and the provider or facility is prohibited from billing the participant or Dependent in excess of the required cost-sharing amount.
- The Plan will pay a total plan payment directly to the Non-Contract Provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

Section 14.05. 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 14.06. 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. For disability claims, the notice will also include a discussion of the decision, including the basis for disagreeing with or not following:

(1) The views of a treating physician or vocational professional who evaluated the claimant;

(2) The views of medical or vocational experts obtained by the plan, and

(3) Any disability determination by the Social Security Administration.

k. 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;

l. 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

m. For Urgent Care Claims, a description of the expedited review process applicable to Urgent Care Claims.

Section 14.07. 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 Retired 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) Disability Claims. Appeals of Adverse Benefit Determinations regarding Disability Claims must be submitted in writing to the Trust Fund Office via mail or fax.

(6) Dental and Vision Claims. Appeals of denied dental or vision claims must first be submitted to Delta Dental Plan, Hawaii Dental Service, MetLife Dental or Vision Service Plan. After exhausting the appeals procedures of Delta Dental Plan, Hawaii Dental Service, MetLife Dental 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 and Disability 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, Clamant may request an External Review for a claim that fits within the parameters for External Review.

Section 14.08. 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;

l. 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 14.09. 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 15. 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 15.01. If an appeal of a health care claim, whether urgent, concurrent, pre-service, or post-service, is denied, the Claimant may request further external review by an independent review organization (IRO) if the denial fits within the one or more of the parameters described in paragraphs a., b., and c. 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;

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; and

c. The denial involves surprise billing or cost-sharing issues that are protected under the No Surprises Act for Emergency Services, Air Ambulance Services, and non-emergency services provided by a Non-Contract Provider at a Contract Facility.

Section 15.02. 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 15.03. 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:

(i) 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;

(ii) Upon request the Plan shall provide a Notice of Final External Review Decision in that non-English language;

(iii) 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;

(iv) 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 15.04. 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) OptumRx 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 OptumRx 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 OptumRx 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 OptumRx determines that a request is eligible for expedited External Review, Anthem Blue Cross or OptumRx 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 OptumRx 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 16. GENERAL PROVISIONS

Section 16.01. 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 16.02. 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 16.03. 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 16.04. 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 Retired Employee contributions,

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

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

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

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

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

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

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

(m) Reimbursement to the Plan.

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

(a) Quality Assessment,

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

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

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

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

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

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

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

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

(j) Resolution of internal grievances, and

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

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

Section 16.05. Patient Protection Rights of the Affordable Care Act

a. The medical plans in this document do not require the selection or designation of a primary care provider (PCP). A participant may visit any Contracted or Non-Contracted health care provider; however, payment by the Plan may be less for the use of a Non-Contracted provider.

b. Prior authorization from the Fund or from any other person (including a primary care provider) is not required in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Section 16.06. Nondiscrimination in Health Care. In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

ARTICLE 17. RETIRED EMPLOYEE DEATH BENEFIT

Section 17.01. Benefit. If a Retired Employee dies from any cause on or after July 1, 2013 and while eligible under the Plan, the Plan will pay a lump sum benefit of $2,500 to the Retired Employee's beneficiary or designated Trust upon submission of the required documentation to the Trust Fund office.

Section 17.02. Beneficiary. The beneficiary may be any person or persons named by the Retired Employee on his beneficiary form on file at the Trust Fund office.

a. If the Retired Employee did not name a beneficiary, or if the named beneficiary is not living or cannot be found, the benefit will be paid to the surviving person or persons in the following order:

   The Retired Employee's:

   (1) Spouse or domestic partner

   (2) Natural or adopted children

   (3) Parents

   (4) Brothers and sisters

   (5) Nieces and nephews

   (6) Estate

   The Retired Employee may also designate the benefit to be paid to a trust.

b. Change of Beneficiary. A Retired Employee may request a change of beneficiary at any time by submitting a new beneficiary form to the Trust Fund office. A change of beneficiary will take effect as of the date the new beneficiary form is signed by the Retired Employee but will not affect any payment the Trust Fund made before receiving the new beneficiary form.

ENROLL IN MEDICARE

It is very important that you are enrolled in both Parts A and B of Medicare in order to prevent a reduction in Plan benefits. If you or your Spouse is eligible for Medicare, benefits available under Parts A and B of Medicare will be deducted from the benefits payable under the Plan's comprehensive medical benefits, **regardless of whether or not you have actually enrolled for Medicare and regardless of whether or not your doctor or other medical provider has chosen to participate in Medicare.**

This Plan will estimate that Medicare Part A paid everything except the deductible and that Medicare Part B paid 80% of Medicare Part B charges and cover only the remaining 20%, even if you have not actually enrolled in Medicare. See "If You Are Eligible for Medicare" on page 66 for more information.