OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND

PLAN RULES AND REGULATIONS

Restated Effective October 1, 2012

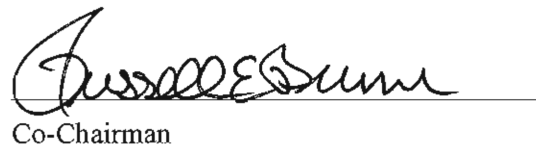
(Including Through Amendment No. 7)

ADOPTION RESOLUTION

RESOLVED, that effective October 1, 2012 the Trustees of the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund adopt the attached Restated Rules and Regulations.

The undersigned hereby certify that the above Resolution to the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund was duly adopted by the Board of Trustees at a meeting held on August 30, 2012.

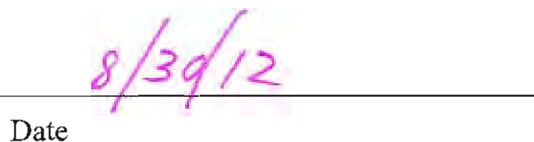
Chairman



Co-Chairman

Board of Trustees

Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund



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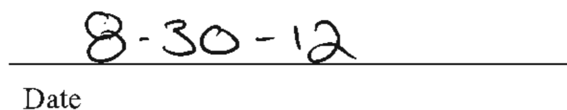

Date

OPERATING ENGINEERS
PUBLIC AND MISCELLANEOUS EMPLOYEES
HEALTH AND WELFARE TRUST FUND

PLAN RULES AND REGULATIONS

UPDATED TO INCLUDE THROUGH AMENDMENT NO. 7

FOR PLANS A, B, C and D

Restated Effective October 1, 2012

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OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND

RULES AND REGULATIONS

(Restated Effective January 1, 2012)

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, 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. The term "Board" means the Board of Trustees established by the Trust Agreement.

Section 1.04. 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 1.05. 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 1.06. 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 1.07. 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 1.08. The term "Contract Physician" means a Physician who has a contract in effect with the Fund's Preferred Provider Organization.

Section 1.09. 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 1.10. The term "Contract Provider Area" means the geographic location that is within 30 miles of a Contract Provider.

Section 1.11. 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 1.12. 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 1.13. 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 1.14. 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, provides or directs the care.

Section 1.15. The term "Dentist" means a person licensed to practice dentistry in the state in which he/she or she provides treatment.

Section 1.16. 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 1.17. A Domestic Partner is eligible to enroll in the Plan only if the Participant's employer is required by law to provide domestic partner coverage* and the Participant remits the required tax payments to the Fund. The term "Domestic Partner" means a person who resides with the Participant in the same residence, is at least 18 years of age and whose relationship with the Participant meets each of the following requirements:

A. The Domestic Partner and the Participant have had an intimate, committed relationship of mutual caring for a period of at least 6 months and are each other's sole Domestic Partner;

B. The Domestic Partner and the Participant share joint responsibility for each other's common welfare and financial obligations and can submit proof of that joint responsibility as required by the Board of Trustees;

C. Neither the Domestic Partner or the Participant is married;

D. The Domestic Partner and Participant are each competent to contract;

E. The Domestic Partner and Participant are not related by blood closer than would prohibit legal marriage in the State of California;

F. Any prior domestic partnership of either person has been terminated not less than 6 months prior to the date of the signing of the final declaration of domestic partnership with the Trust Fund Office; and

G. Application for domestic partnership with the Participant is properly made as required by the Board of Trustees.

* Exception for Participants Enrolled in Kaiser – A Participant enrolled in Kaiser whose Employer is not required by law to provide domestic partner coverage may enroll a domestic partner if the Participant provides a valid Certificate of Domestic Partnership issued by the California Secretary of State or another governmental subdivision within California that has developed regulations for the recognition of such relationships, provided the required tax payments are remitted to the to the Fund.

Section 1.18. 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 1.19. 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 1.20. The term "Eligible Individual" means each Participant and each of his eligible Dependents, if any.

Section 1.21. The term "Emergency Services" means with respect to an Emergency Medical Condition (defined below), a medical screening examination within the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

(1) The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver a newborn child (including the placenta).

(2) The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or of her unborn child), (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. The Trust Fund Office or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Section 1.22. "Experimental or Investigational". See Section 12.01.J. for definition of Experimental or Investigational Procedures.

Section 1.23. The term "Fund" means the Operating Engineers Public And Miscellaneous Employees Health and Welfare Trust Fund .

Section 1.24. 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 1.25. 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 1.26. 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 1.27. The term "Illness" means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes.

