OE3 Trust Funds

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OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND

Summary Plan Description

2023

Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund

Summary Plan Description

November 1, 2023 Edition

For Plans A, B, C and D

Introduction

The Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund offers a wide range of benefits, including:

- Comprehensive Medical;
- Substance Use Disorder Treatment;
- Hearing Aids;
- Prescription Drugs;
- Dental;
- Orthodontic;
- Vision;
- Burial Expense; and
- Life and Accidental Death and Dismemberment Benefits.

This booklet serves as your Summary Plan Description (SPD), which provides an overview of the benefits available under the Fund. Full details are contained in the Rules and Regulations (Plan Document). If there is a discrepancy between this SPD and the legal documents, the Plan Documents will govern. The Board reserves the right to amend, modify, or terminate the Plan at any time.

We are pleased to provide you with your Summary Plan Description (SPD), which is designed to help you understand the benefits available to you. The Plan described in this SPD is effective November 1, 2023 and replaces all other plan documents previously provided to you. We urge you to read this SPD and, if you are married, share it with your Spouse. In addition, we recommend that you keep this SPD with your important papers so you can refer to it when needed.

Choice of Medical Programs

Recognizing that our Participants have different needs, the Plan allows you to choose your medical benefits from two different benefit programs. Each program covers the same basic range of services; however, how benefits are covered varies. You may elect medical and prescription drug coverage under either the Fund's Plan or the Kaiser Health Maintenance Organization (HMO) program.

If you (and your Dependents) are eligible for Kaiser HMO benefits, you will receive a separate Evidence of Coverage (EOC) from Kaiser outlining your benefits. Please contact Kaiser for a copy of your EOC at the telephone number listed on the Quick Reference Chart.

About this SPD

Benefits can be very technical and complicated. In this SPD, we have tried to describe your benefits as completely as possible and in everyday language. This SPD includes:

- An **important contact information** section, which includes phone numbers and Web sites for organizations providing services under this Plan, including contact information for pre-approval.
- An eligibility section that tells you how you become a member of the Plan, who in your family is eligible for coverage, what you need to do to continue to be eligible, when coverage under the Plan ends, and when you can reinstate your eligibility.

- An explanation about your coverage under each benefit program, including a Schedule of Benefits that summarizes the coverage available under your Plan.
- A how-to section on filing claims, including what you need to do if a claim is denied.
- An administrative information section, including general Plan information.
- A glossary of important terms that have special meaning under the Plan. These terms are capitalized throughout this SPD.

If you are not familiar with the terms used in this booklet, please check the definitions section at the back.

Please Note

Plan rules and benefits may change from time to time. If this occurs, you will receive a written notice explaining the change. Please be sure to read all Plan communications and keep these notices with your SPD. If you have questions about your benefits, please contact the Fund Office.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. No individual Trustee, Employer, or Union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The Board has authorized the Fund Office or the Benefit Director's office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Fund Office for an answer. As a courtesy to you, the Fund Office may also respond informally to oral questions. However, oral information is not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the 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. If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE. Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Be Wise Health Care Consumers

To help the Fund remain financially stable and to reduce some of your expenses, you are encouraged to be wise health care consumers. You can do so by taking advantage of cost-saving features built into the Plan. Whenever possible:

- ***Use Contract Providers.*** Hospitals, Physicians, pharmacies, and other health care providers that participate in a network have agreed to negotiated rates, which are generally less than other providers. If you elect the Kaiser HMO, you must use Kaiser facilities and providers, unless there is an emergency.
- ***Get regular physical exams.*** Getting regular physicals can help you be healthier by identifying potential health risks earlier, which could mean less health care problems overall.
- ***Request generic equivalents.*** The cost of a generic medication can be significantly less than the cost of a brand name medication and, by law, they are required to be equivalent.
- ***Review your medical bills to ensure that they are accurate.*** If something does not seem right, or if you are charged for a procedure or supply you never received, question the bill.

Thank you for your efforts and cooperation in keeping our Fund financially strong.

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Important Contact Information

The Plan is sponsored and administered by the Board of Trustees. However, the Trustees have delegated administrative responsibilities to other individuals or organizations as follows:

Fund Office:

- Maintains eligibility records;
- Accounts for Employer and self-payment contributions;
- Administers Comprehensive Medical, Substance Use Disorder Treatment, and Hearing Aid Benefits;
- Answers Participant inquiries; and
- Handles other routine administrative functions.

Benefits Director:

- Provides supplemental assistance to the Fund Office;
- Health fair and open enrollment participation; and
- Presentations and education to participants and Employers.

Anthem BlueCross of California provides access to a Preferred Provider Organization network for comprehensive indemnity medical benefits and provides the Plan's utilization review program for medical benefits.

Kaiser Permanente offers a Health Maintenance Organization (HMO) plan for medical and prescription drug benefits.

Operating Engineers Assistance Recovery Program (ARP) administers the Plan's utilization review program for Substance Use Disorder Treatment Benefits.

OptumRx provides access to contract pharmacies for the Indemnity Plan and administers the mail service program and specialty pharmacy program.

Delta Dental of California administers the Plan's dental and orthodontic benefits.

Vision Service Plan (VSP) administers and provides access to Contract Providers for Vision Benefits.

Union Labor Life Insurance Company insures and administers the Plan's Burial Expense Benefits.

ReliaStar Life Insurance Company insures and administers the Plan's life insurance and accidental death and dismemberment benefit.

The chart that follows shows the phone numbers for the various organizations that provide these services under our Plan.

Quick Reference Chart – Where to Call for Information

Information Needed	Contact	Contact Information
Eligibility Information	Fund Office	(800) 251-5014 or (510) 433-4422
Claims Information	Fund Office	(800) 251-5014 or (510) 433-4422
Comprehensive Medical Contract Providers In California Outside California	Fund Office Anthem Blue Cross BlueCard	(800) 251-5014 or (510) 433-4422 www.anthem.com/ca www.bcbs.com
Online Physician Consultation	LiveHealth Online (through Anthem Blue Cross)	To sign up for LiveHealth online, go to www.Livehealth.com

Information Needed	Contact	Contact Information
Kaiser HMO Providers	Kaiser Permanente	(800) 464-4000 www.kaiserpermanente.org
Pre-admission Review Pre-approval required for Hospital admissions, transplants and bariatric surgery	Anthem BlueCross	Have your provider call (800) 274-7767
Required pre-approvals for outpatient diagnostic imaging procedures (CT/PET scans, MRIs)	American Imaging Management	Have your doctor call (877) 291-0360
Prescription Drug Program – Network Pharmacy, Mail Service and Specialty Pharmacy Services *Kaiser HMO Participants, contact Kaiser*	OptumRx	(855) 672-3644 or www.optumrx.com
Substance Use Disorder Treatment Benefits Network providers, referrals, and pre-approval	Operating Engineers Assistance Recovery Program (ARP)	(800) 562-3277
Vision Benefits	Vision Service Plan (VSP)	(800) 877-7195 or www.vsp.com
Dental Benefits and Orthodontic Benefits	Delta Dental of California	(800) 335-8227 or www.deltadentalins.com
Burial Expense Benefits	Union Labor Life Insurance Company or The Trust Fund Office	Union Labor Life Insurance Company 111 Massachusetts Avenue, N.W. Washington, DC 20001
Life and Accidental Death and Dismemberment	ReliaStar Life Insurance Company or The Trust Fund Office	ReliaStar Life Insurance Company P.O. Box 20 Minneapolis, Minnesota 55440

Eligibility

Eligibility for Active Employees

Initial Eligibility

The employer's first contribution to the Fund will provide you with eligibility for both the month in which the contribution was received and the next following month. Eligibility will begin on the first day of the month in which the employer's contribution is made to the Fund on your behalf.

Example:

Sam begins work for County A today (January 23, 2023). The Fund receives the contribution for work performed January 23 through January 31 on February 19. Sam's initial coverage will begin February 1st and he will be provided February and March coverage from the first contribution.

Election of Coverage

When you are initially eligible for coverage, you will be given the opportunity to elect the Fund's Comprehensive Medical and Prescription Drug Benefits, as described in this booklet, or the Kaiser HMO plan. Once you make your election, you will remain covered under that option for the next 12 months unless:

- You elected the Kaiser HMO and move out of the Kaiser service area (applicable to retiree coverage only); or
- The Board of Trustees approve a change.
- You elect a different plan through open enrollment

Note: Not all Employers provide all of the benefits described in this SPD. Some Employers may provide for medical/prescription drug coverage only, or dental only, vision only, etc. Contact the Trust Fund to find out which benefits apply to you.

Your Dependents will be covered under the same medical and prescription drug option that you choose. Regardless of which medical and prescription drug option you elect, Substance Use Disorder Treatment and Hearing Aid Benefits will be provided through the Fund; Dental and Orthodontic benefits will be administered by Delta Dental Plan; Vision Benefits will be administered by Vision Service Plan; the life insurance and accidental death and dismemberment benefits will be insured by ReliaStar Life Insurance Company, Substance Use Disorder benefits will be administered by the Operating Engineers Assistance and Recovery Program and the Burial Expense Benefit will be insured by Union Labor Life Insurance Company.

The terms of the contract between the Fund and any prepaid plan, such as the Kaiser HMO, only govern the payment of claims or services rendered to those persons covered by the contract. The Fund's eligibility rules are established by the Board of Trustees and govern whether you are eligible for benefits, regardless of the medical option elected.

Continuing Eligibility

Eligibility will continue from month to month as long as your Employer continues to contribute to the Fund on your behalf. However, a lag month will be used in determining continuing eligibility after initial eligibility is established. The lag month is the month between the payroll period in which hours are worked and the month of eligibility provided by those hours. Contributions received on your behalf in one month will provide you with eligibility for the month following the month in which the contribution is received by the Fund.

Initial and Continuing Eligibility Example

Mike is initially eligible for coverage on July 1 because his Employer's contributions were received by the Fund on his behalf in July. Mike's initial eligibility will be for July 1 through August 31. Mike continues to work for this Employer and has contributions made on his behalf for August. A lag month is used to determine Mike's continuing eligibility after his initial eligibility is established. As a result, Mike will continue to be eligible for benefits for September due to the hours contributed on his behalf in August. August is the lag month between the payroll period in which hours are worked and the month (September) of eligibility provided by those hours.

Termination of Eligibility

Your eligibility for benefits will end on the earlier of the:

- Last day of the month following the month for which Employer contributions are made on your behalf; or
- Day the Plan is terminated.

Eligibility for Retired Employees

Initial Eligibility

To be eligible for benefits as a Retired Employee:

- You must be eligible to receive pension benefits from your former Employer who was a contributing employer to this Fund; and
- The required contributions must be paid to the Fund on your behalf.

Benefits are not automatic. If you are eligible for benefits as a Retired Employee, you must apply for Retiree coverage. You must request enrollment by filing an application with the Fund Office within 30 days of retirement.

When you retire, your Employer must begin reporting you as a retiree unless the Employer does not remit retiree contributions to the Fund. In such a case, you will receive a monthly bill from the Fund Office. If you do not apply for retiree coverage within 30 days of your retirement date, or if you or a Dependent terminate coverage, you and your Dependent will not be eligible for benefits under the Plan unless you qualify for Special Enrollment as described beginning on page 6.

If You Are Eligible for Medicare

If you or your spouse is eligible for Medicare, you must enroll in Parts A and B of Medicare in order to avoid unreduced coverage under this Plan. **Benefits available under Parts A and B of Medicare will be deducted from the benefits payable by the Plan's comprehensive medical benefits regardless of whether or not you have actually enrolled in Medicare**. This Plan will estimate Medicare's payments and will pay only the remaining covered charges after the estimated Medicare benefits are deducted.

Continuing Eligibility

You will continue to be eligible for coverage on a month-to-month basis provided the required contributions are made for Retiree coverage.

Termination of Eligibility

Your eligibility for benefits will end on the earlier of the last day of the month:

- For which the required contribution was received by the Fund; or
- In which your former Employer is no longer a Contributing Employer.

However, if your eligibility for benefits would otherwise end because your former Employer is no longer a Contributing Employer as the result of your bargaining unit decertifying itself with the Union, your benefits may continue if you:

- Retired when your Employer was a Contributing Employer; and
- Meet all other Plan eligibility requirements.

Dependent Eligibility

Generally, your Dependents are eligible for benefits when you are eligible for benefits, or if later, on the date you acquire an eligible Dependent, provided the required contribution for Dependent coverage is made to the Fund. If your Employer is not required by a Collective Bargaining Agreement to provide Dependent coverage, you may elect coverage for your eligible Spouse and/or children; however, you will be required to contribute to the Fund on a monthly basis for this Dependent coverage.

In general, your Dependents are your legal Spouse or Domestic Partner and your children. For more information about who qualifies as a dependent, see the definition of Dependent on page 9696

Domestic Partners

Your eligible Dependents may include your Domestic Partner and your Domestic Partner's eligible children. Domestic partner coverage may be considered "imputed income" to the employee under federal law. You must make payment to your employer for any taxes that are required to be paid on the value of this imputed income. Failure to do so will result in termination of coverage for your Domestic Partner.

* See the Domestic Partner definition for information on who qualifies as a Domestic Partner.

Enrolling Dependents

You must enroll each eligible Dependent in the Plan by submitting a completed enrollment form (including any required documentation) along with any required premium payment, to the Fund Office within 90 days of the date you become eligible or, if later, within 90 days of the date you acquire the Dependent, for coverage to become effective. Except as described under *Special Late Enrollment* on page 6, a Dependent who is not enrolled within 90 days of the dates described above will not be eligible to enroll until the later of:

- 12 months following the date you (the Participant) became eligible; or
- 12 months after the date you acquired the Dependent.

You may acquire a new Dependent through marriage, birth, adoption, or placement for adoption. A child is considered placed for adoption on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Termination of Eligibility

Your Dependent's eligibility for benefits will end on the earliest of the date:

- You are no longer eligible for benefits;
- The end of the month in which your Dependent no longer meets the Plan's Dependent definition; or
- The full, required contribution for the Dependent coverage is not made.

Note: If your employer is paying a contribution that includes the full cost of Dependent coverage, an eligible Dependent cannot be removed from the Plan.

No Rescission of Coverage (for all Participants)

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions and self-payments are not paid on time, or in cases when an individual 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.

Special Late Enrollment

If you did not enroll yourself or your Dependent(s) in the Plan when first eligible and you subsequently acquire a new Dependent by marriage, birth, adoption, placement for adoption or legal guardianship, you may request enrollment for yourself and your newly acquired Dependent in the Plan no later than 90 days after the date the new Dependent is acquired. Benefits will become effective the first day of the month in which the corresponding contributions are received.

If you did not enroll in the Plan on the date you first became eligible because you or your Dependent had other health coverage under any other health insurance policy or program (including COBRA Continuation Coverage, individual insurance, Medicaid, or other public program) and the other coverage ends, you may enroll yourself and any eligible Dependents in this Plan within 31 days after termination of the other coverage if that other coverage ended (60 days for loss of Medicaid or CHIP coverage). Please refer to the Rules and Regulations for a complete description of the events that qualify as a loss of coverage for this purpose.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options at the same costs and the same enrollment requirements, as are available to similarly situated employees at initial enrollment.

Extension of Eligibility for Surviving Spouses

In the event of your death while an Active or Retired Employee, your legal surviving Spouse or Domestic Partner will be given **a one-time opportunity** to continue medical (including Substance Use Disorder Benefits) and Prescription Drug Benefits for him or herself and eligible Dependent children by making the required self-payments to the Fund; self-payments must be continuous. If payment is not received for any month, eligibility for benefits will end and may not be reinstated. In addition, eligibility for benefits will end upon your surviving Spouse's remarriage or for a Dependent child, the end of the month in which a Dependent child reaches age 26.

Surviving Spouse benefits do **not** include hearing aid, dental, orthodontic, vision, life or burial expense benefits.

Extension of Health Benefits for Total Disability - *For Active Employees and Their Dependents Only*

If you are an Active Employee or the Dependent of an Active Employee, health benefits may be extended (for up to 12 months) if you or your Dependent is Totally Disabled on the date eligibility would otherwise end. Extension of health benefits due to a Total Disability are subject to the following conditions:

You must submit a Physician's written certification of the Total Disability to the Fund Office within 90 days after eligibility ends. You will also be required to submit continued certification every 90 days.

Benefits will only be extended for Covered Expenses incurred for treatment of the Illness or Injury that caused the Total Disability.

You must be Totally Disabled on the date a Covered Expense is incurred.

This extension of health benefits does **not** apply to individuals enrolled in an HMO plan.

Benefits are subject to all Medical Plan limitations and maximums in effect at the time eligibility would otherwise have ended.

Extension of benefits will continue until the earliest of the:

- Date you are no longer Totally Disabled;
- Date you become covered under another health plan that provides similar benefits; or
- End of the 12-month period following the date eligibility under the Plan originally ended.

Extension of Health Benefits if You Are Hospitalized on the Date Eligibility Terminates – *For All Eligible Individuals*

If you are an Active or Retired Employee, or the Dependent of an Active or Retired Employee, and you are confined as an inpatient in a Hospital on the date your eligibility terminates, Comprehensive Health Plan benefits will be continued for treatment of the covered medical condition(s) that existed before or during the Hospital confinement and which requires continued hospitalization.

This extension of health benefits does **not** apply to individuals enrolled in an HMO plan.

This extension will continue until the earlier of:

- the 91st day following termination of eligibility; or
- the date you are discharged from the Hospital.

If you are confined in a Hospital as an inpatient on the date your eligibility for benefits is changed by the Employer from one comprehensive health plan offered by the Fund to another comprehensive health plan offered by the Fund, the plan with the more generous benefits will continue to apply during the period of hospitalization.

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) allows you to take up to 12 weeks of unpaid leave (or in some cases, up to 26 weeks) during any 12-month period due to:

- The birth of a child or placement of a child with you for adoption;
- The care of a seriously ill Spouse, parent, or child; or
- Your serious Illness.

It is not the Fund's role to determine whether you are entitled to FMLA leave with medical coverage. Any determination regarding entitlement to FMLA leave with continuing medical coverage must be made by your Employer.

Additional leave may be available if the need for leave is related to call up into U.S. military service or to care for a family member who was in injured while on active duty in military service.

If you are an Active Employee and your Employer approves taking a leave under the FMLA, you and your Dependents will continue to be eligible for benefits if:

- You were eligible when the leave began;
- Your Employer properly grants the leave under the FMLA; and
- Your Employer makes the required notification and contributions to the Fund during the leave.

Military Leave

If you are an Active Employee and you enter military service, you are eligible to continue your eligibility for benefits in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active military duty for 31 days or less, your eligibility for benefits will continue for up to 31 days; with no self-payments required. However, if your period of military service is more than 31 days, you may elect to continue eligibility for benefits for up to 24 months; however, you will be required to make self-payments for this continued coverage. If you do not elect to continue coverage, your Dependents will have the opportunity to elect COBRA Continuation Coverage independently of you.

Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively.

During the first 18 months of continued coverage, you will have the same rights as if you had elected COBRA Continuation Coverage (see section below). However, COBRA Continuation Coverage provisions, such as the right to elect additional months of coverage in the event of a second Qualifying Event or a Social Security disability determination, do not apply during the last 6 months of the 24-month period.

Benefits are not provided for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, your military service.

Reinstatement

When you are discharged from military service, your eligibility will be reinstated on the day you return to work with a Contributing Employer, provided you return within the required period. When you are discharged or released from military service:

- That lasted less than 31 days, you have until the beginning of the first full regularly-scheduled work period on the first full calendar day following the completion of the period of service to return to work for a Contributing Employer;
- That lasted more than 30 days but less than 181 days, you have up to 14 days to return to work for a Contributing Employer; or
- That lasted more than 180 days, you have up to 90 days to return to work for a Contributing Employer.

If you are Hospitalized or convalescing from an Illness or Injury incurred in military service, you have until the end of the period that is necessary for you to recover to return to work for a Contributing Employer, up to a maximum of two years.

COBRA Continuation Coverage

NOTE: Domestic Partners and children of Domestic Partners are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends (described in this chapter); however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary.

Under a federal law commonly called COBRA, you and/or your Dependents may elect a temporary continuation of health care coverage past the date coverage would normally end. Under certain circumstances, you or your Dependents may make self-payments to continue Comprehensive Medical, Substance Use Disorder treatment, Hearing Aid, Prescription Drug, Dental, Orthodontic, and Vision Benefits under the program you were covered under when your coverage would have otherwise ended. You will *not* be eligible to continue coverage for Burial Expense or Life Insurance Benefits under COBRA.

This section is only a summary of the Plan's COBRA Continuation Coverage; it is not a complete description of the coverage or your rights under the Plan. More information about COBRA Continuation Coverage and your rights under the Plan is available from the Fund Office.

If you get married, have a newborn child, adopt a child, or have a child placed with you for adoption or legal guardianship (for whom you have financial responsibility) while your COBRA Continuation Coverage is in effect, you may add your new spouse and/or child to your coverage for the balance of your COBRA Continuation Coverage period. To have this Dependent added to your coverage, you must provide written notification to the Fund Office within 30 days of the marriage, birth, legal guardianship, adoption, or placement of a child with you for adoption.

Children born, adopted, or placed for adoption or legal guardianship as described above, have the same COBRA Continuation Coverage rights as a Dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, these children's continued coverage depends on timely and uninterrupted self-payments on their behalf.

Special Enrollment Rights

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage under the Plan ends because of the qualifying events indicated in this section. You also will have the same special enrollment right at the end of COBRA Continuation Coverage if you get COBRA Continuation Coverage for the maximum time available to you.

Other Health Coverage 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** (*the Marketplace helps people without health coverage find and enroll in a health plan For California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov*).

Qualifying Events

You do not have to show that you are in good health for COBRA Continuation Coverage. It is offered if you or your Dependents lose coverage because of a qualifying event. Qualifying events that result in a loss of Plan coverage may include your:

It is important to notify the Fund Office of a qualifying event to maintain your COBRA Continuation Coverage rights.

- Termination of employment (for any reason other than your gross misconduct);
- Reduction in hours;
- Death;
- Divorce; and
- Child losing Dependent status under the Plan.

Notifying the Fund Office

You, your Dependent, or an authorized representative must inform the Fund Office, in writing, of a divorce or a child losing Dependent status under the Plan within 60 days of the later of the qualifying event or the date your Dependent would otherwise lose Plan coverage. If you, your Dependent(s), or representative do not notify the Fund Office within 60 days of the event, you and your Dependent(s) will lose your right to elect COBRA Continuation Coverage.

Your Employer will notify the Fund Office of your termination of employment, reduction in hours, or death. However, because Employers contributing to multiemployer funds may not be aware of all qualifying events, the Fund Office will rely on its records for determining when eligibility is lost under certain circumstances. To help ensure that you and/or your Dependent(s) do not suffer a gap in coverage, we urge you, your Dependent(s), or representative to notify the Fund Office, in writing, of qualifying events as soon as they occur.

To ensure your and/or your Dependent(s) rights to COBRA Continuation Coverage, you, your Dependent, or your representative should notify the Fund Office, in writing, of any qualifying event.

Be sure that the Fund Office has your Dependents' name and address on file to ensure that that they receive any important information.

When the Fund Office is notified that one of these events has occurred, you, your Dependent(s), or your representative will be notified by mail as to whether or not you and/or your Dependent(s) have a right to elect COBRA Continuation Coverage. If you and/or your Dependent(s) are eligible for COBRA Continuation Coverage, the notice will include information on what you, your Dependent(s), or your representative need to do to elect COBRA Continuation Coverage. If you and/or your Dependent(s) are not eligible for COBRA Continuation Coverage, you, your Dependent(s), or your representative will be notified, including information explaining why you (or your Dependent) are not eligible.

Once you receive a COBRA Continuation Coverage notice, **you, your Dependent(s), or representative have to respond within 60 days of the later of the qualifying event or the date of the notice** if you or your Dependent(s) wish to elect COBRA Continuation Coverage. Your Dependent(s) will be given the opportunity to elect coverage independently from you. If you, your Dependent(s), or representative do not respond by the deadline, you and/or your Dependent(s) will not be able to elect COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on an annual basis, and will not exceed 102% of the cost to provide this coverage. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your Dependents' coverage under the Plan ended. Your first payment is due no later than 45 days after the date you or your Dependents signed the COBRA Continuation Coverage election form and returned it to the Fund Office. Future payments should be sent in by the 20th of each month prior to the month of coverage. If payment is not made within 30 days after the 1st day of the coverage month for which payment is due, your coverage will end immediately. Once your COBRA Continuation Coverage ends, it cannot be reinstated.

For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?

If the Fund Office receives a COBRA premium payment that is not for the full amount due, they 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 on the last day full COBRA premium was made.

If there is not a significant shortfall, the Fund Office will notify you of the deficiency 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.

Periods of Coverage

Coverage Continues for 18 Months*. You may elect to purchase continued coverage for yourself and your Dependents for up to 18 months if coverage ends due to your termination of employment or your reduction in hours.

Coverage Continues for 29 Months*. If your employment ends due to your termination of employment or reduction in hours, and at that time, or within 60 days of the event, you or one of your Dependents is Totally Disabled (as determined by the Social Security Administration), coverage may continue for you and your Dependents for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Fund Office, in writing, of your determination of disability by the Social Security Administration. Written notice must be provided within 60 days of the Social Security Administration's determination of disability and before the end of the initial 18-month period. In addition, if you (or your Dependent) later learn that you are no longer considered Totally Disabled by the Social Security Administration, you must notify the Fund Office, in writing, within 30 days of the determination.

COBRA Continuation Coverage lasts for up to 36 Months. Your Dependents may elect COBRA Continuation Coverage for up to 36 months if coverage ends because of:

- Your Death;
- The date the premium payment amount due for COBRA coverage is **not paid in full and on time**;
- The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan.
- The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
- Divorce; or
- Dependent child no longer qualifying for Dependent coverage under the Plan.

* **Second Qualifying Events:** If a second qualifying event occurs within the 18- or 29-month period (as applicable), the maximum period of coverage for your Dependents is extended up to a total of 36 months. A second qualifying event may include your death or divorce or a Dependent child no longer meeting the Plan's definition of a Dependent. These events are a second qualifying event only if they would have caused your Dependent to lose Plan coverage if the first qualifying event had not occurred. You must notify the Fund Office, in writing, of any second qualifying event within 60 days after the second qualifying event.

USERRA VS. COBRA - Coverage Continues for 24 Months. You may elect to purchase continued coverage for yourself and your Dependents for up to 24 months if coverage ends due to your termination of employment to enter military service. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively

Can I Enroll in Medicare instead of COBRA Continuation Coverage after my Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Parts A, B or D when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A, B or D, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A, B or D before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A, B or D is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Loss of Continued Coverage

The period of COBRA Continuation Coverage for you or your Dependents may end sooner if:

- You or your Dependents do not make the required self-payments within 30 days after the first day of the coverage month;
- The Fund ceases to provide any group health benefits;
- During an extension of the COBRA coverage period to 29 months due to disability, you or your Dependents are determined by the Social Security Administration to no longer be disabled;
- You or your Dependents first become covered under another Group Plan after the date on which COBRA Continuation Coverage is elected; or
- You or your eligible Dependent first becomes entitled to Medicare after the date on which COBRA Continuation Coverage is elected. However, if you become entitled to Medicare, your Dependents receiving COBRA Continuation Coverage will be eligible to continue their COBRA Continuation Coverage until the end of the 36-month period immediately following the date of the qualifying event.

Update your information on file with the Fund Office. To protect your and your Dependent's rights, you should notify the Fund Office, in writing, of any address change for you or your Dependents. You should also keep a copy, for your records, of any notice you send to the Fund Office.

Continuation Coverage may also be terminated for any reason that the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit www.HealthCare.gov.

Comprehensive Medical Benefits

The Plan's Comprehensive Medical Benefits provide protection you and your family need and help cover the cost of routine and unexpected medical expenses. The Plan provides benefits for a wide range of services and supplies, including Hospital charges, Physician charges, diagnostic testing, surgery, and certain preventive care benefits. Benefits are intended to provide coverage for Covered Expenses incurred by an Eligible Individual for treatment or care of a non-occupational Illness or Injury, including treatment in connection with a pregnancy, and for covered preventive care.

If you have coverage under the Kaiser HMO when your eligibility ends, you may be eligible for additional coverage under Cal-COBRA. All arrangements for additional months of coverage under California COBRA laws must be made directly with Kaiser; the Fund is not involved. Contact Kaiser for more information.

There are four schedules of benefits provided by the Fund: Plan A, Plan B Plan C and Plan D. The Plan you are eligible for is determined by the Collective Bargaining or Subscriber Agreement under which your Employer is subject to make contributions to the Fund. Note that there are some differences between how Comprehensive Medical Benefits work depending on whether you are covered under Plan A, Plan B, Plan C or Plan D, as described in the following information. In addition, some Expenses may be covered differently or subject to benefit maximums. See the *Schedule of Benefits* for the Plan (A, B, C or D) under which you are covered. Comprehensive Medical Benefits are subject to all provisions and limitations of the Plan's Rules and Regulations, which may limit or exclude certain benefits.

How the Plan Works for Plan A and Plan B Participants

In general, you are considered an Out-of-Area Participant if you live more than 30 miles from a Contract Provider.

How the Plan works is simple. Each year, the Plan pays medical benefits like this:

The Plan pays a percentage of Covered Expenses and you pay the rest. This is known as coinsurance. The coinsurance percentage the Plan pays varies depending on whether you use a Contract or Non-Contract Providers and whether or not you live in the Plan's PPO network area.

Once your Out-of-Pocket Covered Expenses for the year reach the Annual Out-of-Pocket Limit on Coinsurance or the Annual Out-of-Pocket Limit on Cost-sharing, the Plan pays 100% of most Covered Expenses (up to the eligible charge or maximum allowance) for the remainder of that calendar year. Please see page 16 for an explanation of how these Out-of-Pocket Limits work together.

How the Plan Works for Plan C and Plan D Participants

How the Plan works is simple. Each year, the Plan pays medical benefits like this:

You are responsible for meeting your calendar year Deductible.

Plans C and D Only
An annual Deductible is a dollar amount that you must pay each year before the Plan begins paying benefits.

Once you or your family meets the calendar year Deductible, the Plan pays a percentage of Covered Expenses and you pay the rest. This is known as coinsurance. The coinsurance percentage the Plan pays varies depending on whether you use Contract or Non-Contract Providers and whether or not you live in the Plan's PPO network area.

Once your Out-of-Pocket Covered Expenses for the year, **not** including the amounts you paid toward your calendar year Deductible, reach the Annual Out-of-Pocket Limit on Coinsurance, the Plan pays 100% of most Covered Expenses (up to the eligible charge or maximum allowance) for the remainder of that calendar year. The Out-of-Pocket Limit on Cost Sharing **does include** amounts you paid toward your Deductible.

Plan C and Plan D Deductible

The Deductible is the amount of Covered Expenses that you pay each calendar year before the Plan begins to pay benefits. Deductible amounts are limited to a family maximum (or if only two Eligible Individuals are covered, once both individuals meet their individual Deductible). For a family, once the family has combined covered expenses equal to the family maximum, no further individual Deductibles are required. However, no more than the individual Deductible amount will be applied to any one covered family member for the calendar year. The amounts you pay toward the Deductible do not apply toward meeting the Plan's coinsurance limit (but they do apply toward meeting the Out-of-Pocket limit on Cost Sharing).

Plans C and D Only
Deductible amounts are listed on the Plan C and Plan D Schedule of Benefits.

Note: The Deductible is waived for some Covered Expenses. See the *Schedule of Benefits* for your plan to see what expenses are not subject to the Deductible.

Carryover Provision. If you or your Dependent incurs Covered Expenses during the last three months of the calendar year that were applied toward meeting your Deductible for that calendar year, those Covered Expenses will also be applied to your Deductible for the next calendar year.

Emergency Room Deductible – Plan D Only

If you are in Plan D, you must pay the emergency room Deductible amount each time you visit a Hospital emergency room before Plan benefits are payable. This Deductible applies to both Emergencies and non-emergencies; however it is waived if you are admitted to the Hospital directly from the emergency room. The amounts you pay toward the Deductible apply to the Out-of-Pocket limits on cost sharing and coinsurance.

Plan D Only. The emergency room Deductible amount is shown on the Plan D Schedule of Benefits.

Note: Emergency room charges that are not due to an Emergency Medical Condition are subject to both the emergency room Deductible and the Plan D annual Deductible.

Copayments (Copays)

When you or a family member go to a Physician's office or use the Online Physician Consultation benefit, you pay a separate Copay for each Physician visit (including visits for acupuncture or specialist consultations) before the Plan pays any benefits. The Copay is a flat dollar amount you are responsible for paying before the Plan begins to pay benefits and is in addition to any coinsurance amounts you are responsible for paying. Copays do not apply toward meeting your coinsurance limit (but Contract Provider Copays do apply toward meeting the Out-of-Pocket limit on Cost Sharing) and you must pay this Copay even after you have met your coinsurance limit. You and your family members do not have to pay any Copay for Contract and Out-of-Area Providers (for Plan C only) once you meet your Annual Out-of-Pocket Limit on Cost Sharing.

Plan C and D Participants
The Physician Office Visit Copay only applies to Contract Providers (and to Out-of-Area Providers for Plan C only) and the annual Deductible is waived for these services.

For Plan A and Plan B, this Copay also applies to Physician Hospital inpatient visits, home visits and acupuncture visits.

