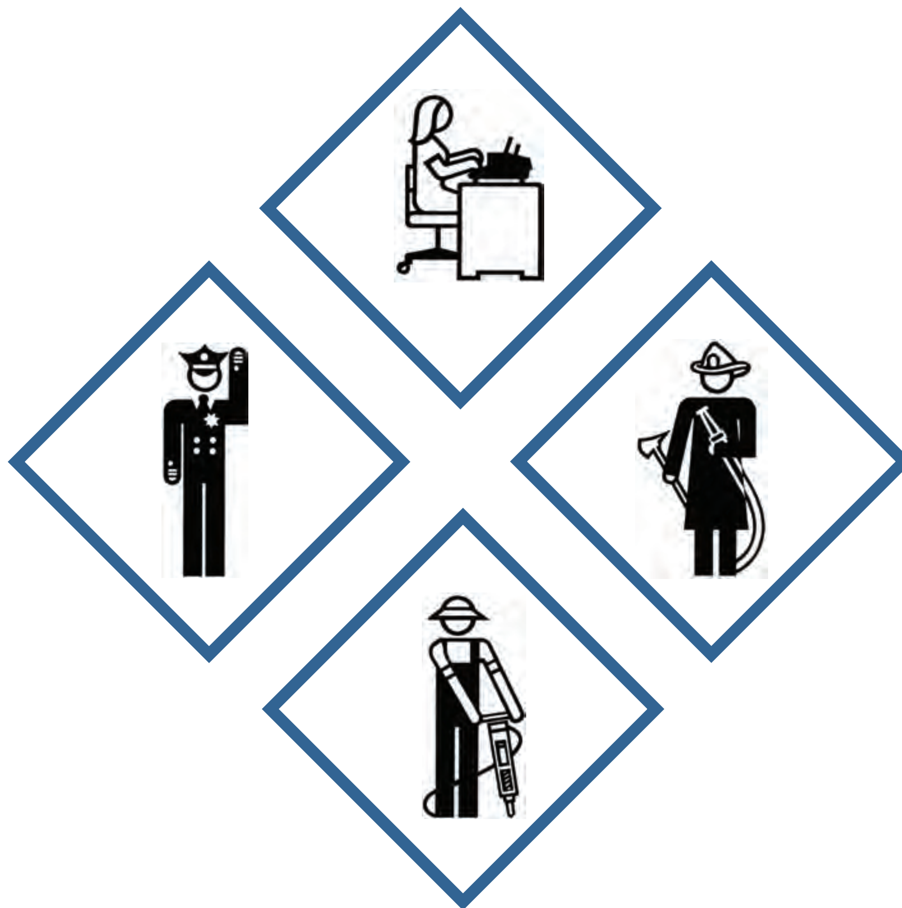
OPERATING ENGINEERS

PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND



SUMMARY PLAN DESCRIPTION AND PLAN RULES AND REGULATIONS

JULY 1, 2008 EDITION - FOR PLANS A, B, AND C

Introduction

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

- Comprehensive Medical;
- Chemical Dependency Treatment;
- Hearing Aid;
- Prescription Drug;
- Dental;
- Orthodontic;
- Vision; and
- Burial Expense.

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

We are pleased to provide you with this 2008 edition of your Summary Plan Description (SPD), which is designed to help you understand the benefits available to you. The Plan described in this SPD is effective July 1, 2008 and replaces all other plan documents previously provided to you. We urge you to read this SPD and, if you are married, share it with your Spouse. In addition, we recommend that you keep this SPD with your important papers so you can refer to it when needed.

Choice of Medical Programs

Once you elect a medical program, you must remain in that program for at least 12 months before you can elect the other program, unless you are covered under the Kaiser HMO and move out of the Kaiser service area.

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

About this SPD

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

- An **important contact information** section, which includes phone numbers and Web sites for organizations providing services under this Plan, including contact information for pre-approval.
- An **eligibility** section that tells you how you become a member of the Plan, who in your family is eligible for coverage, what you need to do to continue to be eligible, when coverage under the Plan ends, and when you can reinstate your eligibility.
- An explanation about your coverage under **each benefit** program, including ***Schedule of Benefits*** inserts that summarizes the coverage available under your benefit program.
- A **how-to** section on filing claims, including what you need to do if a claim is denied.
- An **administrative information** section, including general Plan information.

- A **glossary** of important terms that have special meaning under the Plan. These terms are capitalized throughout this SPD.

Please Note

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

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

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

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

Be Wise Health Care Consumers

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

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

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

Table of Contents

Introduction ..... **i**
Choice of Medical Programs i
About this SPD i
Please Note ii
Be Wise Health Care Consumers ii

Important Contact Information **1**

Eligibility **3**
Eligibility for Active Employees 3
Eligibility for Retired Employees 4
Dependent Eligibility 5
Extension of Eligibility for Surviving Spouses 7
Extension of Health Benefits for Total Disability *For Active Employees and Their Dependents* 7
Family and Medical Leave Act 7
Military Leave 8
COBRA Continuation Coverage 9

Comprehensive Medical Benefits **13**
How the Plan Works for Plan A and Plan B Participants 13
How the Plan Works for Plan C Participants 13
Copayments 14
Coinsurance 14
Coinsurance Limit 14
Lifetime Maximum 15
Preferred Provider Network – BlueCross Prudent Buyer Plan 15
Professional Review Organization Utilization Review Program 16
Disease Management Program 17
Covered Expenses 19
Exclusions and Limitations 23

Prescription Drug Benefits **25**
Generic Versus Brand Name Medications 25
Retail Pharmacy Program 25
Mail Service Program 25
Specialty Pharmacy Services 26
Covered Expenses 26
Exclusions and Limitations 27

Chemical Dependency Treatment Benefits **29**
Schedule of Benefits 29
Covered Expenses 29
Exclusions and Limitations 29

Hearing Aid Benefits **31**
Schedule of Benefits 31
Covered Expenses 31
Exclusions and Limitations 31

Dental Benefits **32**
Choice of Dentists / Provider Network 32
Schedule of Benefits 32
Covered Dental Expenses 32
Limitations 34
Exclusions 35
How to File a Claim for Dental Benefits 37

Orthodontic Benefits **38**

Schedule of Benefits 38
Covered Expenses 38
Exclusions and Limitations 38
How to File a Claim for Orthodontic Benefits 39

Vision Benefits 40
How the Plan Works 40
The Copayment 40
Schedule of Benefits 41
Covered Vision Expenses 41
Low Vision Benefit 41
Exclusions and Limitations 42
How to File a Claim 42

Burial Expense Benefit 44
Beneficiary Designation 44
How to file a Claim for Burial Expense Benefits 44

General Plan Exclusions and Limitations 45

Claims and Appeals 47
Filing Claims 47
Claim Decisions 49
If a Claim is Denied 50
Appealing a Denied Claim 50
Appeal Decisions 51
Medical Judgments 52
Authorized Representative 52
Following an Appeal 53
Third Party Liability 53
Privacy Policy 55
Coordination of Benefits with Other Plans 55

Plan Information 60

Plan Information 60
Administrative Information 60
Your ERISA Rights 62

Definitions 66

Important Contact Information

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

- Fund Office:
  - Maintains eligibility records;
  - Accounts for Employer and self-payment contributions;
  - Administers Comprehensive Medical, Chemical Dependency Treatment, and Hearing Aid Benefits;
  - Answers Participant inquiries; and
  - Handles other routine administrative functions.
- Anthem BlueCross of California provides access to a Preferred Provider Organization network for medical benefits and provides the Plan's utilization review program for medical benefits. Kaiser Permanente offers a Health Maintenance Organization (HMO) plan for medical and prescription drug benefits.
- Operating Engineers Assistance Recovery Program (ARP) administers the Plan's utilization review program for Chemical Dependency Treatment Benefits.
- Caremark provides access to contract pharmacies and administers the Plan's mail service program and specialty pharmacy program.
- Delta Dental of California (effective July 1, 2008) insures and administers the Plan's dental and orthodontic benefits (for orthodontic treatment that began after July 1, 2008).
- Vision Service Plan (VSP) administers and provides access to Contract Providers for Vision Benefits.
- Union Labor Life Insurance Company insures and administers the Plan's Burial Expense Benefits.