Section 1.28. 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 1.29. 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 1.30. The term "Medicare" means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

Section 1.31. 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 1.32. 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-9-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 1.33. 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 1.34. 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 1.35. The term "Non-Contract Physician" means a Physician that does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.36. 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 1.37. The term "Out-of-Area" means a geographic area that is more than 30 miles from the nearest Contract Provider.

Section 1.38. 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 1.39. The term "Patient" means that Eligible Individual who is receiving medical treatment, services, or supplies covered by the Plan.

Section 1.40. 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, upon the referral of a Physician, a licensed or certified: (a) physical therapist; (b) clinical social worker and (c) psychologist.

The term “Physician” shall not include the Participant or Dependent; or the spouse, parent, child, sister or brother of the Participant or Dependent.

Section 1.41. 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 1.42. The term “Plan Year” means January 1 through December 31 of any year.

Section 1.43. 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 1.44. 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 1.45. 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 1.46. The term “Retiree” or “Retired Employee” means each person who qualifies under the eligibility rules in Section 2.02.

Section 1.47. The term “Skilled Nursing Facility” means an institution as defined in Section 1861(j) of the Social Security Act.

Section 1.48. 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 1.49. 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 1.50. 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 1.51. The term “Union” means the Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Section 1.52. 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.

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 1.16; 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. Certificate of Health Coverage. In accordance with The Health Insurance Portability and Accountability Act (HIPAA), Eligible Individuals are entitled to receive a certificate of health coverage when coverage under this Plan ends. The certificate will indicate the period of time the individual was covered under the Plan. If, within 62 days after coverage under this Plan ends, the Eligible Individual becomes covered under another health plan or insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply in the new health plan or insurance policy. The certificate will be provided to Eligible Individuals by mail shortly after their coverage under the Plan ends. In addition, a certificate will be provided upon request if the request is received by the Fund Office within 2 years after the date Plan coverage ended.

Section 2.10. 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 2.10.

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;

(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 a 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) <u>Second Qualifying Event</u>. 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) <u>Extension of Coverage Period for Disability</u>. 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) <u>Entitlement to Medicare</u>. 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 form 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 after the date of his election of 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. 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 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 2.11. 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 Chemical Dependency 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. Four schedules of comprehensive health plan benefits are provided by the Fund, as described in Sections 4.02, 4.03, 4.04 and 4.05, which are included as attachments 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.

Sections 4.02, 4.03, 4.04 and 4.05. Schedules of Comprehensive Health Plan Benefits for Plans A, B, C and D. See Addendum A at the end of these Rules and Regulations.

Section 4.06. Annual Maximum Benefit. The Annual Maximum Benefit shown in the Schedule of Benefits may be paid for each Eligible Individual for Covered Expenses incurred in any one calendar year, except that certain benefits may be subject to a lower limited annual benefit maximum.

Section 4.07. 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 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, subject to the exceptions described in Subsection C below. There is no family Coinsurance Limit for Plan C.

C. Exceptions to Coinsurance Limit. 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; and

(6) For Plan C and Plan D, any amounts used to satisfy the Calendar Year Deductible.

Section 4.08. 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 4.09. 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 well child care visits, acupuncture visits

(2) Plan C: Physician office visits, including well child care visits, 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

(6) Non-Contract Provider visits In-Area for Plan C

Section 4.10. 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 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) The Plan will continue to pay Contract Provider benefits for services received from the terminated provider for 90 days after the date of the provider's termination from the PPO, or until postpartum services are complete, or longer if Medically Necessary.

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." 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 4.11. 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. 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 4.12. 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 described in Sections 4.02, 4.03, 4.04 and 4.05:

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, 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.

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:

(1) Benefits are limited to a combined maximum of 40 visits per calendar year for all chiropractic and physical therapy services.

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 Copayment or Deductible when received from a Contract Provider, including the Contract Physician's charge for a routine physical examination. The complete list of covered preventive care services is as shown on the Government website: www.healthcare.gov/law/about/provisions/services/lists.html.

a. 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

b. 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

c. Preventive Care for Women (including pregnant women). Covered Services include but are not limited to:

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

The above services are not covered if provided by a Non-Contract Provider.

(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, 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 benefits are payable for treatment provided by a Physician, psychologist or licensed clinical social worker.

N. **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.

O. **Services of a Registered Nurse or licensed vocational nurse** when ordered by a Physician.

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

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

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

S. **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.

T. **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.

U. **Home Infusion Therapy Drugs** and equipment for their administration.

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

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

(2) Benefits for speech therapy provided for any condition other than those specified in paragraph (1) above are limited to a maximum payment of $1,000 per calendar year and $2,000 lifetime. However, the Physician's evaluation of the need for speech therapy will not be applied to these maximums. Benefits are payable only until understandable speech is attained or until a determination is made that understandable speech cannot be attained.