However, please note that no Copay is required for:

- Second surgical opinion visits;
- Chemotherapy, radiation therapy, or dialysis;
- Home health care visits;
- Adult routine physical examinations, well childcare visits (including immunizations);

- X-ray and laboratory services; or
- Non-Contract Provider visits In-Area for Plan C.

Copays are listed on the Schedule of Benefits.

Coinsurance

The Plan pays a percentage of covered charges, and you are responsible for paying the rest. Your coinsurance is the percentage of charges you are responsible for paying for certain covered health services. The applicable percentage paid by the Plan, which is shown on the Schedule of Benefits, varies depending on if you use Contract or Non-Contract Providers and whether or not you live in the Plan's PPO network area.

Annual Out-of-Pocket Limit on Coinsurance

The Plan limits the amount you pay in coinsurance for Covered Expenses each year. Once Covered Expenses for a particular individual (you or one of your Dependents) amount to the coinsurance limit for the year, 100% of most of that individual's covered medical expenses will be paid for the remainder of the calendar year.

If your family reaches the family annual Out-of-Pocket limit on coinsurance, 100% of most of you and your eligible Dependents covered medical expenses will be paid for the remainder of the calendar year.

The Out-of-Pocket limits on coinsurance are listed in the Schedule of Benefits.

The following expenses for Covered Services do not count toward your Out-of-Pocket limit on coinsurance and will not be paid at 100% after you reach this limit:

- Covered Expenses that were reimbursed by the Plan at 100%;
- Charges that exceed any Plan maximums or that are not Covered Expenses;
- Physician visit Copays;
- Charges from Non-Contract Providers within the Contract Provider Service Area , except for No Surprise Services; and
- For Plan C and Plan D Participants only, amounts used to satisfy your Deductible.

Out-of-Pocket Limit on Cost Sharing

This Plan has an Out-of-Pocket Limit on cost sharing is shown in the Schedule of Benefits. It limits the Eligible Individual's annual cost-sharing for covered health benefits **received from Contract Providers** related to Medical Plan Deductibles, coinsurance, and Copays to the amounts permitted under the Affordable Care Act and implementing regulations. The Out-of-Pocket Limit is the most an Eligible Individual pays during a one year period (the calendar year) before the plan starts to pay 100% for covered health benefits received from Contract Providers. This annual cost-sharing limit includes the Coinsurance Maximum described above.

For all Plans:: The Out-of-Pocket Limit on Cost Sharing also applies to Out-of-Area Providers.

- The Out-of-Pocket Limit is accumulated on a calendar year basis.
- Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan.
- 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.

No Surprises Act Services will apply to meet the Contract Provider Out-of-Pocket Limit on cost sharing including, to the extent they are otherwise covered under the Plan. This includes:

- Non-Contract Emergency Services;
- Non-Contract air ambulance services;
- Non-emergency ancillary services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at an in-network Health Care Facility; and
- Other Non-Contract non-Emergency Services performed by a Non-Contract Provider at a Contract Health Care Facility with respect to which the provider does not comply with federal notice and consent requirements.

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.

The medical Out-of-Pocket Limit on cost sharing does not include or accumulate:

- Contributions for coverage;
- Expenses for medical services or supplies that are not covered by the Plan,
- Except for No Surprises Services, charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers;
- Penalties for non-compliance with Utilization Management programs;
- Expenses for the use of Non-Contract providers, except emergency services performed in a Non-Contracted Emergency Room and other No Surprise Services;
- Outpatient prescription drug expenses (refer to the Prescription Drug chapter of this SPD for the separate Out-of-Pocket limit on outpatient prescription drug expenses);
- Expenses for dental plan and vision plan services.

Preferred Provider Network – Anthem Blue Cross

To help manage certain health care expenses, the Plan contains a cost management feature – the Anthem Blue Cross Preferred Provider Organization (PPO) network in California, and the BlueCard PPO network outside California. Providers (Physicians, Hospitals, and other professional health care providers) participating in the BlueCross PPO network (Contract Providers) have agreed to negotiated, reduced fees. When you use Contract Providers, you save money for yourself and the Plan because Contract Providers have agreed to negotiated rates for their services.

It is always a good idea to verify if your provider is part of the network **before** receiving care. To find out if a provider participates in the Plan's network, contact the Fund Office, ask the provider, or visit the BlueCross Web site.

Non-Contract Providers have no agreements with the Anthem Blue Cross PPO or the Plan regarding their fees for services or supplies provided. As a result, when you or a Dependent use Non-Contract Providers, the Plan will base its reimbursements on the Allowed Charge, as defined by the Plan (see page 94). Non-Contract Providers, except for No Surprises Services, may bill you for any balance that is not paid by the Plan.

The Anthem Blue Cross PPO network is big enough to provide just about any type of health care service that you and your family will need. However, since health care is a very personal issue, sometimes you might feel better going to a certain provider that is not a Contract Provider. The Plan accommodates these circumstances. Each time you receive medical care, you can choose whether to use a Contract or Non-Contract Provider. However, remember that to encourage you to use Contract Providers whenever possible, the Plan pays a higher percentage of most Covered Expenses when you use Contract

If you require medical services that are not available in a Contract Hospital, your doctor should contact Anthem Blue Cross. Under certain circumstances, Anthem Blue Cross may approve payment of the Non-Contract Hospital expenses at the Contract Hospital rate.

Providers. Coinsurance amounts for Contract and Non-Contract Providers are listed on the Schedule of Benefits.

CAUTION: Non-Contract Health Care Providers(except for No Surprise services) may bill you for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than Copays, coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. **You can avoid balance billing by using Contract providers.**

Exceptions to Non-Contract Provider Coinsurance

In certain circumstances where you have no choice in the provider you use, benefits for covered services received from the following Non-Contract Providers will be paid at the Contract Provider Coinsurance (or percentage), provided services are received in a Contract Hospital or Facility and are ordered by a Contract Physician:

- No Surprise Services;
- Anesthesiologist;
- Assistant surgeon;
- Emergency room Physician; or
- Radiologist.

Out-of-Area Participants (Does not apply to Plan D)

If you live more than 30 miles from a Contract Provider (or are temporarily outside the service area while away from home on vacation or attending school), you are considered to be Out-of-Area. As an Out-of-Area Participant, you may still use Contract Providers; however, this may not always be convenient. If you are in Plan A, B or C, the Plan provides a separate level of benefits for Out-of-Area Participants. Refer to the "Out-of-Area" column on the applicable Schedule of Benefits.

Finding Contract Providers

To take advantage of the savings a PPO provides, you must check to see if your provider is in the Anthem Blue Cross network or the ARP network for substance use (providers participating in the network change periodically). In addition, you must show your ID card at the time that you receive services. Finding an Anthem Blue Cross or ARP network provider is easy, you can:

- For medical claims, ask your provider if he/she participates in the Anthem Blue Cross PPO network in California (or the BlueCard network if outside California);
- For substance use claims, ask your provider if he/she participates in the ARP network;
- Contact the Fund Office by calling (800) 251-5014; or
- Visit www.anthem.com for providers in California or www.bcbs.com for providers outside of California.

Anthem and ARP will update their Provider Directory at least every ninety (90) days. If you are informed by the Plan (through a telephone, electronic, or internet-based inquiry), or receive information from a printed 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:

- 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
- Apply the out-of-pocket limit, if any, as if the services were provided by a Contract Provider.

Continuity of Care

When a provider terminates from the Preferred Provider Organization network, an Eligible Individual who is receiving care from that provider for an acute condition, serious chronic condition or pregnancy that has reached the second trimester may request continuity of care by contacting the Fund Office. The Plan will provide continuity of care in accordance with the following:

- Notify the Eligible Individual of the Plan's termination of its contract(s) with the in-network provider or facility and inform them of their right to elect continued transitional care from the provider or facility; and

- The Plan will continue to pay Contract Provider benefits for services received from the terminated provider for 90 days after notifying the Eligible Individual of the provider's termination or until the Eligible Individual is no longer a Continuing Care Patient, whichever is earlier.

Patient Protection Rights

The following provisions apply only to Anthem Blue Cross Participants because this is a Non-grandfathered plan under the Affordable Care Act. These provisions do not apply to Participants covered under Kaiser.

PCP Designation

Anthem Blue Cross does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any Contract or Non-Contract healthcare provider; however, payment may be less when you use a Non-Contract provider.

Access to OB/GYN Provider

You also do not need prior 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 prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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 Fund will not discriminate with respect to participation under the Fund 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 Fund 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.

Professional Review Organization Utilization Review Program

Anthem Blue Cross of California is the Professional Review Organization (PRO) that administers the utilization review program for medical services and mental health claims. ARP is the Professional Review Organization (PRO) that administers the utilization review program for substance abuse services. The PROs helps ensure that you receive quality care in a way that uses valuable health care resources as wisely as possible. To make it work, you need to become involved in the decisions regarding your care.

Your doctor must call Anthem Blue Cross (or ARP) before any non-Emergency Hospitalization at a Non-Contract Hospital. It is your responsibility to ensure your doctor makes the call.

Generally, the utilization review program includes pre-approval, preadmission reviews, and Concurrent Reviews. Anthem Blue Cross' professional medical review staff can provide treatment alternatives, pre-approval, and referrals when needed. For example, when your Physician calls Anthem Blue Cross before a non-Emergency Hospital admission, Anthem Blue Cross will evaluate whether a Hospital admission is needed and determine the expected length of stay. Once you are admitted to a Hospital, Anthem Blue Cross monitors your Hospital stay. If additional days are required because of complications or other medical reasons, your stay will be pre-approved for the appropriate number of additional days of inpatient care. This program does not apply to the length of Hospital confinements related to a mastectomy, childbirth or to other health care services.

When you go to a Contract Hospital, you do not need to worry about getting pre-approval, because the Hospital will do so for you. However, if you use a Non-Contract Hospital, your doctor must contact Anthem Blue Cross before you are Hospitalized.

Plan Requirements for Pre-Authorization	
Situation	**Pre-Authorization Requirement**
Elective, non-emergency hospitalization at an acute-care or skilled nursing facility	Anthem Blue Cross must approve the hospital stay **before admission**.
Hospitalization as a result of a medical emergency	You or someone acting on your behalf must contact Anthem Blue Cross **within 24 hours of admission** so that Anthem Blue Cross 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.
Organ or tissue transplant and bariatric surgery	All planned services must be approved by Anthem Blue Cross **before services begin.**
Inpatient treatment for substance use disorder	The Assistance Recovery Program (ARP) must approve the inpatient stay **before admission.**
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.**
Outpatient Diagnostic Imaging (CT/PET scans, MRIs)	Your physician must contact American Imaging Management.

Covered Expenses

The Plan's Comprehensive Medical Benefits cover Allowed Charges for Medically Necessary treatment, services, and supplies, subject to any Plan maximums. See the Schedule of Benefits for the percent payable by the Plan and any specific Plan maximums. The following information describes the specific coverage provided.

A. ***Hospital inpatient services,*** including well-baby nursery care, are covered if Medically Necessary. For confinement in a Non-Contract Hospital, Covered Expenses for room and board are limited to the Hospital's semi-private room rate or intensive care unit, when confinement in an intensive care unit is Medically Necessary.

Plan D participants: See the *Schedule of Benefits*. A benefit limit applies to Non-Contract ambulatory surgery facilities.

Newborns' and Mothers' Health Protection Act. Under federal law, Group Health Plans 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 normal delivery, or less than 96 hours following a cesarean section. However, the law does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. This Plan does not require that a provider or Eligible Individual obtain Pre-admission Review for prescribing a Hospital length of stay not in excess of 48 hours for normal delivery or 96 hours for cesarean section.

B. ***Emergency Services.*** The No Surprises Act requires Emergency Services to be covered as follows:

- Without the need for any prior authorization determination, even if the services are provided on a Non-Contract basis;
- Without regard to whether the health care provider furnishing the Emergency Services is an Contract Provider or an Contract Facility, as applicable, with respect to the services;
- 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 Contact Providers and Contract emergency facilities; 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 an Contact Provider or an Contact Facility;
- 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; and;
- By counting cost-sharing requirements for Non-Contract Emergency Services toward the Contract Provider deductible and Contract Provider out-of-pocket maximum in the same manner as those received from a Contract Provider.

C. Non-Emergency Services. The No Surprises Act requires Non-Emergency Services performed by Non-Contract Provider at a Contract Health Care Facility to be 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 an Contract Provider;
- 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; and
- 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 Contact 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 participating provider.

Notice and Consent Exception: Non-emergency items or services performed by a Contact Provider at a Contract Facility will be covered based on the Non-Contract coverage 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 an 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 provided treatment and that the Patient may elect to be referred to one of the Contract Providers listed; and

- The Patient give informed 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.

The notice and consent exception does not apply to Ancillary services and items or services furnished 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 will be 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 an Contact 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; and

- 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.

D. ***Licensed ambulatory surgery facility services.***

E. ***Physician visits and services,*** including office, Hospital, and home visits. Benefits are limited to one visit per day. A visit is a personal interview between the Patient and the Physician and does not include telephone consultations or other situations where the Patient is not personally examined by the Physician (except for the Online Physician Consultation benefit). This benefit includes specialist Physician and second surgical opinion services. However, second surgical opinions are not subject to the Plan's Physician office visit Copay.

F. ***Online Physician Consultation***. You can use a smart phone, tablet or computer to have a live video visit with a board certified doctor affiliated with the Anthem Blue Cross *LiveHealth Online* Services to discuss non-emergency health issues from home, work or wherever you happen to be. *LiveHealth Online* offers a secure means of reaching board-certified, primary care doctors on demand, especially when it is inconvenient to leave work or home and go to a doctor's office. Online care, for non-urgent medical conditions, is more convenient and affordable than a visit to the emergency room or an urgent care clinic. Patients use online care typically to communicate with a doctor about colds, aches, sore throats, allergies, infections as well as wellness and nutrition advice.

See your Schedule of Benefits for the Copay that applies to the Online Physician Consultation. The Plan C and Plan D Deductible is waived.

G. ***Surgeon, Assistant Surgeon, Anesthesiologist,*** subject to the following:

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

Covered bariatric surgery and 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.

No Plan benefits will be payable for bariatric surgery or for specified organ or tissue transplant procedures performed in a Hospital or Facility that is not an Anthem Blue Cross "Center of Medical Excellence" or a "Blue Distinction Center" (even if the Hospital or Facility is a Contracted facility).

Bariatric Surgery. Bariatric surgery for weight loss is covered subject to Utilization Review, only when Medically Necessary for morbid obesity and only when performed at an Anthem Blue Cross Center of Medical Excellence (CME) or Blue Distinction Center.

- ***Travel Expense Benefit for Bariatric Surgery***. Bariatric travel expense is covered when the Patient's home is 50 miles or more from the nearest Bariatric CME or Blue Distinction Center, with benefits payable subject to the following limitations:
  - 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);
  - 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);
  - 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.
  - 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.

Organ and Tissue Transplants. Allowed Charges incurred by the organ donor and the organ recipient when the organ recipient is an Eligible Individual are Covered Expenses. Covered Expenses in connection with the organ transplant include Patient screening, organ procurement and transportation of the organ, surgery, and Hospital charges for the recipient and donor, follow-up care in the home or a Hospital, and immunosuppressant Drugs, subject to the following:

- Transplant is not considered Experimental or Investigational and services must be pre-approved by the Anthem Blue Cross utilization review program.
- ***Center of Medical Excellence (CME):*** The Professional Review Organization will determine, prior to surgery, if the organ or tissue transplant is one that must be performed in a CME.
- ***Travel and Donor Search Benefit for Organ or Tissue Transplants***: If the authorized organ or tissue transplant is one that must be performed at a CME and the nearest CME is more than 100 miles from your home, the Plan will reimburse travel expenses as follows.
  - Travel expenses for the organ recipient and a companion and/or donor transportation will be covered up to $10,000 per transplant.
  - The organ and tissue transplant benefit includes a benefit for unrelated donor search, limited to $30,000 per transplant.

- Recipient of the organ must be an Eligible Individual under the Plan. Benefits for an organ donor who is not an Eligible Individual will be reduced by any amounts paid or payable by that donor's own health coverage.

H. ***Diagnostic X-ray and laboratory services, nuclear medicine /imaging services*** when ordered by a Physician. Outpatient imaging tests (CT scans, PET scans and MRIs) require pre-authorization by American Imaging Management.

I. ***Radiation therapy, chemotherapy, and dialysis treatment.***

J. ***Acupuncture treatment*** of intractable pain (or for Medically Necessary treatment of a mental health or substance use diagnosis) only from a licensed acupuncturist, limited to 1 visit per week and 12 visits per diagnosis (visit limits will not apply to Medically Necessary treatment of mental health or substance use). Additional benefits may be covered if pre-approved by the Professional Review Organization.

K. ***Reconstructive surgery*** when required to correct a functional disorder or due to an Injury sustained in an accident. In addition, the Plan provides for certain reconstructive surgery in connection with a mastectomy in accordance with the Women's Health and Cancer Rights Act. If you are receiving benefits under the Plan in connection with a mastectomy and elect breast reconstruction, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:

– Reconstruction of the breast on which the mastectomy was performed;

– Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

– Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

L. ***Preventive Care Services from a Contract Provider***: The following Preventive Services that are required to be covered under Health Care Reform will be payable at 100% with no Copay or Deductible when received from a Contract Provider, including the Contract Physician's charge for a routine physical examination. The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations. Where the information in this document conflicts with newly released ACA regulations affecting the coverage of preventive care, this Plan will comply with the new requirements on the date required.

The complete list of covered preventive care services is as shown on the government websites:

→ https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at

→ http://www.uspreventiveservicestaskforce.org/BrowseRec/Index

→ http://www.hrsa.gov/womensguidelines/

→ http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001

- ***Preventive Care for Children.*** Covered Services include but are not limited to:

– Newborn screening lab tests (typically payable as part of hospitalization at birth);

– At least 11 office visits payable during first 30 months of age, then annual office visits are payable from age 3 years through age 18 years;

– Hemoglobin and lead blood tests in first year of life;

– Tuberculosis (TB) skin test in first year of life;

– Hemoglobin blood test in second year of life; and

– CDC recommended immunizations (including any FDA approved COVID-19 immunization).

- ***Preventive Care for Men.*** Covered Services include but are not limited to:
  - Abdominal aortic aneurysm screening;
  - Colonoscopy, sigmoidoscopy or fecal occult blood test;
  - Four blood tests for cholesterol/lipid, blood sugar, HIV, syphilis; and
  - CDC recommended immunizations (including any FDA approved COVID-19 immunization).
- ***Preventive Care for Women (including pregnant women).*** Covered Services include but are not limited to:
  - Breast cancer screening mammography;
  - Cervical cancer screening and Chlamydia screening;
  - Osteoporosis screening x-ray;
  - Colonoscopy, Sigmoidoscopy or fecal occult blood test;
  - Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV;
  - CDC recommended immunizations (including any FDA approved COVID-19 immunization);
  - BRCA 1 and 2 lab tests with a personal or family history of breast cancer;
  - Well-woman visits (including pre-natal visits);
  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immuno-deficiency virus;
  - FDA-approved contraceptive methods and counseling;
    - Coverage is provided without cost sharing for items and services integral to the furnishing of contraceptive services, such as anesthesia for a tubal ligation procedure or pregnancy tests needed before the provision of certain forms of contraception, such as an intrauterine device (IUD) regardless of whether the items and services are billed separately.
    - An exceptions process is available if an individual's health care provider recommends an item or service not covered under the plan's contraceptive coverage policies.
  - Breastfeeding support, supplies and counseling;
  - Screening and counseling for interpersonal and domestic violence; and
  - Sterilization procedures.

M. ***Covered Services from a <u>Non-Contract Provider</u>***

- *Adult routine physical examination* (for members age 17 and over), including any related routine diagnostic tests; subject to any limits listed on the Schedule of Benefits. Please note that no coverage is provided for any physical examination required for employment, an examination for which an employer is required to pay, or for vision examinations covered under the Plan's Vision Benefits.
- *Immunizations*
- *Mammography screening*, the outpatient X-ray and laboratory benefits shown in the Schedule of Benefits are payable~~,~~ in accordance with the following schedule for women with no symptoms or history of breast cancer:

– Ages 35 through 39, one baseline mammogram

– Ages 40 and over, one mammogram every year

- *Well-childcare*, benefits shown in the Schedule of Benefits are payable for members aged 16 and younger in accordance with the American Academy of Pediatrics guidelines, including routine physical examinations, related laboratory services, and immunizations.

N. ***Home Health Care, including Hospice Care,*** provided and billed by a licensed Home Health Agency; limited to 1 visit per day per provider, up to 60 visits total per calendar year. Covered Services include visits by a registered nurse, medical social worker, occupational, speech, and physical therapists, and health aides or any other provider that is licensed in the state and rendering Medically Necessary services that are within the scope of his or her license. Please note that housekeeping services are not covered. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

O. ***Skilled Nursing Facility***, limited to 180 days per calendar year. The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

P. ***Inpatient and Outpatient Mental Illness treatment,*** payable on the same basis as inpatient and outpatient treatment for medical conditions (including Allowed Charges for partial hospitalization and intensive outpatient care).

Q. ***Ambulance transportation*** for medically necessary transportation by local ground ambulance to and from a Hospital.

R. ***Air Ambulance transportation,*** in the case of an Emergency where land transportation would be hazardous to the Patient's health, coverage is provided for transportation by air ambulance to the nearest Hospital where Medically Necessary treatment can be provided. 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;

- 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;

- 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

- In general, Eligible Individuals cannot be balance billed for these Air Ambulance Services.

S. ***Services of a registered nurse or licensed vocational nurse*** when ordered by a Physician.

T. ***Blood transfusions***, including blood processing and the cost of unreplaced blood and blood products.

U. ***Splints, casts, surgical dressings, and other supplies*** for reduction of fractures and dislocations.

V. ***Oxygen and rental of equipment*** for its administration.

W. ***Prosthetic or artificial devices*** that replace all or part of a bodily organ or that improve the function of an impaired body organ or part, including intraocular lens implants placed after cataract surgery and purchase of initial and subsequent prosthetic devices necessary to restore a method of speaking following a

laryngectomy. The initial replacement of natural eyes and limbs and replacement of the artificial eyes or limbs are covered only if prescribed by a Physician.

X. ***Durable medical equipment*** rental, or if more economical, purchase of wheelchair, hospital bed, and other durable medical equipment that is:

- Ordered by a Physician;
- Of no further use when medical need ends;
- Usable only by the Patient;
- Not primarily for the comfort of the Patient;
- Not for environmental control;
- Not for exercise;
- Manufactured specifically for medical use;
- Approved as effective and Customary and Reasonable Medically Necessary treatment of a medical condition as determined by the Fund; and
- Not for preventive purposes.

It is recommended that you call the Trust Fund for pre-approval of any medical equipment costing more than $500.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Y. ***Home infusion therapy Drugs*** and equipment for their administration.

Z. ***Chiropractic and physical therapy services*** of a license-d Chiropractor, Registered Physical Therapist, or for physical therapy treatment provided by a Physician limited to a combined maximum of 40 visits per calendar year for all chiropractic and physical therapy services. The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

AA. ***Speech and occupational therapy services,*** when prescribed by a Physician and provided by a licensed speech or occupational therapist. Benefits are payable only until understandable speech is attained or until a determination is made that understandable speech cannot be attained, subject to the following conditions:

i. Speech therapy benefits are provided only for Eligible Individuals who had normal speech at one time but lost it due to Illness or Injury (this limitation will not apply to an approved autism therapy plan).

ii. Benefits for speech therapy provided for any condition other than those specified in paragraph i. above (e.g., for childhood speech delay) are limited to 20 visits per calendar year and 40 visits lifetime. However, the Physician's evaluation of the need for speech therapy will not be applied to these maximums. The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

BB. ***Dental services,*** as follows:

i. Services of a Physician or Dentist to treat an Injury to teeth provided services are received within 90 days following the date of Injury even if the date of the Injury is prior to the date the individual is enrolled in the Plan. Damage to teeth due to chewing or biting is not covered.

ii. Services of a Physician or Dentist to remove cysts or tumors of the gums.

CC. ***Temporomandibular joint syndrome (TMJ) services,*** which include treatment of TMJ syndrome, myofascial pain dysfunction syndrome, mandibular pain dysfunction, facial pain, mandibular dysfunction, Costen's syndrome, craniocervical mandibular syndrome, and craniofacial pain and dysfunction. Non-surgical treatment is limited to a lifetime maximum as listed on the *Schedule of Benefits*.

DD. ***Cardiac rehabilitation services,*** for Eligible Individuals who have had cardiac surgery or a heart attack. The program must be ordered by a Physician.

EE. ***Contraceptive Services:*** Coverage is provided without cost sharing for items and services integral to the furnishing of contraceptive services, such as anesthesia for a tubal ligation procedure or pregnancy tests needed before the provision of certain forms of contraception, such as an intrauterine device (IUD) regardless of whether the items and services are billed separately.

An exceptions process is available if an individual's health care provider recommends an item or service not covered under the plan's contraceptive coverage policies.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period.

See also the Claim Filing and Appeal Information chapter for more information.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Deductible	None			None			$750 per person; $2,250 family maximum. Deductible does not apply to: Contract Provider and out-of-area physician office visits, the on-line physician consultation benefit, emergency room charges for an Emergency Medical Condition, Contract Provider preventive care covered under health care reform, the adult physical exam benefit for Non-Contract Providers, or out-of-area preventive care for children.			$500 per person; $1,000 family maximum Deductible does not apply to Contract Provider physician office visits, emergency room charges for an Emergency Medical Condition, Contract Provider preventive care covered under health care reform, the on-line physician consultation benefit or the adult physical exam benefit for Non-Contract Providers.	
Emergency Room Deducible	Not applicable			Not applicable			Not applicable			$50 per visit (waived if admitted)	
Coinsurance	Plan pays the percentage shown below; subject to Out-of-Pocket limits			Plan pays the percentage shown below; subject to Out-of-Pocket limits			Plan pays the percentage shown below; subject to Out-of-Pocket limits			Plan pays the percentage shown below; subject to Out-Pocket limits	

[+] All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Out-of-Pocket Limit on **Coinsurance**	$1,500/Individual; $3,000/Family			$3,000/Individual; $6,000/Family			$3,000/Individual			$3,000/Individual; $6,000/Family	
Out-of-Pocket Limit on **Cost Sharing** (includes deductible, coinsurance and copays except prescription drugs which are subject to their own limit)	$5,275/Individual; $10,550/Family			$5,275/Individual; $10,550/Family			$5,275/Individual; $10,550/Family			$5,275/Individual; $10,550/Family	
Out-of-Pocket Limit for Non-Contract Providers	Unlimited			Unlimited			Unlimited			Unlimited	
Inpatient Hospital (pre-authorization required)	90%	60%	90%	80%	60%	80% -	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Hospital Emergency Room for an Emergency Medical Condition	90%	90%	90%	80%	80%	80%	80%, no deductible	80%, no deductible	80%, no deductible	After emergency room deductible, 80%	After emergency room deductible, 80%

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Ambulatory Surgery Facility or Outpatient Hospital for Surgery	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Other Outpatient Hospital (including Allowed Charges for Partial Hospitalization and Intensive Outpatient Treatment)	80%	60%	80%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60% (Emergency room deductible applies if emergency room used)
Physician Visits (Office, Hospital and Home)	After $10 Copay per visit, 100%	After $10 Copay per visit, 60%	After $10 Copay per visit, 90%	After $15 Copay per visit, 100%	After $15 Copay per visit, 60%	After $15 Copay per visit, 80%	**Office, Home:** After $15 Copay per visit, 100%; no deductible **Hospital:** After deductible, 80%	After deductible, 60%	**Office, Home:** After $15 Copay per visit, 80%; no deductible **Hospital:** After deductible, 80%	**Home, Office:** After $20 Copay per visit, 100%; no annual deductible **Hospital:** After deductible, 80%	After deductible, 60%
Online Physician Consult (Anthem Blue Cross Live Health Online)	After $15 Copay per consult, 100%	Not Covered	Not Covered	After $15 Copay per consult, 100%	Not Covered	Not Covered	After $15 Copay per consult, 100%; no deductible	Not Covered	Not Covered	After $15 Copay per consult, 100%; no deductible	Not Covered

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Surgeon, Assistant Surgeon, Anesthesiologist, Outpatient X-ray and Lab Services, Radiation Treatment, Chemotherapy, Dialysis	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Speech Therapy Calendar Year Max: 20 visits Lifetime Max: 40 visits (Visit maximums apply to therapy for childhood speech delay of services that are part of an approved autism therapy plan)[2]	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

[2] The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Occupational Therapy	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Preventive Care for Children as required by the ACA	100%	60%	90%	100%	60%	80%	100%, no deductible	After deductible, 60%	After $15 Copay per visit, 80%; no deductible	100%, no deductible	After deductible, 60%
Preventive Care for Men as required by the ACA	100%	100% for a routine physical exam, up to $150 per exam	100% for a routine physical exam, up to $150 per exam	100%	100% for a routine physical exam, up to $150 per exam	100% for a routine physical exam, up to $150 per exam	100%, no deductible	100% for a routine physical exam, up to $150 per exam, no deductible	100% for a routine physical exam, up to $150 per exam, no deductible	100%, no deductible	100%, up to $250 per exam
Preventive Care for Women including Pregnant Women as required by the ACA	100% (including screening mammogram)	100% for a routine physical exam, up to $150 per exam. Mammogram: 60%	100% for a routine physical exam, up to $150 per exam Mammogram: 90%	100% (including screening mammogram)	100% for a routine physical exam, up to $150 per exam' Mammogram: 60%	100% for a routine physical exam, up to $150 per exam Mammogram: 80%	100%, no deductible (including screening mammogram)	100% for a routine physical exam, up to $150 per exam, no deductible Mammogram: After deductible, Plan pays 60%	100% for a routine physical exam, up to $150 per exam, no deductible Mammogram: After deductible, 80%	100% no deductible (including screening mammogram)	100%, up to $250 per exam Mammogram: After deductible, 60%

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Adult Immunizations (CDC recommended immunizations covered under Preventive Care for Men and Women above)	100%	60%	90%	100%	60%	80%	100%, no deductible	After deductible, 60%	After deductible, 80%	100%, no deductible	After deductible, 60%
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)[3]	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

[3] The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Acupuncture ✓ Weekly Maximum: 1 visit ✓ Per Diagnosis Maximum: 12 weeks	After $10 Copay per visit, 100%	After $10 Copay per visit, 60%	After $10 Copay per visit, 90%	After $15 Copay per visit, 100%	After $15 Copay per visit, 60%	After $15 Copay per visit, 80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Skilled Nursing Facility Calendar Year Maximum: 180 days for Plans A, B and C, 100 days for Plan D [4]	90%	90%	90%	80%	80%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

[4] The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Home Health Care[5] and/or Hospice Care ✓ Daily Maximum: 1 visit ✓ Calendar Year Maximum: 60 visits	90%	90%	90%	80%	80%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Ambulance	80%	80%	80%	80%	80%	80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	80%	80%	80%	80%	80%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
TMJ Treatment Non-Surgical Lifetime Maximum: $1,500	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

[5] The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +
Inpatient Mental Illness (Pre-authorization required)	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Outpatient Mental Illness	Professional charges: After $10 Copay per visit, 100% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $10 Copay per visit, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $10 Copay per visit, 90% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 100% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 80% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 100%; no deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After deductible, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 80%; no deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $20 Copay per visit, 100%; no annual deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After deductible, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital
Other Covered Expenses Not Shown Above	80%	80%	80%	80%	80%	80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%

Substance Use Disorder Treatment Benefits – Plans A, B, C and D	
Inpatient Residential Treatment The Assistance Recovery Program (ARP) must approve the inpatient stay before admission	Paid the same as Inpatient Hospital for Contract and Non-Contract Providers (except that the physician copy will NOT be applied to inpatient physician visits on Plans A and B)
Outpatient Treatment	Professional charges: Paid the same as Physician Visits for Contract and Non-Contract Providers.

Substance Use Disorder Treatment Benefits – Plans A, B, C and D	
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.	Facility charges: Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers

Hearing Aid Benefits					
Benefit	Plan A Contract or Non-Contract Provider	Plan B Contract or Non-Contract Provider	Plan C Contract or Non-Contract Provider	Plan D	
				Contract Provider	Non-Contract Provider
Hearing Examination	80%	80%	80%	After deductible, 80%	After deductible, 60%
Hearing Aid	80% (limited to one device per ear in any 3-year period)	80% (limited to one device per ear in any 3-year period)	80% (limited to one device per ear in any 3-year period)		
Maximum Benefit	$450 per ear	$450 per ear	$450 per ear	$500 per ear in any 36-month period	

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (beginning on page 63), Comprehensive Medical Benefits are not paid for the following expenses.