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

Quick Reference Chart – Where to Call for Information

Information Needed	Contact	Contact Information
Eligibility Information	Fund Office	(800) 844-8392 or (510) 433-4422
Claims Information	Fund Office	(800) 844-8392 or (510) 433-4422
Comprehensive Medical Contract Providers In California Outside California	Fund Office BlueCross Prudent Buyer Plan BlueCard	(800) 844-8392 or (510) 433-4422 www.bluecrossca.com www.bluecares.com
Kaiser HMO Providers	Kaiser Permanente	(800) 464-4000 www.kaiserpermanente.org
Utilization Review Pre-approval required for Hospital admissions and transplants	BlueCross Prudent Buyer Plan	Have your provider call (800) 274-7767
Prescription Drug Program – Network Pharmacy, Mail Service and Specialty Pharmacy Services *Kaiser HMO Participants, contact Kaiser*	Caremark	(888) 790-4258 or www.caremark.com Specialty pharmacy services: CaremarkConnect (800) 237-2767
Chemical Dependency Treatment Benefits Network providers, referrals, and pre-approval	Operating Engineers Assistance Recovery Program (ARP)	(800) 562-3277
Vision Benefits	Vision Service Plan (VSP)	(800) 877-7195 or www.vsp.com

Information Needed	Contact	Contact Information
Dental Benefits and Orthodontic Benefits (effective July 1, 2008)	Delta Dental of California	(800) 765-6003 or www.deltadentalins.com
Disease Management Program and Nurse Connections Hotline	Matria Health Care	(866) 676-0740
Burial Expense Benefits	Union Labor Life Insurance Company or The Trust Fund Office	Union Labor Life Insurance Company 111 Massachusetts Avenue, N.W. Washington, DC 20001

Eligibility

Eligibility for Active Employees

Initial Eligibility

You are eligible for benefits on the first day of the month for which Employer contributions are made to the Fund on your behalf. Your Employer's first contribution to the Fund will provide you with eligibility for both the month in which the contribution is received and the next following month.

Exception for Employees With Previous Eligibility. If you were previously covered under the Plan and your eligibility is reinstated, you will receive eligibility for only the month in which the contribution is received from your Employer.

Election of Coverage

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

- You elected the Kaiser HMO and move out of the Kaiser service area; or
- The Board of Trustees approve a change.

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

Your Dependents will be covered under the same medical and prescription drug option that you choose. Regardless of which medical and prescription drug option you elect, Chemical Dependency Treatment and Hearing Aid Benefits will be provided through the Fund; Dental and Orthodontic benefits will be administered by Delta Dental Plan; Vision Benefits will be administered by Vision Service Plan; and the Burial Expense Benefit will be insured by Union Labor Life Insurance Company.

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

Continuing Eligibility

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

Initial and Continuing Eligibility Example

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

Termination of Eligibility

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

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

Eligibility for Retired Employees

Initial Eligibility

To be eligible for benefits as a Retired Employee:

- You must have been covered under the Plan as an Active Employee for 12 consecutive months before your retirement;
- You must be eligible to receive pension benefits from your former Employer who was a contributing employer to this Fund; and
- The required contributions must be paid to the Fund on your behalf.

Benefits are not automatic. If you are eligible for benefits as a Retired Employee, you must apply for Retiree coverage. You must request enrollment by filing an application with the Fund Office within 30 days of retirement and your coverage under the Plan must be continuous, with no break in coverage.

When you retire, your Employer cannot continue to report you as an active Employee. If you do not apply for retiree coverage within 30 days of your retirement date, you will not be eligible for benefits under the Plan unless you qualify for late enrollment as described on page 12.

If You Are Eligible for Medicare

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

Continuing Eligibility

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

Termination of Eligibility

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

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

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

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

Dependent Eligibility

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

In general, your Dependents are your legal Spouse and your unmarried children. For more information about who qualifies as a dependent, see the definition of Dependent on page 67.

Domestic Partners

Your eligible Dependents may include your Domestic Partner and your Domestic Partner's eligible children only if your Employer is legally required to provide coverage for domestic partners.* Contact the Fund Office to see if this applies. Domestic partner coverage is considered "imputed income" to the employee under federal law. You must make payment to the Trust Fund Office for any taxes that are required to be paid on the value of this imputed income. Failure to do so will result in termination of coverage for your Domestic Partner.

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

Enrolling Dependents

You must enroll each eligible Dependent in the Plan by submitting a completed enrollment form, including any required documentation, to the Fund Office within 90 days of the date you become eligible or, if later, within 90 days of the date you acquire the Dependent, for coverage to become effective. Except as described under *Late Enrollment* on page 12, a Dependent who is not enrolled within 90 days of the dates described above will not be eligible to enroll until the later of:

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

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

Termination of Eligibility

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

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

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

Certificate of Creditable Coverage When Coverage Ends

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

The certificate will be provided by mail shortly after the Plan knows or has reason to know that eligibility for you and/or your covered Dependent(s) has ended. In addition, a certificate will be provided upon request if the request is received by the Fund Office within two years after the date Plan coverage ended. To request a certificate, call the eligibility department of the Fund Office at (800) 844-8392 or (510) 433-4422.

Late Enrollment

If you did not enroll yourself or your Dependent(s) in the Plan when first eligible and you subsequently acquire a new Dependent by marriage, birth, adoption, placement for adoption or legal guardianship, you may request enrollment for yourself and your newly acquired Dependent in the Plan no later than 90 days after the date the new Dependent is acquired.

If you did not enroll in the Plan on the date you first became eligible because you or your Dependent had other health coverage under any other health insurance policy or program (including COBRA Continuation Coverage, individual insurance, Medicaid, or other public program) and the other coverage ends, you may enroll yourself and any eligible Dependents in this Plan within 31 days after termination of the other coverage if that other coverage ended due to the:

- Loss of eligibility for the other coverage as a result of termination of employment, reduction in the number of hours of employment, death, divorce or legal separation, or loss of dependent status under the other plan;
- Termination of benefit package of the other plan;
- Other plan ceasing to offer coverage to a group of similarly situated individuals;
- Moving out of an HMO service area if the other plan is an HMO;
- Loss of eligibility due to reaching the lifetime maximum on all benefits;
- Termination of Employer contributions toward the other coverage; or
- Other coverage being COBRA Continuation Coverage that has continued for the maximum period or any other reason other than failure to pay the applicable COBRA premium on a timely basis.

Extension of Eligibility for Surviving Spouses

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

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

Extension of Health Benefits for Total Disability

For Active Employees and Their Dependents

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

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

- You must submit a Physician's written certification of the Total Disability to the Fund Office within 90 days after eligibility ends. You will also be required to submit continued certification every 90 days.
- Benefits will only be extended for Covered Expenses incurred for treatment of the Illness or Injury that caused the Total Disability.
- You must be Totally Disabled on the date a Covered Expense is incurred.
- Benefits are subject to all Medical Plan limitations and maximums in effect at the time eligibility would otherwise have ended.

Extension of benefits will continue until the earliest of the:

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

Family and Medical Leave Act

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

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

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

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

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

- You were eligible when the leave began;

- Your Employer properly grants the leave under the FMLA; and
- Your Employer makes the required notification and contributions to the Fund during the leave.

Military Leave

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

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

> If your military service began before December 10, 2004, you are only eligible to continue your eligibility for benefits for up to 18 months.

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

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

Reinstatement

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

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

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

COBRA Continuation Coverage

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

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

If you get married, have a newborn child, adopt a child, or have a child placed with you for adoption or legal guardianship (for whom you have financial responsibility) while your COBRA Continuation Coverage is in effect, you may add your new spouse and/or child to your coverage for the balance of your COBRA Continuation Coverage period. To have this Dependent added to your coverage, you must provide written notification to the Fund Office within 90 days of the marriage, birth, legal guardianship, adoption, or placement of a child with you for adoption.

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

Please note, when considering whether to elect COBRA Continuation Coverage, you should take into account that if you do not continue your group health coverage it will affect your future rights under federal law.

- First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. Electing COBRA Continuation Coverage may prevent a gap in coverage.
- Second, if you do not elect Continuation Coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health coverage with no pre-existing condition exclusions.
- Finally, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage under the Plan ends because of the qualifying events indicated in this section. You also will have the same special enrollment right at the end of COBRA Continuation Coverage if you get COBRA Continuation Coverage for the maximum time available to you.

Qualifying Events

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

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

- Termination of employment;
- Reduction in hours;
- Death;
- Divorce; and
- Child losing Dependent status under the Plan.

Notifying the Fund Office

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

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

> To ensure your and/or your Dependent(s) rights to COBRA Continuation Coverage, you, your Dependent, or your representative should notify the Fund Office, in writing, of any qualifying event.
>
> Be sure that the Fund Office has your Dependents' name and address on file to ensure that that they receive any important information.

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

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

Paying for COBRA Continuation Coverage

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

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

Periods of Coverage

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

- ***Coverage Continues for 24 Months*.*** You may elect to purchase continued coverage for yourself and your Dependents for up to 24 months if coverage ends due to your termination of employment to enter military service.
- ***Coverage Continues for 29 Months*.*** If your employment ends due to your termination of employment or reduction in hours, and at that time, or within 60 days of the event, you or one of your Dependents is Totally Disabled (as determined by the Social Security Administration), coverage may continue for you and your Dependents for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Fund Office, in writing, of your determination of disability by the Social Security Administration. Written notice must be provided within 60 days of the Social Security Administration's determination of disability and before the end of the initial 18-month period. In addition, if you (or your Dependent) later learn that you are no longer considered Totally Disabled by the Social Security Administration, you must notify the Fund Office, in writing, within 30 days of the determination.
- ***Coverage Continues for 36 Months.*** Your Dependents may elect COBRA Continuation Coverage for up to 36 months if coverage ends because of your:
  - Death;
  - Divorce; or
  - Dependent child no longer qualifying for Dependent coverage under the Plan.