W. **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 natural teeth which occurred while the Patient was eligible under this Plan. Services must be received within 90 days following the date of Injury. 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.

X. **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.** Admission to a skilled nursing facility must begin within 14 days of discharge from a covered inpatient stay in an acute care Hospital.

(1) <u>Plan A, Plan B and Plan C</u>: Benefits are limited to 180 days per calendar year

(2) <u>Plan D</u>: Benefits are limited to 100 days per calendar year

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.

Section 4.13. 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. Professional services received from any provider who lives in the Patient's home or who is related to the Patient by blood or marriage.

C. Custodial Care, rest cures, services provided by a rest home or a home for the aged.

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.

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 applied behavioral analysis, applied behavioral therapy or training, auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aides, vision therapy, synthesizers, auxiliary aids such as communication boards, and listening systems), auditory perception or listening/learning skills and/or programs and services to remedy or enhance concentration, memory, motivation, reading or self-esteem.

K. Nutritional counseling, food supplements or substitutes (except that the initial Diabetes instruction visit is covered).

L. Services or supplies which are primarily for weight loss, (except for covered bariatric surgery as specifically provided in Subsection 4.12.E.(1)), 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.

N. Orthopedic shoes (except when they are joined to a leg brace), shoe inserts, and foot orthotics.

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. Chemical dependency treatment, except while Hospital confined for acute care of detoxification. (Chemical dependency treatment is covered as described in Chapter 6.)

Q. Expenses for transportation, except as provided under the Ambulance Transportation benefit.

R. Sex changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

S. Dental services or prostheses, extraction of teeth, or any treatment to the teeth or gums, except as specifically under Sections 4.12.W. and 4.12.X.

T. 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 under Section 4.12.K. Routine Preventive Care Services and except for well-baby nursery care as described in Section 4.12.A.(2).

U. 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.

V. Any service or supply excluded under General Exclusions, Limitations and Reductions as described in Chapter 12.

W. 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.

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 and Plan B.** The following benefits are payable for each 34-day supply of a prescription or refill obtained from a retail Contract pharmacy:

(1) For Generic Drugs, the charge incurred after a $10 Copay.

(2) For Brand Name Drugs when a generic equivalent is not available, the charge incurred after a $15 Copay.

(3) For Brand Name Drugs when a generic equivalent is available, the reasonable cost of the equivalent generic drug after a $15 Copay.

B. **Retail Contract Pharmacy – Plan C and Plan D.** The following benefits are payable for each 34-day supply of a prescription or refill obtained from a retail Contract pharmacy:

(1) For Generic Drugs – the charge incurred after a $20 Copay.

(2) For Brand Name Drugs when a generic equivalent is not available – the charge incurred after a $40 Copay.

(3) For Brand Name Drugs when a generic equivalent is available – the reasonable cost of the equivalent generic drug after a $40 Copay.

C. **Mail Order Program – Plan A and Plan B:** The following benefits are payable for each 90-day supply of a prescription or refill obtained through the Fund's mail order program:

(1) For Generic Drugs – the charge incurred after a $5 Copay.

(2) For Brand Name Drugs when a generic equivalent is not available – the charge incurred after a $10 Copay.

(3) For Brand Name Drugs when a generic equivalent is available – the charge incurred after a $25 Copay.

D. **Mail Order Program – Plan C and Plan D:** The following benefits are payable for each 90-day supply of a prescription or refill obtained through the Fund's mail order program:

(1) For Generic Drugs, – the charge incurred after a $40 Copay.

(2) For Brand Name Drugs when a generic equivalent is not available, – the charge incurred after an $80 Copay.

(3) For Brand Name Drugs when a generic equivalent is available, – the reasonable cost of the equivalent generic drug after an $80 Copay.

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, Caremark will ask the Physician to provide additional clinical information to the Caremark Prior Authorization department to support the necessity of the Drug before it will be covered by the Plan. If an Eligible Individual does not receive prior authorization from Caremark for a Drug requiring step therapy, no benefits will be payable for the Drug. (Exception: Eligible Individuals who received a Drug subject to step therapy prior to 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, Caremark will ask the Physician to provide additional clinical information to the Caremark 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 Caremark for a Specialty Drug requiring step therapy, no benefits will be payable for the Drug. The following Drug classes are subject to step therapy: AutoImmune, Multiple Sclerosis and Growth Hormones.