1. Services furnished by a naturopath or any other provider not meeting the Plan's definition of a Physician, except as specifically provided otherwise by the Plan.
2. Professional services received from any provider who lives in a Patient's home or who is related to the Patient by blood or marriage.
3. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, custodial care, 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 (medical necessity must be re-established by Anthem every two months);
4. Hyperkinetic syndromes, learning disabilities, behavioral problems, developmental delay, attention deficit disorders, or mental disability except that the exclusion of developmental delay does not apply to the Plan's covered speech therapy benefits provided to a Dependent child who has failed to attain appropriate speech or as part of an approved autism therapy plan.
5. Radial keratotomy, photorefractive keratectomy (PRK), laser in-situ keratomileusis (LASIK), or any other refractive eye surgery. Eye refractions, eyeglasses, contact lenses (except for intraocular lens implants placed after cataract surgery).
6. Vision therapy, vision training, and orthoptics.
7. Cosmetic surgery or treatment, or any services for beautification, except as specifically provided otherwise by the Plan.
8. In vitro fertilization, artificial insemination, surrogate pregnancy, or any other infertility related services.
9. Services to reverse voluntary, surgically induced infertility.
10. 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 if part of an approved autism therapy plan.
11. Nutritional counseling, food supplements, or substitutes, except for the following:
    - Counseling rendered in connection with treatment of an eating disorder;
    - Initial Diabetes instruction visit, and
    - Enteral feeding when preauthorized as Medically Necessary by the Professional Review Organization. Enteral feeding is defined as a formula that is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and supplies used to administer the formula. This does not include the following which are not covered:
        a. Standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen), or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to food allergies, multiple protein intolerances, lactose intolerances, gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems; or

b. Food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like; or

c. Weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and minerals.

12. Services or supplies that are primarily for weight loss (except as otherwise required under ACA), health club memberships, spas, and exercise and physical fitness programs or equipment.

13. Hypnotism, stress management, biofeedback, and any goal oriented behavior modification therapy, such as to lose weight, or control pain. However, please note, the Plan will cover medically necessary psychotherapy to treat a mental health or substance use disorder condition as a behavioral health benefit under the plan.

14. Orthopedic shoes, shoe inserts, and foot orthotics (Exceptions: Covered when related to diabetes and prescribed by a Physician or when the shoe is joined to a leg brace).

15. Wigs (except when hair loss is due to cancer treatment), services or supplies for comfort, hygiene, or beautification, air purifiers, humidifiers, or any other equipment or supplies for environmental control.

16. Expenses for transportation, except as provided under the Plan's ambulance transportation benefits and travel expense benefits for bariatric surgery and organ and tissue transplants.

18. Dental services or prostheses, extraction of teeth, or any treatment to the teeth or gums, except as specifically covered under the Plan's Dental Benefits.

19. Any treatment or services, whether or not prescribed by a Physician, for which charges incurred are not the direct result of an Illness or Injury, except as specifically provided otherwise.

20. Habilitation Services including delays in physical development. Benefits may be available for delays in childhood speech and services that are part of an approved autism therapy plan.

21. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, precertification is required in order to determine if the Patient is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.

22. Any services, whether or not prescribed by a Physician, that are not listed in this Plan under Covered Expenses, and those services that are not Medically Necessary.

23. Non-emergency care when traveling outside the United States.

24. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 63.

Prescription Drug Benefits

If you are covered under the Kaiser HMO, you will receive prescriptions drug benefits through the Kaiser program.

Prescription Drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Fund offers Prescription Drug Benefits to you and your eligible Dependents though a retail pharmacy program and a mail order program. When you have your prescriptions filled at a contract retail pharmacy or through the mail order program, you save money for yourself and the Plan.

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 a medication on a long-term basis, it is usually best to have it filled through the mail order program.

Generic Versus Brand Name Medications

See the Schedule of Benefits for your Copays and annual Out-of-Pocket limit.

Many prescription Drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. On average, generic medications can save about half the cost of the brand name medications, but for some medications this savings can be as great as 90%. This can be a significant source of savings for you and the Fund. In general, the savings achieved by using generic medications will help control the cost of health care while providing quality medications. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

To encourage you to use generic medications whenever possible, the amount the Plan pays will be more when you use generic medications.

You may want to ask your Physician or pharmacist if a generic equivalent is available for the prescriptions you need filled.

Retail Pharmacy Program

When you are eligible for coverage, you will receive a Prescription Drug ID card. When you have a prescription filled at a contract retail pharmacy:

- Show the pharmacist your ID card; and
- Pay your Copay for the prescription (the pharmacy bills the Plan the remaining amount).

You may only have your prescription filled at a retail pharmacy for up to a maximum of a 34-day supply. The Fund will also allow you to obtain a 90-day supply of maintenance drugs at a retail pharmacy instead of only being able to use mail order. You will pay three (3) retail Copays for each 90-day prescription at a network retail pharmacy. Please note that prescriptions filled at a non-participating retail pharmacy are covered under the Plan; however, you will have to pay the full cost of your prescription when you have it filled and then submit a claim for reimbursement to OptumRx. You will be reimbursed based on the amount the Fund would have paid if the Drug were purchased at a Contract Pharmacy, and you will be responsible for any remaining charges.

Finding a Contract Pharmacy
Most of the major retail pharmacies are in the pharmacy network. The list of contract pharmacies is updated periodically and is provided to you without charge. If you are not sure you have the most recent list, call OptumRx at (855) 672-3644 to locate the nearest contract pharmacy. You can also call the Trust Fund Office.

Mail Service Program

You can save money by using the mail service program for your maintenance (long-term) medications. Maintenance medications are prescription Drugs that are used on an ongoing basis. These prescriptions can be used to treat chronic Illnesses, such as arthritis, heart conditions, or diabetes.

Refer to the separate OptumRx prescription benefit brochure or call OptumRx for more detailed information on how to use the Mail Service program or Specialty Pharmacy services.

When you use the mail service program, you can have your prescription filled for up to a 90-day supply. To use the mail order program:

- Ask your Physician for a written prescription for up to a 90-day supply, with refills if appropriate.
- Mail the original prescription along with the appropriate form to the mail service program. Allow 10-14 days from the time you mail in your order to receive your prescription(s).

If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions: a short-term supply that you can have filled right away at a participating retail pharmacy; and a refillable supply that you can have filled through the mail service program.

For mail service questions, call OptumRx at (855-672-3644.

For Specialty Pharmacy Services, call OptumRx at (855) 672-3644.

Specialty Pharmacy Services

Certain chronic and/or genetic conditions require special pharmacy products, often in the form of injected or infused medicines. The Specialty Pharmacy Services program provides these products directly to you along with the supplies, equipment and care coordination. The program will provide delivery to the location of your choice – home, doctor's office, etc.

Step Therapy for Drugs (including Specialty Drugs)

Step Therapy encourages the use of cost-effective, therapeutically appropriate medications before other, more costly prescription medication options are considered. Often, the most cost-effective therapeutic option is a generic medication. Certain drugs may not be covered by the Plan until an alternative Drug within the same class of Drugs has been tried and failed. 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.

The list of drugs that are subject to step therapy is continually being updated by OptumRx. Please contact Optum Rx at the number listed on the Quick Reference Chart for a current list of drugs that are subject to the Step Therapy guidelines.

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: Auto Immune, Multiple Sclerosis and Growth Hormones.

(1) Exception Applicable to the Auto Immune 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.

Quantity Limits

Certain medications have quantity limits less than regular 34-day retail supply or 90-day mail order supply. These limits affect only the amount of medication that the Plan will pay for. Examples of some medications subject to special quantity limits include, but are not limited to, the following:

- Dermatology: Topical Immunomodulators
- Miscellaneous: Anticholinergic
- Oncology: Kinase and Molecular Target Inhibitors

Required Preauthorization

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

- Anti-Infective: Antivirals
- Authorized Brand Alternatives
- Enzyme-Related: Enzyme Replacement
- Endocrinology: GLP-1 Agonists
- Miscellaneous: Anticholinergic

Schedule of Benefits for Prescription Drugs

Prescription Drug Benefits – Plans A, B, C and D	
Annual deductible	• Plans A and B do not have an annual deductible • Deductible does not apply on Plans C and D
Annual Out-of-Pocket Limit on Outpatient Drug Cost Sharing **for Participating Pharmacies**	$1,875/Individual; $3,750/Family
Participating Retail Pharmacy	Your Copay for each prescription: Generic Drug: $5 Formulary Brand Name Drug: 10% coinsurance (maximum copay $100) Non-formulary Brand Name Drug: 25% coinsurance (maximum copay $200) Maximum Supply: 34 days Exception for FDA approved contraceptives: No charge for Generic Drugs; no charge for Brand Name Drugs if Generic is medically inappropriate. Compound Drugs: Brand Name Drug Copay applies Compound drugs costing more than $150 are subject to review by OptumRx. Subject to annual Out-of-Pocket Limit on Outpatient Drug Cost Sharing
Specialty Drugs	Generic: 20% copay (maximum copay $50) Formulary Brand: 20% copay (maximum copay $100) Non-Formulary Brand: 20% copay (maximum copay $200)

Prescription Drug Benefits – Plans A, B, C and D	
Mail Order Program: You may obtain a 90-day supply at a Participating Retail Pharmacy. You will pay three (3) retail copays for each 90-day prescription at a network retail pharmacy.	Your Copay for each prescription: Generic Drug: $10 Formulary Brand Name Drug: 5% coinsurance (maximum copay $100) Non-Formulary Brand Name Drug: 15% coinsurance (maximum copay $200) Maximum Supply: 90 days Exception for FDA approved contraceptives: No charge for Generic Drugs; no charge for Brand Name Drugs if Generic is medically inappropriate. Compound Drugs: Brand Name Drug Copay applies (if available at mail order). Compound drugs costing more than $150 are subject to review by OptumRx. Subject to annual Out-of-Pocket Limit on Outpatient Drug Cost Sharing
Preventive Care Drugs Certain Preventive Care drugs are payable by Fund in accordance with ACA regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released ACA regulations affecting the coverage of Preventive Care drugs, this Plan will comply with the new requirements on the date required.	No charge if a covered Preventive Care drug is purchased at a Network Pharmacy with a prescription. Covered Preventive Care drugs that are purchased at a Non-Network Pharmacy are **NOT COVERED**.
If the actual cost of the prescription is less than the Copay, you pay the actual cost. If you have your prescription filled with a brand name drug when a generic equivalent is available, the Fund will only pay up to the reasonable cost of the generic equivalent, the remaining amount will be your responsibility, in addition to your Copay.	

Preventive Care Drugs

In accordance with Health Care Reform, certain Preventive Care drugs are payable at no charge when prescribed by your doctor and purchased at an OptumRx retail pharmacy. For a Preventive Care 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 OTC drug from your physician.

The following chart outlines the Preventive Care drugs currently payable by the Fund at no charge when prescribed by your doctor and purchased from a network retail pharmacy:

Coverage Details for Preventive Care Drugs *	
Aspirin	Generic OTC aspirin (1 bottle of 100 tablets every 3 months) 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).
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 50 for preparation before a colonoscopy
Smoking Cessation Products	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
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.

* Where the information in this notice conflicts with any newly released Health Reform regulations affecting the coverage of Preventive Care drugs, the Fund will comply with the new requirements on the date required.

Covered Expenses

Your Copays for prescription drug benefits are listed on the *Schedule of Benefits*. The Plan covers the following Prescription Drug Benefits:

A. Charges made by a Licensed Pharmacist for Drugs prescribed by a Physician for treatment of an Illness or Injury, including new Drugs approved by the federal Food and Drug Administration.

B. Charges made by a Licensed Pharmacist for insulin or diabetic supplies.

C. Charges made by a Licensed Pharmacist for female contraceptives.

D. Charges made by a Physician licensed by law to administer Drugs for any Drugs or diabetic supplies that are supplied to the Patient in the Physician's office and for which a charge is made separately from the charge for any other item of expense.

E. Charges made by a Hospital for Drugs or for insulin or diabetic supplies that are for use outside the Hospital in connection with treatment received in the Hospital, provided they are prescribed by a Physician.

F. Charges made by a Licensed Pharmacist for compounding drugs prescribed by a Physician are covered at the Brand Name Drug Copay outlined in the Schedule of Benefits, 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.

G. Charges made by a Licensed Pharmacist for prenatal vitamins and therapeutic vitamins prescribed by a Physician for the treatment of a specific Illness or Injury.

H. Injectable and infusion Drugs listed in the United States Pharmacopoeia and approved by the Federal Food and Drug Administration, subject to the following:

   i. The Drug must be obtained through OptumRx Specialty Pharmacy Services. Direct member reimbursement claims (paper claims) submitted to OptumRx for reimbursement will not be covered. Exception: This rule does not apply to chemotherapy drugs.

ii. The Drug must be prescribed by a Physician for the direct care and treatment of a covered Illness or Injury.

iii. The Drug must not be for immunization.

iv. The Drug must be one that is not otherwise covered under the Plan's Comprehensive medical benefits.

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (beginning on page 63), Prescription Drug Benefits are not paid for the following expenses.

1. Drugs administered while the Patient is confined in a Hospital or Skilled Nursing Facility.

2. Patent or proprietary medicines that do not require a Physician's prescription by federal law, regardless of whether a state law mandates dispensing only with a prescription, except insulin, diabetic supplies, and those items specifically listed as covered by the Plan.

3. Any medications that are:

   a. Not Medically Necessary for the care or treatment of an Illness or Injury (except for contraceptives or as otherwise required under the Affordable Care Act); or

   b. Used for Experimental indications and/or dosage regimens determined to be Experimental or Investigational.

4. Medications with no federal Food and Drug Administration (FDA) indications and any non-FDA-approved bulk chemicals used in Compound Drugs.

5. Medications prescribed for cosmetic purposes (e.g. Retin-A for other than acne or Rogaine/Minoxidil for hair loss).

6. Appetite suppressants or any other weight loss drugs.

7. Drugs or devices prescribed for treatment of sexual dysfunction, except when due to a medical condition or mental health or substance use disorder as certified by your Physician.

8. Drugs prescribed for treatment of infertility.

9. Prescription and non-prescription contraceptives for men.

10. Immunization agents.

10. Appliances, devices, and other supplies or equipment, except for diabetic supplies.

11. Non-therapeutic and multiple vitamins (except as otherwise required under ACA), nutritional supplements, and health and beauty aids.

12. Charges for prescription drugs in excess of a 90-day supply.

13. Drugs covered under workers' compensation laws or similar legislation or prescribed to treat an occupational Illness or Injury.

14. Drugs provided by or paid for by any governmental program (federal, state, county, or municipal).
15. Replacement prescription drugs resulting from loss, theft or breakage.
16. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 63.

Substance Use Disorder Treatment Benefits

The Plan provides Substance Use Disorder Treatment Benefits described below for covered services received through the Operating Engineers Assistance Recovery Program (ARP).

Covered Expenses

Covered Expenses include:

A. **Inpatient Hospital and residential treatment:** paid the same as Inpatient Hospital for Contract and Non-Contract Providers for a medical diagnosis. ***The Assistance Recovery Program (ARP) must approve the inpatient stay before admission.***

B. **Outpatient treatment:** Rehabilitation, treatment and counseling received on an outpatient basis (including intensive outpatient treatment and partial hospitalization). ***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.

C. **Professional charges:** Paid the same as Physician Visits under the Medical Plan for Contract and Non-Contract Providers.

D. **Facility charges:** Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers.

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (beginning on page 63), Substance Use Disorder Treatment Benefits are not paid for the following expenses.

1. Any treatment that is determined by the Assistance Recovery Program to be not Medically Necessary.

2. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 63.

Hearing Aid Benefits

Hearing Aid Benefits are available to all Eligible Individuals covered under the Plan, including Participants enrolled in the HMO plan.

Schedule of Benefits - Plans A, B, C and D

Hearing Aid Benefits	Coverage
Hearing Examination and Testing	Plan pays 100% of Allowed Charges[1]
Hearing Aid	Plan pays 100% of Allowed Charges[1]
Maximum Benefit	$1,350 per ear, per four-year period

[1] Deductible does not apply to HMO participants.

Covered Expenses

Upon certification by a Physician that you have a hearing loss that may be lessened by the use of a hearing aid, Covered Expenses include:

A. Hearing examination and testing.

B. Hearing aid(s).

Upon certification by a Physician, the Participant may purchase the hearing aid from a vendor that requires a prescription as well as devices approved by the FDA for over-the-counter purchase.

Exclusions and Limitations

In addition to any general Plan exclusions and limitations, hearing aid benefits are not paid for the following expenses.

1. More than one hearing aid for each ear.
2. The replacement of a hearing aid for any reason more often than once during any four-year period.
3. Batteries or any other ancillary equipment other than those obtained upon the purchase of the hearing aid.
4. Expenses incurred for which the individual is not required to pay.
5. Repairs, servicing, or alterations of a hearing aid more often than once during any three-year period.
6. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 63.

Dental Benefits

Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Even though the Fund is not required to do so under PPACA, the Fund offers Dental plan benefits for covered Dependents up to age 26.

Dental Benefits help you manage the amount you pay for dental treatment. Dental Benefits are provided under an administrative services contract between the Trust Fund and Delta Dental of California (Delta Dental). The plan is the Delta Dental PPO, a preferred provider organization (PPO) program that provides access to PPO dentists nationwide.

You are eligible for dental benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.

Choice of Dentists / Provider Network

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 they have agreed to accept set fees as part of their contract with Delta Dental. You can maximize your benefits and pay less out of pocket by seeing a Delta Dental PPO dentist

Note: See "Advantages to Using a Delta PPO Dentist" in the section following Covered Expenses for more information, including how to find a Delta Dental Dentist.

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

Schedule of Benefits

The dental plan covers several categories of benefits when the services are provided by a licensed Dentist and when they are necessary and customary under the generally accepted standards of dental practice.

Dental Benefits	In-PPO Network	Out-of-PPO Network
Deductible	None	None
Diagnostic and Preventive Benefits	Plan pays 100%	Plan pays 100%
Basic Benefits	Plan pays 85%	Plan pays 85%
Restoration Benefits	Plan pays 85%	Plan pays 85%
Prosthodontic Benefits	Plan pays 60%	Plan pays 60%
Calendar Year Maximum The Calendar Year Maximum does not apply to Dependent children up to age 18	$2,500 per person	

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

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

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

Covered Dental Expenses

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

- **For a Delta Dental PPO Dentist**, the lesser of the fee actually charged or the fee the Dentist has contractually agreed with Delta Dental to accept for treating patients covered by this plan.

- **For a Delta Dental Dentist**, the lesser of the fee actually charged or the accepted fee that the Dentist has on file with Delta Dental.

- **For a Dentist who is not a Delta Dental Dentist**, the lesser of the fee actually charged or the fee that satisfies the majority of Delta Dental Dentists.

Covered dental expenses include:

A. Diagnostic and Preventive benefits, such as:

   i. Diagnostic procedures to assist the Dentist in evaluating existing conditions to determine the required dental treatment, including oral examination, bite-wing X-rays, Emergency palliative treatment, specialist consultation (and diagnostic casts only if eligible for orthodontic benefits).

   ii. Preventive procedures such as prophylaxis and fluoride treatment, and sealants.

B. Basic benefits, such as:

   i. X-rays (other than bitewing X-rays) and space maintainers.

   ii. Oral surgery, including extractions, certain other surgical procedures, and pre- and post-operative care.

   iii. Restorative, which is amalgam, synthetic porcelain, and plastic restorations (fillings) for treatment of carious lesions.

   iv. Endodontic, which is treatment of the tooth pulp.

   v. Periodontic, which is the treatment of gums and bones supporting teeth.

C. Restoration benefits, such as crowns and cast restorations for treatment of carious lesions that cannot be restored with amalgam, synthetic porcelain, or plastic restorations.

D. Prosthodontic benefits, such as procedures for construction or repair of fixed bridges, partial dentures and complete dentures if provided to replace missing natural teeth. Benefits are payable for Implant surgical placement and removal and for 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 include one additional oral examination and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant. Written confirmation of pregnancy must be provided by your or your Dentist when the claim is submitted.

Advantages to Using a Delta Dental PPO Dentist

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

Finding a Delta Dentist: Call 800-335-8227 for a list of Delta Dental PPO Dentists and Delta Dental Premier Dentists.

Delta Dental PPO Dentists. You will usually pay the lowest amount for services when you visit a Delta Dental PPO Dentist because PPO Dentists agree to accept a reduced fee for patients covered under the PPO plan. You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to the Dentist. PPO Dentists will complete claim forms and submit them for you at no charge,

Delta Dental Dentists (Premier Network). While Premier Dentists' contract fees are often slightly higher than PPO Dentists' fees, Premier network Dentists may not balance bill above Delta Dental's approved amount, so your out of pocket costs may be lower than with a non-Delta Dentist. Delta Dental Dentists charge you only the patient's share at the time of treatment and will submit claim forms for you at no charge.

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"
- Click on the National Online Directory link
- Select "Delta Dental PPO" and your state, then click "Continue"

Non-Delta Dental Dentists. You are responsible for the difference between the amount Delta Dental pays and the amount the non-Delta Dentist bills. Non-Delta Dental Dentists may require you to pay the entire amount of the bill and wait for reimbursement. You may have to complete and submit your own claim forms or pay your non-Delta Dental Dentist a fee to submit them for you.

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

Limitations

Dental Benefits are limited for the following expenses.

1. Bitewing X-rays are covered twice per calendar year. Full mouth X-rays are limited to once every three years.

2. Prophylaxis (cleaning) is limited to two treatments in a calendar year. Routine prophylaxes are covered as a Diagnostic and Preventive benefit and periodontal prophylaxes are covered as a Basic benefit. A third cleaning is covered for pregnant women; see Note on additional benefits during pregnancy.

3. Fluoride treatments are covered twice each calendar year.

4. Only the first two oral examinations in a calendar year, including office visits for observation and specialist consultations, or any combination of these, are benefits while you are eligible under any Delta Dental plan. See Note on additional benefits during pregnancy.

5. Sealant benefits include the application of sealants only to permanent first molars through age 8 and second molars through age 15 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 two years of its application.

6. Direct composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspids. Any other posterior or direct composite (resin) restorations are covered at an 85% coinsurance level.

7. Periodontal scaling and root planning is covered once for each quadrant each 24-month period. See Note on additional benefits during pregnancy.

8. Crowns, inlays, onlays, and cast restorations are covered on the same tooth only once every five years while you are eligible under the 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.

9. Prosthodontic appliances and implants (including fixed bridges and partial or complete dentures) are covered only once every five years, while you are eligible under this 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 an implant, a prosthetic appliance or an implant-supported prosthesis you received under another plan will be covered if Delta determines it is unsatisfactory and cannot be made satisfactory.

10. 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.

11. Optional Services. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, an allowance will be made for the least expensive, professionally acceptable alternative treatment plan. The Plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the Dentist's fee. For example, a crown where an amalgam filling would restore the tooth or a precision denture where a standard denture would suffice.

Exclusions

In addition to any general Plan exclusions and limitations (beginning on page 63), Dental Benefits are not paid for the following expenses:

1. Expense incurred for missed appointments.

2. Dietary planning, oral hygiene instruction, or training in preventive dental care.

3. Orthodontic services, except as otherwise specified beginning on page 55.

4. Any services or procedures that are Experimental in nature or are not within the standards of generally accepted dental practice.

5. 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.

6. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such services are equilibration and periodontal splinting.

7. Any single procedure, bridge, denture or other prosthodontic service which was started before the date you became eligible for the services under this Plan. A single procedure is a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

8. Prescribed Drugs, or applied therapeutic drugs, premedication or analgesia.

9. Charges by any Hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

10. Anesthesia, except for general anesthesia given by a Dentist for covered oral surgery procedures.

11. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

12. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues.

13. Replacement of an existing restoration for any purpose other than active tooth decay.

14. Intravenous sedation.

15. Complete occlusal adjustment.

16. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 63.

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. 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.

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.

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

Dental Services Covered Under Medical Plan

Some dental services are covered under the medical plan (treatment of an accidental Injury to teeth within 90 days of the accident and removal of cysts or tumors of the gum). Benefits for these services will be paid under the medical plan first and any remaining covered charges will be covered by the dental plan.

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.

How to File a Claim for Dental Benefits

- Delta PPO Dentist and Delta Premier Dentist – The Dentist will file your claim for you.

- Non-Delta Dental Dentist – Claims for services from non-Delta Dental Dentists may be sent to:

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

Orthodontic Benefits

A Participant must be eligible for the Plan's Dental Benefits to be eligible for Orthodontic Benefits.

Please note that only certain Collective Bargaining Agreements provide for Orthodontic Benefits, and then in most cases only for your Dependent children up to age 23. You must be covered under a Collective Bargaining Agreement that requires your Employer to provide these benefits to be eligible. If eligible, Orthodontic Benefits begin on the first day of the calendar month following three-consecutive months of eligibility. Refer to the Schedule of Benefits or contact the Fund Office to find out if you are eligible for this benefit.

***Note:** Some Collective Bargaining Agreements may provide for adult orthodontic benefits. The Orthodontic Schedule of Benefits indicates your coverage.

Schedule of Benefits

Orthodontic Schedule of Benefits–Plan 1 (Children Only)	Coverage
Deductible	None
Coinsurance	Plan pays 50% of Customary and Reasonable Charges
Lifetime Maximum	$2,500 per person
Orthodontic Benefits are only available if provided for in your Employer's Collective Bargaining Agreement, and then only for Dependent children up to age 23.	
Orthodontic Schedule of Benefits–Plan 2 (Family Benefit)	**Coverage**
Deductible	None
Coinsurance	Plan pays 50% of Customary and Reasonable Charges
Lifetime Maximum	$2,500 per person
Orthodontic Benefits are provided for eligible adults and dependent children.	

Covered Expenses

Treatment must be provided by a Dentist to be covered under the Plan. Periodic benefit payments will be determined by the specific treatment plan prescribed by the Dentist. No payment will be made during any month in which the Participant is not eligible or the Dependent does not meet the Plan's definition of a Dependent.

The Plan will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If you select specialized orthodontic appliances or procedures chosen for aesthetic considerations, an allowance will be made for the cost of a standard orthodontic treatment plan and you are responsible for the remainder of the Dentist's fee.

X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic benefits under the Dental Plan.

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (beginning on page 63), and the Dental Benefits exclusions and limitations listed in the previous section, Orthodontic Benefits are not paid for the following expenses.

1. Initial banding that occurred before the individual became eligible under the Plan or, before the Participant's Employer was first required to contribute to the Fund for Orthodontic Benefits.

2. Orthodontic treatment for the Employee or Spouse unless the Employer's Collective Bargaining Agreement provides for adult orthodontic benefits.

3. The replacement or repair of an appliance that has been lost or damaged.

4. Any services not provided by a Dentist.

5. Any month in which the Participant or Dependent is not eligible.

6. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 63.

How to File a Claim for Orthodontic Benefits

- Delta PPO Dentist and Delta Premier Dentist: The Dentist will file your claim for you.

- Non-Delta Dental Dentist: Claims for services from non-Delta Dental Dentists may be sent to:

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

Vision Benefits

Vision plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Even though the Fund is not required to do so under PPACA, the Fund offers Vision plan benefits for covered Dependents up to age 26.

You and your Dependents are eligible for Vision Benefits if your Employer makes the required contributions for this coverage. If eligible, Vision Benefits begin on the same day as other Plan benefits. Contact the Fund Office if you are not sure if you are eligible for this benefit.

To make the most of your Vision Benefits, use VSP providers.

The Fund has contracted with Vision Service Plan (VSP) and their VSP *Choice Plan* network of vision care providers, to provide covered vision expenses at discounted prices. Your Plan benefits will go farther when you use VSP *Choice Plan* providers because VSP providers have agreed to accept Plan maximums as payment in full. While you can use non-VSP providers, you are responsible for payment of any costs that exceed Plan maximums (as listed below).

How the Plan Works

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

- 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 (usually your social security number) and the name of the group plan ("Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund").
- After you have scheduled an appointment, the VSP participating doctor will contact VSP to verify your eligibility and Plan coverage. The doctor will also obtain authorization from VSP for services and materials.
- When you go for your visit, pay the VSP participating doctor your $7.50 Copay and charges for any costs not covered. VSP will pay the doctor directly for the balance of the charges.

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

When you use a VSP *Choice Plan* provider, you are responsible for payment of the Copay and any amounts that exceed Plan maximums; you do not need to file a claim for reimbursement. However, if you use a non-VSP provider, you must pay for all services and supplies at the time you receive them and then submit a claim for reimbursement. You will be reimbursed the appropriate amount after deduction of your Copay and/or any Plan maximums.

See "How to File a Claim" at the end of this chapter for information on submitting claims for non-VSP provider services.

The Copay

The $7.50 Copay applies regardless of whether you are using a VSP *Choice* Plan Provider or a non-VSP provider. The Copay is per individual.

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

Schedule of Benefits

Vision Benefits	VSP Providers	Non-VSP Providers
Copay	$7.50	$7.50
Vision Examination – Limited to once every 12 months *	Plan pays 100%	Plan pays up to $45 per exam
Lenses – Limited to once every 12 months * Single Vision Bifocal Trifocal Lenticular Tints Frames – Limited to once every 24 months	Plan pays 100% up to network provider scheduled allowances Up to $140 allowance for frames	Plan pays up to: $34 $51 $68 $100 $ 5 $70
Necessary Contact Lenses – Limited to once every 12 months * (in lieu of lenses and frames)	Plan pays 100% of network provider scheduled allowances with pre-approval	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 in full)	Plan pays up to $100 for exam and lenses

* The limitations on frequency of services do not apply to VSP Provider services for children under age 19 except that frames are limited to one frame in each rolling one-year period.

Covered Vision Expenses

Covered Expenses include:

A. Vision exam, including visual analysis of visual functions and prescription of corrective eyewear when indicated, once every 12 months.

B. Lenses, once every 12 months.

C. Frames, once every 24 months if replacement is necessary. VSP offers a wide selection of frames within Plan limits. If more expensive frames are chosen (exceeding Plan limits), you will be responsible for the additional amount over the Plan's maximum. Exception for children under age 19: Frames are limited to one frame in each rolling one-year period for VSP provider only.

D. Necessary contact lenses, in lieu of all other benefits when a prescription change is warranted, once in any 12-month period. Necessary contact lenses, together with necessary professional services are only provided when VSP provides pre-approval. Pre-approval may be requested following cataract surgery, to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, for certain conditions of anisometropia, or for keratoconus.

E. Elective contact lenses, in lieu of lenses and frames, when a prescription change is warranted, once in any 12-month period.

Low Vision Benefit

A Low Vision Benefit is available to Eligible Individuals who have severe visual problems that are not correctable with regular lenses. Low Vision Benefits, which are only available with pre-approval from VSP, include:

A. Supplementary Testing, which includes a comprehensive examination of visual function and the prescription of corrective eyewear or vision aids where indicated. The Plan pays 100% for VSP providers or up to a maximum of $125 for non-VSP providers.

B. Supplemental care, which includes subsequent low vision aids. The Plan pays 75% when provided by a VSP provider or non-VSP provider.

Low Vision Benefits are limited to $1,000 per person every two years**.**

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (beginning on page 63), 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:

    a. Blended lenses.

    b. Oversize lenses.

    c. Progressive lenses.

    d. The coating of the lens or lenses.

    e. The laminating of the lens or lenses.

    f. A frame that costs more than the Plan allowance.

    g. Certain limitations on low vision care.

    h. Cosmetic lenses.

    i. Optional cosmetic processes.

    j. UV (ultraviolet) protected lenses.

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 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.

How to File a Claim

- When you use a VSP participating provider, you do not need to file a claim for reimbursement.

- If you use a non-VSP provider, call VSP at 800-877-7195 to have an Out-of-Network Reimbursement Form mailed or faxed to you. (You can also fill out the form online at www.vsp.com and print it). Mail the completed form with your itemized receipt to VSP at:

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

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

Burial Expense Benefit

The Burial Expense Benefit is provided through an insurance contract between the Trust Fund and The Union Labor Life Insurance Company.

In the event of your death as an eligible Active Participant, the Plan will pay a benefit of $2,500 to your designated beneficiary(ies) to help pay for funeral expenses.

Retired Participants are not eligible for the Burial Expense Benefit.

Beneficiary Designation

To designate or update your beneficiary(ies), you need to complete a beneficiary designation form. This form is available from your Local Union Office, the Trust Fund Office or the Fringe Benefits Office. You may designate anyone as your beneficiary. If you do not designate a beneficiary or if your beneficiary dies before you, the benefit will be paid to your:

- Spouse; or if none,
- Children (in equal shares); or if none,
- Parents (in equal shares); or if none,
- Siblings (in equal shares); or if none,
- Executor or administrator.

How to file a Claim for Burial Expense Benefits

The beneficiary must obtain a burial expense benefit claim form from the Fringe Benefits Office. The completed claim form should be submitted with any required documentation to the Fringe Benefits Office at the following address:

The Fringe Benefits Office
3920 Lennane Drive, Ste 200
Sacramento, CA 95834

Life Insurance and Accidental Death and Disbursement (AD&D) Benefit

The Life Insurance and Accidental Death and Dismemberment Benefits are provided under an insurance contract between the Trust Fund and ReliaStar Life Insurance Company.

Employee Life Insurance

In the event of your death while you are an **eligible Active Participant**, the Plan will pay a benefit of $10,000 to your designated beneficiary. If your Collective Bargaining or Subscriber Agreement provides for an additional benefit amount of $25,000, $50,000 or $75,000 and for which contributions have been received, that amount will also be paid. ReliaStar Life pays a death benefit to your beneficiary if written proof is received that you have died while this insurance is in force. Benefit proceeds are paid in one lump sum.

Dependent Life Insurance is NOT provided and retired Participants are not eligible for life insurance.

Accidental Death and Dismemberment Benefit

The Plan insures you for up to $10,000 against death or dismemberment in an accident on or off the job. Additional amounts may be available if your Collective Bargaining or Subscriber Agreement provides for the additional contributions required and the related contributions have been received. Please refer to the separate Evidence of Coverage from ReliaStar Life Insurance Company for the schedule of benefits.