* **Second Qualifying Events:** If a second qualifying event occurs within the 18-, 24-, or 29-month period (as applicable), the maximum period of coverage for your Dependents is extended up to a total of 36 months. A second qualifying event may include your death or divorce or a Dependent child no longer meeting the Plan's definition of a Dependent. These events are a second qualifying event only if they would have caused your Dependent to lose Plan coverage if the first qualifying event had not occurred. You must notify the Fund Office, in writing, of any second qualifying event within 60 days after the second qualifying event.

When your COBRA Continuation Coverage ends, you will be provided with certification of your length of coverage under the Plan. This may help reduce or eliminate any preexisting limitation under a new Group Plan.

Loss of Continued Coverage

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

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

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

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

HIPAA Certificate of Creditable Coverage When Coverage Ends

When your COBRA coverage ends, the Fund Office will automatically provide you and/or your covered Dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy an individual health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your Dependents in that new group health plan or health insurance policy. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated.

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

The certificate will automatically be provided by mail shortly after Plan coverage ends. In addition, a certificate will be provided upon request if the request is received by the Fund Office within two years after the date Plan coverage ended. To request a certificate, call the eligibility department of the Fund Office at (800) 844-8392 or (510) 433-4422.

Comprehensive Medical Benefits

If you are eligible and elect the HMO medical plan, HMO benefits are described in a separate booklet.

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

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

How the Plan Works for Plan A and Plan B Participants

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

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

- The Plan pays a percentage of Covered Expenses and you pay the rest. This is known as coinsurance. The coinsurance percentage the Plan pays varies depending on whether you use a Contract or Non-Contract Providers and whether or not you live in the Plan's PPO network area.
- Once your Covered Expenses for the year reach the coinsurance limit, the Plan pays 100% of most Covered Expenses (up to the eligible charge or maximum allowance) for the remainder of that calendar year.

How the Plan Works for Plan C Participants

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

- You are responsible for meeting your calendar year deductible.
- Once you or your family meets the calendar year deductible, the Plan pays a percentage of Covered Expenses and you pay the rest. This is known as coinsurance. The coinsurance percentage the Plan pays varies depending on whether you use Contract or Non-Contract Providers and whether or not you live in the Plan's PPO network area.
- Once your Covered Expenses for the year, **not** including the amounts you paid toward your calendar year deductibles, reach the coinsurance limit, the Plan pays 100% of most Covered Expenses (up to the eligible charge or maximum allowance) for the remainder of that calendar year.

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

Plan C Deductible

Plan C Only
Deductible amounts are listed on the Pla*n C Schedule of Benefits* insert to this booklet

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

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

Copayments

When you or a family member go to a Physician's office, you pay a separate Copayment for each Physician office visit (including visits for acupuncture or specialist consultations), before the Plan pays any benefits. The Copayment is a flat dollar amount you are responsible for paying before the Plan begins to pay benefits and is in addition to any coinsurance amounts you are responsible for paying. Copayments do not apply toward meeting your coinsurance limit and you must pay this Copayment even after you have met your coinsurance limit.

> **Plan C Participants**
>
> The Physician Office Visit Copayment only applies to Contract and Out-of-Area Providers and the annual deductible is waived for these services.

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

However, please note that no Copayment is required for:

- Second surgical opinion visits;
- Chemotherapy, radiation therapy, or dialysis;
- Home health care visits;
- Outpatient mental health visits;
- Adult routine physical examinations, well child care visits (including immunizations); or
- X-ray and laboratory services.

> Visit means a personal interview between a Patient and Physician and does not include telephone consultations or other situations where a Patient is not personally examined by a Physician.

Copayment amounts are listed on the *Schedule of Benefits* inserts to this booklet.

Coinsurance

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

Coinsurance Limit

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

For Plan A and Plan B Participants, if your family reaches the family maximum coinsurance limit, 100% of most of your and your eligible Dependents covered medical expenses will be paid for the remainder of the calendar year. For Plan C Participants, there is no family coinsurance limit.

The coinsurance limits are listed on the *Schedule of Benefits* inserts to this booklet.

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

- Covered Expenses that were reimbursed by the Plan at 100%;
- Charges that exceed any Plan maximums or that are not Covered Expenses;
- Physician visit Copayments;
- Charges from Non-Contract Providers within the Contract Provider Area;
- Inpatient and outpatient mental health treatment;
- Chemical dependency treatment; and
- For Plan C Participants only, amounts used to satisfy your deductible.

Lifetime Maximum

While covered under the Plan, all benefits are paid up to the lifetime maximum specified on the *Schedule of Benefits* inserts to this booklet. However, please note that certain benefits have separate lower annual and/or lifetime maximums and may be subject to limitations.

All benefit payments made on behalf of a covered person under the Plan count toward any lifetime maximums, regardless of whether there is a break in coverage. Once you or a Dependent reach a lifetime maximum, no further Plan benefits will be paid.

Preferred Provider Network – BlueCross Prudent Buyer Plan

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

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

Non-Contract Providers have no agreements with the Anthem Blue Cross PPO or the Plan regarding their fees for services or supplies provided. As a result, when you or a Dependent use Non-Contract Providers, the Plan will base its reimbursements on the Customary and Reasonable Charge, as defined by the Plan (see page 25). Non-Contract Providers may bill you for any balance that is not paid by the Plan.

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

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

Exceptions to Non-Contract Provider Coinsurance

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

- Anesthesiologist,
- Assistant surgeon,
- Emergency room Physician
- Radiologist

Out-of-Area Participants

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

Finding Contract Providers

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

- Request a provider directory free of charge from the Fund Office;
- Ask your provider if he/she participates in the Anthem Blue Cross Prudent Buyer PPO network in California (or the BlueCard network if outside California);
- Contact the Fund Office by calling (800) 844-8392 or (510) 433-4422; or
- Visit www.bluecrossca.com for providers in California or www.bluecares.com for providers outside of California.

Continuity of Care

If you receive care from a Contract Provider who subsequently terminates participation in the Anthem Blue Cross PPO network (i.e., becomes a Non-Contract Provider), the Plan may continue to pay certain Covered Expenses from that provider at Contract Provider rates. If you are receiving care from that provider for an acute condition, serious chronic condition, or pregnancy that has reached the second trimester, you may request continuity of care by contacting the Fund Office. If approved, the Plan will continue to pay Contract Provider benefits for services received from that 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.

Professional Review Organization Utilization Review Program

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

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

Generally, the utilization review program includes pre-approval, preadmission reviews, and Concurrent Reviews. Anthem Blue Cross’ professional medical review staff can provide treatment alternatives, pre-approval, and referrals when needed. For example, when your Physician calls Anthem Blue Cross before a non-Emergency Hospital admission, Anthem Blue Cross will evaluate whether a Hospital admission is needed and determine the expected length of stay. Once you are admitted to a Hospital, Anthem Blue Cross monitors your Hospital stay. If additional days are required because of complications or other medical reasons,

your stay will be pre-approved for the appropriate number of additional days of inpatient care. This program does not apply to the length of Hospital confinements related to a mastectomy, childbirth or to other health care services.

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

Plan Requirements for Pre-Authorization	
Situation	**Pre-Authorization Requirement**
Elective, non-emergency hospitalization at an acute-care or convalescent hospital	Anthem Blue Cross must approve the hospital stay **before admission**.
Hospitalization as a result of a medical emergency	You or someone acting on your behalf must contact Anthem Blue Cross **within 24 hours of admission** so that Anthem Blue Cross can approve the hospital stay as soon as possible after admission.
Admission for childbirth	You do not need pre-authorization for a hospital stay for mother and newborn of less than 48 hours following a vaginal delivery or a stay of less than 96 hours following a cesarean section.
Organ or tissue transplant	All planned services must be approved by Anthem Blue Cross **before services begin.**
Treatment for chemical dependency	You must contact the ARP office and be referred to an appropriate authorized treatment program **before seeking treatment.**
Admission to an acute-care hospital for detoxification on an emergency basis	You, your physician, or someone acting on your behalf must contact Anthem Blue Cross **within 24 hours of admission.**

Disease Management Program

Disease Management refers to a health education and self-care promotion program offered at no cost to Participants and their Spouses diagnosed with certain chronic health conditions. The program is managed by Matria Health Care, an independent disease management company whose phone number is listed on the Quick Reference Chart in the front of this SPD. The program is available to Participants and Spouses who have been diagnosed with the following chronic conditions:

- Diabetes;
- Coronary Artery Disease;
- Heart Failure; or
- Chronic Obstructive Pulmonary Disease

The disease management program is a voluntary, telephone-based program that will help you follow your Doctor's treatment plan and avoid complications. It emphasizes techniques for prevention of disease progression and helps you with strategies to improve self-care. While any Participant or Spouse with these diseases can request disease management support and education services by calling CORSolutions/Matria, the company may automatically reach out to some individuals to explain the program in more detail. Participation in the program is voluntary and confidential. You can choose not to participate in the program, or after enrolling, you can stop participating at any time.