(1) <u>Exception Applicable to the AutoImmune and Multiple Sclerosis Drug Classes</u>: 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 oral contraceptives. For Plan C, oral contraceptives are covered only for the Employee and/or Dependent Spouse.

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 dermatological preparations prescribed by a Physician.

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 (Caremark) list of Specialty Drugs, subject to the following requirements:

(1) The Drug must be obtained through the pharmacy benefit manager's (Caremark) 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 oral 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. Smoking cessation medications.

G. Drugs or devices prescribed for treatment of sexual dysfunction, except when due to a medical condition as certified by the Eligible Individual's Physician.

H. Drugs prescribed for treatment of infertility.

I. Contraceptives other than oral contraceptives. For Plan C Participants, any contraceptives for Dependent children.

J. Immunization agents.

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

L. Non-therapeutic and multiple vitamins, nutritional supplements, health and beauty aids.

M. Charges for prescription drugs containing in excess of a 34-day supply for retail purchase, or in excess of a 90-day supply for drugs purchased through the Fund's mail order program.

N. Drugs covered under Workers' Compensation laws or similar legislation, or drugs prescribed to treat an occupational Illness or Injury.

O. Drugs provided by or paid for by any governmental program, either federal, state, county or municipal.

P. Replacement prescription Drugs resulting from loss, theft or breakage.

Q. Any Drug or medication excluded under General Exclusions, Limitations and Reductions as described in Chapter 12.

CHAPTER 6. CHEMICAL DEPENDENCY TREATMENT BENEFITS

Section 6.01. Benefits. Chemical dependency treatment benefits are provided to Eligible Individuals enrolled in the Comprehensive Health Plan and the HMO plan. If an Eligible Individual receives treatment for chemical dependency under the Operating Engineers Assistance Recovery Program (ARP), the Plan will pay the following benefits for covered services. Chemical dependency treatment benefits are subject to the Comprehensive Health Plan Benefits Annual Maximum Benefit as described in Chapter 4.

A. **Inpatient Residential Treatment.** Benefits for Contract and Non-Contract Providers are payable in accordance with the Schedule of Benefits on the same basis as inpatient Hospital services for medical treatment. 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. The hearing aid benefit is subject to the Comprehensive Health Plan Benefits Annual Maximum Benefit as described in Chapter 4.

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 and Plan C. The Fund will, subject to the provisions of this Chapter 7, pay 80% of the Covered Expenses incurred for the examination and the hearing aid up to a maximum payment of $450 per ear.

Section 7.03. Benefit for Plan D. The Fund will, subject to the provisions of this Chapter 7, pay the following benefits:

A. <u>Contract Provider</u>: The Fund will pay 80% of the negotiated fee for the examination and the hearing aid.

B. <u>Non-Contract Provider</u>: The Fund will pay 60% of the Allowed Charge for the examination and hearing aid.

C. The maximum benefit payable is $500 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 3-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; or

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.

F. Any expense excluded under General Exclusions, Limitations and Reductions as described in Chapter 12.

CHAPTER 8. DENTAL BENEFITS

Effective July 1, 2010 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 Dependent children younger than 18 years of age.

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 <u>or</u> 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 Dependent children younger than 18 years of age.

A. **VSP Signature Choice Plan Doctor Benefits**. If services are provided by a doctor who is a member of the VSP Signature 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 $105 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	$ 37.00
Materials:	
Single Vision Lenses, up to	$ 34.00
Bifocal Lenses, up to	51.00
Trifocal Lenses, up to	68.00
Lenticular Lenses, up t o	100.00
Tints, up to	5.00
Frames, up to	40.00

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 75% of network provider allowance after the Copayment is paid.

(2) Out-of-Network Provider Benefit - the Plan will reimburse up $126 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 $\pm$.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, except that this maximum does not apply to Dependent children younger than 18 years of age.

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

The Burial Expense Benefit is provided under a contract of insurance between the Trust Fund and The Union Labor Life Insurance Company. Retired Participants are not eligible for the Burial Expense Benefit.

Section 11.01. Benefits. 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.)

Section 11.02. 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, devise, 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.

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 c. regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule 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) 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, chemical dependency 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 chemical dependency treatment 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) 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.

(6) 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.

(7) 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) 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.