Beneficiary Designation

To designate or update your beneficiary(ies), you need to complete a beneficiary designation form. This form is available from the Trust Fund Office, the Fringe Benefit Service Center, Local Union office or District Office. You may designate anyone as your beneficiary. If you do not designate a beneficiary or if your beneficiary dies before you, the benefit will be paid to your:

- Spouse; or if none,
- Children; or if none,
- Parents; or if none,
- Brothers and sisters; or if none,
- Executor or administrator.

How to file a Claim

Send claims to the Trust Fund Office which will confirm eligibility and forward the claim to the insurance company.

> Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund
> P.O. Box 28416
> Oakland, CA 94604-8416

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

General Plan Exclusions and Limitations

The following general Plan exclusions and limitations apply to all Plan benefits. These limitations and exclusions are in addition to any exclusion listed elsewhere throughout this booklet.

This listing is not all-inclusive, only representative of the type of charges for which benefits are limited or not payable under the Plan. Just because a service or supply is not listed as an exclusion does not mean it is a Covered Expense. Only benefits listed as covered are considered Covered Expenses under the Plan. In addition, benefits are not payable for amounts in excess of allowable expenses as defined by the Plan.

No payment will be made for the following under the Plan:

1. Any amounts in excess of Allowed Charges or any services not considered to be Medically Necessary.

2. Services for which you are not legally obligated to pay, for which no charge is made, or for which no charge would be made in the absence of insurance or other indemnity coverage, except services received at a non-governmental charitable research Hospital, which must meet the following guidelines:

    a. It must be internationally known as being devoted mainly to medical research;

    b. At least 10% of its yearly budget must be spent on research not directly related to Patient care;

    c. At least 1/3 of its gross income must come from donations or grants other than gifts or payments for Patient care;

    d. It must accept Patients who are unable to pay; and

    e. 2/3 of its Patients must have conditions directly related to the Hospital's research.

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

    a. Signs an agreement to prosecute diligently the claim for workers' compensation benefits or for any other available occupational compensation benefits;

    b. Agrees to reimburse the Fund for benefits paid on his or her behalf by consenting to a lien against any occupational compensation benefits received through adjudication, settlement, or otherwise; and

    c. 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.

4. Conditions caused by or arising out of an act of war, armed invasion, or aggression.

5. Injury or Illness caused by or arising out of the commission of a felony unless the Injury or Illness is the result of domestic violence or the commission or attempted commission of a felony is the direct result of an underlying medical (physical or mental) condition.

6. Conditions caused by self-inflicted injuries or suicide attempts unless due to an underlying medical (physical or mental) condition or as a result of domestic violence.

7. Services rendered while an Eligible Individual is confined in a Hospital operated by the United States Government or an agency of the United States Government, except that the Plan, to the extent required by law, will reimburse a Veterans Administration (VA) Hospital for care of a non-service related disability if the Plan would normally cover the care if the VA were not involved.

8. Care or treatment in any penal institution, jail facility, or jail ward of any state or political subdivision.

9. Any claim submitted to the Plan more than one year from the date on which the expense was incurred.

10. Any services or supplies in connection with Experimental or Investigational procedures (see page 98 for a definition of Experimental or Investigational).

Claims and Appeals

Filing a claim is easy if you follow the steps described in this section. If a claim is denied or reduced, there is a process you can follow to have your claim reviewed. Throughout this section, "you" and "your" may refer to you, your Dependent(s), and/or your authorized representative, as applicable.

You must follow the Plan's claims and appeals procedures completely before you bring any legal action to obtain benefits. The Trustees, or their designated representative, have sole, discretionary authority to make final determinations regarding any application for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees.

Filing Claims

Generally, all claims must be submitted within 90 days after you receive a bill. However, if it is not possible to file a claim within 90 days, the claim must be filed within 12 months of the date of service for benefits to be payable under the Plan. Be sure to show your ID card so your provider knows where to submit your claim. Contract providers will file your claim for you. If your provider does not submit your claim for you, it is then you, your Dependent's, or your authorized representative's responsibility to do so.

Dental, Orthodontic and Vision Claims

Information on how to file dental, orthodontic, and vision claims is shown at the end of each chapter describing those benefits earlier in this booklet.

Substance Use Disorder

Inpatient Substance Use Disorder claims should be sent to:

Operating Engineers Assistance Recovery Program (ARP)
3000 Clayton Road
Concord, CA 94519

Outpatient claims should be handled the same as any other medical clam (outlined below).

No claim forms are required for prescription Drugs if you use a network pharmacy. Non-network pharmacy claims may be sent to OptumRx with a claim form and the original prescription receipts. You can print a claim form when you log on to OptumRx.com or call OptumRx at1-855 672-3644.

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.

If you are eligible for other coverage and that coverage should pay first, you must submit your claim to the other plan first.

Providers Outside California

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

Life Insurance and Accidental Death and Dismemberment (AD & D)

To obtain a claim form and to submit a completed claim form with the required documentation, contact ReliaStar Life Insurance Company at the address below:

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

What is Not a Claim. 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 a claim. However, if a Participant files a claim for specific benefits and the claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a denied claim.

Disability Claims

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 (such as a claim for an Extension of Health Benefits for Total Disability or a request to cover a disabled dependent past the limiting age) and must be submitted to the Plan within 90 days after the date of the onset of the disability.

Definitions

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

- A payment of less than 100% of a Claim for benefits (including coinsurance or Copay 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 a claimant is 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. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

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

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

- Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered a Claim. However, if a participant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.
- The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the participant pays the entire

cost, the participant should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

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

Types of Claims

Health care claims include Comprehensive Medical, Substance Use Disorder Treatment, Hearing Aid, Prescription Drug, Dental, Orthodontic, and Vision Benefits claims. Health care claims are divided into four basic types of claims:

Urgent Care is a claim for medical care or treatment, with respect to which a delay of up to 15 days in making decisions under the Pre-Service Claim procedures, would:

Urgent care claims are considered pre-service claims.

- Seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or
- Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Pre-Service is a claim for benefits where pre-approval is required before you obtain care (see page 20 for information on when approval is required). However, the Plan will not deny benefits for these claims if it is not possible for you to obtain pre-approval or if the process would jeopardize your life or health.

Concurrent Care is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of a Hospital stay) and the reconsideration results in reduced benefits or a termination of benefits.

Disability Claim is a claim for benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant's disability (including the Plans' determination of disability related to an eligibility extension due to a disability). A claim regarding rescission of disability coverage will be treated as a disability claim unless related to failure to pay premiums/contributions for disability coverage.

Post-Service is a claim for benefits that is not a pre-service, urgent or concurrent claim. When you file a post-service claim, you have already received the services for which the claim is being submitted. A claim regarding a rescission of coverage will be treated as a Post-Service Claim.

No Surprises Act Services Claims are claims subject to the No Surprises Act. 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.
- If the claim is approved, 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.

Burial Expense Benefit claims and Accidental Death & Dismemberment (AD&D) claims are other types of claims under the Plan.

Claim Decisions

When you submit a claim for benefits, the Plan will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly when complete claim information is received. The Plan will make an initial determination within certain timeframes, as follows:

Health Care Claims (except Dental and Orthodontic claims). Generally, health care determinations will be made as soon as administratively possible, as follows:

Dental and Orthodontic Claims. Refer to the separate Delta Dental Plan Evidence of Coverage and Disclosure Form for information on dental and orthodontic claim decisions.

- ***Urgent Care Claims.*** For properly filed Urgent Claims, the Plan or its designated Review Organization will respond to the participant and provider with a determination as soon as possible, taking into account the medical exigencies, but not later than within 72 hours after receipt of the claim. The determination will also be confirmed in writing.
  - If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Plan or its designated Review Organization will notify the participant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The participant must provide the specified information within 48 hours after receiving the request for additional information. If the information is not provided within that time, the Claim will be denied.
  - During the period in which the participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information.
  - If a participant improperly files an Urgent Claim, the Trust Fund office or its designated Review Organization will notify the participant as soon as possible but not later than 24 hours after receipt of the Claim of the proper procedures required to file an Urgent Claim. Improperly filed Claims include, but are not limited to: (i) Claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or (ii) Claims that do not name a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. The notification may be oral unless the participant or authorized representative requests written notification. Unless refiled properly, it will not constitute a Claim.
- ***Pre-Service Claims.*** The Plan will notify you of its initial determination within 15 days from receipt of your claim. If additional time is necessary, up to 15 additional days, due to matters beyond the control of the Plan, you will be informed of the extension within this 15-day deadline. If additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will notify you of its determination within 15 days.

  If you do not follow the required procedures for filing a pre-service claim, the Plan will notify you within five days of receipt of the claim.
- ***Concurrent Care Claims*.** The Plan will notify you as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment. If a concurrent care claim does not involve urgent care treatment or is filed less than 24 hours before the expiration of the previously approved time period or number of treatments, the Plan will respond according to the type of claim involved.

  If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved.
- ***Post-Service Claims*.** The Plan will notify you of its initial determination within 30 days from receipt of your claim. If additional time is necessary, due to matters beyond the control of the Plan, you will be

informed of the extension within this 30-day deadline. If additional information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will notify you of its determination within 15 days.

- ***Disability Claims:*** Generally, the Plan will make a decision and notify you of the decision within 45 days after receipt of the claim. The Plan may extend this 45 day period up to an additional 30 days.
- ***Burial Expense Benefit Claims.*** Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this 90-day deadline. The Plan may extend this 90-day period up to an additional 90 days maximum.
- ***Life Insurance and Accidental Death and Dismemberment (AD&D) Benefit Claims.*** Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the insurer), you will be notified within this 90-day deadline. The insurer may extend this 90-day period up to an additional 9/0 days maximum.

If circumstances require an extension of time for making a determination on your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. Once the Fund makes payment on a claim, no further payment will be made.

Payment in Event of Incompetency or Lack of Address

In the event the Fund determines that an Eligible Individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Individual has not provided the Fund with an address at which he or she can be located for payment, the Fund may during the lifetime of the Eligible Individual, pay any amount otherwise payable to the Eligible Individual to the Spouse or blood relative of the Eligible Individual, or to any other person or institution determined by the Fund to be equitably entitled to payment. In the case of the death of the Eligible Individual before all amounts payable under the Plan have been paid, the Fund may pay this amount to any person or institution determined by the Fund to be equitably entitled to payment. The remainder of any amount owing will be paid to the Eligible Individual's Spouse, child(ren), parent(s), sibling(s), or estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision discharges the Fund from any further obligation.

Notice of Initial Benefit Determination

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

- Identification of the claim involved (e.g. date of service, health care provider, claim amount (if applicable) and a statement that diagnosis and treatment codes and meaning of the codes are available upon request and free of charge);
- The specific reason(s) for the determination including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
- A description of the internal appeal procedures and External Review processes, including information regarding how to initiate an appeal, and applicable time limits;

- A statement of the participant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination, including an External Review;
- If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon written request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge;
- For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification); and
- Information on the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and External Review processes.

Internal Appeal Procedures

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow and exhaust the Plan's appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits, or initiate proceedings before any administrative agency. In the event you submit a claim for review and the claim again is denied, any legal action must begin within 180 days of the date the Plan provides an adverse appeal determination.

Dental and Orthodontic Claims. Refer to the "Grievance Procedure and Claims Appeal section" in the separate Delta Dental Evidence of Coverage / Disclosure Form for information on how to appeal denied dental and orthodontic claims.

In general, you should send your written request for an appeal to the Board of Trustees at the Fund Office as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days from the date of a decision for health care claims; or
- 60 days from the date of a decision for Burial Expense Benefit claims.
- 60 days from the date of a decision for Life Insurance and Accidental Death and Dismemberment (AD&D) claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative and comply with the Plan's procedures. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim. Your written request for appeal must include:

- The Patient's name and address;
- The Participant's name and address, if different;
- A statement that this is an appeal of a denied claim;
- The date of the denial; and

- The basis of the appeal (i.e., the reason(s) why the claim should not be denied).

When filing an appeal you may:

- Submit additional materials, including comments, statements or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on Medical Necessity, Experimental treatment or similar exclusion or limit.

Appeal Decisions

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made and the decision will not defer to the initial decision. An appropriate fiduciary of the Plan, which is the Board of Trustees, will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on any appeal within five days after a determination is made. However, oral notice of a determination on your urgent care claim may be provided to you sooner.

Appeal Decision Timeframes

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as follows:

Health Care Claims:

- ***Urgent Care Claims.*** Notice of the appeal determination for Urgent Care Claims will be sent within 72 hours of receipt of the appeal by the Trust Fund office or designated Review Organization.
- ***Pre-Service Claims*.** The Plan will notify you of its determination within 30 days from receipt of your appeal.
- ***Concurrent Care Claims.*** The Plan will notify you of its determination before termination of your benefit.
- ***Post-Service Claims*.** A determination will be made at the Trustees' next regularly-scheduled quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require an extension of time, you will be notified and a determination will be made no later than the third quarterly meeting following receipt of the appeal.

Burial Expense and Life and Accidental Death and Dismemberment Benefits. A determination will be made at the Trustees' next quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second quarterly meeting following receipt of your appeal. If special circumstances require an extension of time, you will be notified and a determination will be made no later than the third quarterly meeting following receipt of the appeal.

You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision.

Content of Appeal Determination Notices

The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

- Identification of the claim involved (e.g. date of service, health care provider, claim amount (if applicable) and a statement that diagnosis and treatment codes and meaning of the codes are available upon request and free of charge);
- The specific reason(s) for the 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;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that the participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon written request and free of charge;
- If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon written request at no charge;
- If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge;
- A statement of the participant'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; and
- Information on the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and External Review processes.

Medical Judgments

If your claim or appeal is denied based on a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the original denial of your claim.

You have the right to be advised, upon request, of the identity of any medical experts consulted in making a determination of your appeal.

Disability Claim Decisions

The Plan will ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support a denial of benefits.

Disability Claims

Generally, the Fund Office will make a decision and notify you of the decision within 45 days after receipt of the claim. However, this 45-day period may be extended as follows:

- *First 30-day extension*: If the Fund Office requires an extension of time, up to 30 days, due to matters beyond its control, you will be notified of the reason for the delay and the date by which the Plan expects to render a decision. This notice will occur before the expiration of the initial 45-day period.

- *Second 30-day extension*: If, prior to the end of the first 30-day extension period, the Fund Office determines that, due to matters beyond its control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Fund Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision.

- *For both extensions*: The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You then will have 45 days within which to provide the specified information. If the information is not provided within the 45-day period, the claim may be denied. During the 45-day period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date you respond to the request. Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

The Plan reserves the right to have a Physician examine you (at the Fund's expense) as often as is reasonable while a claim for benefits is pending.

If Your Disability Claim is Denied

You will be provided with written notice of the initial benefit determination. If the determination is an adverse benefit determination, the notice will include:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

(e) 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, without regard to whether the advice was relied upon in making the benefit determination; and

3. Any disability determination by the Social Security Administration.

(f) If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

(g) Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;

(h) A statement when the claim is denied that you are entitled to receive relevant documents upon request; and

(i) A statement that if you are not proficient in English and have questions about a claim denial, you should contact the Fund Office to find out if assistance is available.

Appealing a Disability Denial

If a claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may appeal the decision. Appeals must be made in writing and must be submitted to the Plan within 180 days after you receive the notice of adverse benefit determination. You must follow and exhaust the Plan's appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits, or initiate proceedings before any administrative agency.

Your written appeal must explain the reasons you disagree with the decision on your disability claim. Your written request for appeal must include:

- The Patient's name and address;
- The Participant's name and address, if different;
- A statement that this is an appeal of a denied claim;
- The date of the denial; and
- The basis of the appeal (i.e., the reason(s) why the claim should not be denied).

When filing an appeal, you may:

- Submit additional materials, including comments, statements or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on Medical Necessity, Experimental treatment or similar exclusion or limit.

You will be provided automatically and free of charge, with any new or additional evidence and/or additional rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence/rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of appeal is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the disability claim filing or disability claim appeal process that you would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as you have such an opportunity.

Content of Appeal Determination Notices for Disability appeals

The determination of an appeal will be provided to you in writing. The notice of a denial of an appeal will include:

(a) The specific reason(s) for the determination;

(b) Reference to the specific Plan provision(s) on which the determination is based;

(c) A statement that you are entitled to automatically receive reasonable access to and copies of all documents relevant to the claim, upon request, free of charge;

(d) A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

(e) If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

(f) A discussion of the decision, including the basis for disagreeing with or not following:

1) The view 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.

(g) Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist and a statement that a copy is available at no charge.

(h) A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request; and to respond to new information by presenting written evidence and testimony.

(i) A statement that if you are not proficient in English and have questions about a claim denial, you should contact the Fund Office to find out if assistance is available.

Timeframes for Sending Notices of Appeal Determinations for Disability Claims

Ordinarily, decisions on appeals involving Disability claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the Participant's request for review. However, if the request for review is received at the Trust Fund Office within 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the Participant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the Participant's request for review may be necessary. The Participant will be advised in writing in advance if this extension will be necessary. Once a decision on review of Participant's claim has been reached, they will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

If the decision on review is not furnished to the Participant within the timeframes specified in this section, the claimant is deemed to have exhausted the administrative remedies available under the plan, except for de minimis violations described below. In such case, the claimant is entitled to pursue any available remedies under ERISA Section 502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under ERISA Section 502(a) under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion of the Board of Trustees.

De minimis violations: If the Plan fails to provide a timely response on appeal, a claimant will not be deemed to have exhausted administrative procedures if the Plan's violation:

- Was de minimis and did not cause and is not likely to cause, prejudice or harm to you;

- Occurred in the context of an ongoing, good faith exchange of information with you; and
- Was not part of a pattern or practice of violations.

The Plan must provide a written explanation of the di minimis violation with 10 days or receipt of a request.

The denial of a claim to which the right to review has been waived or the decision of the Board of Trustees with respect to a petition for review is final and binding upon all parties, including the claimant or the petitioner, and is subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration. No Employee, Dependent, beneficiary, or other person may start a lawsuit to obtain benefits until the Plan's claims and appeals process has been completed. Any lawsuit must be filed no later than three years from the date the claim was first incurred.

Claims are limited to benefits due under the terms of the Plan or to clarify rights to future benefits under the terms of the Plan, and do not include any claim or right to damages, either compensatory or punitive.

Physical Examination and Autopsy

The Fund, at its own expense, has the right 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 request an autopsy in case of death where it is not forbidden by law.

Authorized Representative

Unless otherwise elected, you will be considered the authorized representative for your Dependent Spouse and children and your Dependent Spouse will be considered the authorized representative for you and any Dependent children. You may authorize certain individuals to act on your behalf. You will need to submit a written statement authorizing this individual. Your authorized representative will be responsible for, and will receive all information related to, your appeal.

The following will be recognized as your representative upon receipt of a written statement from you:

- Health care provider;
- Dependent child age 18 or older;
- Parents or adult siblings;
- Grandparent;
- Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or
- Other adult.

For an urgent care claim, a health care professional with knowledge of your condition will be recognized as your authorized representative without a written statement from you.

Following an Appeal – Legal Proceedings

A participant may not start a lawsuit to obtain benefits until after:

- The participant has submitted a Claim pursuant to the procedures outlined in this chapter, requested a review after an Adverse Benefit Determination, including an External Review for other than eligibility disputes, and a final decision has been reached on review;
- The appropriate time frame described in this chapter has elapsed since the participant filed a request for review and participant has not received a final decision or notice that an extension will be necessary to reach a final decision; or
- The internal claims and appeals process is deemed to be exhausted under the Affordable Care Act and the applicable regulations, in which case the participant may seek External Review or file a lawsuit under ERISA Section 502(a).

The denial of a Claim to which the right to review has been waived, or the decision of the Board with respect to a petition for review, is final and binding upon all parties including the claimant or the petitioner, subject only to any civil action the claimant may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration. The provisions of this chapter shall apply to and include any and every Claim to benefits from the Fund, and any Claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the Claim, and regardless of when the act or omission upon which the Claim is based occurred, and regardless of whether or not the claimant is a "participant" or "beneficiary" of the Plan within the meaning of those terms as defined in ERISA. Such Claim shall be limited to benefits due under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any Claim or right to damages, either compensatory or punitive.

External Review of Claims

This External Review process is intended to comply with the Affordable Care Act (ACA) and the No Surprises Act (NSA) External Review requirements as set forth in Interim Final Regulations implementing the ACA and in Technical Release 2010-01. 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, whether urgent, concurrent, pre-service or post-service claim, is denied, the claimant may request further review by an independent review organization ("IRO"). Generally, an External Review may be requested only after the claimant has exhausted the internal review and appeals process described above. This External Review process does not pertain to claims for burial expense benefits or if a claim was denied due to the claimant's failure to meet the requirements for eligibility under the terms of the Plan. External review is available for the following:

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/or

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.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

External Review of Standard (Non-Urgent) Claims

A request for External Review of a standard (not urgent) claim must made, in writing, within four (4) months of the date that the claimant receives notice of a denial of an appeal. An appeal denial is referred to as an "Adverse Determination."

An External Review request on a standard claim should be made to the following applicable Plan designee:

- The Trust Fund Office, with respect to a denied claim not involving retail or mail order prescription drug expenses or dental or vision claims;
- OptumRx, with respect to a denied claim involving retail or mail order prescription drug expenses;
- Anthem Blue Cross, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses.

Preliminary Review of Standard Claims

Within five (5) business days of the Plan's receipt of a request for an External Review of a standard claim, the Trust Fund Office will complete a preliminary review of the request to determine whether:

1. 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;

2. The Adverse Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

3. 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

4. The claimant has provided all of the information and forms required to process an External Review.

Within one (1) business day of completing its preliminary review, the Trust Fund Office will notify the claimant in writing as to whether his/her request for External Review meets the above requirements for External Review. This notification will inform the claimant:

If his/her request is complete and eligible for External Review; or

If the request is complete but not eligible for External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

If the request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow the claimant to perfect (complete) the request for External Review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review of Standard Claims by an Independent Review Organization (IRO)

If the request is complete and eligible for an External Review, the Trust Fund Office will assign the request to an accredited Independent Review Organization (IRO). The IRO is not eligible for any financial incentive or

payment based on the likelihood that the IRO would support the denial of benefits. The Plan will rotate assignment among IROs with which it contracts. Once the claim is assigned to an IRO, the following procedure will apply:

- 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 his/her claim (generally, claimants are to submit such information within ten (10) business days).
- Within five (5) business days after the External Review is assigned to the IRO, the Plan will 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 must, within one (1) business day, forward that information to the Plan. 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. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its 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.
- 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.
- If the final External Review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. [If the claimant is dissatisfied with the External Review determination, he or she may seek judicial review as permitted under ERISA Section 502(a).]

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 and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
- 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
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with External Review processes.
- This Plan will also provide the Notice in Spanish, upon request.

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 his/her life or health, or would jeopardize his/her ability to regain maximum function, and he/she has filed a request for an expedited internal appeal; or

2. The claimant receives an Adverse Determination of an appeal that involves a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize his/her life or health or would jeopardize his/her ability to regain maximum function; or, the claimant receives an Adverse Determination that concerns an admission, availability of care, continued stay, or health care item or service for which he/she received services for an emergency, but he/she has not yet been discharged from a facility.

The request for an expedited External Review of a non-standard claim should be made to the following applicable Plan designee:

- Anthem Blue Cross, with respect to a denied urgent, Pre-service or concurrent review determination not involving retail or mail order prescription drug expenses;
- OptumRx, with respect to a denied claim involving retail or mail order prescription drug expenses;
- ARP, with respect to a denied urgent, pre-service or concurrent review determination involving a substance use disorder claim.

Preliminary Review for an Expedited Claim

Immediately upon receipt of the request for expedited External Review, the Trust Fund Office will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Trust Fund Office will immediately notify the claimant (e.g. telephonically, via fax) as to whether his/her 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)

Following the preliminary review that a request is eligible for expedited External Review, the Trust Fund Office will assign an IRO (following the process described under Standard Review above). The Trust Fund Office 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 Adverse Determination.

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.

- 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.
- If the final External Review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. [If the claimant is dissatisfied with the External Review determination, he or she may seek judicial review as permitted under ERISA Section 502(a).

Third Party Liability

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

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

If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund will also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien will be satisfied from any recovery received by the Eligible Individual, however classified, allocated, or held.

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

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

- To prosecute any claim for damages diligently;
- To promptly advise the Fund whenever a claim is made against the responsible third party with respect to any loss for which Fund benefits have been or will be paid because of an Illness, Injury, disease or other condition caused by the responsible third party;
- The Fund's reimbursement rights will be considered as a first priority claim against another person or entity, to be reimbursed before any other claims, including claims for general damages;
- To cooperate and assist the Fund in obtaining reimbursement for payments made, and to refrain from any act or omission that might hinder any reimbursement;
- To provide the Fund with all relevant information or documents requested;
- To consent to the lien and/or constructive trust that will exist in favor of the Fund upon all funds recovered by the Eligible Individual against the responsible third party;

- To hold proceeds of any settlement, verdict, judgment or other recovery in trust for the benefit of the Fund, and that the Fund will be entitled to recover reasonable attorney's fees incurred in collecting reimbursement of benefits due;
- To execute any documents necessary to secure reimbursement;
- Not to assign any rights or cause of action that the Eligible Individual may have against the responsible third party to recover medical expenses without the express written consent of the Fund;

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

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

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

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

Offset and Recoupment of Overpayments

If through mistake or any other circumstance, you, as an Eligible Individual, have been paid or credited with more than you are entitled to under the Plan, under the law, or have become obligated to the Fund under an indemnity agreement or a third party liability agreement or in any other way, the Fund may set off, recoup, and recover the amount of the overpayment, excess credit, or obligation from benefits accrued or thereafter accruing to you, your Dependent, or your beneficiary, and not yet distributed, in any installments and to the extent determined by the Board.

Privacy and Security Policy

The Plan is required to protect the confidentiality of your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- Receive confidential communications of your protected health information, as applicable;
- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan's Privacy Official or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

Protected Health Information (PHI)
All individually identifiable health information transmitted or maintained by the Plan that relates to your past, present, or future health, treatment, or payment for health care services.

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Fund Office.

In compliance with **HIPAA Security** regulations, the Plan has:

- Implemented 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,
- Ensured that the adequate separation specific to electronic PHI, is supported by reasonable and appropriate security measures,
- Ensured 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
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Coordination of Benefits with Other Plans

If you (which refers to an Eligible Individual throughout this section) are entitled to benefits from another Group Plan for Hospital or medical expenses for which benefits are also due from this Plan, this Plan's benefits will be paid in accordance with the Plan's Coordination of Benefits provisions, not to exceed the dollar amount of benefits that would have been paid in the absence of other group coverage or 100% of the Allowable Expense actually incurred.

This Plan's Coordination of Benefits provisions will determine the order of payment as follows:

Allowable Expense

For Coordination of Benefits purposes, Allowable Expense means a health care service or expense, including Deductibles, coinsurance, or Copays, that is covered in full or in part by any of the plans covering you. An expense, service, or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense. When Non-Contract Providers are used, Allowable Expense will not exceed the Allowed Charge that is covered in whole or in part by any of the plans covering you.

1. If you are an Active Employee, Fund benefits will be provided without reduction.

2. If you are the Dependent Spouse of a Participant, Fund benefits will be paid for eligible expenses not covered by the other Group Plan.

3. If a claim is made for a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan that covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, will be determined before the benefits of the Group Plan that covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year. If either Group Plan does not have the provisions of this rule regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule do not apply, and the rules in the plan that does not have this provision will determine the order of benefits.

4. If a claim is made for a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the plan that covers the child as a dependent of the parent with custody will be determined before the benefits of the plan that covers the child as a dependent of the parent without custody.

5. If a claim is made for a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of the plan that covers the child as a dependent of the parent with custody will be determined before the benefits of the plan that covers that child as a dependent of the stepparent, and the benefits of the plan that covers that child as a dependent of the stepparent will be determined before the benefits of the plan that covers that child as a dependent of the parent without custody.

6. If a claim is made for a Dependent child whose parents are separated or divorced and there is a court decree that establishes financial responsibility for medical, dental, or other health care expenses with respect to the child, then notwithstanding the above rules, the benefits of the plan that covers the child as a dependent of the parent with the financial responsibility will be determined before the benefits of any other plan that covers the child as a dependent child.

7. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined using the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule applies between the dependent child's parents coverage and the dependent's self or spouse coverage.

When the preceding rules do not establish an order of benefit determination, Fund benefits will be provided without reduction if you have been continuously eligible for benefits from this Fund for a longer period of time than you have been continuously eligible for benefits from the other Group Plan, provided that the benefits of the Group Plan covering you as a laid-off or Retired Employee will be determined after the benefits of any other Group Plan covering you as an Active Employee, other than a laid-off or Retired Employee. However, if the other Group Plan does not have a provision regarding laid-off or Retired Employees, which results in each Group Plan determining its benefits after the other, then this provision does not apply.

Coordination with Prepaid Plans

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event a spouse/domestic partner (i) has coverage under the Self-Funded portion of this Plan, and (ii) has coverage under a prepaid program under another group plan (regardless of whether the Dependent must pay a portion of the premium for such plan), and (iii) incurs expenses normally covered under the prepaid program, then **this Plan will only reimburse the co-payments required of the eligible Dependents under the prepaid program, and only if such co-payments are required of every person covered by that program.** This includes Copays for prescription drugs. Except for the Copays specified above, the Plan will not pay expenses covered by prepaid programs of other plans.

Prepaid Program

Prepaid programs include:

- Health Maintenance Organization (HMO) plans;
- Individual practice associations; and
- Any other programs that the Board, in its sole discretion, deems to be essentially similar to these prepaid arrangements.

For purposes of this Plan, the term "prepaid program" shall include health maintenance organizations, individual practice associations, and such other programs that the Board of Trustees of the Plan in its sole discretion deems to be essentially similar to such prepaid arrangements.

If your spouse/domestic partner has a pre-paid program as his/her primary carrier, your spouse/domestic partner **must use** the pre-paid program. There are no benefits payable by the Plan when the spouse/domestic partner does not stay within their pre-paid program network.

Example: If your spouse/domestic partner is enrolled in Kaiser HMO coverage through your spouse's/domestic partner's employer, he or she is required to use that HMO coverage first. HMO services that are denied as they are not rendered within the HMO service area or approved by a plan physician (including but not limited to doctor visits and inpatient hospitalizations) that could have been provided by the HMO will not be considered for payment by the plan. When network HMO physician visits/services are utilized, the Fund will reimburse only the Copays for those services and supplies. **This means that if you are enrolled in HMO coverage, you must comply with the preauthorization and service area requirements of that HMO in order to receive benefits from this plan.**

Coordination with Preferred Provider Plans

Where this Plan is secondary and is coordinating benefits with another preferred provider plan, this Plan will pay no more than the difference between the:

Lesser of the:

- Normal charges billed for the expenses by the provider; or
- Contractual rate for the expense under a preferred provider agreement between the provider and the plan that this Plan is coordinating with; and

Amount that the other plan pays as primary.

Coordination with Medicare

If you are eligible as an Active Employee or the Dependent of an Active Employee and are eligible for Medicare, this Plan's benefits will be paid without reduction.

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If you are eligible as an Active Employee or Dependent of an Active Employee and you become Medicare eligible because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

If the Active Employee or Dependent of an Active Employee has not enrolled in Medicare at the time, this Plan becomes the secondary payer, starting with the 31st month after eligibility for Medicare coverage began, this Plan will coordinate benefits as though the individual is receiving benefits under Parts A, B and D of Medicare. This Plan will estimate Medicare's payment as follows: Part A- 100% after applying a Part A Deductible; Part B- 80% of Covered Expenses after applying a Part B Deductible. The Plan will pay only the remaining Covered Expenses after the estimated Medicare benefits are deducted.

If you are a Retired Employee or the Dependent of a Retired Employee and are eligible for Medicare, Medicare will be the primary payer and this Plan will be the secondary payer. Covered Fund benefits will be coordinated with Medicare benefits and based on the lesser of Medicare's allowable charge or the Plan's allowable charge (including PPO discounts). **If you do not enroll in Medicare when eligible, this Plan will coordinate benefits as though you are receiving benefits under Medicare Parts A and B.** The Plan will estimate Medicare's payment as follows: Part A: 100% after applying a Part A Deductible; Part B: 80% after applying a Part B Deductible. The Plan will pay only the remaining Covered Expenses after the estimated Medicare benefits are deducted.

Important Note for Medicare-eligible Retirees and Dependents. Benefits of this Plan are reduced by the amounts payable under Medicare. This reduction will apply even if you are NOT enrolled in Medicare; therefore you should enroll in Medicare Part A, B and D in order to receive the maximum amount of benefits under this Plan.

Medicare Private Contract: Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain health care providers under which the participant agrees that no claim will be submitted to or paid by Medicare for services and supplies furnished by that provider. If you are a Retired Employee or the Dependent of a Retired Employee and you enter into such a contract, this Plan will pay benefits for health care services and supplies you receive under that contract, but those benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, Medical Necessity, Allowed Charges, and the Plan will pay only 20% of the Covered Expenses, and you are responsible for the rest.

Medicare Prescription Drug Coverage. It has been determined that the prescription drug coverage outlined in this SPD is creditable. "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 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.