If your eligibility under the Trust Fund terminates after enrolling in the program, you may continue to participate for up to 12 months even if eligibility for other Trust Fund benefits is not re-established.

Nurse Connections Hotline

As part of the Disease Management program, a nurse telephone hotline is available to all eligible Participants and Dependents, even if you don't have one of the medical conditions listed above. The Nurse Connections program provides you with access to a registered nurse 24 hours a day, 7 days a week. From general wellness and medical information to triage of urgent medical issues, the nurse will help you make informed medical decisions. This benefit is available at no cost to you and can be accessed by calling Matria Health Care toll free at (866)-676-0740.

Covered Expenses

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

A. ***Hospital inpatient services,*** including well-baby nursery care, are covered with the approval of a Physician, subject to any limits listed on the *Schedule of Benefits* inserts to this booklet (such as being limited to 30 days per calendar year for inpatient mental health treatment). 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.

   In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will 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. The Plan does not require pre-approval for prescribing a Hospital length of stay not in excess of 48 hours for normal delivery or 96 hours for cesarean section.

B. ***Hospital outpatient/Emergency Room services.***

C. ***Licensed ambulatory surgery facility services.***

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

E. ***Diagnostic X-ray and laboratory services, nuclear medicine /imaging services*** when ordered by a Physician.

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

G. ***Acupuncture treatment*** of intractable pain only from a licensed acupuncturist, limited to 1 visit per week and 12 visits per diagnosis. Additional benefits may be covered if pre-approved by the Professional Review Organization.

H. ***Reconstructive surgery*** when required to correct a functional disorder or due to an Injury sustained in an accident. In addition, the Plan provides for certain reconstructive surgery in connection with a mastectomy in accordance with the Women's Health and Cancer Rights Act. If you are receiving benefits under the Plan in connection with a mastectomy and elect breast reconstruction, Covered Expenses include:

   i. Reconstruction of the breast on which the mastectomy was performed;

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

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

I. ***Routine preventive care services,*** which include:

i. *Adult routine physical examination* (for employees, spouses and eligible dependent children age 17 and over), including any related routine diagnostic tests; subject to any limits listed on the *Schedule of Benefits* inserts to this booklet. Please note that no coverage is provided for any physical examination required for employment, an examination for which an employer is required to pay, or for vision examinations covered under the Plan's Vision Benefits.

ii. *Immunizations.*

iii. *Mammography screening,* which is covered the same as diagnostic X-ray and laboratory services, in accordance with the following schedule for women with no symptoms or history of breast cancer:

   a. Ages 35 through 39, one baseline mammogram.

   b. Ages 40 through 49, one mammogram every two years, or more frequently if recommended by a Physician.

   c. Age 50 and over, one mammogram every year.

iv. *Well-child care* for children age 16 and younger in accordance with the American Academy of Pediatrics guidelines, including routine physical examinations, related laboratory services, and immunizations.

J. ***Home health care,*** including ***hospice care,*** provided and billed by a licensed Home Health Agency; limited to 1 visit per day per provider, up to 60 visits total per calendar year. Covered Services include visits by a registered nurse, medical social worker, occupational, speech, and physical therapists, and health aides. Please note that housekeeping services are not covered.

K. ***Skilled Nursing Facility***, limited to 180 days per calendar year. Admission to a skilled nursing facility must begin within 14 days of discharge from a covered inpatient stay in an acute care hospital.

L. ***Outpatient Mental Illness treatment*** for outpatient treatment or services provided by a Physician, psychologist, or licensed clinical social worker limited to 1 visit per week up to a maximum of 50 visits per calendar year.

M. ***Ambulance transportation*** for medically necessary transportation by local ground ambulance to and from a Hospital. In the case of an Emergency where land transportation would be hazardous to the Patient's health, coverage is provided for transportation by air ambulance to the nearest Hospital where Medically Necessary treatment can be provided.

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

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

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

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

R. ***Prosthetic or artificial devices*** that replace all or part of a bodily organ or that improve the function of an impaired body organ or part, including intraocular lens implants placed after cataract surgery and purchase of initial and subsequent prosthetic devices necessary to restore a method of speaking following a laryngectomy. The initial replacement of natural eyes and limbs and replacement of the artificial eyes or limbs are covered only if prescribed by a Physician.

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

i. Ordered by a Physician;

ii. Of no further use when medical need ends;

iii. Usable only by the Patient;

iv. Not primarily for the comfort of the Patient;

v. Not for environmental control;

vi. Not for exercise;

vii. Manufactured specifically for medical use;

viii. Approved as effective and Customary and Reasonable treatment of a medical condition as determined by the Fund; and

ix. Not for preventive purposes.

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

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

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

U. ***Chiropractic and physical therapy services*** of a licensed Chiropractor, Registered Physical Therapist, or for physical therapy treatment provided by a Physician limited to a combined maximum of 40 visits per calendar year for all chiropractic and physical therapy services.

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

i. Speech therapy benefits are provided only for Eligible Individuals who had normal speech at one time but lost it due to Illness or Injury.

ii. Benefits for speech therapy provided for any condition other than those specified above are limited to $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.

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

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

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

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

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

Z. ***Organ and tissue transplants.*** Customary and Reasonable Charges incurred by the organ donor and the organ recipient when the organ recipient is an Eligible Individual are Covered Expenses. Covered Expenses in connection with the organ transplant include Patient screening, organ procurement and transportation of the organ, surgery, and Hospital charges for the recipient and donor, follow-up care in the home or a Hospital, and immunosuppressant Drugs, provided the:

i. Transplantation is not considered Experimental or Investigational;

ii. Patient is admitted to a transplant center program in a major medical center approved by either the federal government or the appropriate state agency of the state in which the center is located;

iii. Services are pre-approved by the Anthem Blue Cross utilization review program;

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

In no case will the Plan cover expenses related to a donor search or organ match or for transportation of the donor, surgeons, or family members.

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (see page 45), Comprehensive Medical Benefits are not paid for the following expenses.

1. Services furnished by a naturopath or any other provider not meeting the Plan's definition of a Physician, except as specifically provided otherwise by the Plan.

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

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

4. Hyperkinetic syndromes, learning disabilities, behavioral problems, developmental delay, attention deficit disorders, mental retardation, or autistic disease, except that the exclusion of developmental delay does not apply to the Plan's covered speech therapy benefits provided to a Dependent child who has failed to attain appropriate speech.

5. Radial keratotomy, photorefractive keratectomy (PRK), laser in-situ keratomileusis (LASIK), or any other refractive eye surgery. Eye refractions, eyeglasses, contact lenses (except for intraocular lens implants placed after cataract surgery).

6. Vision therapy, vision training, and orthoptics.

7. Cosmetic surgery or treatment, or any services for beautification, except as specifically provided otherwise by the Plan.

8. In vitro fertilization, artificial insemination, surrogate pregnancy, or any other infertility related services.

9. Services to reverse voluntary, surgically induced infertility.

10. Educational services, nutritional counseling, food supplements, or substitutes (except that the initial Diabetes instruction visit is covered).

11. Services or supplies that are primarily for weight loss, health club memberships, spas, and exercise and physical fitness programs or equipment.

12. Hypnotism, stress management, biofeedback, and any goal oriented behavior modification therapy, such as to quit smoking, lose weight, or control pain.

13. A Dependent daughter's pregnancy, maternity care, or abortion, except for complications of pregnancy.

14. Orthopedic shoes (except when they are joined to a leg brace), shoe inserts, and foot orthotics, except as specifically provided otherwise.

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

16. Chemical dependency treatment, except while Hospital confined for acute care of detoxification. (See page 29 for the Plan's coverage of chemical dependency).

17. Expenses for transportation, except as provided under the Plan's ambulance transportation benefits.

18. Sex changes, care, services, or treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change, including any related medications, implants, hormone therapy, surgery, medical, or psychiatric treatment.

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

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

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

22. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 45.

Prescription Drug Benefits

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

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

When you need a medication for a short time—an antibiotic, for example—it is best to choose the retail pharmacy program. If you are taking a medication on a long-term basis, it is usually best to have it filled through the mail order program.

Generic Versus Brand Name Medications

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

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

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

Retail Pharmacy Program

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

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

You may only have your prescription filled at a retail pharmacy for up to a maximum of a 34-day supply. Please note that prescriptions filled at a non-participating retail pharmacy are covered under the Plan; however, you will have to pay the full cost of your prescription when you have it filled and then submit a claim for reimbursement to Caremark. Caremark will reimburse you based on the amount the Fund would have paid if the Drug were purchased at a Contract Pharmacy, and you will be responsible for any remaining charges.