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

Section 17.01. 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) Caremark, 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 17.02. 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) Caremark, 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 chemical dependency 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 JANUARY 1, 2012

Section 4.02. Plan A Schedule of Benefits

Section 4.03. Plan B Schedule of Benefits

Section 4.04. Plan C Schedule of Benefits

Section 4.05. Plan D Schedule of Benefits

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Section 4.02. Plan A Schedule of Comprehensive Health Plan Benefits – Effective January 1, 2012. All benefits shown in the following Plan A Schedule of Benefits are based on Covered Expenses, as defined in Section 1.13. The payment percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers. The benefits shown in the "Out-of-Area" column apply only when the Eligible Individual resides more than 30 miles from the nearest Contract Provider; they will also apply when the Eligible Individual is temporarily away from home on vacation or attending school.

Comprehensive Health Plan Benefits — Plan A			
Annual Maximum	$2,000,000 per person, per calendar year (starting January 1, 2014 there will not be an annual overall dollar maximum)		
Deductible	None		
Coinsurance	Plan pays the amount shown below; subject to coinsurance limit		
Annual Coinsurance Limit	$15,000 per person; $30,000 family maximum – (of Covered Expenses)		
Benefit Description	**Contract Provider**	**Non-Contract Provider+**	**Out-of-Area+**
Inpatient Hospital (pre-authorization required)	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Hospital Emergency Room for an Emergency Medical Condition	Plan pays 90%; subject to coinsurance limit	Plan pays 90%; subject to coinsurance limit	Plan pays 90%; subject to coinsurance limit
Ambulatory Surgery Facility or Outpatient Hospital for Surgery	Plan pays 90%; subject to coinsurance limit	Plan pays 80%	Plan pays 90%; subject to coinsurance limit
Other Outpatient Hospital	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Physician Visits (Office, Hospital, and Home)	After $10 Copayment per visit, Plan pays 100%	After $10 Copayment per visit, Plan pays 60%	After $10 Copayment per visit, Plan pays 90%
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Speech Therapy[1] Calendar Year Maximum: $1,000 Lifetime Maximum: $2,000	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Occupational Therapy	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Preventive Care for Children (See Section 4.12.K. for covered services)	Plan pays 100% for services required to be covered under Health Care Reform	Plan pays 60%	Plan pays 90%; subject to coinsurance limit

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

Benefit Description — Plan A	Contract Provider	Non-Contract Provider+	Out-of-Area+
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform See Section 4.12.K. for covered services	Plan pays 100% for a routine physical exam, up to $150 per exam	Plan pays 100% for a routine physical exam, up to $150 per exam
Preventive Care for Women	Plan pays 100% for services required to be covered under Health Care Reform (including screening mammograms) See Section 4.12.K. for covered services	Plan pays 100% for a routine physical exam, up to $150 per exam. Mammograms: Plan pays 60%	Plan pays 100% for a routine physical exam, up to $150 per exam Mammograms: Plan pays 90%;subject to coinsurance limit
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After $10 Copayment per visit, Plan pays 100%	After $10 Copayment per visit, Plan pays 60%	After $10 Copayment per visit, Plan pays 90%; subject to coinsurance limit
Skilled Nursing Facility Calendar Year Maximum: 180 days (admission must be within 14 days of discharge from a hospital)	Plan pays 90%; subject to coinsurance limit	Plan pays 90%	Plan pays 90%; subject to coinsurance limit
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	Plan pays 90%; subject to coinsurance limit	Plan pays 90%	Plan pays 90%; subject to coinsurance limit
Ambulance	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
TMJ Treatment Non-Surgical Lifetime Maximum: $1,500	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Inpatient Mental Illness (pre-authorization required)	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit

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

Benefit Description — Plan A	Contract Provider	Non-Contract Provider+	Out-of-Area+
Outpatient Mental Illness for covered providers only	After $10 Copayment per visit, Plan pays 100%	After $10 Copayment per visit, Plan pays 60%	After $10 Copayment per visit, Plan pays 90%
Other Covered Expenses Not Shown Above	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
[1] Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.			

Prescription Drug Benefits	Retail Pharmacy Program:	Mail Order Program:
	Your copayment for each prescription: Generic Drug: $10 Brand Name Drug: $15 Maximum Supply: 34 days	Your copayment for each prescription Generic Drug: $5 Brand Name if a Generic is available: $25 Brand Name if No Generic available: $10 Maximum Supply: 90 days
	If the actual cost of the prescription is less than the copayment, 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 copayment.	
Hearing Aid Benefit		
Hearing Examination	Plan pays 80% of Allowed Charge	
Hearing Aid	Plan pays 80% of Allowed Charges (limited to one device per ear in any 3-year period)	
Maximum Benefit	$450 per ear	
Chemical Dependency Treatment Benefits	***Referral to Contract Providers through Operating Engineers Assistance Recovery Program (ARP) Recommended***	
Inpatient Residential Treatment (pre-authorization by ARP required)	Payable on the same basis as Inpatient Hospital services	
Outpatient Treatment, Recovery Home Treatment	Payable on the same basis as Physician Office Visits for professional services or Other Outpatient Hospital for services billed by a facility	