This section about Medicare Part D does not apply to Kaiser members

If you are a **Retired Employee** or the **Dependent of a Retired Employee** enrolled in the Comprehensive Medical Plan and are eligible for Medicare Prescription Drug Coverage (Medicare Part D), you have the following choices:

- You can keep your current prescription drug coverage with the Fund and not enroll for Medicare Prescription Drug Coverage. In the future, you may enroll in Medicare Prescription Drug Coverage during Medicare's annual enrollment period (October 15th to December 7th of each year) and you will not be charged a penalty.

- You can keep your current prescription drug coverage with the Fund and enroll for Medicare Prescription Drug Coverage. If you enroll for Medicare Prescription Drug Coverage, the Fund's prescription drug coverage will be secondary to Medicare and you will need to pay any Medicare premium out of your own pocket.
- You can drop your prescription drug coverage with the Fund and enroll for Medicare Prescription Drug Coverage on your own. If you enroll for Medicare Prescription Drug Coverage, you can keep your medical coverage with the Fund. You will **not** be able to re-enroll in the Fund's prescription drug coverage in the future and you will need to pay any Medicare premium out of your own pocket.

You should compare your current coverage, including which medications are covered, with the coverage and cost of the plans offering Medicare Prescription Drug Coverage in your area.

Coordination with Other Government Programs

Medicaid: If you are covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second. Payments by this Plan for benefits with respect to you, as an Eligible Individual, will be made in compliance with any assignment of rights made by you or on your behalf, 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 state Medicaid for me.dical 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 that provides that the state has acquired the rights with respect to payment for assistance, provided that the claim is filed by the state within the Plan's filing limits.

TRICARE: If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an 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 the 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 do not exceed 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.

Other Coverage Provided by State or Federal Law: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Plan Information

Administrative Information

Plan Name

The Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund.

Employer Identification Number

The employer identification number (EIN) assigned by the Internal Revenue Service is 94-2567865.

Plan Number

The Plan Number is 501.

Plan Administrator and Plan Sponsor

The Plan is administered and sponsored by the Board of Trustees of the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund, consisting of Trustees appointed by the Contributing Employers and by the Union.

The official Plan Administrator is the Board of Trustees, which is responsible for the operation of the Fund, has full power to interpret the Plan and all Plan documents, agreements, rules, and regulations, and to decide all questions concerning the Plan, including, but not limited to, the eligibility of any person to participate in the Plan and his or her entitlement to Plan benefits. The Board's interpretations and decisions concerning these matters are final and binding and will receive judicial deference to the extent that they are not arbitrary and capricious.

Administrative services are provided to the Plan under a contract with a Fund Manager retained by the Board of Trustees and compensated by the Trust Fund at the direction of the Board of Trustees. The Fund Manager's Office is staffed with persons competent in the fields of accounting, data processing, and claims processing. The Fund Office bills all Contributing Employers monthly, receives the Employer contributions, maintains complete financial records, produces a monthly financial statement, maintains work records and eligibility records of all reported Employees, and receives all claims filed by Eligible Individuals.

If you wish to contact the Board of Trustees or Fund Office, you may use the address and phone number below:

Zenith American Solutions
C/O Administrator
1141 Harbor Bay Parkway
Suite 100
Alameda, CA 94502
(800-251-5014

The Trustees of this Plan, who can all be reached at the Fund's address and phone number above, are:

Union Trustees

Dan Reding, Co-Chairman
Operating Engineers Local 3
3000 Clayton Road
Concord, California 94519

Steve Ingersoll
Operating Engineers Local 3
3000 Clayton Road
Concord, California 94519

Tim Neep
Operating Engineers Local 3
3000 Clayton Road
Concord, California 94519

Employer Trustees

Austris Rungis, Co-Chairman
IDEA
2200 Powell Street, Ste. 1000
Emeryville, CA 94608

Stacey Cue
IDEA
2200 Powell Street, Ste. 1000
Emeryville, CA 94608

Agent for Service of Legal Process

Ryan Ilaqua is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Mr. Ilaqua at the address of the Fund Office. However, legal documents may also be served upon any individual Trustee.

Plan Year

The end of the Plan Year is December 31.

Plan Type

The Plan is maintained for the purpose of providing Comprehensive Medical, Substance Use Disorder Treatment, Hearing Aid, Prescription Drug, Dental, Orthodontic, Vision, Burial Expense Benefits, Life Insurance and Accidental Death and Dismemberment Benefits for Participants and their eligible Dependents who meet the eligibility requirements, as described in this booklet.

Benefits (other than the Burial Expense Benefit and Life and Accidental Death and Dismemberment Benefits) are not insured by any contract of insurance, and there is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for that purpose.

The Plan has no control over any diagnosis, treatment, care or lack thereof, or other services delivered to an Eligible Individual by a health care provider (whether a Contract or Non-Contract Provider), and disclaims liability for any loss or Injury caused to the Eligible Individual by any provider by reason of negligence, failure to provide treatment, or otherwise.

The Plan does not replace and is not affected by any requirement for coverage under workers' compensation, employer liability, occupational disease, or similar law. Benefits that would otherwise be payable under the provisions of such laws are not paid by the Plan.

Plan Funding

Contributing Employers pay for the cost of the Plan by making contributions to the Fund. Contributions are based on employment as described in the Collective Bargaining Agreement between the Employer and the Union. A copy of the Collective Bargaining Agreement under which you are covered is available, upon written request, from the Fund Office and is available for examination at the Fund Office. In addition, Participants and Dependents may obtain, upon written request to the Fund Office, information as to the name and address of a particular Employer and whether an Employer is required to pay contributions to the Plan.

Participant self-payments (such as for COBRA Continuation Coverage) are also used to fund the Plan. The Plan benefits (other than Burial Expense Benefits, Dental and Orthodontic Benefits) are self-funded from accumulated assets and are provided directly from the Trust Fund. Plan assets are also used to pay administrative expenses. A portion of Fund benefits is allocated for reserves to carry out the objectives of the Plan.

Eligibility Requirements

A summary of the Plan's requirements for eligibility for benefits is shown in this booklet. Circumstances that may cause you to lose eligibility are also explained. Your coverage under this Plan does not constitute a guarantee of your continued employment and you are not vested in the benefits described in this booklet. All Plan benefits are made available to you and your Dependents by the Plan as a privilege and not as a right.

Assignment of Benefits

This Plan is intended to pay benefits only for you or your eligible Dependents Covered Expenses. Payments generally are made directly to you unless you assign benefits to a provider. You cannot sell, transfer, anticipate, or otherwise dispose of any Plan benefits or rights. The Fund is exempt from all claims from creditors or other claimants and from all orders, decrees, garnishments, executions, and legal processes or proceedings, except in connection with qualified medical child support orders. You will be notified if such an order is received with respect to your benefits.

Legal Document

This booklet highlights the provisions of the official legal Plan Document governing the Plan. All of your rights and benefits are governed by the official legal Plan Document, as are all final decisions. If you wish, you may examine the legal Plan Document at the Fund Office, or obtain a copy for yourself for a reasonable copying charge. It is also available from the Administrator.

Plan Amendment and Termination

The Board of Trustees expects that the Plan will be permanent. However, the Trustees have the authority at any time to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan as they determine to be in the best interests of Plan Participants and beneficiaries. Any amendment, which will be communicated in writing, will not affect valid claims that originated before the date of the amendment.

This Plan may be discontinued or terminated under certain circumstances, as described in the documents that establish this Plan. In this event, all coverage for Eligible Individuals will end immediately. Any discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets and benefit payments will be limited to the assets available in the Trust Fund for purposes. The Trustees will not be liable for the adequacy or inadequacy of such assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the documents governing this Plan.

Your ERISA Rights

As a Participant in the Plan, 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, all documents governing the Plan, including insurance contracts, 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 (EBSA);
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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); and
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (You or your Dependents may have to pay for such coverage; review this Summary Plan Description and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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 the Plan Documents or the latest annual report from the Plan and do not receive them 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. 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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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 EBSA at:

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
(866) 444-3272

Nearest Regional Office:
Employee Benefits Security Administration
Northern California Regional Office
90 7th Street, 11-300
San Francisco, California 94103
(415) 625-2481

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the Web site of the EBSA at www.dol.gov/ebsa.

Definitions

The following terms are used in this Summary Plan Description and in any supplements or revisions. Terms defined in this section have been capitalized throughout this booklet.

Active Employee or Active Participant
Any employee of a Contributing Employer for whom the Contributing Employer makes contributions to the Fund and who otherwise satisfies the Plan's eligibility requirements.

Allowed Charge
The term "Allowed Charge" means the lesser of the dollar amount the Plan has determined it will allow for covered services or supplies provided by a Non-Contract Provider or the fee actually charged by the Non-Contract Provider. The Plan's Allowed Charge is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), usual, customary and reasonable (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the amount the Plan will allow for submitted claims. When using Non-Contract Providers, except for No Surprises Services, the Eligible Individual is responsible for any difference between the actual billed charge and the Plan's Allowed Charge, in addition to any Copay or coinsurance required by the Plan.

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 Contract provider who can furnish such item or service at such facility.

Board
The Board of Trustees established by the Trust Agreement.

Collective Bargaining Agreement

Any Collective Bargaining Agreement between the Union, or any of its affiliated local unions, and any employer organization or individual employer which provides for the making of employer contributions to the Fund, and any extension or renewal of any of said agreements which provides for the making of Employer contributions to the Fund.

Compound Drug
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.

Concurrent Review
The process of the Professional Review Organization (PRO), under contract with the Fund, to determine the number of authorized days considered Medically Necessary that are eligible for unreduced benefit coverage according to the terms of the Plan once an Eligible Individual has been confined to a Hospital.

Continuing Care Patient
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.

Contract Hospital or Contract Facility
A Hospital or health care facility that has a contract in effect with the Fund's Preferred Provider Organization.

Contract Pharmacy
A pharmacy that has a contract with the Fund's pharmacy benefits manager provider to provide prescription Drugs to Eligible Individuals.

Contract Physician
A Physician who has a contract in effect with the Fund's Preferred Provider Organization.

Contract Provider
Any Physician, Hospital, or other health care provider that has a contract in effect with the Fund's Preferred Provider Organization.

Contract Provider Area
The geographic location that is within 30 miles of a Contract Provider.

Contributing Employer or Employer
An employer who is required by a Collective Bargaining Agreement with the Union or a Subscriber Agreement to make contributions to the Fund or who in fact makes one or more contributions to the Fund on behalf of its employees.

Copayment or Copay
The dollar amount an Eligible Individual is required to pay for a service or Drug before Plan benefits are payable.

Cosmetic Surgery or Treatment
Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Covered Expense(s) or Covered Service(s)
Those charges that do not exceed the Allowed Charge or that are the negotiated charge from a Contract Provider and that are made for the Medically Necessary care and treatment of a non-occupational Illness or Injury (except as specifically provided by the Plan's Preventive Care Benefits). Covered Expenses and Covered Services also means only those charges incurred by a Participant or Dependent while eligible for benefits under this Plan.

Custodial Care
Care or services (including room and board needed to provide that care or service) given mainly for personal hygiene or to perform the activities of daily living. Custodial Care can be given safely and adequately by people who are not trained or licensed medical or nursing personnel. Examples of Custodial Care are training or helping Patients to get in and out of bed, help with bathing, dressing, feeding, or eating, use of the toilet,

ambulating, or taking medications that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

Deductible
The Deductible is the amount of Covered Expenses that you pay each calendar year before the Plan begins to pay benefits. Deductible amounts are limited to a family maximum (or if only two Eligible Individuals are covered, once both individuals meet their individual Deductible). For a family, once the family has combined covered expenses equal to the family maximum, no further individual Deductibles are required. However, no more than the individual Deductible amount will be applied to any one covered family member for the calendar year.

Dentist
A person licensed to practice dentistry in the state in which he or she provides treatment.

Dependent
Eligible Dependents under the Plan include a Participant's:

- Lawful Spouse (or Domestic Partner if qualified under the rules of the Plan).
- Natural or legally adopted child younger than age 26. Legally adopted children are eligible when they are placed for adoption. Placed for adoption means the assumption and retention by a Participant of the legal duty for total or partial support of a child to be adopted.
- Stepchildren younger than age 26. If the Participant and natural/adoptive parent of the stepchildren are legally separated, the stepchildren remain eligible under this Plan until the Participant's divorce from their natural/adoptive parent is finalized. Stepchildren are no longer eligible once there is a final dissolution of the marriage of their natural/adoptive parent and the Participant.
- Unmarried children for whom the Participant has been appointed legal guardian, provided the children are younger than age 23, live with the Participant, and can be claimed as dependents on the Participant's federal income tax return.
- Unmarried children (as otherwise defined above) who are older than age 26, primarily dependent on the Participant for support, and prevented from earning a living because of mental or physical disability (providing the disabled children were so disabled and eligible as Dependents at the time they reached the limiting age). Evidence of the child's dependence and incapacity must be filed with the Board within 31 days after attaining age 26, and periodically thereafter.

In accordance with ERISA Section 609(a), this Plan will provide coverage for a dependent child of a Participant if required by a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice. These procedures are available free of charge at the Fund Office.

Domestic Partner
Domestic Partner means a Domestic Partner of the Participant who has a valid Declaration of Domestic Partnership or Confidential Declaration of Domestic Partnership on file with the California Secretary of State. The Domestic Partner and eligible children of the Domestic Partner may enroll in the Plan upon submission of a copy of the Certificate of Registration of Domestic Partnership received from the state of California and payment of the required imputed income taxes to the Employer.

Drug(s)
Any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments, upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

Eligible for Medicare
An Eligible Individual who is eligible for Part A of Medicare without payment of monthly premiums to the Social Security Administration and is eligible for Part B of Medicare whether or not the Eligible Individual has qualified for Part B Medicare benefits by enrollment or other procedure available to him or her.

Eligible Individual
Each Participant and each of his or her eligible Dependents.

Emergency/Emergency Medical Condition
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 an individual in serious jeopardy, or with respect to a pregnant woman, health of the woman or her unborn child.

Emergency Services
The term "Emergency Services" means with respect to an Emergency Medical Condition (defined below) 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 an Non-Contract Provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services 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.

Experimental or Investigational

A drug, device, treatment, or procedure if:

- It 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.
- It, or the Patient informed consent document utilized with it, 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;
- Reliable Evidence shows that it 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, toxicity, safety, efficacy, or 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, treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence here 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, treatment, or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment, or procedure.

Note that under this medical plan, experimental, investigational or unproven does 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 determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

a. "**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.

b. 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.

c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

e. The plan may rely on its PRO to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Fund (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process.

There is an external independent review process available for review of the Plan's coverage decisions regarding Experimental or Investigational services or supplies. You may request review by the Professional Review Organization (PRO) contracted by the Fund, or if the claim has already been reviewed by the PRO, you may request a second review by another external review organization. You may call the Trust Fund Office to request this review.

Fund
The Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund.

Group Plan
Any plan providing benefits of the type provided by this Plan that is supported wholly or in part by Employer payments.

Habilitative/Habilitation
Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services include physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Care Facility
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.

Home Health Agency
A home health care provider that is licensed according to state or local laws to provide skilled nursing and other services on a visiting basis in the Eligible Individual's home and is recognized as a provider under federal Medicare.

Hospital
Any acute care hospital that:

- Is licensed under any applicable state statute;
- Provides 24-hour inpatient care; and
- Provides basic services on the premises such as medical, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

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

Illness

A bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. For purposes of this Plan, pregnancy is considered an Illness for an Employee and Dependent Spouse only. For a pregnant dependent child, screenings necessary for prenatal care will be an illness that is covered by this Plan, but not ultrasounds and other pregnancy-related services of the pregnant dependent child, including the delivery and/or newborn expenses.

Independent Freestanding Emergency Department

The term "Independent Freestanding Emergency Department**"** means health-care facility that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Injury
Physical harm sustained as the direct result of an accident, affected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Licensed Pharmacist
A person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Medicare
The benefits provided under Title XVIII of the Social Security Amendment of 1965.

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

- Appropriate and necessary for the symptoms, diagnosis, or treatment of the Illness or Injury;
- Provided for the diagnosis or direct care and treatment of the Illness or Injury;
- Within standards of good medical practice within the organized medical community;
- Not primarily for the convenience of the Patient, the Patient's Physician, or another provider; and
- The most appropriate supply or level of service that 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.

Mental Illness or Mental Disorder
Any nervous or mental disease, disorder, or condition that is defined within the Mental Disorders section of the current edition of the International Classification of Diseases (ICD-10-CM) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), regardless of any underlying physical or organic cause, including, but not limited to, depression, schizophrenia, phobia, mania, and anxiety conditions, panic disorders, and adjustment disorders.

Non-Contract Hospital or Non-Contract Facility
A Hospital or health care facility that does not have a contract in effect with the Fund's Preferred Provider Organization.

Non-Contract Pharmacy
A pharmacy that does not have a contract with the Fund's pharmacy benefits manager to provide prescription Drugs to Eligible Individuals.

Non-Contract Physician
A Physician that does not have a contract in effect with the Fund's Preferred Provider Organization.

Non-Contract Provider
Any Physician, Hospital, or other health care provider that does not have a contract in effect with the Fund's Preferred Provider Organization.

No Surprises Act Services
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) No Contract Emergency Services, (2) Non-Contract air ambulance services; (3) non-emergency ancillary services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at an in-network Health Care Facility; and (4) other Non-Contract non-Emergency Services performed by a Non-Contract Provider at a Contract Health Care Facility with respect to which the provider does not comply with federal notice and consent requirements.

Out-of-Area
A geographic area that is more than 30 miles from the nearest Contract Provider.

Participant
Any Active or Retired Employee of a Contributing Employer who meets the eligibility requirements of the Fund, other than as a Dependent.

Patient
An Eligible Individual who is receiving medical treatment, services, or supplies covered by the Plan.

Physician
A Physician or surgeon (MD), Osteopath (DO), or Dentist (DDS or DMD) licensed to practice medicine or dentistry in the state in which he or she is providing services.

It also includes any provider who is rendering Medically Necessary covered services and acting within the scope of his or her license.

Physician does not include the Participant or Dependent, or the spouse, parent, child, sister or brother of the Participant or Dependent.

Plan
The health and welfare benefits provided under the rules and regulations of the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund, including any amendments.

Plan Year
January 1 through December 31 of any year.

Pre-Admission Review
The process of the Professional Review Organization (PRO), under contract with the Fund, that occurs before an elective Hospital confinement to determine the Medical Necessity of an Eligible Individual's elective confinement to a Hospital, and if Medically Necessary, the number of pre-authorized days eligible for unreduced benefit coverage according to the terms of the Plan.

Preferred Provider Organization
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 Hospitalization and medical services to Eligible Individuals based on negotiated fees.

Professional Review Organization or PRO
An organization under contract with the Fund that is responsible to determine whether the confinement of an Eligible Individual to a Hospital is Medically Necessary, and if Medically Necessary, to determine the number of Medically Necessary days for the confinement solely for the purpose of determining whether the Eligible Individual is to receive unreduced benefit coverage according to the terms of the Plan for Covered Expenses incurred as a result of that Hospital confinement.

Qualifying Payment Amount
The term "Qualifying Payment Amount" means generally the median contracted rates of the plan or issuer for the item or service in the geographic region.

Recognized Amount
The term **"**Recognized Amount" means (in order of priority) 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-PPO providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Retiree or Retired Employee
Each person who qualifies under the Plan's eligibility rules for such individuals.

Serious and Complex Condition
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; or

b. In the case of a chronic illness or condition, a condition that is the following:

- Life-threatening, degenerative, potentially disabling, or congenital; and

- Requires specialized medical care over a prolonged period of time.

Skilled Nursing Facility
An institution as defined in Section 1861(j) of the Social Security Act.

Spouse
The legal Spouse of a Participant, or only when eligible according to the rules of the Plan, the domestic partner of a Participant.

Subscriber Agreement
Means any written agreement between the Fund and an employer which provides for the making of employer contributions to the Fund.

Total Disability or Totally Disabled
Total Disability or Totally Disabled means, with respect to:

- An Active Participant, that the individual is unable to engage in any occupation or employment for wages or profit due to Illness or Injury; or
- A Dependent or Retired Participant, that the individual is prevented, by Illness or Injury, from performing the regular and customary activities usual for a person of similar age and family status.

Trust Agreement
The Trust Agreement establishing the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund, dated September 1, 1998, including any amendments, extensions, or renewals.

Union
The Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Utilization Review Program or UR Program
If an Eligible Individual is to be confined in a Hospital on a non-emergency basis, the Physician must obtain Pre-admission Review by the Professional Review Organization (PRO) to determine, prior to the occurrence of the confinement, the Medical Necessity of the Hospital confinement, and if Medically Necessary, the number of pre-authorized days, if any, determined by the PRO to be Medically Necessary for the confinement. All organ or tissue transplant procedures must be pre-approved by the PRO in order for benefits to be payable by the Plan. In addition precertification is required for all individuals who participate in a clinical trial. The following provisions and exceptions apply:

When confinement will be in a Contract Hospital, Pre-admission Review will be automatically obtained by the Contract Hospital.

The length of Hospital confinement for a mastectomy will not be limited by the Review Organization but will be determined solely by the Physician and Patient.

OPERATING ENGINEERS
PUBLIC AND MISCELLANEOUS EMPLOYEES
HEALTH AND WELFARE TRUST FUND

PLAN RULES AND REGULATIONS

FOR PLANS A, B, C and D

Restated Effective November 1, 2023

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OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND

RULES AND REGULATIONS
(Restated Effective November 1, 2023)

CHAPTER 1. DEFINITIONS

Unless the context or subject matter otherwise requires, the following definitions shall govern in these Rules and Regulations:

Section 1.01. The term "Active Employee" or "Active Participant" means any employee of a Contributing Employer for whom the Contributing Employer makes contributions to the Fund and who otherwise satisfies the eligibility requirements set forth in Section 2.01.

Section 1.02. The term "Allowed Charge" means the lesser of the dollar amount the Plan has determined it will allow for covered services or supplies provided by a Non-Contract Provider or the fee actually charged by the Non-Contract Provider. The Plan's Allowed Charge is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), usual, customary and reasonable (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the amount the Plan will allow for submitted claims. When using Non-Contract Providers, except for No Surprises Services, the Eligible Individual is responsible for any difference between the actual billed charge and the Plan's Allowed Charge, in addition to any Copayment or coinsurance required by the Plan.

Section 1.03. Ancillary Services: Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished b 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 Contract provider who can furnish such item or service at such facility.

Section 1.04. The term "Board" means the Board of Trustees established by the Trust Agreement.

Section 1.05. The term "Collective Bargaining Agreement" means any collective bargaining agreement between the Union, or any of its affiliated local unions, and any employer organization or individual employer which provides for the making of employer contributions to the Fund, and any extension or renewal of any of said agreements which provides for the making of employer contributions to the Fund.

Section 1.06. The term "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.

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 days considered medically necessary that are eligible for unreduced benefit coverage according to the terms of the Plan once an Eligible Individual has been confined 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 Hospital" or "Contract Facility" means a Hospital or health care facility that has a contract in effect with the Fund's Preferred Provider Organization.

Section 1.10. The term "Contract Pharmacy" means a pharmacy which has a contract with the Fund's pharmacy benefit management provider to provide prescription drugs to Eligible Individuals.

Section 1.11. The term "Contract Physician" means a Physician who has a contract in effect with the Fund's Preferred Provider Organization.

Section 1.12. The term "Contract Provider" means any Physician, Hospital 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 Area" means the geographic location that is within 30 miles of a Contract Provider.

Section 1.14. The term "Contributing Employer" and "Employer" means an employer who is required by a collective bargaining agreement with the Union or a Subscriber's Agreement to make contributions to the Fund or who in fact makes one or more contributions to the Fund on behalf of its employees.

Section 1.15. The term "Copay" and "Copayment" means the dollar amount the Eligible Individual is required to pay for a service or Drug before Plan benefits are payable.

Section 1.16. The term "Covered Expense(s)" or "Covered Service(s)" means only those charges which are the negotiated charge from a Contract Provider or the Allowed Charge from a Non-Contract Provider, and which are made for the Medically Necessary care and treatment of a non-occupational Illness or Injury (except as specifically provided by the Plan's Preventive Care Benefits). Covered Expenses include only charges for care or treatment received by a Participant or Dependent while eligible for benefits under the Plan.

Section 1.17. The term "Custodial Care" means care or services (including room and board needed to provide that care or service) given mainly for personal hygiene or to perform the activities of daily living. Custodial Care can be given safely and adequately by people who are not trained or licensed medical or nursing personnel. Examples of Custodial Care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating or taking medications that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, pro/vides or directs the care.

Section 1.18. The term "Dentist" means a person licensed to practice dentistry in the state in which he/she or she provides treatment.

Section 1.19. The term "Dependent" means:

A. The Participant's lawful spouse or Domestic Partner if qualified under the rules of the Plan.

B. Children of the Participant if they are:

(1) The Participant's natural children, stepchildren or legally adopted children younger than 26 years of age, whether married or unmarried. Legally adopted children are considered eligible under the Plan when they are placed for adoption. Placed for adoption means the assumption and retention

by the Participant of the legal duty for total or partial support of a child to be adopted. Stepchildren are no longer eligible once there is a final dissolution of the marriage of their natural parent and the Participant.

(2) Children for whom the Participant has been appointed legal guardian, provided they are unmarried, younger than 23 years of age, and can be claimed as a dependent on the Participant's federal income tax return.

(3) A Participant's unmarried natural child, legally adopted child or stepchild who is older than age 26 (or older than age 23 if a legal guardianship child) and is prevented from earning a living because of mental or physical disability, provided the child:

a. was disabled and eligible as a Dependent under this Plan at the time he/she reached the limiting age, and

b. is primarily dependent on the Participant for support.

Evidence of the child's dependence and disability must be filed with the Board within 31 days after the child attains the limiting age and periodically thereafter upon request.

(4) In accordance with ERISA Section 609(a), the Plan will provide coverage for a Participant's child under 26 years of age if required by a Qualified Medical Child Support Order, including a National Medical Support Order.

(5) A spouse of a Dependent child is not eligible for coverage under the Plan.

(6) Unmarried children younger than age 23 of the Participant's Domestic Partner are eligible if the Domestic Partner qualifies for coverage in accordance with Section 1.17.

Section 1.20. The term "Domestic Partner" means a Domestic Partner of the Participant who has a valid Declaration of Domestic Partnership or Confidential Declaration of Domestic Partnership on file with the California Secretary of State. The Domestic Partner and eligible children of the Domestic Partner may enroll in the Plan upon submission of a copy of the Certificate of Registration of Domestic Partnership received from the state of California and payment of the required imputed income taxes to the Fund.

Section 1.21. The term "Drug(s)" means any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

Section 1.22. The term "Eligible for Medicare" means that the Eligible Individual is eligible for Part A of Medicare without payment of monthly premiums to the Social Security Administration and is eligible for Part B of Medicare whether or not the Eligible Individual has qualified for Part B Medicare benefits by enrollment or other procedure available to him or her.

Section 1.23. The term "Eligible Individual" means each Participant and each of his eligible Dependents, if any.

Section 1.24. The term "Emergency Services" means with respect to an Emergency Medical Condition (defined below) 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 an Non-Contract Provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services 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.
- 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 an individual in serious jeopardy, or with respect to a pregnant woman, health of the woman or her unborn child.

Section 1.25. "Experimental or Investigational". See Section 12.01.J. for definition of Experimental or Investigational Procedures.

Section 1.26. The term "Fund" means the Operating Engineers Public And Miscellaneous Employees Health and Welfare Trust Fund .

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 "Habilitative/Habilitation" means Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking or talking at the expected age.

Section 1.29. 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 1.30. The term "Home Health Agency" means a home health care provider which is licensed according to state or local laws to provide skilled nursing and other services on a visiting basis in the Eligible Individual's home and is recognized as a provider under federal Medicare.

Section 1.31. The term "Hospital" means any acute care Hospital which is licensed under any applicable state statute and must provide: (1) 24-hour inpatient care, and (b) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to state law. The requirement that a Hospital must provide surgical, anesthesia and/or radiology services does not apply to facilities for mental, nervous and/or substance abuse treatments.

Section 1.32. The term "Illness" means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes.

Section 1.33 The term "Independent Freestanding Emergency Department**"** means health-care facility that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Section 1.34. The term "Injury" 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 1.35. 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 1.36. The term "Medical Coverage" means the hospital-medical coverage provided directly by the Fund (the Comprehensive Health Plan Benefits) as described in these Rules and Regulations, or the HMO plan offered through Kaiser.

Section 1.37. The term "Medicare" means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

Section 1.38. 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.

Section 1.39. The term "Mental Illness or Disorder" means any nervous or mental disease, disorder or condition that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-10-CM) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), regardless of any underlying physical or organic cause, including, but not limited to, autism, depression, schizophrenia, phobic, manic and anxiety conditions, panic disorders and adjustment disorders.

Section 1.40. The term "Non-Contract Hospital" or "Non-Contract Facility" means a Hospital or health care facility which does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.41. The term Non-Contract Pharmacy" means a pharmacy which does not have a contract with the Fund's pharmacy benefit management provider to provide prescription drugs to Eligible Individuals.

Section 1.42. The term "Non-Contract Physician" means a Physician that does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.43. The term "Non-Contract Provider" means any Physician, Hospital or other health care provider that does not have a contract if effect with the Fund's Preferred Provider Organization.

Section 1.44. 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) No Contract Emergency Services, (2) Non-Contract air ambulance services; (3) non-emergency ancillary services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at an in-network Health Care Facility; and (4) other Non-Contract non-Emergency Services performed by a Non-Contract Provider at a Contract Health Care Facility with respect to which the provider does not comply with federal notice and consent requirements.

Section 1.45. The term "Out-of-Area" means a geographic area that is more than 30 miles from the nearest Contract Provider.

Section 1.46. The term "Participant" means any active or retired employee of a Contributing Employer who meets the eligibility requirements of the Fund, other than as a Dependent.

Section 1.47. The term "Patient" means that Eligible Individual who is receiving medical treatment, services, or supplies covered by the Plan.

Section 1.48. The term "Physician" means a physician or surgeon (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 or she is providing services.

It shall also mean any provider who is rendering Medically Necessary covered services and acting within the scope of his or her license.

Section 1.49. The term "Plan" means the health and welfare benefits provided under these Rules and Regulations of the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund including any amendments.

Section 1.50. The term "Plan Year" means January 1 through December 31 of any year.

Section 1.51. The "Pre-admission Review" means the process whereby the Professional Review Organization (PRO) under contract to the Fund determines the Medical Necessity of an Eligible Individual's elective confinement to 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 elective Hospital confinement actually occurring.

Section 1.52. The term "Preferred Provider Organization" 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 hospitalization and medical services to Eligible Individuals on the basis of negotiated fees.

Section 1.53. The term "Professional Review Organization (PRO)" means an organization under contract with the Fund that is responsible to determine whether the confinement of an Eligible Individual to a Hospital is Medically Necessary, and if Medically Necessary, to determine the number of Medically Necessary days for the confinement solely for the purpose of determining whether the Eligible Individual is to receive unreduced benefit coverage according to the terms of the Plan for Covered Expenses incurred as a result of that Hospital confinement.

Section 1.54. The term "Qualifying Payment Amount" means generally the median contracted rates of the plan or issuer for the item or service in the geographic region.

Section 1.55. The term **"**Recognized Amount" means (in order of priority) 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-PPO providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Section 1.56. The term "Retiree" or "Retired Employee" means each person who qualifies under the eligibility rules in Section 2.02.

Section 1.57. 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; or

b. In the case of a chronic illness or condition, a condition that is the following:

- Life-threatening, degenerative, potentially disabling, or congenital; and
- Requires specialized medical care over a prolonged period of time.

Section 1.58. The term "Skilled Nursing Facility" means an institution as defined in Section 1861(j) of the Social Security Act.

Section 1.59. The term "Spouse" means the legal spouse of the Participant or, only when eligible according to the eligibility rules of the Plan, the Domestic Partner of the Participant.

Section 1.60. The term "Total Disability" or "Totally Disabled" means:

A. With respect to an Active Participant, the individual is unable to engage in any occupation or employment for wages or profit due to Illness or Injury.

B. With respect to a Dependent or Retired Participant, the individual is prevented, by Illness or Injury, from performing the regular and customary activities usual for a person of similar age and family status.

Section 1.61. The term "Trust Agreement" means the Trust Agreement establishing the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund , dated September 1, 1998, including any amendment, extension or renewal.

Section 1.62. The term "Union" means the Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Section 1.63. The term "Utilization Review (UR) Program" means a program whereby an Eligible Individual who is scheduled for confinement in a Hospital on an elective, non-emergency basis must obtain Preadmission Review and Concurrent Review from the Professional Review Organization (PRO) under contract to the Fund as to the Medical Necessity of that confinement in order to receive unreduced benefit coverage for Covered Expenses incurred as a result of that Hospital confinement. For Emergency Medical Condition confinements, the review must be obtained retrospectively.

CHAPTER 2. ELIGIBILITY FOR BENEFITS

Section 2.01. Eligibility Rules for Active Participants

A. **Establishment and Maintenance of Eligibility.** A person who is an employee of a Contributing Employer with respect to whom contributions are made to the Fund for the maintenance of a health and welfare plan will become eligible, and remain eligible, in accordance with the terms of the Collective Bargaining Agreement in effect between his Employer and the Union.