> **Finding a Contract Pharmacy**
> Most of the major retail pharmacies are in the pharmacy network. The list of contract pharmacies is updated periodically and is provided to you without charge. If you are not sure you have the most recent list, call Caremark at (888) 790-4258 to locate the nearest contract pharmacy. You can also call the Trust Fund Office.

Mail Service Program

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

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

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

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

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

Specialty Pharmacy Services

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

For mail service questions, call Caremark at (888) 790-4258.

For Specialty Pharmacy Services, call Caremark Connect at (800) 237-2767.

Covered Expenses

Your copayments for prescription drug benefits are listed on the *Schedule of Benefits* inserts to this booklet.

The Plan covers the following Prescription Drug Benefits:

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

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

C. Charges made by a Licensed Pharmacist for oral contraceptives. For Plan C Participants, oral contraceptives are only covered 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 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 and therapeutic vitamins prescribed by a Physician for the treatment of a specific Illness or Injury.

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

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

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

iii. The Drug must not be for immunization.

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

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (see page 45), Prescription Drug Benefits are not paid for the following expenses.

1. Drugs administered while the Patient is confined in a Hospital or Skilled Nursing Facility.
2. Patent or proprietary medicines that do not require a Physician's prescription by federal law, regardless of whether a state law mandates dispensing only with a prescription, except insulin, diabetic supplies, and those items specifically listed as covered by the Plan.
3. Drugs:
    a. Not Medically Necessary for the care or treatment of an Illness or Injury (except for oral contraceptives);
    b. With no approved Federal Drug Administration indications; and
    c. Used for Experimental indications and/or dosage regimens determined to be Experimental or Investigational.
4. Medications prescribed for cosmetic purposes (e.g. Retin-A for other than acne or Rogaine/Minoxidil for hair loss).
5. Appetite suppressants or any other weight loss Drugs.
6. Smoking cessation medications.
7. Drugs or devices prescribed for treatment of sexual dysfunction, except when due to a medical condition as certified by your Physician.
8. Drugs prescribed for treatment of infertility.
9. Contraceptives other than oral contraceptives. For Plan C Participants, any contraceptives for Dependent daughters.
10. Immunization agents.
11. Appliances, devices, and other supplies or equipment, except for diabetic supplies.
12. Non-therapeutic and multiple vitamins, nutritional supplements, and health and beauty aids.
13. Charges for prescription Drugs in excess of a 34-day supply for retail purchase or 90-day supply for mail order program purchase.
14. Drugs covered under workers' compensation laws or similar legislation or prescribed to treat an occupational Illness or Injury.

15. Drugs provided by or paid for by any governmental program (federal, state, county, or municipal).
16. Replacement prescription Drugs resulting from loss, theft or breakage.
17. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 45.

Chemical Dependency Treatment Benefits

Plan provides Chemical Dependency Treatment Benefits through the Operating Engineers Assistance Recovery Program (ARP). **Treatment must be pre-approved by the ARP to be covered under the Plan.** These benefits are subject to the Comprehensive Medical Plan lifetime maximum.

Schedule of Benefits

Chemical Dependency Treatment Benefits	Coverage
Inpatient Residential Treatment Coinsurance First Admission Second Admission Program Maximum Lifetime Program Maximum	 Plan pays: 100%[1] 80%[1] 30 days per treatment 2 programs
Outpatient Treatment Coinsurance Maximums	 Plan pays 80%[1] $2,000 per calendar year 50 visits per calendar year
Recovery Home Treatment Coinsurance Calendar Year maximum Lifetime Maximum	 Plan pays lesser of $20 per day or actual charges[1] 30 days 60 days

[1] Plan C participants, you must meet the Comprehensive Medical Benefits annual deductible before the Plan begins paying benefits.

Covered Expenses

Covered Expenses include:

A. **Inpatient residential treatment,** paid as shown and up to the limits listed on the *Schedule of Benefits*.

B. **Outpatient treatment,** paid as shown and up to the limits listed on the *Schedule of Benefits*.

C. **Recovery home treatment,** up to the lesser of $20 per day or actual charges incurred for up to 30 days per calendar year for residential treatment in an approved recovery home (halfway or three-quarter way home) following confinement in an ARP approved inpatient facility. Plan benefits are limited to an overall lifetime maximum of 60 days per person.

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (see page 45), Chemical Dependency Treatment Benefits are not paid for the following expenses.

1. Any treatment that has not been pre-approved by the Assistance Recovery Program and provided by a facility or provider approved by the Assistance Recovery Program.

2. More than the Plan's inpatient treatment program lifetime maximum.

3. More than the Plan's outpatient visits calendar year maximum.

4. More than the Plan's recovery home treatment calendar year or lifetime maximum.

5. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 45.

Hearing Aid Benefits

Hearing Aid Benefits are available to all Eligible Individuals covered under the Plan, including Participants enrolled in the HMO plan. These benefits are subject to the Comprehensive Medical Plan lifetime maximum.

Schedule of Benefits

Hearing Aid Benefits	Coverage
Hearing Examination and Testing	Plan pays 80% of Customary and Reasonable Charges[1]
Hearing Aid	Plan pays 80% of Customary and Reasonable Charges[1]
Maximum Benefit	$450 per ear

[1] Plan C participants, you must meet the Comprehensive Medical Benefits annual deductible before the Plan begins paying benefits.

Covered Expenses

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

A. Hearing examination and testing.

B. Hearing aid(s).

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (see page 45), Hearing Aid Benefits are not paid for the following expenses.

1. More than one hearing aid for each ear.
2. The replacement of a hearing aid for any reason more often than once during any three-year period.
3. Batteries or any other ancillary equipment other than those obtained upon the purchase of the hearing aid.
4. Expenses incurred for which the individual is not required to pay.
5. Repairs, servicing, or alterations of a hearing aid more often than once during any three-year period.
6. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 45.

Dental Benefits

Dental Benefits help you manage the amount you pay for dental treatment. Effective July 1, 2008 Dental Benefits are provided under an insurance contract between the Trust Fund and Delta Dental of California (Delta Dental). The plan is the Delta Dental PPO, a preferred provider organization (PPO) program that provides access to PPO dentists nationwide.

Choice of Dentists / Provider Network

Under the Delta Dental PPO Plan, you are free to use any licensed dentist for treatment, but it is to your advantage to use a Delta Dental Dentist because his or her fees are approved in advance by Delta Dental. Nearly 27,000 dentists in California are Delta Dental Dentists that participate in the Delta Premier network. About 16,000 of these Delta Dental Dentists are also Delta Dental PPO Dentists.

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

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

Schedule of Benefits

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

Dental Benefits	In-PPO Network	Out-of-PPO Network
Deductible	None	None
Diagnostic and Preventive Benefits	Plan pays 100%	Plan pays 100%
Basic Benefits	Plan pays 85%	Plan pays 85%
Restoration Benefits	Plan pays 85%	Plan pays 85%
Prosthodontic Benefits	Plan pays 60%	Plan pays 60%
Calendar Year Maximum	$2,500 per person	

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

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

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

Covered Dental Expenses

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

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

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

Covered dental expenses include:

A. Diagnostic and Preventive benefits, such as:

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

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

B. Basic benefits, such as:

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

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

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

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

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

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

D. Prosthodontic benefits, such as procedures for construction or repair of fixed bridges, partial dentures and complete dentures if provided to replace missing natural teeth. Benefits are payable for Implant surgical placement and removal and for implant supported prosthetics, including implant repair and re-cementation.

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

Advantages to Using a Delta Dental PPO Dentist

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

Finding a Delta Dentist: Call 800-765-6003 for a list of Delta Dental PPO Dentists and Delta Dental Premier Dentists.

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

- **Delta Dental Dentists (Premier Network).** While Premier Dentists' contract fees are often slightly higher than PPO Dentists' fees, Premier network Dentists may not balance bill above Delta Dental's approved amount, so your out of pocket costs may be lower than with a non-Delta Dentist. Delta Dental Dentists charge you only the patient's share at the time of treatment and will submit claim forms for you at no charge.
- **Non-Delta Dental Dentists.** You are responsible for the difference between the amount Delta Dental pays and the amount the non-Delta Dentist bills. Non-Delta Dental Dentists may require you to pay the entire amount of the bill and wait for reimbursement. You may have to complete and submit your own claim forms or pay your non-Delta Dental Dentist a fee to submit them for you.

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

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

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

Limitations

Dental Benefits are limited for the following expenses.