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

Section 4.03. Plan B Schedule of Comprehensive Health Plan Benefits – Effective January 1, 2012. All benefits shown in the following Plan B Schedule of Benefits are based on Covered Expenses, as defined in Section 1.13. The payment percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers. The benefits shown in the "Out-of-Area" column apply only when the Eligible Individual lives more than 30 miles from the nearest Contract Provider; they will also apply when the Eligible Individual is temporarily away from home on vacation or attending school.

Comprehensive Health Plan Benefits — Plan B			
Annual Maximum	$2,000,000 per person, per calendar year (starting January 1, 2014 there will not be an annual overall dollar maximum)		
Deductible	None		
Coinsurance	Plan pays the percentage shown below; subject to coinsurance limit		
Annual Coinsurance Limit	$15,000 per person; $30,000 family maximum – (of Covered Expenses)		
Benefit Description	**Contract Provider**	**Non-Contract Provider+**	**Out-of-Area+**
Inpatient Hospital (pre-authorization required)	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Hospital Emergency Room for an Emergency Medical Condition	Plan pays 80%; subject to coinsurance limit	Plan pays 80%; subject to coinsurance limit	Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility / Outpatient Hospital for Surgery	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Other Outpatient Hospital	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Physician Visits (Office, Hospital, and Home)	After $15 Copayment per visit, Plan pays 100%	After $15 Copayment per visit, Plan pays 60%	After $15 Copayment per visit, Plan pays 80%
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Speech Therapy[1] Calendar Year Maximum: $1,000 Lifetime Maximum: $2,000	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Occupational Therapy	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Preventive Care for Children (See Section 4.12.K. for covered services)	Plan pays 100% for services required to be covered under Health Care Reform	Plan pays 60%	Plan pays 80%; subject to coinsurance limit

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

Benefit Description — Plan B	Contract Provider	Non-Contract Provider+	Out-of-Area+
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform See Section 4.12.K. for covered services	Plan pays 100% for a routine physical exam, up to $150 per exam	Plan pays 100% for a routine physical exam, up to $150 per exam
Preventive Care for Women	Plan pays 100% for services required to be covered under Health Care Reform (including screening mammograms) See Section 4.12.K. for covered services	Plan pays 100% for a routine physical exam, up to $150 per exam' Mammograms: Plan pays 60%	Plan pays 100% for a routine physical exam, up to $150 per exam Mammograms: Plan pays 80%;subject to coinsurance limit
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After $15 Copayment per visit, Plan pays 100%	After $15 Copayment per visit, Plan pays 60%	After $15 Copayment per visit, Plan pays 80%; subject to coinsurance limit
Skilled Nursing Facility Calendar Year Maximum: 180 days (admission must be within 14 days of discharge from a hospital)	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Ambulance	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
TMJ Treatment Non-Surgical Lifetime Maximum: $1,500	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Inpatient Mental Illness (pre-authorization required)	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Outpatient Mental Illness	After $15 Copayment per visit, Plan pays 100%	After $15 Copayment per visit, Plan pays 60%	After $15 Copayment per visit, Plan pays 80%

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

Benefit Description — Plan B	Contract Provider	Non-Contract Provider+	Out-of-Area+
Other Covered Expenses Not Shown Above	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
[1] Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.			

Prescription Drug Benefits	**Retail Pharmacy Program:** Your copayment for each prescription: Generic Drug: $10 Brand Name Drug: $15 Maximum Supply: 34 days	**Mail Order Program:** Your copayment for each prescription Generic Drug: $5 Brand Name if a Generic is available: $25 Brand Name if No Generic available: $10 Maximum Supply: 90 days
	If the actual cost of the prescription is less than the copayment, 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 copayment.	
Hearing Aid Benefit		
Hearing Examination	Plan pays 80% of Allowed Charge	
Hearing Aid	Plan pays 80% of Allowed Charge (limited to one device per ear in any 3-year period)	
Maximum Benefit	$450 per ear	
Chemical Dependency Treatment Benefits	***Referral to Contract Providers through Operating Engineers Assistance Recovery Program (ARP) Recommended***	
Inpatient Residential Treatment (pre-authorization by ARP required)	Payable on the same basis as Inpatient Hospital Services	
Outpatient Treatment, Recovery Home Treatment	Payable on the same basis as Physician Office Visits for professional services or Other Outpatient Hospital for services billed by a facility	

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

Section 4.04. Plan C Schedule of Comprehensive Health Plan Benefits – Effective January 1, 2012. All benefits shown in the following Schedules of Benefits are based on Covered Expenses, as defined in Section 1.13 and are payable after the Deductible is satisfied for the calendar year, unless the Schedule specifically indicates the Deductible is waived for the service. The benefit percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers. The benefits shown in the "Out-of-Area" column apply only when the Eligible Individual lives more than 30 miles from the nearest Contract Provider; they will also apply when the Eligible Individual is temporarily away from home on vacation or attending school.