(1) Initial Eligibility. The Employer's first contribution to the Fund will provide the Participant with eligibility for both the month in which the contribution was received and the next following month. Eligibility will begin on the first day of the month in which the Employer's contribution is received.

(2) Continuing Eligibility. A lag month will be used in determining monthly eligibility after initial eligibility is established. The lag month is the month between the payroll period in which hours were worked and the month of eligibility provided by those hours. Contributions received from a Contributing Employer in a month will provide the Participant with eligibility for the month following the month in which the contribution was received by the Fund.

B. **Termination of Eligibility.** An Active Participant's eligibility will terminate on the earlier of the following dates:

(1) The last day of the month following the month for which the last required Employer contribution was received by the Fund on his behalf; or

(2) The day the Plan is terminated.

Section 2.02. Eligibility Rules for Retired Participants.

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

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

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

(3) Application to enroll in the Plan as a Retired Participant must be filed with the Fund Office within 30 days of retirement. A Retired Employee or Dependent who terminates coverage under the Fund will not be allowed to re-enroll unless one of the events described under Late Enrollment Provisions in Section 2.04 occurs.

B. **Termination of Eligibility.** A Retired Participant's eligibility will terminate on the earlier of the following dates:

(1) The last day of the month for which the last contribution was received by the Fund; or

(2) The last day of the month in which the Retired Participant's former Employer ceases to be a Contributing Employer in the Trust Fund.

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

(1) The Retired Participant became retired when his/her Employer was a Contributing Employer; and

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

Section 2.03. Dependents' Eligibility

A. A Participant whose Employer is not obligated by the Collective Bargaining Agreement to provide coverage for Dependents may elect coverage for his Dependent Spouse and children by paying the contribution required for such coverage to the Fund on a monthly basis.

B. **When Dependents Become Eligible**. Provided the required contribution for Dependent coverage and completed enrollment form are received by the Fund Office, a Dependent will become eligible for benefits on the later of:

(1) The date the Participant becomes eligible; or

(2) The date the Participant acquires the Dependent. Newborn or legally adopted Dependent children are covered from birth or from the date the child is placed for adoption with the Participant. A child is considered "placed for adoption" on the date the Participant first becomes legally obligated to provide full or partial support of the child whom he/she plans to adopt.

C. **Enrollment Requirements**. In order for a Dependent's coverage to become effective, the Participant must enroll each eligible Dependent in the Plan by submitting a completed enrollment form to the Fund Office within 90 days of the date the Participant becomes eligible or, if later, within 90 days of the date the Participant acquires the Dependent. The actual birth certificate from the state or the birth certificate that the Hospital provides will be required to enroll a newborn child.

Except as provided in Late Enrollment Provisions in Section 2.04, a Dependent who is not enrolled within 90 days of the dates described above will not be allowed to enroll until the later of:

(1) 12 months after the date the Participant became eligible, or

(2) 12 months after the date the Participant acquired the Dependent.

D. **Termination of Dependents' Eligibility**. The eligibility of a Dependent will terminate on the earliest of the following dates:

(1) The date the Participant ceases to be eligible,

(2) The date the Dependent no longer qualifies as a Dependent, as defined in Section 1.17; or

(3) The date the full required contribution for the Dependent's coverage are not paid.

If the Employer is paying a contribution that includes the full cost of Dependent coverage, an eligible Dependent cannot be removed from the Plan.

Section 2.04. Late Enrollment Provisions. In accordance with the Health Insurance Portability and Accountability Act of 1996, the following provisions will apply to Participants and Dependents who did not enroll in the Plan when first eligible:

A. If a Participant did not enroll himself or his Dependent(s) in the Plan when first eligible and the Participant subsequently acquires a new Spouse or Dependent child(ren) by marriage, birth, adoption, placement for adoption or legal guardianship, the Participant may request enrollment in the Plan for himself and his newly acquired Dependent(s) no later than 90 days after the date the new Dependent is acquired.

B. If a Participant did not enroll in the Plan on the date he/she first became eligible because the Participant or Dependent had other health coverage under any other health insurance policy or program (including COBRA Continuation Coverage, individual insurance, Medicaid or other public program) and the Participant and/or Dependent ceases to be covered by that other health coverage, the Participant may enroll himself and any eligible Dependents in this Plan within 31 days after termination of the other coverage if that other coverage terminated due to:

(1) The loss of eligibility for the other coverage as a result of termination of employment or reduction in the number of hours of employment, death, divorce or legal separation, or loss of dependent status under the other plan; or

(2) Termination of benefit package or the other plan ceases to offer coverage to a group of similarly situated individuals; or

(3) Moving out of an HMO service area if the other plan offers only an HMO; or

(4) Loss of eligibility under the other plan due to reaching the lifetime maximum on all benefits; or

(5) Termination of employer contributions toward the other coverage, or

(6) If the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is exhausted if it ceases for any reason other than the failure of the individual to pay the applicable COBRA premium on a timely basis.

Section 2.05. Extension of Eligibility for Surviving Spouses. In the event of the Active or Retired Participant's death, the surviving legal spouse will be given a one-time only opportunity to continue hospital, medical and prescription drug benefits for the spouse and eligible Dependent children by making the required self-payments to the Fund. The burial expense benefit is not included under this extension of eligibility provision. Self-payments must be continuous. If payment is not received for any month, coverage may not be reinstated at a later date.

Eligibility under this provision will terminate upon the surviving spouse's remarriage.

Section 2.06. Leave of Absence Due to Military Leave. A Participant who enters military service with the Uniformed Services of the United States will be provided continuation and reinstatement of eligibility rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

A. A Participant who is on active military duty for 31 days or less will continue to be eligible for up to 31 days with no self-payments required.

B. Participants whose period of military service is 31 days or more may continue their eligibility by self-payment for up to 18 months, as described in Section 2.09. Continuation Coverage Under COBRA. Participants whose continuation period begins on and after December 10, 2004 may continue their eligibility for a total of 24 months. During the first 18 months of coverage the Participant will have all COBRA rights. However, COBRA rights, such as the right to elect additional months of coverage in the event of a second Qualifying Event or a Social Security disability determination, do not apply during the last 6 months of the 24-month period.

C. Coverage will not be provided for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

D. When the Participant is discharged from military service, eligibility will be reinstated on the day he/she returns to work with a Contributing Employer, provided that he/she returns to work within:

(1) Ninety (90) days from the date of discharge if the period of service was more than 180 days; or

(2) Fourteen (14) days from the date of discharge if the period of service was 31 days or more but less than 180 days; or

(3) On the first regularly scheduled work day following discharge if the period of service was less than 31 days.

If the Participant is hospitalized or convalescing from an Injury caused by active duty, the above time limits are extended up to 2 years.

Section 2.07. Extension of Health Benefits for Total Disability – For Active Participants and Dependents Only. This Extension of Benefits provision does not apply to individuals enrolled in an HMO plan.

A. If an Active Participant or Dependent is Totally Disabled when eligibility terminates, Comprehensive Health Plan benefits may be extended after termination, subject to the following conditions:

(1) Benefits will be extended only for Covered Expenses incurred for treatment of the Illness or Injury that caused the Total Disability.

(2) The Eligible Individual remains Totally Disabled to the date the Covered Expense is incurred.

(3) Benefits will be payable subject to all comprehensive health Plan limitations and maximums that were in effect at the time eligibility terminated.

(4) A Physician's written certification of Total Disability is received by the Fund Office with 90 days after eligibility has terminated and at 90-day intervals thereafter to continue extended benefits.

B. **Termination of Extended Benefits**. Benefits will continue until the earliest of the following occurrences:

(1) The date the Eligible Individual is no longer Totally Disabled;

(2) The date the Eligible Individual becomes covered under another health plan which provides similar benefits; or

(3) The end of a period of 12 months following the date eligibility under this Plan terminated.

Section 2.08. Extension of Health Benefits For Eligible Individuals Who Are Hospitalized on the Date Their Eligibility Terminates.

A. If an Eligible Individual is confined as an inpatient in a Hospital on the date his/her eligibility terminates, Comprehensive Health Plan benefits will be continued for treatment of the covered medical condition(s) that existed before or during the Hospital confinement and which requires continued hospitalization. This extension will continue until the earlier of:

(1) The 91st day following termination of eligibility; or

(2) The date the Eligible Individual is discharged from the Hospital.

B. If an Eligible Individual is confined in a Hospital as an inpatient on the date his/her eligibility for benefits is changed by the Employer from one comprehensive health plan offered by the Fund to another comprehensive health plan offered by the Fund, the plan with the more generous benefits will continue to apply during the period of hospitalization.

.Section 2.09. Continuation Coverage Under COBRA. COBRA requires that under specific circumstances when coverage terminates, certain health plan benefits available to Eligible Individuals must be offered for

extension through self-payments. To the extent that COBRA applies to any Eligible Individual under this Plan, these required benefits shall be offered in accordance with this Section 2.09.

A. **General.** Participants and Dependents who lose eligibility under the Plan may continue Plan coverage subject to the terms of this Section. This Chapter is intended to comply with the health care continuation provisions of COBRA. Those provisions are incorporated by reference in the Plan and shall be controlling in the event of any conflict between those provisions and the terms of this Section.

B. **Continuation Coverage.** Eligible Individuals who would otherwise lose Plan coverage because of a "qualifying event" may continue coverage (except the Burial Expense benefit) under COBRA.

A "qualifying event" is defined as any of the following:

(1) Termination of Employment or reduction in hours which results in a loss of coverage;

(2) Death of the Participant;

(3) Divorce of the Participant from his Dependent Spouse; or

(4) Cessation of a Dependent child's Dependent status.

C. **Qualified Beneficiary.** A Qualified Beneficiary as defined under COBRA is an individual who loses coverage under any of the above referenced Qualifying Events. A child born to, or placed for adoption with, a Participant during a period of COBRA continuation coverage is also a Qualified Beneficiary.

D. **Addition of New Dependents.** If, while a Qualified Beneficiary is enrolled for COBRA continuation coverage, the Qualified Beneficiary marries, has a newborn child or has a child placed for adoption, he/she may enroll that spouse or child for coverage for the balance of the period of COBRA continuation coverage, by doing so within 30 days after the birth, marriage or placement for adoption. Adding a child or spouse may cause an increase in the amount that must be paid for COBRA continuation coverage.

E. Any Qualified Beneficiary may add a newborn or adopted child or new Spouse to his or her COBRA Continuation Coverage for the balance of the continuation coverage period, but the only newly added family members who have the rights of a Qualified Beneficiary, such as the right to stay on COBRA continuation coverage longer if a second Qualifying Event occurs, are natural or adopted children of the former Participant.

F. **Duration of Coverage**

(1) A Qualified Beneficiary whose coverage would otherwise terminate because of a termination of employment or reduction in work hours may elect continuation coverage for up to 18 months from the date of the Qualifying Event.

(2) A Qualified Beneficiary whose coverage would otherwise terminate because of an initial Qualifying Event other than a termination of employment or reduction in hours may elect continuation coverage for up to 36 months from the date of the Qualifying Event.

(3) Second Qualifying Event. The 18-month period described in paragraph (1) above, or the 29-month period under the disability extension described in paragraph (4) below, may be extended to a maximum of 36 months from the date of the Qualifying Event if a second Qualifying Event (other than a termination of employment or reduction in hours) occurs with respect to that Qualified Beneficiary during the original 18 or 29-month period, and while the Qualified Beneficiary is covered under the Plan.

(4) Extension of Coverage Period for Disability. A Qualified Beneficiary who is entitled to continuation coverage because of a termination of employment or reduction in hours may extend coverage beyond the original 18 months to a total of 29 months if he/she is determined by Social Security to be totally disabled as of the date of the Qualifying Event or during the first 60 days of COBRA continuation coverage. Other Qualified Beneficiaries in the disabled person's family are also eligible for the 29 month extended coverage period.

To qualify for the additional 11 months of continuation coverage, a Qualified Beneficiary must report the Social Security disability determination to the Fund Office in writing before the original 18-month period expires and within 60 days after the date of the Social Security determination.

(5) Entitlement to Medicare. If a Participant loses coverage due to a termination of employment or reduction in hours *after* he/she became entitled to Medicare, the Participant may continue coverage under COBRA for 18 months from the date of the Qualifying Event. However, the Dependents of the Participant may continue coverage under COBRA until the later of:

a. 18 months from the date of the Qualifying Event; or

b. 36 months from the date the Participant became entitled to Medicare.

G. **Termination of COBRA Continuation Coverage.** Notwithstanding the maximum duration of coverage described in Section 2.10.F., a Qualified Beneficiary's continuation coverage will end on the earliest of the following occurrences:

(1) The Contributing Employer ceases to provide group health coverage to any of its employees;

(2) The premium described in Subsection 2.09.J. is not timely paid;

(3) The Qualified Beneficiary first obtains health coverage, after the date of his COBRA election, under another Group Plan which does not exclude or limit any pre-existing condition of the Qualified Beneficiary; or,

(4) The Qualified Beneficiary first becomes entitled to Medicare coverage on or after the start date of his COBRA coverage.

H. **Election Procedure.** A Qualified Beneficiary must elect continuation coverage within 60 days after the later of:

/(1) The date of the Qualifying Event; or

(2) The date of the notice from the Fund Office notifying the Qualified Beneficiary of his or her right to COBRA continuation coverage.

Any election by a Qualified Beneficiary who is a Dependent Spouse with respect to continuation coverage for any other Qualified Beneficiary who would lose coverage under the Plan as a result of the Qualifying Event will be binding. However, the failure to elect continuation coverage by a Dependent Spouse will result in any other Qualified Beneficiary being given a 60 day period to so elect or reject COBRA coverage.

I. **Types of Benefits Provided.** A Qualified Beneficiary will be provided coverage under the Plan which, as of the time the coverage is being provided, is identical to the coverage that is provided to similarly situated Eligible Individuals with respect to whom a Qualifying Event has not occurred. A Qualified Beneficiary shall have the option of taking "core coverage" only. "Core coverage" refers to the health benefits the Qualified Beneficiary was receiving immediately before the Qualifying Event, *excluding* dental and vision benefits.

J. **Premiums.** A premium for continuation coverage will be charged to Qualified Beneficiaries in amounts established by the Board of Trustees. This premium shall be payable in monthly installments.

K. 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 (if coverage was elected on a timely basis). Thereafter, monthly premium payments must be made no later than the 30th day of the month for which continuation coverage is elected. Notwithstanding the previous sentence, the Board of Trustees may, for good cause shown, extend the premium payment due date.

L. **Notice Requirement.** A Qualified Beneficiary shall notify the Fund Office in writing of the Qualifying Event no later than 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary loses coverage. No later than 14 days after the later of the loss of coverage date or the date on which the Fund Office receives this written notification, the Fund Office will notify in writing the Qualified Beneficiary affected by the Qualified Event of his rights to continuation coverage.

M. Notwithstanding the preceding paragraph, the Plan's written notification to a Qualified Beneficiary who is a Dependent Spouse shall be treated as notification to all other Qualified Beneficiaries residing with that person at the time the notification is made.

N. It is the responsibility of a Qualified Beneficiary to notify the Fund Office of any change in address.

Section 2.10. Family and Medical Leave Act of 1993. If an Active Employee's Employer approves taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Employee and eligible Dependents will continue to be eligible under this Plan during the leave subject to the following conditions:

A. The Employee was eligible when the leave began; and

B. The Employer properly grants the leave under the Family and Medical Leave Act; and

C. The Employer makes the required notification and contributions to the Fund during the leave.

It is not the role of the Fund to determine whether or not an Employee is entitled to FMLA leave with medical coverage. Any determination regarding entitlement to FMLA leave with continuing medical coverage must be made by the Employer.

CHAPTER 3. ELECTION OF COVERAGE

A. Each Participant who becomes eligible will be given the opportunity to elect hospital-medical coverage provided directly by the Fund (the Comprehensive Health Plan Benefits) as described in these Rules and Regulations, or the HMO plan offered through Kaiser. A Participant must live within the service area of the HMO plan to enroll in that plan. Eligible Individuals must remain in the health plan selected for a minimum of 12 months, unless the Participant moves out of the HMO plan's service area or a change is approved by the Board of Trustees.

B. Coverage selected by the Participant will apply to any Dependents of the Participant. The eligibility rules established by the Board of Trustees shall prevail, regardless of coverage selected. The terms of the contract between the Fund and any prepaid plan shall prevail in the payment of claims or services rendered to those persons covered by the contract.

C. Participants who select the HMO plan will remain eligible for the Fund's Dental, Vision, Hearing Aid and Substance Use Disorder rehabilitation benefits (provided they continue to meet the eligibility requirements set forth in Chapter 2).

CHAPTER 4. COMPREHENSIVE HEALTH PLAN BENEFITS

The benefits described in this Chapter 4 are provided for Covered Expenses incurred by an Eligible Individual for treatment or care of a non-occupational Illness or Injury, or for treatment in connection with a pregnancy. Benefits are also payable for routine preventive care as specifically provided in Section 4.12.K. Expenses are incurred on the date the Eligible Individual receives the service or supply for which the charge is made. These Comprehensive Health Plan are subject to all provisions and limitations of these Rules and Regulations which may limit benefits or result in benefits not being payable.

Section 4.01. Schedule of Benefits. The schedule of comprehensive health plan benefits provided by the Fund are included as an attachment at the end of this Rules and Regulations document. "Plan A" means the plan of health benefits available to Employees whose Employers elect to provide Plan A benefits. "Plan B" means the plan of benefits available to Employees whose Employers elect to provide Plan B benefits. "Plan C" means the plan of benefits available to Employees whose Employers elect to provide Plan C benefits. "Plan D" means the plan of benefits available to Employees whose Employers elect to provide Plan D benefits. See Appendix A of these Rules and Regulations for the Schedule of Benefits.

Section 4.02. Except as stated in Section 4.14 for No Surprises Act Services, payment for covered expenses is as follows:

Section 4.03. Coinsurance Limit

A. Plan A, Plan B and Plan D: After an Eligible Individual or family has incurred Covered Expenses during a calendar year equal to the per-person or family Coinsurance Limit shown in the Schedule of Benefits, benefits will be payable at 100% of Covered Expenses incurred during the balance of that calendar year for the individual, or family if the family Coinsurance Limit is reached, subject to the exceptions described in Subsection C below.

B. Plan C: After an Eligible Individual or family has incurred Covered Expenses during a calendar year equal to the Coinsurance Limit shown in the Schedule of Benefits, benefits will be payable at 100% of Covered Expenses incurred during the balance of that calendar year for that individual.

C. Exceptions to Coinsurance Limit. Except as stated in Section 4.14 for No Surprises Act Services, the Coinsurance Limit does not apply to the following expenses:

(1) Covered Expenses that were reimbursed by the Plan at 100%;

(2) Physician visit Copayments;

(3) For Plans A, B and C: Charges from Non-Contract Providers within the Contract Provider Area;

(4) For Plan D: Any charges from Non-Contract Providers;

(5) Charges in excess of any Plan maximums or that are not Covered Expenses;

(6) For Plan C and Plan D, any amounts used to satisfy the Calendar Year Deductible;

(7) Contributions for coverage; and

(8) Expenses for dental plan and vision plan services.

Section 4.04. Out-of-Pocket Limit on Cost Sharing

A. This Plan has an Out-of-Pocket Limit on cost sharing is shown in the Schedule of Benefits. It limits the Eligible Individual's annual cost-sharing for covered health benefits received from Contracted providers related to Medical Plan deductibles, coinsurance, and copayments to the amounts permitted under the Affordable Care Act and implementing regulations. The Out-of-Pocket Limit is the most an Eligible Individual pays during a one year period (the calendar year) before the plan starts to pay 100% for covered health benefits received from Contracted providers. This annual cost-sharing limit includes the Coinsurance Maximum described in the previous Section.

(1) The Out-of-Pocket Limit is accumulated on a calendar year basis.

(2) Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan.

(3) 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.

(4) Emergency services performed in a Non-Contracted Emergency Room will apply to meet the Contracted Out-of-Pocket Limit on cost sharing.

(5) 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.

B. The Out-of-Pocket Limit on cost sharing **does not include or accumulate**:

(1) Contributions for coverage;

(2) Expenses for medical services or supplies that are not covered by the Plan,

(3) Except for No Surprises Services, charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers;

(4) Penalties for non-compliance with Utilization Management programs;

(5) Expenses for the use of Non-Contract providers, except for No Surprise Services;

(6) Outpatient prescription drug expenses (which has its own Out-of-Pocket limit); or

(7) Expenses for dental plan and vision plan services.

Section 4.05. Annual Deductible

A. Annual Deductible for Plan C and Plan D. The Fund will not begin paying benefits until the Eligible Individual or family has satisfied the deductible amount for the calendar year as specified in the Schedule of Benefits. Only Covered Expenses are applied to the Annual Deductible. Only amounts that have been applied to an individual's deductible will apply to the family deductible amount. The deductible is waived for some services, as indicated in the specific Plan C and Plan D Schedule of Benefits.

B. Deductible Carry Over Provision. Covered Expenses that are incurred in the last three months of a calendar year and applied to the Annual Deductible for that calendar year will also be applied to the deductible for the following calendar year.

Section 4.06. Copayments. Certain Covered Services are subject to a Copayment, or Copay, as specified in the Schedule of Benefits. The Copayment is the dollar amount the Eligible Individual is required to pay for each service before Plan benefits become payable. The Copayment continues to apply after the Coinsurance Limit has been reached.

A. A per visit Copayment will apply to the following services:

(1) Plan A and Plan B: Physician office, hospital and home visits, including specialist visits, consultations and acupuncture visits.

(2) Plan C: Physician office visits, including specialist visits and consultations, only if a Contract Provider or Out-of-Area.

(3) Plan D: Physician office visits, including specialist visits and consultations, only if a Contract Provider.

B. No Copayment will apply to:

(1) Second surgical opinion visits;

(2) Chemotherapy, radiation therapy, dialysis;

(3) Home health care visits;

(4) Adult routine physical examinations, well child care visits for Plans A, B and D, immunizations;

(5) X-ray and laboratory services; and

(6) Non-Contract Provider visits In-Area for Plan C.

Section 4.07. Preferred Provider Organization (PPO). Eligible Individuals may obtain health care services from Contract Providers or Non-Contract Providers. Contract Providers have agreements with the Plan's Preferred Provider Organization under which they provide health care services and supplies to Participants and Dependents for a negotiated fee. When an Eligible Individual uses the services of a Contract Provider, he or she is responsible for paying only the applicable coinsurance and Copayment required by the Plan for any Covered Expense.

Non-Contract Providers have no agreements with the Plan or its Preferred Provider Organization with regard to the fees they may charge for the services or supplies they provide. The Plan will base its reimbursements for Non-Contract Provider services on the Allowed Charge. Non-Contract Providers, except for No Surprises Services, may bill the Participant for any balance that may be due in addition to the amount payable by the Plan.

A. **Continuity of Care**. When a provider terminates from the Preferred Provider Organization network, an Eligible Individual who is receiving care from that provider for an acute condition, serious chronic condition or pregnancy that has reached the second trimester may request continuity of care by contacting the Fund Office. The Plan will provide continuity of care in accordance with the following:

(1) Notify the Eligible Individual of the Plan's termination of its contract(s) 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) The Plan will continue to pay Contract Provider benefits for services received from the terminated provider for 90 days after notifying the Eligible Individual of the provider's termination or until the Eligible Individual is no longer a Continuing Care Patient, whichever is earlier.

B. **Exceptions to Non-Contract Provider Benefits**

(1) If an Eligible Individual requires medical services that are not available in a Contract Hospital, the Plan will pay Contract Hospital benefits for confinement in a Hospital that can provide the required services, subject to approval by the Professional Review Organization.

(2) Benefits for the following services from a Non-Contract Provider will be paid at the Contract Provider benefit level provided the services are received in a Contract Hospital or Facility and are ordered by a Contract Physician:

a. Anesthesiologist

b. Assistant Surgeon

c. Emergency Room Physician, and

d. Radiologist

C. **Preferred Provider Organization (PPO) Centers of Excellence for Organ and Tissue Transplants and Bariatric Surgery.** Covered bariatric surgery and specified organ and tissue transplant procedures are covered only when performed at a Contract Hospital or Facility that is a "Center of Medical Excellence" in the PPO network administered by Anthem Blue Cross or a "Blue Distinction Center" in the PPO network administered by the Blue Cross and Blue Shield Association. **No Plan benefits will be payable for bariatric surgery or for specified organ or tissue transplant procedures performed in a Hospital or Facility that is not an Anthem Blue Cross "Center of Medical Excellence" or a "Blue Distinction Center" (even if the Hospital or Facility is a Contracted facility).** Plan coverage is subject to compliance with the Pre-admission review requirement outlined in Section 4.11. The Professional Review Organization will determine, prior to surgery, if the transplant procedure is one that is subject to this limitation.

Section 4.08. Utilization Review Program. If an Eligible Individual is to be confined in a Hospital on a non-emergency basis, the Physician must obtain Pre-admission Review by the Professional Review Organization (PRO) to determine, prior to the occurrence of the confinement, the Medical Necessity of the Hospital confinement, and if Medically Necessary, the number of pre-authorized days, if any, determined by the PRO to be Medically Necessary for the confinement. All organ or tissue transplant procedures must be pre-approved by the PRO in order for benefits to be payable by the Plan. In addition, precertification is required for all individuals who participate in a clinical trial. The following provisions and exceptions apply:

A. When confinement will be in a Contract Hospital, Pre-admission Review will be automatically obtained by the Contract Hospital.

B. The length of Hospital confinement for a mastectomy will not be limited by the Review Organization but will be determined solely by the Physician and Patient.

C. Newborns' and Mothers' Health Protection Act. Under federal law, group health plans 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 normal delivery, or less than 96 hours following a cesarean section. However, the law does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. This Plan does not require that a provider or Eligible Individual obtain Pre-admission Review for prescribing a Hospital length of stay not in excess of 48 hours for normal delivery or 96 hours for cesarean section

Section 4.09. Covered Expenses. Subject to the terms and conditions stated in the Plan, benefits are payable for the following Covered Expenses in accordance with the applicable Schedule of Benefits.

A. **Hospital Inpatient Services.** If an Eligible Individual is confined in a Hospital with the approval of a Physician, benefits will be payable by the Plan for up to 365 days of confinement during any one Period of Disability, subject to the following conditions and limitations:

(1) For purposes of this Section, a Period of Disability includes all Hospital confinements due to the same or related causes, unless they are separated by a return to work by the Active Participant, or, for a Dependent or Retired Participant, by a period of at least 3 consecutive months, in which cases they will be considered separate Periods of Disability.

(2) Well baby nursery care is covered on the same basis as other Hospital care.

(3) For confinement in a Non-Contract Hospital, Covered Expenses for room and board are limited to the Hospital's semi-private room rate or intensive care unit, when confinement in an intensive care unit is Medically Necessary.

B. **Hospital Outpatient Services / Emergency Room**

C. **Licensed Ambulatory Surgery Facility services**

D. **Physician Office, Hospital and Home Visits:**

(1) Physician Visit Copayment. Benefits for some Physician visits are subject to the per visit Copayment as specified in the Schedule of Benefits and described in detail in Section 4.09.

(2) The term "visit" means a personal interview between the Patient and the Physician and does not include telephone consultations or other situations where the Patient is not personally examined by the Physician.

(3) Benefits are limited to one office, Hospital or home visit per day.

E. **Other Physician Services, Surgeon, Assistant Surgeon, Anesthesiologist:**

(1) Bariatric Surgery for weight loss is covered subject to Utilization Review, only when Medically Necessary for morbid obesity and only when performed at a Contract Provider Center of Medical Excellence (CME) or Blue Distinction Center. Bariatric travel expense is covered when the Patient's home is 50 miles or more from the nearest Bariatric CME or Blue Distinction Center, with benefits payable subject to the following limitations:

a. The Patient's transportation to and from CME or Blue Distinction Center is limited to $130/person/trip for 3 trips (pre-surgical visit, initial surgery and one follow-up visit);

b. One companion's transportation to and from CME or Blue Distinction Center is limited to $130/person/trip for 2 trips (initial surgery and one follow-up visit);

c. Hotel for Patient and one companion is limited to one room, double occupancy and $100/day for 2 days/trip, or as Medically Necessary, for pre-surgical and follow-up visit. Benefit for hotel for one companion is limited to one room double occupancy and $100/day for duration of Patient's initial surgery stay for 4 days.

d. Other reasonable expenses limited to $25/day/person for 4 days/trip. These expenses will not include meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and

expenses for persons other than the Patient and his/her designated family member/travel companion.

F. **Diagnostic X-ray and Laboratory Services, Nuclear Medicine / Imaging Services** when ordered by a Physician.

G. **Radiation Therapy, Chemotherapy, Dialysis Treatment**

H. **Acupuncture**, payable for treatment of intractable pain only (or for Medically Necessary treatment of a mental health or substance use diagnosis), subject to the following conditions:

(1) Copayment. Benefits for Plan A and Plan B are payable after the Eligible Individual pays the per visit Copayment specified in the Schedule of Benefits.

(2) Benefits are limited to one visit per week and 12 visits per diagnosis, unless the Professional Review Organization approves further treatment (visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder).

I. **Reconstructive Surgery:**

(1) Women's Health and Cancer Rights Act. Under this federal law, health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of an Eligible Individual who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the Plan will provide coverage, in accordance with the Schedule of Benefits, for:

a. Reconstruction of the breast on which the mastectomy was performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

(2) Other Reconstructive Surgery. Plan benefits will be payable for surgery required to correct a functional disorder or due to an Injury sustained in an accident that occurred while the Patient was eligible under the Plan.

J. **Chiropractic and Physical Therapy Services.** Benefits for services of a licensed Chiropractor, Registered Physical Therapist or for physical therapy treatment provided by a Physician are payable in accordance with the Schedule of Benefits, subject to the following limitation:

- Benefits are limited to a combined maximum of 40 visits per calendar year for all chiropractic and physical therapy services. The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

K. **Routine Preventive Care Services:**

(1) **Preventive Care Services From A Contract Provider.** The following Preventive Services that are required to be covered under Health Care Reform will be payable at 100% with no Copay or Deductible when received from a Contract Provider, including the Contract Physician's charge for a routine physical examination. The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations. Where the information in this document conflicts with newly released ACA regulations affecting the coverage of preventive care, this Plan will comply with the new requirements on the date required.

The complete list of covered preventive care services is as shown on the government websites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at
- http://www.uspreventiveservicestaskforce.org/BrowseRec/Index
- http://www.hrsa.gov/womensguidelines/
- http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001

(2) **Preventive Care Services From a Non-Contract Provider.** The following Preventive Services are covered in accordance with the Schedule of Benefits for Non-Contract Providers:

a. Adult Routine Physical Examination Benefit (for the Participant, Dependent Spouse and Dependent Children age 17 and over). The Plan will pay benefits up to the maximum amount shown in the Schedule of Benefits for a physical exam and related routine diagnostic tests ordered as part of the exam. No benefits are payable for a physical examination required for employment, an examination for which an employer is required to pay or for vision examinations covered under the Vision Care Plan.

b. Immunizations

c. Mammography Screening. The outpatient x-ray and laboratory benefits shown in the Schedule of Benefits are payable in accordance with the following schedule for women with no symptoms or history of breast cancer:

– Ages 35 through 39: one baseline mammogram
– Ages 40 and over: one mammogram every year

d. Well Child Care. Benefits are payable in accordance with the Schedule of Benefits for children age 16 and under for routine physical examinations, related laboratory services and immunizations.

L. **Home Health Care, including Hospice Care.** Benefits are provided for up to 60 visits per calendar year, limited to one visit per day (visit limits will not apply for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice), subject to the following:

(1) Services must be provided and billed by a licensed Home Health Agency.

(2) Covered services include visits by a registered nurse, medical social worker, occupational, speech and physical therapists and health aides.

(3) Housekeeping services are not covered.

M. **Mental Illness Treatment.** Benefits are payable in accordance with the Schedule of Benefits for the applicable plan on the same basis as other medical treatment. Outpatient and inpatient benefits are payable for Medically Necessary treatment provided by a licensed provider practicing within the scope of his or her license.

N. Substance Use Disorder Treatment. Benefits are payable in accordance with the Schedule of Benefits for the applicable plan on the same basis as other medical treatment. Outpatient (including intensive outpatient treatment and partial hospitalization) and inpatient benefits (including residential treatment) are payable for Medically Necessary treatment provided by a licensed provider practicing within the scope of his or her license.

O. **Ambulance Transportation.** The Plan will pay benefits for necessary transportation by local ground ambulance to and from a Hospital. In the case of an Emergency Medical Condition where land transportation would be hazardous to the Patient's health, benefits will be payable for transportation by air ambulance to the nearest Hospital where Medically Necessary treatment can be provided.

P. **Services of a Registered Nurse or licensed vocational nurse** when ordered by a Physician.

Q. **Blood transfusions**, including blood processing and the cost of unreplaced blood and blood products.

R. **Splints, casts, surgical dressings and other supplies** for reduction of fractures and dislocations.

S. **Oxygen and rental of equipment for its administration.**

T. **Prosthetic or Artificial Devices** that replace all or part of a bodily organ or that improve the function of an impaired body organ or part, including intraocular lens implants placed after cataract surgery and purchase of initial and subsequent prosthetic devices necessary to restore a method of speaking following a laryngectomy.

(1) The Plan will cover the initial replacement of natural eyes and limbs, and replacement of the artificial eyes or limbs only if prescribed by a Physician.