1. Bitewing X-rays are covered twice per calendar year. Full mouth X-rays are limited to once every three years.
2. Prophylaxis (cleaning) is limited to two treatments in a calendar year. Routine prophylaxes are covered as a Diagnostic and Preventive benefit and periodontal prophylaxes are covered as a Basic benefit. A third cleaning is covered for pregnant women; see Note on additional benefits during pregnancy.
3. Fluoride treatments are covered twice each calendar year.
4. Only the first two oral examinations in a calendar year, including office visits for observation and specialist consultations, or any combination of these, are benefits while you are eligible under any Delta Dental plan. See Note on additional benefits during pregnancy.
5. Sealant benefits include the application of sealants only to permanent first molars through age 8 and second molars through age 15 if they are without caries (decay), or restorations on the occlusal surface. Sealant benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.
6. Direct composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspids. Any other posterior or direct composite (resin) restorations are optional services and the plan's payment is limited to the cost of the equivalent amalgam restoration.
7. Periodontal scaling and root planning is covered once for each quadrant each 24-month period. See Note on additional benefits during pregnancy.
8. Crowns, inlays, onlays, and cast restorations are covered on the same tooth only once every five years while you are eligible under the Delta Dental plan or the prior Trust Fund plan, unless Delta determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the placement of the restoration.
9. Prosthodontic appliances and implants (including fixed bridges and partial or complete dentures) are covered only once every five years, while you are eligible under this Delta Dental plan or the prior Trust Fund plan, unless Delta determines there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of an implant, a prosthetic appliance or an implant supported prosthesis you received under another plan will be covered if Delta determines it is unsatisfactory and cannot be made satisfactory.

10. The Plan pays the applicable percentage of the Dentist's fee for a standard partial or complete denture. A standard partial or complete denture is one made from accepted materials and by conventional methods.

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

Exclusions

In addition to any general Plan exclusions and limitations (see page 45), Dental Benefits are not paid for the following expenses:

1. Expense incurred for missed appointments.

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

3. Orthodontic services, except as otherwise specified beginning on page 45.

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

5. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, and teeth that are discolored or lacking enamel.

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

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

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

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

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

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

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

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

14. Intraveneous sedation.

15. Complete occlusal adjustment.

16. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 45.

Predetermination of Benefits

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If your proposed dental treatment is extensive and involves crowns or bridges, or if the service will cost more than $300, it is recommended that you ask your Dentist to request a predetermination from Delta Dental. To receive a predetermination, your Dentist must send a claim form listing the proposed treatment. Delta Dental will send your Dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your Dentist and decide to go ahead with the treatment plan, your Dentist returns the form to Delta for payment when the treatment has been completed.

A predetermination does not guarantee payment. It is an estimate of the amount the plan will pay if your are eligible at the time the treatment you have planned is completed.

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

Dental Services Covered Under Medical Plan

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

How to File a Claim for Dental Benefits

- Delta PPO Dentist and Delta Premier Dentist – The Dentist will file your claim for you.
- Non-Delta Dental Dentist – Claims for services from non-Delta Dental Dentists may be sent to:

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

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

Orthodontic Benefits

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

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

Note: Come collective bargaining agreements may provide for adult orthodontic benefits. The Orthodontic Schedule of Benefits insert in the back of this SPD indicates your coverage.

If orthodontic treatment began before July 1, 2008, send your claim to the Trust Fund office and not to Delta Dental.

Schedule of Benefits

Orthodontic Benefits	Coverage
Deductible	None
Coinsurance	Plan pays 50% of Customary and Reasonable Charges
Lifetime Maximum	$2,500 per person

Covered Expenses

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

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

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

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (see page 45), and the Dental Benefits exclusions and limitations listed in the previous section, Orthodontic Benefits are not paid for the following expenses.

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

2. Orthodontic treatment for the Employee or Spouse unless the Employer's collective bargaining agreement provides for adult orthodontic benefits.

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

4. Any services not provided by a Dentist.

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

6. Any general Plan exclusions, limitations, or reductions, as listed beginning on page 45.

How to File a Claim for Orthodontic Benefits

- Delta PPO Dentist and Delta Premier Dentist: The Dentist will file your claim for you.
- Non-Delta Dental Dentist: Claims for services from non-Delta Dental Dentists may be sent to:

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

Vision Benefits

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

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

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

How the Plan Works

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

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

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

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

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

The Copayment

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

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

Schedule of Benefits

Vision Benefits	VSP Providers	Non-VSP Providers
Copayment	$7.50	$7.50
Vision Examination – Limited to once every 12 months	Plan pays 100%	Plan pays up to $37 per exam
Lenses – Limited to once every 12 months Single Vision Bifocal Trifocal Lenticular Tints Frames – Limited to once every 24 months	Plan pays 100% up to network provider scheduled allowances Up to $105 allowance for frames	Plan pays up to: $34 $51 $68 $100 $ 5 $40
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays 75% of network provider scheduled allowances with pre-approval	Plan pays up to $126
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to $100 for contact lenses and fitting, (exam covered in full)	Plan pays up to $100 for exam and lenses

Covered Vision Expenses

Covered Expenses include:

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

B. Lenses, once every 12 months.

C. Frames, once every 24 months if replacement is necessary. VSP offers a wide selection of frames within Plan limits. If more expensive frames are chosen (exceeding Plan limits), you will be responsible for the additional amount over the Plan's maximum.

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

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

Low Vision Benefit

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

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

B. Supplemental care, which includes subsequent low vision aids. The Plan pays 50% when provided by a VSP provider or non-VSP provider.

Low Vision Benefits are limited to $500 per person every two years.

Exclusions and Limitations

In addition to any general Plan exclusions and limitations (see page 45), Vision Benefits are not paid for the following expenses.

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

1. The Plan will pay the basic cost of allowed lenses, and you must pay any additional cost when you select any of the following extra items:
    a. Blended lenses.
    b. Oversize lenses.
    c. Progressive lenses.
    d. The coating of the lens or lenses.
    e. The laminating of the lens or lenses.
    f. A frame that costs more than the Plan allowance.
    g. Certain limitations on low vision care.
    h. Cosmetic lenses.
    i. Optional cosmetic processes.
    j. UV (ultraviolet) protected lenses.
2. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± 0.50 diopter power); or two pair of glasses in lieu of bifocals.
3. Replacement of lenses and frames that are lost or broken, except at the normal intervals when services are otherwise available.
4. Medical or surgical treatment of the eyes, including any refractive vision surgery.
5. Corrective vision treatment of an Experimental nature.

How to File a Claim

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

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

Vision Service Plan

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

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

Burial Expense Benefit

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

In the event of your death as an eligible Active Participant, the Plan will pay a benefit of $2,500 to your designated beneficiary to help pay for funeral expenses. Please note that certain Collective Bargaining Agreements may provide for a higher burial expense benefit. Contact the Fund Office to determine your benefit amount.

Retired Participants are not eligible for the Burial Expense Benefit.

Beneficiary Designation

To designate or update your beneficiary(ies), you need to complete a beneficiary designation form. This form is available from the Union. You may designate anyone as your beneficiary. If you do not designate a beneficiary or if your beneficiary pre-deceases you, the benefit will be paid to your:

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

How to file a Claim for Burial Expense Benefits

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

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

General Plan Exclusions and Limitations

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

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

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

1. Any amounts in excess of Customary and Reasonable Charges or any services not considered to be customary and reasonable.

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

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

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

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

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

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

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

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

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

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

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

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

6. Conditions caused by self-inflicted injuries or suicide attempts unless due to an underlying medical (physical or mental) condition.

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

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

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

10. Any services or supplies in connection with Experimental or Investigational procedures (see page 74 for a definition of Experimental or Investigational).

Claims and Appeals

Filing a claim is easy if you follow the steps described in this section. If a claim is denied or reduced, there is a process you can follow to have your claim reviewed (see page 56). Throughout this section, "you" and "your" may refer to you, your Dependent(s), and/or your authorized representative, as applicable.

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

Filing Claims

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

Dental. Orthodontic and Vision Claims

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

> No claim forms are required for prescription Drugs if you use a network pharmacy or the mail order program. Non-network pharmacy claims may be sent to Caremark with a claim form and the original prescription receipts. You can print a claim form when you log on to Caremark.com or call Caremark Customer Care at 1-888-790-4258

Chemical Dependency and Burial Expense Benefit Claims

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

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

Medical and Hearing Aid Claims

If you need to file a medical or hearing aid claim, you should:

- Obtain the appropriate claim form from the Fund Office or your local Union office; forms supplied by Hospitals and Physicians are usually acceptable substitutes for claim processing.
- Complete your portion of the form.
- Have the provider of services complete the rest of the form.
- Completed forms and any attachments (such as bills or statements) should be submitted as soon as you receive them. Itemized bills, showing the date of service, charge, and description for ***each*** service will be accepted. Mail to:

  Anthem Blue Cross Prudent Buyer Plan
  P.O. Box 60007
  Los Angeles, California 90060-0007

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

Note: Contract providers will usually send your claims to Anthem Blue Cross.

Complete information is required when submitting a claim. If you use a provider's form, you must be sure that the following information is included:

- Participant or Retiree name;
- Patient name;
- Patient's date of birth;
- Social Security or other identification number of Participant or Retiree;
- Date of service;
- Information on other insurance coverage, if any, including coverage that may be available to Participant's Spouse through his or her employer;
- If treatment is due to an accident, accident details;
- 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;
- 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);
- Number of units (for anesthesia and certain other claims);
- Billed charge (bills must be itemized with all dates of Physician visits shown);
- Federal taxpayer identification number (TIN) of the provider; and
- Provider's billing name, address, and phone number.