Comprehensive Health Plan Benefits – Plan C			
Annual Maximum	$2,000,000 per person, per calendar year (starting January 1, 2014 there will not be an annual overall dollar maximum)		
Annual Deductible	$750 per person; $2,250 family maximum Deductible does not apply to Contract Provider and out-of-area office visits, 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.		
Coinsurance	Plan pays the percentage shown below; subject to coinsurance limit		
Annual Coinsurance Limit	$30,000 per person (of Covered Expenses). Deductible amounts do not apply toward meeting limit		
Benefit Description	**Contract Provider**	**Non-Contract Provider+**	**Out-of-Area+**
Inpatient Hospital (pre-authorization required)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Hospital Emergency Room for an Emergency Medical Condition	Plan pays 80%, no deductible; subject to coinsurance limit	Plan pays 80%, no deductible; subject to coinsurance limit	Plan pays 80%, no deductible; subject to coinsurance limit
Ambulatory Surgery Facility / Outpatient Hospital for Surgery	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Other Outpatient Hospital	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Physician Office Visits	After $15 Copayment per visit, Plan pays 100%; no deductible	After deductible, Plan pays 60%	After $15 Copayment per visit, Plan pays 80%; no deductible
Physician Hospital Visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit

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

Benefit Description — Plan C	Contract Provider	Non-Contract Provider+	Out-of-Area+
Speech Therapy[1] Calendar Year Maximum: $1,000 Lifetime Maximum: $2,000	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Occupational Therapy	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Preventive Care for Children (See Section 4.12.K. for covered services)	Plan pays 100% for services required to be covered under Health Care Reform, no deductible	After deductible, Plan pays 60%	After $15 Copayment per visit, Plan pays 80%; subject to coinsurance limit; no deductible
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform, no deductible See Section 4.12.K. for covered services	Plan pays 100% for a routine physical exam, up to $150 per exam, no deductible	Plan pays 100% for a routine physical exam, up to $150 per exam, no deductible
Preventive Care for Women	Plan pays 100% for services required to be covered under Health Care Reform, no deductible (including screening mammograms) See Section 4.12.K. for covered services	Plan pays 100% for a routine physical exam, up to $150 per exam, no deductible Mammograms: After deductible, Plan pays 60%	Plan pays 100% for a routine physical exam, up to $150 per exam, no deductible Mammograms: After deductible, Plan pays 80%; subject to coinsurance limit
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Skilled Nursing Facility Calendar Year Maximum: 180 days (admission must be within 14 days of discharge from a hospital)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Ambulance	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%	After deductible, Plan pays 80%; subject to coinsurance limit

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

Benefit Description — Plan C	Contract Provider	Non-Contract Provider+	Out-of-Area+
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
TMJ Treatment Non-Surgical Lifetime Maximum: $1,500	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Inpatient Mental Illness (pre-authorization required)	After deductible, Plan pays 80%, subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%, subject to coinsurance limit
Outpatient Mental Illness	After $15 Copayment per visit, Plan pays 100%; no deductible	After deductible, Plan pays 60%	After $15 Copayment per visit, Plan pays 80%; no deductible
Other Covered Expenses Not Shown Above	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%	After deductible, Plan pays 80%; subject to coinsurance limit
[1] Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.			