U. **Durable Medical Equipment.** Rental, or if more economical, purchase of wheelchair, hospital bed and other durable medical equipment, which is:

(1) ordered by a Physician,

(2) of no further use when medical need ends,

(3) usable only by the Patient,

(4) not primarily for the comfort of the Patient,

(5) not for environmental control,

(6) not for exercise,

(7) manufactured specifically for medical use,

(8) approved as effective and Medically Necessary treatment of a medical condition as determined by the Fund, and

(9) not for preventive purposes.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

V. **Home Infusion Therapy Drugs** and equipment for their administration.

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

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

(2) Benefits for speech therapy provided for any condition other than those specified in paragraph (1) above are limited to a maximum payment of 20 visits per calendar year and 40 visits per lifetime. The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice. In addition, the Physician's evaluation of the need for speech therapy will not be applied to these maximums. Benefits are payable only until understandable speech is attained or until a determination is made that understandable speech cannot be attained.

X. **Dental Services.** Benefits under this Chapter will be payable for the following dental services:

(1) Services of a Physician or Dentist to treat an Injury to teeth which occurred while the Patient was eligible under this Plan. Services must be received within 90 days following the date of Injury even if the date of the Injury is prior to the date the individual is enrolled in the Plan. Damage to natural teeth due to chewing or biting is not covered.

(2) Services of a Physician or Dentist to remove cysts or tumors of the gums.

Y. **Temporomandibular Joint Syndrome (TMJ).** Covered Expenses include treatment of TMJ syndrome, myofacial pain dysfunction syndrome, mandibular pain dysfunction, facial pain and mandibular dysfunction, Costen's syndrome, craniocervical mandibular syndrome and craniofacial pain and dysfunction, subject to the following limitation:

(1) Benefits for all non-surgical treatment are limited to a lifetime maximum of $1,500.

Y. **Skilled Nursing Facility.**

(1) Plan A, Plan B and Plan C: Benefits are limited to 180 days per calendar year

(2) Plan D: Benefits are limited to 100 days per calendar year

The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Z. **Cardiac Rehabilitation Services** for Eligible Individuals who have had cardiac surgery or a heart attack. The program must be ordered by a Physician to be covered by the Plan.

AA. **Organ and Tissue Transplants.** The Plan will cover the 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 and Hospital charges for the recipient and donor, follow-up care in the home or a Hospital and immunosuppressant drugs, under the following conditions:

(1) The transplantation is not considered an Experimental or Investigational Procedure as that term is described in Section 12.01.J., and

(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 must be approved by the Professional Review Organization (PRO).

(4) The recipient of the organ is an Eligible Individual under the Plan.

(5) Benefits payable for an organ donor who is not an Eligible Individual will be reduced by any amounts paid or payable by that donor's own health coverage.

(6) Transplant travel expense for an authorized, specified transplant at a CME or Blue Distinction Center for the organ recipient and companion and/or donor transportation is limited to $10,000 per transplant. Benefits for unrelated donor search are limited to $30,000 per transplant. In no case will the Plan cover expenses for transportation of surgeons.

BB. **Online Physician Consultation.** Benefits are payable for online interactive video Physician consultation through the Anthem Blue Cross LiveHealth Online Services with a $15 Copayment per consultation.

CC. **Autism Therapy.** The Plan will cover all medically necessary services related to the treatment of autism, including Applied Behavioral Analysis (ABA) therapy. These will be covered at the Plan's regular cost-sharing depending on the type/location of services, and subject to the Plan's requirements, terms, and limitations.

Section 4.10. Excluded Expenses. No benefits will be payable for the following:

A. Services furnished by a naturopath or any other provider not meeting the definition of a Physician, except as specifically provided under Subsections H, J, L, M, O, and V of Section 4.12.

B. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, custodial care, 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 (medical necessity must be re-established by Anthem every two months);

D. Hyperkinetic syndromes, learning disabilities, behavioral problems, developmental delay, attention deficit disorders or mental retardation, except that the exclusion of developmental delay will not apply to benefits payable under Section 4.12.V.(2) for covered speech therapy services provided to a Dependent child who has failed to attain appropriate speech or as part of an approved autism therapy plan.

E. Radial keratotomy, photorefractive keratectomy (PRK), laser in-situ keratomileusis (LASIK), or any other refractive eye surgery. Eye refractions, eyeglasses, and contact lenses (except for intraocular lens implants placed after cataract surgery).

F. Vision therapy, vision training, orthoptics.

G. Cosmetic surgery or any services for beautification, except as specifically provided under Section 4.12.I. Reconstructive Surgery.

H. In vitro fertilization, artificial insemination, surrogate pregnancy or any other infertility related services.

I. Services to reverse voluntary surgically induced infertility.

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 (except if part of an approved autism therapy plan).

K. Nutritional counseling, food supplements or substitutes, except for the following:

(1) Initial Diabetes instruction visit;

(2) Counseling when rendered in connection with treatment of an eating disorder

(3) Enteral feeding when preauthorized as Medically Necessary by the Professional Review Organization. Enteral feeding is defined as a formula that is the primary source of nutrition (i.e.,

60% or more of caloric nutritional intake) and supplies used to administer the formula. This does not include:

a. Standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen), or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to food allergies, multiple protein intolerances, lactose intolerances, gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems; or

b. Food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like; or

c. Weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and minerals.

L. Services or supplies which are primarily for weight loss, (except for covered bariatric surgery as specifically provided, health club membership, spas, exercise and physical fitness programs or equipment.

M. Hypnotism, stress management, biofeedback, and any goal oriented behavior modification therapy, such as to quit smoking, lose weight or control pain. However, please note, the Plan will cover medically necessary psychotherapy to treat a mental health or substance use disorder condition as a behavioral health benefit under the plan.

N. Orthopedic shoes, shoe inserts, and foot orthotics. (Exceptions: Covered when related to diabetes and prescribed by a Physician or when the shoe is joined to a leg brace).

O. Wigs (except when hair loss is due to cancer treatment), services or supplies for comfort, hygiene or beautification, air purifiers, humidifiers or any other equipment or supplies for environmental control.

P. Expenses for transportation, except as provided under the Ambulance Transportation benefit.

Q. Dental services or prostheses, extraction of teeth, or any treatment to the teeth or gums, except as specifically provided.

R. Any treatment or services, whether or not prescribed by a Physician, for which charges incurred are not the direct result of an Illness or Injury, except as specifically provided.

S. Any services, whether or not prescribed by a Physician, that are not listed in this Plan under Covered Expenses, or those services which are not Medically Necessary.

T. Any service or supply excluded under General Exclusions, Limitations and Reductions as described in Chapter 12.

U. Bariatric surgery or any specified organ or tissue transplant that is performed in a Hospital or Facility that is not designated as a "Center of Medical Excellence" under the Anthem Blue Cross PPO or as a "Blue Distinction Center" under the PPO network administered by the Blue Cross and Blue Shield Association. The Professional Review Organization will determine, prior to surgery, if the organ or tissue transplant is one that is subject this limitation.

V. Habilitation Services including delays in physical development. Benefits may be available for delays in childhood speech or as part of an approved autism therapy plan..

W. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that

are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. [For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.

Section 4.10. 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:

- 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;
- 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;
- 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
- In general, Eligible Individuals cannot be balance billed for these Air Ambulance Services.

b. Emergency Services. The No Surprises Act requires Emergency Services to be covered as follows:

- Without the need for any prior authorization determination, even if the services are provided on a Non-Contract basis;
- Without regard to whether the health care provider furnishing the Emergency Services is an Contract Provider or an Contract Facility, as applicable, with respect to the services;
- 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 Contact Providers and Contract emergency facilities;
- 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 an Contact Provider or an Contact Facility;
- 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; and;
- By counting cost-sharing requirements for Non-Contract Emergency Services toward the Contract Provider deductible and Contract Provider out-of-pocket maximum in the same manner as those received from a Contract Provider.

c. Non-Emergency Services. The No Surprises Act requires Non-Emergency Services performed by Non-Contract Provider at a Contract Health Care Facility to be 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 an Contract Provider;
- 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; and

- 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 Contact 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 participating provider.

Notice and Consent Exception: Non-emergency items or services performed by a Contact Provider at a Contract Facility will be covered based on the Non-Contract coverage 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 an 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 provided treatment and that the Patient may elect to be referred to one of the Contract Providers listed; and
- The Patient give informed consent to continued treatment by the Non-Contract Provider, acknowledging that the Patient understands that continued treatment by the out-of network provider may result in greater costs.

  The notice and consent exception does not apply to Ancillary services and items or services furnished 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 will 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 an Contact 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; and
- 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.

d. 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-

- 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
- Apply the out-of-pocket limit, if any, as if the services were provided by a Contract Provider.

CHAPTER 5. PRESCRIPTION DRUG BENEFITS

Section 5.01. Benefits. If prescription medicines (or insulin) are prescribed by a Physician for an Eligible Individual, the Fund will pay the following benefits:

A. **Retail Contract Pharmacy – Plan A, Plan B, Plan C and Plan D.** The Participant is responsible for the following copays (for each 34-day supply of a prescription or refill obtained from a retail Contract pharmacy):

(1) For Generic Drugs: $5 Copay.

(2) For Brand Name Drugs when a generic equivalent is not available: 10% coinsurance (maximum copay of $100).

(3) For Brand Name Drugs when a generic equivalent is available: 15% coinsurance (maximum copay of $200).

(4) Exception for Contraceptives. No Copay will apply to Generic contraceptive medications. The normal Brand Name Copay described above will apply to Brand Name contraceptives unless the prescribing Physician states that the Generic product will not work, in which case no Copay will apply.

B. **Mail Order Program – Plan A, Plan B, Plan C and Plan D:** The Participant is responsible for the following copays (for each 90-day supply of a prescription or refill obtained through the Fund's mail order program). Effective July 1, 2014 the Fund will allow a Participant to obtain a 90-day supply of maintenance Drugs at a retail pharmacy instead of only being able to use mail order. The Participant will pay three (3) retail copays for each 90-day prescription at a network retail pharmacy.

(1) For Generic Drugs – $10 Copay.

(2) For Brand Name Drugs when a generic equivalent is not available – 5% coinsurance (maximum copay of $100).

(3) For Brand Name Drugs when a generic equivalent is available – 20% coinsurance (maximum copay of $200).

(4) Exception for Contraceptives. No Copay will apply to Generic contraceptive medications. The normal Brand Name Copay described above will apply to Brand Name contraceptives unless the prescribing Physician states that the Generic product will not work, in which case no Copay will apply.

E. **Non-Contract Pharmacy.** The same Copays and day supply limits described above in Sections 5.01.A and B will apply to generic and brand name drugs purchased at a Non-Contract Pharmacy; however, the Fund reimbursement will be limited to the amount it would have paid if the drug were purchased at a Contract Pharmacy, and the Eligible Individual will be responsible for any remaining charges.

F. If the actual cost of a prescription Drug is less than the Copay amounts listed above, the Eligible Individual will pay the actual cost.

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

subject to step therapy prior to January 1, 2012 may continue to receive Plan benefits for the Drug for 12 months. At the end of the 12-month period, the step therapy requirements will apply.) The following classes of drugs are subject to step therapy:

(1) Cholesterol medications;

(2) Pain medications;

(3) Sleep aids;

(4) Blood pressure medications;

(5) Antihistamines/combinations for allergies;

(6) Nasal steroids for allergies;

(7) Urinary antispasmodics for overactive bladder/incontinence;

(8) Bisphosphonates for osteoporosis;

(9) SSRIs for depression;

(10) Selective serotonin agonists/combinations for migraines;

(11) Short acting beta agonists inhalers.

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: Auto Immune, Multiple Sclerosis and Growth Hormones.

(1) Exception Applicable to the Auto Immune 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.

Section 5.02. Covered Expenses. Covered Expenses include:

A. Charges made by a Licensed Pharmacist for Drugs prescribed by a Physician for treatment of an Illness or Injury, including new Drugs approved by the federal Food and Drug Administration.

B. Charges made by a Licensed Pharmacist for insulin or diabetic supplies.

C. Charges made by a Licensed Pharmacist for contraceptives.

D. Charges made by a Physician licensed by law to administer Drugs, for any Drugs or diabetic supplies that are supplied to the Patient in the Physician's office and for which a charge is made separately from the charge for any other item of expense.

E. Charges made by a Hospital for Drugs, or for insulin or diabetic supplies, that are for use outside the Hospital in connection with treatment received in the Hospital, provided that with respect to Drugs, they are prescribed by a Physician.

F. Charges made by a Licensed Pharmacist for compounding Drugs prescribed by a Physician are covered at Brand Name Drugs Copayment described in Sections 5.01.A and B, 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.

G. Charges made by a Licensed Pharmacist for prenatal vitamins or therapeutic vitamins prescribed by a Physician for the treatment of a specific Illness or Injury. Claims for these items must be accompanied by a statement from the Physician as to the nature of the Illness or Injury.

H. Injectable and infusion Drugs, and any other Drug included in the pharmacy benefit manager's (OptumRx) list of Specialty Drugs, subject to the following requirements:

(1) The Drug must be obtained through the pharmacy benefit manager's (OptumRx) Specialty Pharmacy Services. Direct member reimbursement claims submitted to the pharmacy benefit manager, or prescriptions presented to a retail Contract Pharmacy, will not be covered. Exception: this rule does not apply to chemotherapy injectable and infusion Drugs.

(2) The Drug must not be for immunization.

(3) The Drug must be one which is not otherwise covered under the Fund's Comprehensive Health Plan benefits.

Section 5.03. Exclusions. No benefits will be payable for:

A. Drugs administered while the Patient is confined in a Hospital or Skilled Nursing Facility.

B. Patent or proprietary medicines which do not require a Physician's prescription by federal law, regardless of whether a state law mandates dispensing only with a prescription, except insulin, diabetic supplies and those items listed as "Covered Charges" in Subsections f. and g. above.

C. Drugs not Medically Necessary for the care or treatment of an Illness or Injury (except for contraceptives when covered under the Plan); drugs with no approved Federal Drug Administration indications; medications used for Experimental indications, and/or dosage regimens determined to be Experimental or Investigational.

D. Medications prescribed for cosmetic purposes (e.g. Retin-A for other than acne or Rogaine/Minoxidil for hair loss).

E. Appetite suppressants or any other weight loss drugs.

F. Drugs or devices prescribed for treatment of sexual dysfunction, except when due to a medical or mental health condition as certified by the Eligible Individual's Physician.

G. Drugs prescribed for treatment of infertility.

H. Immunization agents.

I. Appliances, devices and other supplies or equipment, except for diabetic supplies.

J. Non-therapeutic and multiple vitamins, nutritional supplements, health and beauty aids.

K. Charges for prescription drugs containing in excess of a 34-day supply for retail purchase (or a 90-day supply of maintenance drugs at a retail pharmacy) or in excess of a 90-day supply for drugs purchased through the Fund's mail order program.

L. Drugs covered under Workers' Compensation laws or similar legislation, or drugs prescribed to treat an occupational Illness or Injury.

M. Drugs provided by or paid for by any governmental program, either federal, state, county or municipal.

N. Replacement prescription Drugs resulting from loss, theft or breakage.

O. Any Drug or medication excluded under General Exclusions, Limitations and Reductions as described in Chapter 12.

P. Medications with no federal Food and Drug Administration (FDA) indications and any non-FDA-approved bulk chemicals used in Compound Drugs.

CHAPTER 6. SUBSTANCE USE DISORDER BENEFITS

Section 6.01. Benefits. Substance use disorder treatment benefits are provided to Eligible Individuals enrolled in the Comprehensive Health Plan and the HMO plan. If an Eligible Individual receives treatment for substance use disorder under the Operating Engineers Assistance Recovery Program (ARP), the Plan will pay the following benefits for covered services.

A. **Inpatient Residential Treatment.** Benefits for Contract and Non-Contract Providers are payable at 100% (not subject to the deductible if your Kaiser option has a deductible). Inpatient treatment requires pre-authorization by the Operating Engineers Assistance Recovery Program.

B. **Outpatient Treatment and Recovery Home Treatment.** Benefits for Contract and Non-Contract Providers are payable in accordance with the Schedule of Benefits on the same basis as outpatient Physician visits or outpatient Hospital charges, as applicable.

Section 6.02. Exclusions and Limitations. No benefits will be provided for the following:

A. Any treatment or service that is determined not Medically Necessary by the Operating Engineers Assistance Recovery Program.

B. Any treatment or service excluded under General Exclusions, Limitations and Reductions as described in Chapter 12.

CHAPTER 7. HEARING AID BENEFIT

Section 7.01. The Hearing Aid Benefit is provided to Eligible Individuals enrolled in the Comprehensive Health Plan and the HMO plan, with certification by a Physician that the Eligible Individual has a hearing loss that may be lessened by the use of a hearing aid. Upon certification by a Physician, the Participant may purchase the hearing aid from a vendor that requires a prescription as well as devices approved by the FDA for over-the-counter purchase.

For Plan D only, the hearing aid benefit is subject to the Comprehensive Health Plan Benefits calendar year deductible, as described in Chapter 4, except that the deductible will not apply to HMO enrollees.

Section 7.02. Benefit for Plan A, Plan B, Plan C and Plan D. The Fund will, subject to the provisions of this Chapter 7, pay 100% of the Covered Expenses incurred for the examination and the hearing aid up to a maximum payment of $1,350 per ear.

Section 7.03. Exclusions. No benefits will be provided for:

A. The replacement of a hearing aid for any reason more often than once during any 4-year period;

B. Batteries or any other ancillary equipment other than those obtained upon the purchase of the hearing aid;

C. Expenses incurred for which the individual is not required to pay;

D. Repairs, servicing or alterations of the hearing aid more often than once during any 3-year period;

E. More than one hearing aid for each ear; or

F. Any expense excluded under General Exclusions, Limitations and Reductions as described in Chapter 12.

CHAPTER 8. DENTAL BENEFITS

Dental benefits are provided under an Administrative Services Only contract between the Trust Fund and Delta Dental of California (Delta Dental), providing the Delta Dental PPO plan, a preferred provider organization (PPO) program that provides access to Delta PPO Dentists.

Section 8.01. Definitions. The following definitions will apply to this Chapter 8.

A. The term "Covered Dental Expense" means:

(1) 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.

(2) For a Delta Dental Dentist – the lesser of the fee actually charged or the accepted fee that the Dentist has on file with Delta Dental.

(3) 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.

B. The term "Delta Dental Dentist" means a Dentist who has signed an agreement with Delta Dental or a Participating Plan agreeing to provide services under the terms and conditions established by Delta Dental or the Participating Plan.

C. The term "Delta Dental PPO Dentist" means a Dentist with whom Delta Dental has a written agreement to provide services at the in-network level for Eligible Individuals in this Delta Dental PPO Plan offered by the Fund.

D. The term "Participating Plan" means Delta Dental and any other member of the Delta Dental Plans Association with whom Delta Dental contracts for assistance in administering the dental benefits of the Plan.

Section 8.02. Benefits. If an Eligible Individual incurs a Covered Dental Expense, the Plan will pay, subject to the terms and conditions stated in the Plan, the applicable percentage (as stated under Section 8.03) of the lesser of: a) the Covered Expense for the treatment, examination or procedure, or b) the Dentist's usual fee, subject to the following:

A. **Maximum Amount**. Dental benefits payable by the Plan will not exceed a maximum payment of $2,500 per person, per calendar year, except that this maximum will not apply to pediatric dental services for individuals younger than 19.

Section 8.03. Schedule of Dental Services. Subject to the Limitations and Exclusions described in Sections 8.04 and 8.05, benefits for Covered Dental Expenses will be paid in accordance with the following Schedule of Services.

A. **Diagnostic and Preventive Benefits**. **Payable at 100% of Covered Dental Expenses**.

(1) Diagnostic. Procedures to assist the Dentist in evaluating existing conditions to determine the required dental treatment, including oral examination, bite-wing x-rays, emergency palliative treatment, specialist consultation (and diagnostic casts only if eligible for orthodontic benefits).

(2) Preventive. Prophylaxis, fluoride treatment and sealants.

B. **Basic Benefits. Payable at 85% of Covered Dental Expenses**.

(1) X-rays (other than bitewing x-rays) and space maintainers.

(2) Oral surgery, including extractions and certain other surgical procedures, including pre- and postoperative care.

(3) Restorative. Amalgam, synthetic porcelain and plastic restorations (fillings) for treatment of carious lesions.

(4) Endodontic. Treatment of the tooth pulp.

(5) Periodontic. Treatment of gums and bones supporting teeth.

C. **Crowns and Cast Restoration Benefits**. **Payable at 85% of Covered Dental Expenses**.

Crowns and cast restorations for treatment of carious lesions which cannot be restored with amalgam, synthetic porcelain or plastic restorations.

D. **Prosthodontic Benefits**. **Payable at 60% of Covered Dental Expenses**.

Procedures for construction or repair of fixed bridges, partial and complete dentures, if provided to replace missing natural teeth. Benefits are payable for implant surgical placement and removal and for implant supported prosthetics, including implant repair and re-cementation.

E. **Additional Benefits During Pregnancy.** Additional services are covered during pregnancy. The additional services each calendar year include: one additional oral examination and either one additional routine prophylaxis or one additional periodontal scaling and root planning per quadrant. Written confirmation of pregnancy must be provided by the Patient or Dentist when the claim is submitted. The additional services are payable at the applicable percentage payable for Diagnostic and Preventive Benefits or Basic Benefits.

Section 8.04. Dental Limitations. The benefits described in Section 8.03. are subject to the following limitations:

A. Bitewing x-rays are covered twice each calendar year. Full mouth x-rays are limited to once every 3 years

B. Prophylaxis is limited to 2 treatments in a calendar year. Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit. See Additional Benefits During Pregnancy in Section 8.03.E.

C. Fluoride treatments are covered twice each calendar year.

D. Only the first two oral examinations in a calendar year, including office visits for observation and specialist consultations, or any combination of these, are benefits while the individual is eligible under any Delta Dental plan. See Additional Benefits During Pregnancy in Section 8.03.E.

E. Sealant benefits include the application of sealants only to permanent first molars through age 8 and second molars through age 15 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 two years of its application.

F. Direct composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspids. Any other posterior or direct composite (resin) restorations are optional services and the Plan's payment is limited to the cost of the equivalent amalgam restoration.

G. Periodontal scaling and root planning is covered once for each quadrant each 24-month period. See Additional Benefits During Pregnancy in Section 8.03.E.

H. Crowns, inlays, onlays, and cast restorations are covered on the same tooth only once every 5 years while eligible under the 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.

I. Prosthodontic appliances and implants (including fixed bridges and partial or complete dentures) are covered only once every 5 years, while eligible under this 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 an implant, a prosthetic appliance or an implant supported prosthesis received under another plan will be covered if Delta determines it is unsatisfactory and cannot be made satisfactory.

J. 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.

K. Optional Services. If an Eligible Individual selects a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, an allowance will be made for the least expensive, professionally acceptable alternative treatment plan. The Plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and the Eligible Individual is responsible for the remainder of the Dentist's fee. For example, a crown where an amalgam filling would restore the tooth or a precision denture where a standard denture would suffice.

Section 8.05. Dental Exclusions. Dental benefits are not payable for:

A. Expense incurred for missed appointments.

B. Dietary planning, oral hygiene instruction, or training in preventive dental care.

C. Orthodontic services, except as otherwise specified in Chapter 9.

D. Any services or procedures that are Experimental or Investigational in nature or are not within the standards of generally accepted dental practice.

E. 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.

F. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such services are equilibration and periodontal splinting.

G. Any single procedure, bridge, denture or other prosthodontic service which was started before the date the person became eligible for the services under this Plan. A single procedure is a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

H. Prescribed Drugs, or applied therapeutic drugs, premedication or analgesia.

I. Charges by any Hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

J. Anesthesia, except for general anesthesia given by a Dentist for covered oral surgery procedures.

K. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

L. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues.

M. Replacement of an existing restoration for any purpose other than active tooth decay.

N. Intraveneous sedation.

O. Complete occlusal adjustment.

P. Any services excluded under the General Exclusions, Limitations and Reductions listed in Chapter 12.

CHAPTER 9. ORTHODONTIC BENEFITS

Effective July 1, 2010 orthodontic benefits are provided under an Administrative Services Only contract between the Trust Fund and Delta Dental of California.

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

Section 9.02. When Eligibility for Orthodontic Benefits Begins. Eligibility for orthodontic benefits begins on the first day of the calendar month following 3 consecutive months of eligibility under the Fund.

Section 9.03. Benefits. The Plan will pay 50% of Covered Expenses incurred for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures, subject to the following:

A. Lifetime Maximum. Benefits are limited to a lifetime maximum of $2,500 per person.

B. Treatment must be provided by a Dentist. Periodic benefit payments will be determined by the specific treatment plan prescribed by the Dentist. No payment will be made during any month in which the Participant is not eligible under the Plan or the Dependent does not meet the Plan definition of a Dependent.

C. If the Eligible Individual selects specialized orthodontic appliances or procedures chosen for aesthetic considerations an allowance will be made for the cost of a standard orthodontic treatment plan and the Eligible Individual will be responsible for the remainder of the Dentist's fee.

D. X-rays and extractions that might be necessary for orthodontic treatment are not covered by the Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits under the Dental Benefits described in Chapter 8.

Section 9.04. Covered Orthodontic Services. Covered Orthodontic Services include: corrective, interceptive and preventive orthodontic treatment to realign natural teeth, to correct malocclusion and to provide pre-orthodontic guidance.

Section 9.05. Exclusions. In addition to the Dental limitations and exclusions listed in Chapter 8, Orthodontic Benefits are not paid for the following expenses:

A. Initial banding that occurred before the individual became eligible under the Plan or, before the Participant's Employer was first required to contribute to the Fund for Orthodontic Benefits.

B. Orthodontic treatment for the Employee or Spouse unless the Employer's collective bargaining agreement provides for adult orthodontic benefits.

C. The replacement or repair of an appliance that has been lost or damaged.

D. Any services not provided by a Dentist.

E. Any month in which the Participant or Dependent is not eligible.

F. Any services excluded under the General Exclusions, Limitations and Reductions listed in Chapter 12.

CHAPTER 10. VISION CARE BENEFITS

Section 10.01. Eligibility. Participants and their Dependents who meet the eligibility requirements described in Chapter 2 are eligible to receive Vision Care Benefits, provided the Employer pays the required contribution to the Fund for these benefits. If the required Employer contribution is paid, these benefits are provided to Eligible Individuals enrolled in the Comprehensive Health Plan and the HMO plan.

Section 10.02. Benefits. Vision Care Benefits are provided as specified in the Group Vision Care Plan Administrative Services Program agreement between Vision Service Plan (VSP) and the Fund. The vision care benefits cover a regular vision examination, lenses and frames when necessary for proper visual function.

The limitations on frequency of services stated in Subsections B, D and E of this Section do not apply to individuals younger than 19 years of age, except that frames are limited to one frame in each rolling one-year period.

A. **VSP Choice Plan Doctor Benefits**. If services are provided by a doctor who is a member of the VSP Choice Plan network, the services described below under "Covered Vision Care Services" are covered in full after a Copayment of $7.50 per Eligible Individual. The Copayment is due once each year, for the first service received each year, and must be paid to the VSP Doctor at the time services are received. Exception: The Low Vision Benefit requires additional Copayments.

B. **Covered Vision Care Services**. The following services are covered by the Plan:

(1) Vision Exam – provided once every 12 months. This is a thorough analysis of the visual functions, including the prescription of corrective eyewear when indicated.

(2) Lenses – provided once every 12 months if a prescription change is necessary.

(3) Frames – available once every 24 months if replacement is necessary. VSP covers a wide selection of frames up to a $140 frame allowance. The Eligible Individual has the option to pay the additional cost for more expensive frames than those provided by the Plan.

C. **Out-of-Network Provider Benefits**. If services are provided by an out-of-network provider, the Plan will pay the following benefits for Covered Vision Services after a Copayment of $7.50. The Copayment will be deducted from the benefit payment made by VSP.

Vision Examination, up to	$ 45.00
Materials:	
Single Vision Lenses, up to	$ 34.00
Bifocal Lenses, up to	51.00
Trifocal Lenses, up to	68.00
Lenticular Lenses, up to	100.00
Tints, up to	5.00
Frames, up to	70.00

D. **Visually Necessary Contact Lenses** are provided in lieu of all other lens and frame benefits when a prescription change is warranted, but in no event more than once in any 12 month period. Necessary contact lenses, together with necessary professional services will be provided only when the doctor secures prior approval from VSP for the following conditions: (1) following cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) certain conditions of Anisometropia; or(4) Keratoconus

(1) VSP Signature Choice Plan Doctor Benefit – Plan pays 100% of network provider allowance after the Copayment is paid.

(2) Out-of-Network Provider Benefit - the Plan will reimburse up $210 for the exam and materials after the Copayment is paid.

E. **Elective Contact Lenses**. For contact lenses provided for purposes other than described in Section D. above, the Plan will pay the following benefits when a prescription change is warranted but in no event more than once in any 12 month period. Contact lenses are provided in lieu of spectacle lenses and frames.

(1) VSP Signature Choice Plan Doctor Benefit - The Plan will cover up to $100 for the contact lenses and fitting, exam covered in full, after the Copayment is paid.

(2) Out-of-Network Provider Benefit - The Plan will reimburse up to $100 for the exam and contact lenses, after the Copayment is paid.

Section 10.03. Limitations and Exclusions.

A. **Limitations**. The Plan is designed to cover visual needs rather than cosmetic materials. When an Eligible Individual selects any of the following extra items, the Plan will pay the basic cost of the allowed lenses, and the Eligible Individual must pay the additional cost for the options:

(1) Blended lenses.

(2) Oversize lenses.

(3) Progressive lenses.

(4) The coating of the lens or lenses.

(5) The laminating of the lens or lenses.

(6) A frame that costs more than the Plan allowance.

(7) Certain limitations on low vision care.

(8) Cosmetic lenses.

(9) Optional cosmetic processes.

(10) UV (ultraviolet) protected lenses.

B. **Exclusions.** There is no benefit for professional services or materials connected with:

(1) Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±.50 diopter power); or 2 pair of glasses in lieu of bifocals.

(2) Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.

(3) Medical or surgical treatment of the eyes, including any refractive vision surgery.

(4) Corrective vision treatment of an Experimental nature.

Section 10.04. Low Vision Benefit. The Low Vision benefit is available to Eligible Individuals who have severe visual problems that are not correctable with regular lenses. The following services under this benefit require prior approval from VSP.

A. **Supplementary Testing** includes a comprehensive examination of visual function and the prescription of corrective eyewear or vision aids where indicated. The Plan pays 100% for VSP Signature Choice Plan providers, or up to a maximum of $125 when provided by an Out-of-Network provider.

B. **Supplemental Care, including subsequent low vision aids.** The Plan will pay 50% of the cost for supplemental care provided by a VSP Signature Choice Plan provider or an out-of-network provider.

C. **Benefit Maximum.** The maximum benefit payable for all low vision benefits is $500 per Eligible Individual every 2 years.

D. **Out-of-Network Provider Benefit.** Services received from an out-of-network provider are subject to the same time limits, benefit maximum and payment provisions described above except that supplementary testing is limited to a maximum of $125. The Eligible Individual must pay the out-of-network provider his full fee and will be reimbursed in an amount not to exceed what VSP would pay a VSP Doctor for the service.

CHAPTER 11. BURIAL EXPENSE BENEFIT

Section 11.01. Burial Expense Benefits.

A. The Burial Expense Benefit is provided under a contract of insurance between the Trust Fund and The Union Labor Life Insurance Company. Please refer to the separate Evidence of Coverage from the Union Labor Life Insurance Company for the terms of coverage. All Active Employees are eligible for Burial Expense Benefits. COBRA Participants, Retired Participants and Dependents are not eligible for the Burial Expense Benefit.

B. In the event of the death of an eligible Active Participant, the Plan will pay a benefit of $2,500 to the designated beneficiary to help pay for funeral expenses. (Certain Collective Bargaining Agreements provide for a burial expense benefit of $10,000.)

Participants or beneficiaries should contact the Fund Office to determine the applicable benefit amount.)

C. Beneficiary Designation. Anyone may be named by the Participant as the designated beneficiary. A Participant may change his or her beneficiary at any time by completing the proper form and sending it to the Union Office. If no beneficiary designated, or if the beneficiary has pre-deceased the Participant, the benefit will be paid to the first surviving of the following classes of successive preference beneficiaries: the Participant's spouse; surviving children; surviving parents; surviving brothers and sisters; executors or administrators.

Section 11.02. Life Insurance Benefits

A. The Life Insurance Benefit is provided under a contract of insurance between the Trust Fund and ReliaStar Life Insurance Company. Please refer to the separate Evidence of Coverage from ReliaStar Life Insurance Company for the terms of coverage. All Active Employees enrolled in Medical Coverage are eligible for Life Insurance Benefits. COBRA Participants, Active Employees not enrolled in Medical Coverage, Retired Participants and Dependents are not eligible for Life Insurance Benefits.

B. In the event of the death of an eligible Active Participant, the Plan will pay a benefit of $10,000 to the designated beneficiary.

C. Beneficiary Designation. Anyone may be named by the Participant as the designated beneficiary. A Participant may change his or her beneficiary at any time by completing the proper form and sending it to the Union Office. If no beneficiary designated, or if the beneficiary has pre-deceased the Participant, the benefit will be paid to the first surviving of the following classes of successive preference beneficiaries: the Participant's spouse; surviving children; surviving parents; surviving brothers and sisters; executors or administrators.