What is Not a Claim. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered 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.

Types of Claims

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

- ***Urgent Care*** is a claim for medical care or treatment, with respect to which a delay of up to 15 days in making decisions under the Pre-Service Claim procedures, would:
  - Seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or
  - Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.
- ***Pre-Service*** is a claim for benefits where pre-approval is required before you obtain care (see page 55 for information on when approval is required). However, the Plan will not deny benefits for these claims if it is not possible for you to obtain pre-approval or if the process would jeopardize your life or health.
- ***Concurrent Care*** is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of a Hospital stay) and the reconsideration results in reduced benefits or a termination of benefits.
- ***Post-Service*** is a claim for benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services for which the claim is being submitted.

Urgent care claims are considered pre-service claims.

Burial Expense Benefit claims are one other type of claim under the Plan.

Claim Decisions

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

- **Health Care Claims (except Dental and Orthodontic claims).** Generally, health care determinations will be made as soon as administratively possible, as follows:
  - ***Urgent Care Claims.*** The Plan will notify you of its determination within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 48 hours to respond. The Plan will notify you of its determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.

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

  - ***Pre-Service Claims.*** The Plan will notify you of its initial determination within 15 days from receipt of your claim. If additional time is necessary, up to 15 additional days, due to matters beyond the control of the Plan, you will be informed of the extension within this 15-day deadline. If additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will notify you of its determination within 15 days.

If you do not follow the required procedures for filing a pre-service claim, the Plan will notify you within five days of receipt of the claim.

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

    If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved.
  - ***Post-Service Claims.*** The Plan will notify you of its initial determination within 30 days from receipt of your claim. If additional time is necessary, due to matters beyond the control of the Plan, you will be informed of the extension within this 30-day deadline. If additional information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will notify you of its determination within 15 days.
- **Burial Expense Benefit Claims.** Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this 90-day deadline. The Plan may extend this 90-day period up to an additional 90 days maximum.

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

Payment in Event of Incompetency or Lack of Address

In the event the Fund determines that an Eligible Individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Individual has not provided the Fund with an address at which he or she can be located for payment, the Fund may during the lifetime of the Eligible

Individual, pay any amount otherwise payable to the Eligible Individual to the Spouse or blood relative of the Eligible Individual, or to any other person or institution determined by the Fund to be equitably entitled to payment. In the case of the death of the Eligible Individual before all amounts payable under the Plan have been paid, the Fund may pay this amount to any person or institution determined by the Fund to be equitably entitled to payment. The remainder of any amount owing will be paid to the Eligible Individual's Spouse, child(ren), parent(s), sibling(s), or estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision discharges the Fund from any further obligation.

If a Claim is Denied

If your claim is denied (in whole or in part), you will be notified. When the Plan notifies you of its initial denial on your claim, the written notice will provide:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim, including:
  - A description of the expedited review process of urgent care claims, if applicable; and
  - A statement that you may bring a lawsuit under ERISA following the appeal and review of your claim; and
- If your claim is denied based on:
  - Any rule, guideline, protocol or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
  - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.

Appealing a Denied Claim

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

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

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

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

- 180 days from the date of a decision for health care claims; or
- 60 days from the date of a decision for Burial Expense Benefit claims.

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

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

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

When filing an appeal you may:

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

Appeal Decisions

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

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

Appeal Decision Timeframes

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

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

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

Information Requirements

When the Plan notifies you of an adverse determination on your appeal, it will provide:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A statement that you have a right to bring a civil action under §502(a) of ERISA; and
- If your claim is denied based on:
  - Any rule, guideline, protocol or similar criteria, a statement that a copy of the information is available to you at no cost upon request;
  - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request; or
  - A statement that you have a right to receive, upon request and free of charge, reasonable access to, or copies of, all documents, records, or other information relevant to your claim.

Medical Judgments

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

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

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

Physical Examination and Autopsy

The Fund, at its own expense, has the right to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to request an autopsy in case of death where it is not forbidden by law.

Authorized Representative

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

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

- Health care provider;
- Dependent child age 18 or older;
- Parents or adult siblings;
- Grandparent;

- Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or
- Other adult.

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

Following an Appeal

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

The Plan's claims and appeals provisions apply to and include any and every benefits claim from the Fund and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, when the act or omission upon which the claim is based occurred, or whether or not the claimant is a Participant or beneficiary of the Plan within the meaning of those terms as defined in ERISA. Claims are limited to benefits due under the terms of the Plan or to clarify rights to future benefits under the terms of the Plan, and do not include any claim or right to damages, either compensatory or punitive.

Third Party Liability

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

- The Fund shall be reimbursed first, before any other claims, for 100% of this advance or loan from any recovery received by way of judgment, arbitration award, verdict, settlement or other source by the Eligible Individual or by any other person or party for the Eligible Individual, pursuant to such Illness, Injury, disease or other condition, including recovery from any under-insured or uninsured motorist coverage or other insurance, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. The Fund will be reimbursed from said recovery without any deduction for legal fees incurred or paid by the Eligible Individual. The Eligible Individual promises not to waive or impair any of the rights of the Fund without written consent. In addition, the Fund shall be reimbursed for any legal fees incurred or paid by the Fund to secure reimbursement of the advance or loan.
- If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund will also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien will be satisfied from any recovery received by the Eligible Individual, however classified, allocated, or held.
- If reimbursement is not made as specified, the Fund, at its sole option, may take any legal and/or equitable action to recover the amount that was paid for the Eligible Individual's Illness, Injury, disease or other condition (including any legal expenses incurred or paid by the Fund) and/or may offset future benefits

payments by the amount of such reimbursement (including any legal fees incurred or paid by the Fund). The Fund, at its sole option, may cease advancing benefits, if there is a reasonable basis to determine that the Eligible Individual will not honor the terms of the Plan, or there is a reasonable basis to determine that this section is not enforceable.

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

- To prosecute any claim for damages diligently;
- To promptly advise the Fund whenever a claim is made against the responsible third party with respect to any loss for which Fund benefits have been or will be paid because of an Illness, Injury, disease or other condition caused by the responsible third party;
- The Fund's reimbursement rights will be considered as a first priority claim against another person or entity, to be reimbursed before any other claims, including claims for general damages;
- To cooperate and assist the Fund in obtaining reimbursement for payments made, and to refrain from any act or omission that might hinder any reimbursement;
- To provide the Fund with all relevant information or documents requested;
- To consent to the lien and/or constructive trust that will exist in favor of the Fund upon all funds recovered by the Eligible Individual against the responsible third party;
- To hold proceeds of any settlement, verdict, judgment or other recovery in trust for the benefit of the Fund, and that the Fund will be entitled to recover reasonable attorney's fees incurred in collecting reimbursement of benefits due;
- To execute any documents necessary to secure reimbursement;
- Not to assign any rights or cause of action that the Eligible Individual may have against the responsible third party to recover medical expenses without the express written consent of the Fund;
- The Fund has the right to intervene, independently of the Eligible Individual, in any legal action brought against the third party or any insurance company, including the Eligible Individual's own carrier for uninsured motorists coverage;
- The Fund's right of first reimbursement will not be affected, reduced or eliminated by the make whole doctrine, comparative fault or regulatory diligence or the common fund doctrine;
- It will constitute an immediate breach of the agreement and a failure to comply with the terms of the Plan, if, within 30 days following recovery from the responsible third party or insurer, the Eligible Individual does not agree to reimburse the Fund pursuant to this Third Party Liability provision, and pay the reimbursement amount. If the Eligible Individual breaches the agreement and/or fails to comply with this Third Party Liability provision, the amount of benefits advanced by the Fund which are related to the Injury, Illness, disease or other condition will become immediately due and payable together with interest, and all costs of collection, including reasonable attorney fees and court costs.

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

Offset and Recoupment of Overpayments

If through mistake or any other circumstance, you, as an Eligible Individual, have been paid or credited with more than you are entitled to under the Plan, under the law, or have become obligated to the Fund under an indemnity agreement or a third party liability agreement or in any other way, the Fund may set off, recoup, and recover the amount of the overpayment, excess credit, or obligation from benefits accrued or thereafter accruing to you, your

Dependent, or your beneficiary, and not yet distributed, in any installments and to the extent determined by the Board.

Privacy Policy

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

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

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

Your rights under HIPAA include the right to:

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

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

Coordination of Benefits with Other Plans

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

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

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

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

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

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

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

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

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

Allowable Expense

For Coordination of Benefits purposes, 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 you. An expense, service, or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense. When Non-Contract Providers are used, Allowable Expense will not exceed the Customary and Reasonable Charge that is covered in whole or in part by any of the plans covering you.

Coordination with Prepaid Plans

Regardless of whether this Plan is considered primary or secondary under the Plan's coordination of benefits provisions, this Plan will only reimburse the Copayments you, as an Eligible Individual, are required to pay under a pre-paid plan, and then only if the Copayments are required of every person covered by that program if you:

- Have coverage under the indemnity portion of this Plan;
- Have coverage under a prepaid program under another Group Plan (regardless of whether you must pay a portion of the premium for that plan); and
- Incur expenses normally covered under the prepaid program.