Prescription Drug Benefits (not subject to annual deductible)	**Retail Pharmacy Program**: Your copayment for each prescription: Generic Drug: $20 Brand Name Drug: $40 Maximum Supply: 34 days	**Mail Order Program**: Your copayment for each prescription Generic Drug: $40 Brand Name Drug: $80 Maximum Supply: 90 days
	If the actual cost of the prescription is less than the copayment, 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 copayment.	
Hearing Aid Benefit		
Hearing Examination	After deductible, Plan pays 80% of Allowed Charge	
Hearing Aid	After deductible, Plan pays 80% of Allowed Charge (limited to one device per ear in any 3-year period)	
Maximum Benefit	$450 per ear	
Chemical Dependency Treatment Benefits	***Referral to Contract Providers through Operating Engineers Assistance Recovery Program (ARP) Recommended***	
Inpatient Residential Treatment (pre-authorization by ARP required)	Payable on the same basis as Inpatient Hospital Services	
Outpatient Treatment, Recovery Home Treatment	Payable on the same basis as Physician Office Visits for professional services or Other Outpatient Hospital for services billed by a facility	

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

Section 4.05. Plan D Schedule of Comprehensive Health Plan Benefits – Effective January 1, 2012. All benefits shown in the following Schedules of Benefits are based on Covered Expenses, as defined in Section 1.13 and are payable after the Deductible is satisfied for the calendar year, unless the Schedule specifically indicates the Deductible is waived for the service. The benefit percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers.

Comprehensive Health Plan Benefits – Plan D		
Annual Maximum	$2,000,000 per person, per calendar year (starting January 1, 2014 there will not be an annual overall dollar maximum)	
Annual Deductible	$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, or the adult physical exam benefit for Non-Contract Providers.	
Emergency Room Deductible	$50 per visit (waived if admitted)	
Coinsurance	Plan pays the percentage shown below; subject to coinsurance limit	
Annual Coinsurance Limit Contract Providers only	$15,000 per person, maximum $30,000 family (of Covered Expenses), deductible amounts do not apply toward meeting limit. Does not apply to Non-Contract Providers. (This means that your annual out-of-pocket limit is $3,000 or a maximum of $6,000 per family.)	
Benefit Description	**Contract Provider**	**Non-Contract Provider**+
Inpatient Hospital (pre-authorization required)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Hospital Emergency Room for an Emergency Medical Condition	After annual deductible and emergency room deductible, Plan pays 80%; subject to coinsurance limit	After annual deductible and emergency room deductible, Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%, subject to $1,000 maximum per visit
Other Outpatient Hospital	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60% (Emergency room deductible applies if emergency room used for other than an Emergency Medical Condition)
Physician Office Visits	After $20 Copayment per visit, Plan pays 100%; no annual deductible	After deductible, Plan pays 60%
Physician Hospital Visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Speech Therapy[1] Calendar Year Maximum: $1,000 Lifetime Maximum: $2,000	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Occupational Therapy	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%

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

Benefit Description — Plan D	Contract Provider	Non-Contract Provider[+]
Preventive Care for Children See Section 4.12.K. for covered services	Plan pays 100%, no deductible	After deductible, Plan pays 60%
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform, no deductible See Section 4.12.K. for covered services	Plan pays 100%, up to $250 per exam
Preventive Care for Women	Plan pays 100% for services required to be covered under Health Care Reform, no deductible (including screening mammograms) See Section 4.12.K. for covered services	Plan pays 100%, up to $250 per exam Mammograms: After deductible, Plan pays 60%
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	After deductible, Plan pays 60%
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Skilled Nursing Facility Calendar Year Maximum: 100 days	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Ambulance	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%
Durable Medical Equipment / Prosthetic Devices Calendar Year Maximum: $3,000	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
TMJ Treatment Non-Surgical Lifetime Maximum: $1,500	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Inpatient Mental Illness (pre-authorization required)	After deductible, Plan pays 80%, subject to coinsurance limit	After deductible, Plan pays 60%
Outpatient Mental Illness for covered providers only	After $20 Copayment per visit, Plan pays 100%; no annual deductible	After deductible, Plan pays 60%
Other Covered Expenses Not Shown Above	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%
[1] Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.		

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

Benefit Description — Plan D	**Contract Provider**	**Non-Contract Provider**[+]
Hearing Aids and Examination	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Maximum Benefit	$500 per ear in any 36-month period	
Prescription Drug Benefits (not subject to annual deductible)	**Retail Pharmacy Program**: Your copayment for each prescription: Generic Drug: $20 Brand Name Drug: $40 Maximum Supply: 34 days	**Mail Order Program**: Your copayment for each prescription Generic Drug: $40 Brand Name Drug: $80 Maximum Supply: 90 days
	If the actual cost of the prescription is less than the copayment, 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 copayment.	
Chemical Dependency Treatment Benefits	**Referral to Contract Providers through Operating Engineers Assistance Recovery Program (ARP) Recommended**	
Inpatient Residential Treatment (pre-authorization by ARP required)	Payable on the same basis as Inpatient Hospital Services	
Outpatient Treatment, Recovery Home Treatment	Payable on the same basis as Physician Office Visits for professional services or Other Outpatient Hospital for services billed by a facility	

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