Section 11.03. Accidental Death and Dismemberment Benefits

A. The Accidental Death and Dismemberment Benefit is provided under a contract of insurance between the Trust Fund and Relia Star Life Insurance Company. Please refer to the separate Evidence of Coverage from ReliaStar Life Insurance Company for the terms of coverage. All Active Employees enrolled in Medical Coverage are eligible for Accidental Death and Dismemberment Benefits. COBRA Participants, Active Employees not enrolled in Medical Coverage, Retired Participants and Dependents are not eligible for Accidental Death and Dismemberment Benefits.

B. In the event of a death or dismemberment in an accident on or off the job, the Plan will pay a benefit of up to $10,000 to the designated beneficiary. Please refer to the separate Evidence of Coverage from ReliaStar Life Insurance Company for the schedule of benefits.

C. Beneficiary Designation. Anyone may be named by the Participant as the designated beneficiary. A Participant may change his or her beneficiary at any time by completing the proper form and sending it to the Union Office. If no beneficiary designated, or if the beneficiary has pre-deceased the Participant, the benefit will be paid to the first surviving of the following classes of successive preference beneficiaries: the Participant's spouse; surviving children; surviving parents; surviving brothers and sisters; executors or administrators.

CHAPTER 12. EXCLUSIONS, LIMITATIONS, AND REDUCTIONS

Section 12.01. Exclusions and Limitations. The Plan will not provide benefits for:

A. Any amounts in excess of Allowed Charges or any services not considered to be Covered Expenses.

B. Services for which the Eligible Individual is not legally obligated to pay. Services for which no charge is made to the Eligible Individual. Services for which no charge would be made to the Eligible Individual in the absence of insurance or other indemnity coverage, except services received at a non-governmental charitable research Hospital which 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.

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

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

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

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

D. Conditions caused by or arising out of an act of war, armed invasion or aggression.

E. Conditions caused by or arising out of the commission of a felony, unless the Injury or Illness is the result of domestic violence or the commission or attempted commission of a felony is the direct result of an underlying medical (physical or mental) condition.

F. Conditions caused by self-inflicted injuries or suicide attempts unless due to an underlying medical (physical or mental) condition.

G. Services rendered while an Eligible Individual is confined in a Hospital operated by the United States Government or an agency of the United States Government except that the Plan, to the extent required by law, will reimburse a Veterans Administration (VA) Hospital for care of a non-service related disability if the Plan would normally cover the care if the VA were not involved.

H. Care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision.

I. Any claim submitted to the Plan more than 1 year from the date on which the expenses were incurred.

J. Any services and supplies in connection with Experimental or Investigational Procedures.

(1) For purposes of this Exclusion, the term Experimental or Investigational Procedures means a drug or 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.

(2) 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.

(3) There is an external independent review process available for review of the Plan's coverage decisions regarding Experimental or Investigational services or supplies. The Participant may request review by the Professional Review Organization (PRO) contracted by the Fund, or if the claim has already been reviewed by the PRO, the Participant may request a second review by another external review organization. Participants may call the Trust Fund Office to request this review.

(4) Note that under this medical plan, experimental, investigational or unproven does 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 determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

a. "**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.

b. 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.

c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

e. The plan may rely on its PRO to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Fund (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process.

Section 12.02. Third Party Liability. If an Eligible Individual has an Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission, or insurance coverage of that third party or parties (hereinafter referred to collectively as "responsible third party"), the Fund shall not be liable to pay any benefits. However, upon the execution and delivery to the Fund of all documents it requires to secure the Plan's right of reimbursement, including without limitation a Reimbursement Agreement, the Fund may pay benefits on account of Hospital, medical or other expenses in connection with, or arising out of, such Illness, Injury, disease or other condition. Such payment shall be considered only as an advance or loan to the Eligible Individual and the Fund shall have all rights as set forth herein.

A. The Fund shall be reimbursed first, before any other claims, for 100% of this advance or loan from any recovery received by way of judgment, arbitration award, verdict, settlement or other source by the Eligible Individual or by any other person or party for the Eligible Individual, pursuant to such Illness, Injury, disease or other condition, including recovery from any under-insured or uninsured motorist coverage or other insurance, even if the judgment, verdict, award, settlement or any recovery does not

make the Eligible Individual whole or does not specifically include medical expenses. The Fund shall be reimbursed from said recovery without any deduction for legal fees incurred or paid by the Eligible Individual. The Eligible Individual promises not to waive or impair any of the rights of the Fund without written consent. In addition, the Fund shall be reimbursed for any legal fees incurred or paid by the Fund to secure reimbursement of the advance or loan.

B. If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund shall also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien shall be satisfied from any recovery received by the Eligible Individual, however classified, allocated, or held.

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

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

(1) To prosecute any claim for damages diligently;

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

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

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

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

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

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

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

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

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

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

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

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

Section 12.03. Coordination of Benefits With Other Plans. If an Eligible Individual is entitled to benefits from another Group Plan for Hospital or medical expenses for which benefits are also due from this Plan, then the benefits provided by the Plan will be paid in accordance with the following provisions, not to exceed the dollar amount of benefits which would have been paid in the absence of other group coverage or 100% of the "Allowable Expense" actually incurred by the Eligible Individual.

A. Allowable Expense. For the purpose of this Coordination of Benefits provision, Allowable Expense means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense. When Non-Contract Providers are used, Allowable Expense will not exceed the Allowed Charge that is covered in whole or in part by any of the plans covering the person.

B. Order of Benefit Payment. Benefits of the Plan will be paid in accordance with the following order of payment provisions:

(1) If the Eligible Individual is the Active Participant, Fund benefits will be provided without reduction.

(2) If the Eligible Individual is the Dependent Spouse of a Participant, Fund benefits will be paid for eligible expenses not covered by the other Group Plan.

(3) If the Eligible Individual for whom claim is made is a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan which covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, shall be determined before the benefits of the Group Plan which covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year. If either Group Plan does not have the provisions of this rule regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule shall not apply, and the rule set forth in the Plan which does not have the provisions of this rule C. shall determine the order of benefits.

(4) In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(5) In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(6) In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d. and e. above, the benefits of a Plan which covers the child as a dependent of the parent with the financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(7) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined using the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule applies between the dependent child's parents coverage and the dependent's self or spouse coverage.

(8) When rules (1), (2), (3), (4), (5) or (6) do not establish an order of benefit determination, Fund benefits will be provided without reduction if the Eligible Individual has been eligible continuously for benefits from this Fund for a longer period of time than he or she has been continuously eligible for benefits from the other Group Plan, provided that:

a. The benefits of a Group Plan covering the Eligible Individual on whose expenses claim is based as a laid-off or retired employee shall be determined after the benefits of any other Group Plan covering the person as an active employee, other than a laid-off or retired employee; and

b. If either Group Plan does not have a provision regarding laid-off or retired employees, which results in each Group Plan determining its benefits after the other, then the provision (1) above shall not apply.

C. 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) incurs expenses normally covered under the prepaid program, then this Plan will only reimburse the co-payments required of the Eligible Individual under the pre-paid plan, and only if the co-payments are required of every person covered by that program. Except for the co-payments specified above, the Plan will not pay expenses of eligible employees or dependents covered by prepaid programs of other plans. For purposes of this Plan, the term "prepaid program" shall include health maintenance organizations, individual practice associations, and any other programs that the Board in its sole discretion deems to be essentially similar to these prepaid arrangements.

D. Coordination with Preferred Provider Plans. Where this Plan, as secondary, is coordinating benefits with another plan which has entered into a preferred provider agreement with a medical or Hospital provider, this Plan will pay no more than the difference between:

(1) The lesser of:

a. The normal charges billed for the expenses by the provider, or

b. The contractual rate for the expense under a preferred provider agreement between the provider and the plan that this Plan is coordinating with, and

(2) The amount that the other plan pays as primary.

Section 12.04. 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 payment for assistance, provided that the claim is filed by the State within the Plan's filing limits as set forth in Section 13.04.

Section 12.05. Coordination with Medicare.

A. Retired Participants. If the Eligible Individual is a Retired Employee or Dependent of a Retired Employee and is Eligible For Medicare, Medicare will be the primary payer and this Plan will be the secondary payer. Fund benefits will be coordinated with benefits paid by Medicare. If the individual does not enroll in Medicare when eligible, this Plan will coordinate benefits as though the individual is receiving benefits under Parts A and B of Medicare.

The Plan will estimate Medicare's payment as follows: Part A: 100% after applying a Part A deductible; Part B: 80% of Covered Expenses after applying a Part B deductible. The Plan will pay only the remaining Covered Expenses after the estimated Medicare benefits are deducted.

B. Active Participants. Subject to the exception for end stage renal disease described in Subsection C. below, if the Eligible Individual is an Active Participant or Dependent of an Active Participant and is entitled to Medicare either because of age or because he/she is entitled to a disability pension from Social Security, this Plan's benefits will be payable without reduction.

C. End Stage Renal Disease. If an Active Participant or Dependent of an Active Participant becomes Medicare eligible because of end-stage renal disease (ESRD), this Plan is the primary payer and Medicare is the secondary payer for 30 months, starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Starting with the 31st month after Medicare coverage begins, Medicare is the primary payer and this Plan will be the secondary payer.

If the Active Participant or Dependent has not enrolled in Medicare at the time this Plan becomes the secondary payer, starting with the 31st month after eligibility for Medicare coverage began, this Plan will coordinate benefits as though the individual is receiving benefits under Parts A and B of Medicare. The Plan will estimate Medicare's payment as follows: Part A: 100% after applying a Part A deductible; Part B: 80% of Covered Expenses after applying a Part B deductible. The Plan will pay only the remaining Covered Expenses after the estimated Medicare benefits are deducted.

D. Medicare Private Contract. A Medicare participant is entitled to enter into a Medicare private contract with certain health care providers under which the participant agrees that no claim will be submitted to or paid by Medicare for services and supplies furnished by that provider. If a Retired Employee or Dependent of a Retired Employee enters into such a contract, the Plan's benefits for health care services and supplies the individual receives under that contract will be limited to 20% of the Covered Expenses, and the Eligible Individual is responsible for paying any remaining charges. Benefits payable by the Plan

will be subject to all of the Plan's terms and provisions, including those relating to exclusions, Medical Necessity, and Allowed Charges.

E. Medicare Prescription Drug Coverage. Retired Employees and their Dependents who are enrolled in the Fund's Comprehensive Health Plan and are eligible for Medicare Prescription Drug Coverage (Medicare Part D) have the following choices:

(1) The Eligible Individual may keep his/her current prescription drug coverage with the Fund and not enroll for Medicare Prescription Drug Coverage. In the future, the individual may choose to enroll in Medicare Prescription Drug Coverage during Medicare's annual enrollment period (November 15 to December 31 of each year).

(2) The Eligible Individual can keep his/her current prescription drug coverage with the Fund and enroll for Medicare Prescription Drug Coverage. If the individual enrolls for Medicare Prescription Drug Coverage, the Fund's prescription drug coverage will be secondary to Medicare and the individual must pay any Medicare premium.

(3) The Eligible Individual can drop prescription drug coverage with the Fund and enroll for Medicare Prescription Drug Coverage on his/her own and continue to be covered under the Fund's Comprehensive Health Plan benefits. An individual who drops the Fund's prescription drug coverage will not be able to re-enroll in the Fund's prescription drug coverage in the future and is responsible for paying the Medicare premium.

Section 12.06. Coordination with Other Government Programs.

A. TRICARE: If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an Employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is the primary payer 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 the Plan.

B. Veterans Affairs/Military Medical Facility Services. If an Eligible Individual 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 Covered Expenses.

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.

D. Other Coverage Provided by State or Federal Law. If an Eligible Individual is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

CHAPTER 13. GENERAL PROVISIONS

Section 13.01. Payment of Benefits

A. All benefits will be paid by the Fund to the Participant as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character and extent of the event for which the claim is paid.

B. Proof of claim forms, as well as other forms, and method of administration and procedure will be solely determined by the Fund.

Section 13.02. Benefits May Not Be Alienated

A. Except to the extent otherwise specifically provided in Subsection B. of this Section or elsewhere in the Plan, each Eligible Individual is restrained from selling, transferring, anticipating or otherwise disposing of any benefit payable under the Plan, or any other right or interest under the Plan, and the Fund shall not be required to recognize the sale, transfer anticipation, assignment, alienation, hypothecation or other disposition. Any benefit, right or interest shall not be subject in any manner to voluntary transfer or transfer by operation of law or otherwise, and shall be exempt from the claims of creditors or other claimants and from all orders, decrees, garnishments, executions or other legal process or proceedings to the fullest extent permitted by federal law.

B. Any Participant may direct that benefits due him be paid to an institution in which he or his Dependent is hospitalized, or to any provider of medical, drug, dental or other health services or supplies in consideration for Hospital, medical or other services rendered, or supplies furnished, or to any other agency that may have provided or paid for, or agreed to provide or pay for, any benefits provided.

Section 13.03. Offset and Recoupment of Overpayments. In the event that through mistake or any other circumstance, an Eligible Individual has been paid or credited with more than he/she is entitled to under the Plan or under the law or has become obligated to the Fund under an indemnity agreement or a third party liability agreement or in any other way, the Fund may set off, recoup and recover the amount of the overpayment, excess credit or obligation from benefits accrued or thereafter accruing to the Eligible Individual, Dependent or beneficiary, and not yet distributed, in any installments and to the extent determined by the Board.

Section 13.04. Notice of Claim Required. Benefits will be paid by the Fund only if notice of claim is made within ninety days from the date on which Covered Expenses were first incurred unless it shall be shown by the Participant not to have been reasonably possible to give notice within this time limit, but in no event shall benefits be allowed if notice of claim is made beyond one year from the date on which expenses were incurred.

Section 13.05. Payment in Event of Incompetency or Lack of Address. In the event the Fund determines that the Eligible Individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Individual has not provided the Fund with an address at which he/she can be located for payment, the Fund may during the lifetime of the Eligible Individual, pay any amount otherwise payable to the Eligible Individual to the husband or wife or relative by blood of the Eligible Individual, or to any other person or institution determined by the Fund to be equitably entitled to payment; or in the case of the death of the Eligible Individual before all amounts payable under the Plan have been paid, the Fund may pay this amount to any person or institution determined by the Fund to be equitably entitled to payment. The remainder of any amount owing shall be paid to one or more of the following surviving relatives of the Eligible Individual: Spouse, child or children, mother, father, brothers or sisters, or to the Eligible Individual's estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Fund hereunder.

Section 13.06. Physical Examination and Autopsy. The Fund, at its own expense, shall have 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 request an autopsy in case of death where it is not forbidden by law.

Section 13.07. Benefits Not in Lieu of Workers' Compensation. 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 13.08. Trust Agreement Governs. 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 shall prevail.

Section 13.09. Authority To Interpret Plan. Only the full Board of Trustees is authorized to interpret the plan of benefits described in these Rules and Regulations. No employer, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board, nor can any such person act as an agent of the Board of Trustees.

Section 13.10. Use And Disclosure of Protected Health Information

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

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

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

b. Coordination of benefits,

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

d. Subrogation of health benefit claims,

e. Establishing employee contributions,

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

g. Billing, collection activities and related health care data processing,

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

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

j. Medical necessity reviews, or reviews of appropriateness of care or justification of charges,

k. Utilization review, including Precertification, Preauthorization, concurrent review and retrospective review,

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

m. Reimbursement to the Plan.

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

a. Quality Assessment,

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

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

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

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

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

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

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

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

j. Resolution of internal grievances, and

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

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

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

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

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

(1) Not to use or further disclose the information other than as permitted or required by the Plan Rules and Regulations 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 the provisions of this Section, 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 Public & Miscellaneous Employees Health and Welfare Trust Fund, who are the Plan Sponsor:

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

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

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

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

CHAPTER 14. AMENDMENT AND TERMINATION

Section 14.01. The Board has determined that each of the conditions, limitations and other terms of this Plan is essential to carry out the obligation of the Fund to provide comprehensive Hospital, medical and other benefits to all Participants and eligible Dependents. In furtherance of that obligation the Board expressly reserves the right, in its sole discretion at any time, but upon a non-discriminatory basis:

A. To terminate or amend either the amount or condition with respect to any benefit even though the termination or amendment affects claims which have already accrued; and

B. To alter or postpone the method or payment of any benefit; and

C. To amend or rescind any other provisions of the Plan.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim for the benefits occurs.

CHAPTER 15. DISCLAIMER OF LIABILITY

Section 15.01. The comprehensive health plan, prescription drug, substance use disorder rehabilitation, dental, vision care, orthodontic, and hearing aid benefits are not insured by any contract of insurance, and there is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for that purpose.

Section 15.02. The Plan has no control over any diagnosis, treatment, care or lack thereof, or other services delivered to an Eligible Individual by a health care provider (whether a Contract or Non-contract Provider),

and disclaims liability for any loss or Injury caused to the Eligible Individual by any provider by reason of negligence, failure to provide treatment or otherwise.

CHAPTER 16. INTERNAL CLAIMS AND APPEALS PROCEDURES

A. Definitions

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

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

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

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

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

e. 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. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

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

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

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

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

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

(3) Claims are Categorized as Follows:

a. 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.

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

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

d. Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a Claim for reimbursement for services already rendered. A claim regarding a rescission of coverage will be treated as a Post-Service Claim.

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

B. **Claim Procedures**

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

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

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

c. If an extension is required because the Plan needs additional information from the participant, the Plan will issue a request for additional information that specifies the information needed. The participant will have 45 days from the date of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the participant is allowed to supply additional information,

the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until the earlier of: (i) 45 days; or (ii) the date the participant responds to the request. The Review Organization then has 15 days to make a determination on the Claim.

(2) Urgent Claims. The Plan will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies the Plan of such, it will be treated as an Urgent Claim. Urgent Claims, which may include requests for Precertification of hospital admissions and Prior Authorization of services, must be submitted by telephone. Urgent Claims may **not** be submitted via the US Postal service.

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

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

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

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

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

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

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

   Participant completes:

   (i) -Participant or retiree name
   (ii) Patient Name
   (iii) Patient's Date of Birth
   (iv) SSN of Participant or retiree
   (v) Date of Service
   (vi) Information on other insurance coverage, if any, including coverage that may be available to participant's spouse through his or her employer
   (vii) If treatment is due to an accident, accident details

   Provider completes:

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

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

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

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

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

(5) 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.

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

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

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

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

a. Identification of the claim involved (e.g. date of service, health care provider, claim amount (if applicable) and scheduled to begin January 1, 2012, a statement that diagnosis and treatment codes and meaning of the codes are available upon request and free of charge);

b. The specific reason(s) for the determination including the denial code 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 internal appeal procedures and External Review processes, including information regarding how to initiate an appeal, and applicable time limits;

f. A statement of the participant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination, including an External Review;

g. If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon written request at no charge;

h. If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge;

i. For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification); and

j. Information on the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and External Review processes.

C. **Appeal Procedures**

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

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

b. Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made either by calling the designated Review Organization or by other available similarly expeditious method, including electronic means. Appeals of Urgent Claims may **not** be submitted via the US Postal service.

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

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

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

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

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

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

(3) Timeframes for Sending Notices of Appeal Determinations.

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

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

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

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

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

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

a. Identification of the claim involved (e.g. date of service, health care provider, claim amount (if applicable) and scheduled to begin January 1, 2012, a statement that diagnosis and treatment codes and meaning of the codes are available upon request and free of charge);

b. The specific reason(s) for the 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;

c. Reference to the specific Plan provision(s) on which the determination is based;

d. A statement that the participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon written request and free of charge;

e. If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon written request at no charge;

f. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge;

g. A statement of the participant'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; and

h. Information on the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and External Review processes.

CHAPTER 17. EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the Affordable Care Act (ACA) and the No Surprises Act (NSA). External Review requirements as set forth in Interim Final Regulations implementing the ACA and in Technical Release 2010-01. 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).

If an appeal, whether urgent, concurrent, pre-service or post-service claim, is denied, the claimant may request further review by an independent review organization ("IRO") as described below. Generally, an External Review may be requested only after the claimant has exhausted the internal review and appeals process described above. This External Review process does not pertain to claims for burial expense benefits or if a claim was denied due to the claimant's failure to meet the requirements for eligibility under the terms of the Plan.

External review is available for the following:

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/or

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.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

Section 17.01. If an appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied, the Claimant may request further external review by an independent review organization ("IRO") if the denial fits within the parameters described in paragraphs a. b. and c. below:

d. 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;
e. 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/or

f. 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 17.02. External Review of Standard (Non-Urgent) Claims. A request for External Review of a standard (not urgent) claim must made, in writing, within four (4) months of the date that the claimant receives notice of a denial of an appeal. An appeal denial is referred to below as an "Adverse Determination."

A. An External Review request on a standard claim should be made to the following applicable Plan designee:

(1) The Trust Fund Office, with respect to a denied claim not involving retail or mail order prescription drug expenses or dental or vision claims;

(2) OptumRx, with respect to a denied claim involving retail or mail order prescription drug expenses;

(3) Anthem Blue Cross, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses;

(4) Delta Dental Plan with respect to a denied claim involving dental or orthodontic benefits;

(5) Vision Service Plan with respect to a denied claim involving vision benefits.

B. **Preliminary Review of Standard Claims**

(1) Within five (5) business days of the Plan's receipt of a request for an External Review of a standard 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;

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) Within one (1) business day of completing its preliminary review, the Trust Fund Office will notify the claimant in writing as to whether his/her request for External Review meets the above requirements for External Review. This notification will inform the claimant:

a. If his/her 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.

C. **Review of Standard Claims by an Independent Review Organization (IRO)**

If the request is complete and eligible for an External Review, the Trust Fund Office will assign the request to an accredited Independent Review Organization (IRO). The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan will rotate assignment among IROs with which it contracts. Once the claim is assigned to an IRO, the following procedure will apply:

(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 his/her claim (generally, claimants are to submit such information within ten (10) business days).

(2) Within five (5) business days after the External Review is assigned to the IRO, the Plan will 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 must, within one (1) business day, forward that information to the Plan. 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. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its 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.

a. 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.

b. If the final External Review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. [If the claimant is dissatisfied with

the External Review determination, he or she may seek judicial review as permitted under ERISA Section 502(a).]

(7) 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 and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

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. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with External Review processes.

h. This Plan will also provide the Notice in Spanish, upon request.

Section 17.03. 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 his/her life or health, or would jeopardize his/her ability to regain maximum function, and he/she has filed a request for an expedited internal appeal; or

(2) The claimant receives an Adverse Determination of an appeal that involves a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize his/her life or health or would jeopardize his/her ability to regain maximum function; or, the claimant receives an Adverse Determination that concerns an admission, availability of care, continued stay, or health care item or service for which he/she received services for an emergency, but he/she has not yet been discharged from a facility.

B. The request for an expedited External Review of a non-standard claim should be made to the following applicable Plan designee:

(1) Anthem Blue Cross, with respect to a denied urgent, Pre-service or concurrent review determination not involving retail or mail order prescription drug expenses;

(2) OptumRx, with respect to a denied claim involving retail or mail order prescription drug expenses;

(3) Delta Dental, with respect to a denied claim involving dental or orthodontic benefits;

(4) Vision Service Plan, with respect to a denied claim involving vision benefits;

(5) ARP, with respect to a denied urgent, pre-service or concurrent review determination involving a substance use disorder claim.

C. **Preliminary Review for an Expedited Claim.** Immediately upon receipt of the request for expedited External Review, the Trust Fund Office will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Trust Fund Office will immediately notify the claimant (e.g. telephonically, via fax) as to whether his/her 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)**

Following the preliminary review that a request is eligible for expedited External Review, the Trust Fund Office will assign an IRO (following the process described under Standard Review above). The Trust Fund Office 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 Adverse Determination.

(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.

a. 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.

b. If the final External Review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. [If the claimant is dissatisfied with the External Review determination, he or she may seek judicial review as permitted under ERISA Section 502(a).

CHAPTER 18. WHEN A LAWSUIT MAY BE STARTED

A. No Employee, Dependent, beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein.

B. A participant may not start a lawsuit to obtain benefits until after:

(1) The participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, including an External Review for other than eligibility disputes, and a final decision has been reached on review;

(2) The appropriate time frame described in Chapter 16 has elapsed since the participant filed a request for review and participant has not received a final decision or notice that an extension will be necessary to reach a final decision; or

(3) The internal claims and appeals process is deemed to be exhausted under the Affordable Care Act and the applicable regulations, in which case the participant may seek External Review or file a lawsuit under ERISA Section 502(a).

C. The denial of a Claim to which the right to review has been waived, or the decision of the Board with respect to a petition for review, is final and binding upon all parties including the claimant or the petitioner, subject only to any civil action the claimant may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration. The provisions of this Chapter 18 shall apply to and include any and every Claim to benefits from the Fund, and any Claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the Claim, and regardless of when the act or omission upon which the Claim is based occurred, and regardless of whether or not the claimant is a "participant" or "beneficiary" of the Plan within the meaning of those terms as defined in ERISA. Such Claim shall be limited to benefits due under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any Claim or right to damages, either compensatory or punitive.

ADDENDUM A. SCHEDULE OF COMPREHENSIVE HEALTH PLAN BENEFITS EFFECTIVE NOVEMBER 1, 2023 FOR PLANS A, B, C AND D

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Deductible	None			None			$750 per person; $2,250 family maximum. Deductible does not apply to: Contract Provider and out-of-area physician office visits, the on-line physician consultation benefit, emergency room charges for an Emergency Medical Condition, Contract Provider preventive care covered under health care reform, the adult physical exam benefit for Non-Contract Providers, or out-of-area preventive care for children.			$500 per person; $1,000 family maximum Deductible does not apply to Contract Provider physician office visits, emergency room charges for an Emergency Medical Condition, Contract Provider preventive care covered under health care reform, the on-line physician consultation benefit or the adult physical exam benefit for Non-Contract Providers.	
Emergency Room Deducible	Not applicable			Not applicable			Not applicable			$50 per visit (waived if admitted)	
Coinsurance	Plan pays the percentage shown below; subject to Out-of-Pocket limits			Plan pays the percentage shown below; subject to Out-of-Pocket limits			Plan pays the percentage shown below; subject to Out-of-Pocket limits			Plan pays the percentage shown below; subject to Out-Pocket limits	
Out-of-Pocket Limit on **Coinsurance**	$1,500/Individual; $3,000/Family			$3,000/Individual; $6,000/Family			$3,000/Individual			$3,000/Individual; $6,000/Family	

+ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Out-of-Pocket Limit on **Cost Sharing (**includes deductible, coinsurance and copays except prescription drugs which are subject to their own limit)	$5,275/Individual; $10,550/Family			$5,275/Individual; $10,550/Family			$5,275/Individual; $10,550/Family			$5,275/Individual; $10,550/Family	
Out-of-Pocket Limit for Non-Contract Providers	Unlimited			Unlimited			Unlimited			Unlimited	
Inpatient Hospital (pre-authorization required)	90%	60%	90%	80%	60%	80% -	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Hospital Emergency Room for an Emergency Medical Condition	90%	90%	90%	80%	80%	80%	80%, no deductible	80%, no deductible	80%, no deductible	After emergency room deductible, 80%	After emergency room deductible, 80%
Ambulatory Surgery Facility or Outpatient Hospital for Surgery	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Other Outpatient Hospital (including Allowed Charges for Partial Hospitalization and Intensive Outpatient Treatment)	80%	60%	80%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60% (Emergency room deductible applies if emergency room used)
Physician Visits (Office, Hospital and Home)	After $10 Copay per visit, 100%	After $10 Copay per visit, 60%	After $10 Copay per visit, 90%	After $15 Copay per visit, 100%	After $15 Copay per visit, 60%	After $15 Copay per visit, 80%	**Office, Home:** After $15 Copay per visit, 100%; no deductible **Hospital:** After deductible, 80%	After deductible, 60%	**Office, Home:** After $15 Copay per visit, 80%; no deductible **Hospital:** After deductible, 80%	**Home, Office:** After $20 Copay per visit, 100%; no annual deductible **Hospital:** After deductible, 80%	After deductible, 60%
Online Physician Consult (Anthem Blue Cross Live Health Online)	After $15 Copay per consult, 100%	Not Covered	Not Covered	After $15 Copay per consult, 100%	Not Covered	Not Covered	After $15 Copay per consult, 100%; no deductible	Not Covered	Not Covered	After $15 Copay per consult, 100%; no deductible	Not Covered

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Surgeon, Assistant Surgeon, Anesthesiologist, Outpatient X-ray and Lab Services, Radiation Treatment, Chemotherapy, Dialysis	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Speech Therapy Calendar Year Max: 20 visits Lifetime Max: 40 visits (Visit maximums apply to therapy for childhood speech delay of services that are part of an approved autism therapy plan)[1]	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Occupational Therapy	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

[1] The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Preventive Care for Children as required by the ACA	100%	60%	90%	100%	60%	80%	100%, no deductible	After deductible, 60%	After $15 Copay per visit, 80%; no deductible	100%, no deductible	After deductible, 60%
Preventive Care for Men as required by the ACA	100%	100% for a routine physical exam, up to $150 per exam	100% for a routine physical exam, up to $150 per exam	100%	100% for a routine physical exam, up to $150 per exam	100% for a routine physical exam, up to $150 per exam	100%, no deductible	100% for a routine physical exam, up to $150 per exam, no deductible	100% for a routine physical exam, up to $150 per exam, no deductible	100%, no deductible	100%, up to $250 per exam
Preventive Care for Women including Pregnant Women as required by the ACA	100% (including screening mammogram)	100% for a routine physical exam, up to $150 per exam. Mammogram: 60%	100% for a routine physical exam, up to $150 per exam Mammogram: 90%	100% (including screening mammogram)	100% for a routine physical exam, up to $150 per exam' Mammogram: 60%	100% for a routine physical exam, up to $150 per exam Mammogram: 80%	100%, no deductible (including screening mammogram)	100% for a routine physical exam, up to $150 per exam, no deductible Mammogram: After deductible, Plan pays 60%	100% for a routine physical exam, up to $150 per exam, no deductible Mammogram: After deductible, 80%	100% no deductible (including screening mammogram)	100%, up to $250 per exam Mammogram: After deductible, 60%
Adult Immunizations (CDC recommended immunizations covered under Preventive Care for Men and Women above)	100%	60%	90%	100%	60%	80%	100%, no deductible	After deductible, 60%	After deductible, 80%	100%, no deductible	After deductible, 60%

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)[2]	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Acupuncture ✓ Weekly Maximum: 1 visit ✓ Per Diagnosis Maximum: 12 weeks	After $10 Copay per visit, 100%	After $10 Copay per visit, 60%	After $10 Copay per visit, 90%	After $15 Copay per visit, 100%	After $15 Copay per visit, 60%	After $15 Copay per visit, 80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Skilled Nursing Facility Calendar Year Maximum: 180 days for Plans A, B and C, 100 days for Plan D[3]	90%	90%	90%	80%	80%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

[2] The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

[3] The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Home Health Care[4] and/or Hospice Care ✓ Daily Maximum: 1 visit ✓ Calendar Year Maximum: 60 visits	90%	90%	90%	80%	80%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Ambulance	80%	80%	80%	80%	80%	80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	80%	80%	80%	80%	80%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
TMJ Treatment Non-Surgical Lifetime Maximum: $1,500	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%

4 The Plan will not apply visit limits for these services with respect to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

Benefit Description	PLAN A			PLAN B			PLAN C			PLAN D	
	Contract Provider	Non-Contract Provider+	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider +	Out-of-Area+	Contract Provider	Non-Contract Provider+
Inpatient Mental Illness (Pre-authorization required)	90%	60%	90%	80%	60%	80%	After deductible, 80%	After deductible, 60%	After deductible, 80%	After deductible, 80%	After deductible, 60%
Outpatient Mental Illness	Professional charges: After $10 Copay per visit, 100% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $10 Copay per visit, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $10 Copay per visit, 90% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 100% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 80% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 100%; no deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After deductible, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $15 Copay per visit, 80%; no deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After $20 Copay per visit, 100%; no annual deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After deductible, 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital
Other Covered Expenses Not Shown Above	80%	80%	80%	80%	80%	80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%	After deductible, 80%

Substance Use Disorder Treatment Benefits – Plans A, B, C and D	
Inpatient Residential Treatment Pre-authorization by Assistance Recovery Program (ARP) required	Paid the same as Inpatient Hospital for Contract and Non-Contract Providers (except that the physician copy will NOT be applied to inpatient physician visits on Plans A and B)
Outpatient Treatment	Professional charges: Paid the same as Physician Visits for Contract and Non-Contract Providers.

Substance Use Disorder Treatment Benefits – Plans A, B, C and D	
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.	Facility charges: Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers

Hearing Aid Benefits					
Benefit	Plan A Contract or Non-Contract Provider	Plan B Contract or Non-Contract Provider	Plan C Contract or Non-Contract Provider	Plan D	
				Contract Provider	Non-Contract Provider
Hearing Examination	80%	80%	80%	After deductible, 80%	After deductible, 60%
Hearing Aid	80% (limited to one device per ear in any 3-year period)	80% (limited to one device per ear in any 3-year period)	80% (limited to one device per ear in any 3-year period)		
Maximum Benefit	$450 per ear	$450 per ear	$450 per ear	$500 per ear in any 36-month period	