Except for the Copayments specified above, the Plan will not pay expenses covered by prepaid programs of other plans.

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

Coordination with Preferred Provider Plans

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

- Lesser of the:
  - Normal charges billed for the expenses by the provider; or
  - Contractual rate for the expense under a preferred provider agreement between the provider and the plan that this Plan is coordinating with; and
- Amount that the other plan pays as primary.

Coordination with Medicare

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

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

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

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

Medicare Private Contract: Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain health care providers under which the participant agrees that no claim will be submitted to or paid by Medicare for services and supplies furnished by that provider. If you are a Retired Employee or the Dependent of a Retired Employee and you enter into such a contract, this Plan will pay benefits for health care services and supplies you

receive under that contract, but those benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, Medical Necessity, Customary and Reasonable Charges, and the Plan will pay only 20% of the Covered Expenses, and you are responsible for the rest.

Medicare Prescription Drug Coverage. It has been determined that the prescription drug coverage outlined in this SPD is creditable. "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare.

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

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

- You can keep your current prescription drug coverage with the Fund and not enroll for Medicare Prescription Drug Coverage. In the future, you may enroll in Medicare Prescription Drug Coverage during Medicare's annual enrollment period (November 15 to December 31 of each year) and you will not be charged a penalty.
- You can keep your current prescription drug coverage with the Fund and enroll for Medicare Prescription Drug Coverage. If you enroll for Medicare Prescription Drug Coverage, the Fund's prescription drug coverage will be secondary to Medicare and you will need to pay any Medicare premium out of your own pocket.
- You can drop your prescription drug coverage with the Fund and enroll for Medicare Prescription Drug Coverage on your own. If you enroll for Medicare Prescription Drug Coverage, you can keep your medical coverage with the Fund. You will **not** be able to re-enroll in the Fund's prescription drug coverage in the future and you will need to pay any Medicare premium out of your own pocket.

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

Coordination with Other Government Programs

Medicaid: If you are covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second. Payments by this Plan for benefits with respect to you, as an Eligible Individual, will be made in compliance with any assignment of rights made by you or on your behalf, as required by California's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

Where payment has been made by state Medicaid for 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 that provides that the state has acquired the rights with respect to payment for assistance, provided that the claim is filed by the state within the Plan's filing limits.

TRICARE: If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an Employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

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

Motor Vehicle Coverage Required by Law: If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second.

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

Plan Information

Administrative Information

Plan Name

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

Employer Identification Number

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

Plan Number

The Plan Number is 501.

Plan Administrator and Plan Sponsor

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

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

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

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

Associated Third Party Administrators
1640 South Loop Road
Alameda, California 94502
(510) 433-4422

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

Union Trustees

Russell E. Burns, Chairman
Operating Engineers Local 3
3920 Lennane Drive
Sacramento, California 95834

Carl Carey
Operating Engineers Local 3
1620 S. Loop Road
Alameda, California 94502

Don Dietrich
Operating Engineers Local 3
3920 Lennane Drive
Sacramento, California 05834

Employer Trustees

Austris Rungis, Co-Chairman
IEDA
2200 Powell Street
Emeryville, California 94608

Deborah McHenry
Human Resources Director
City of Antioch
City Hall, Third and "H" Street
Antioch, California 94531

Agent for Service of Legal Process

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

Plan Year

The end of the Plan Year is December 31.

Plan Type

The Plan is maintained for the purpose of providing Comprehensive Medical, Chemical Dependency Treatment, Hearing Aid, Prescription Drug, Dental, Orthodontic, Vision, and Burial Expense Benefits for Participants and their eligible Dependents who meet the eligibility requirements, as described in this booklet.

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

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

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

Plan Funding

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

obtain, upon written request to the Fund Office, information as to the name and address of a particular Employer and whether an Employer is required to pay contributions to the Plan.

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

Eligibility Requirements

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

Assignment of Benefits

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

Legal Document

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

Plan Amendment and Termination

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

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

Your ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information about your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (You or your Dependents may have to pay for such coverage; review this Summary Plan Description and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.); and
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA Continuation Coverage; or
  - Your COBRA Continuation Coverage ends.

  You may also request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you

up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA at:

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

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

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

Definitions

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

Active Employee or Active Participant
For Plan A, Plan B and Plan C, any employee of a Contributing Employer for whom the Contributing Employer makes contributions to the Fund and who otherwise satisfies the Plan's eligibility requirements.

Board
The Board of Trustees established by the Trust Agreement.

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

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

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

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

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

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

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

Contributing Employer or Employer
An employer who is required by a Collective Bargaining Agreement with the Union or a Subscriber'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.

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

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

Covered Expense(s) or Covered Service(s)
Those charges that are Customary and Reasonable or that are the negotiated charge from a Contract Provider and that are made for the Medically Necessary care and treatment of a non-occupational Illness or Injury (except as specifically provided by the Plan, such as Preventive Care Benefits. Covered Expenses and Covered Services also means only those charges incurred by a Participant or Dependent while eligible for benefits under this Plan.

Customary and Reasonable Charge(s)
A charge that:

- Falls within the common range of fees billed by a majority of health care providers for a procedure, service, or supply in a given geographic region; or
- Is justified based on the complexity or the severity of treatment for a specific case, as determined by Anthem Blue Cross.

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

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

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

- Lawful Spouse (or Domestic Partner if qualified under the rules of the Plan).
- Unmarried natural or legally adopted children younger than age 23. Legally adopted children are eligible when they are placed for adoption. Placed for adoption means the assumption and retention by a Participant of the legal duty for total or partial support of a child to be adopted.
- Unmarried stepchildren or children for whom the Participant has been appointed legal guardian, provided the children are younger than age 23, live with the Participant, and can be claimed as dependents on the Participant's federal income tax return. If the Participant and natural parent of the stepchildren are legally separated, the stepchildren do not need to be living with the Participant to remain eligible under this Plan until the Participant's divorce from their natural parent is finalized. Stepchildren are no longer eligible once there is a final dissolution of the marriage of their natural parent and the Participant.
- Unmarried children (as otherwise defined above) who are older than age 23, primarily dependent on the Participant for support, and prevented from earning a living because of mental or physical handicap (providing the disabled children were so handicapped and eligible as Dependents at the time they reached the limiting age). Evidence of the child's dependence and incapacity must be filed with the Board within 31 days after attaining age 23, and periodically thereafter.

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

Domestic Partner
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. Domestic Partner means a person who resides with the Participant in the same

* See exception for Kaiser members following the Domestic Partner definition.

residence, is at least 18 years of age and whose relationship with the Participant meets each of the following requirements:

- 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;
- 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;
- Neither the Domestic Partner or the Participant is married;
- The Domestic Partner and Participant are each competent to contract;
- The Domestic Partner and Participant are not related by blood closer than would prohibit legal marriage in the State of California;
- 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
- 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.

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

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

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

Emergency
The sudden onset of a medical condition that requires immediate treatment because it is either life threatening or it would cause a serious dysfunction or impairment of a body organ or part if not immediately treated.

Experimental or Investigational
A drug, device, treatment, or procedure if:

- It cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- It, or the Patient informed consent document utilized with it, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval;
- Reliable Evidence shows that it is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study, or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis; or

- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence here means only:

- Published reports and articles in peer reviewed authoritative medical and scientific literature;
- The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment, or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment, or procedure.

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

Fund

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

Group Plan

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

Home Health Agency

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

Hospital

Any acute care hospital that:

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

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

Illness

A bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. For purposes of this Plan, pregnancy is considered an Illness for an Employee and Dependent Spouse only.

Injury

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

Licensed Pharmacist

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

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

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

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

For Hospital confinement, this means that acute care as a bed Patient is needed due to the kind of services the Patient is receiving or the severity of the Patient's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Mental Illness or Mental Disorder
Any nervous or mental disease, disorder, or condition that is defined within the Mental Disorders section of the current edition of the International Classification of Diseases (ICD-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, phobia, mania, and anxiety conditions, panic disorders, and adjustment disorders.

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

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

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

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

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

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

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

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

It also includes, upon the referral of a Physician, a licensed or certified physical therapist, clinical social worker, or psychologist.

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

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

Plan Year
January 1 through December 31 of any year.

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

Preferred Provider Organization
The entity under contract with the Fund that is responsible for negotiating contracts with Hospitals, Physicians, facilities, and other health care providers who agree to provide Hospitalization and medical services to Eligible Individuals based on negotiated fees.

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

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

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

Spouse
The legal Spouse of a Participant, or only when eligible according to the rules of the Plan, the domestic partner of a Participant.

Total Disability or Totally Disabled
Total Disability or Totally Disabled means, with respect to:

- An Active Participant, that the individual is unable to engage in any occupation or employment for wages or profit due to Illness or Injury; or
- A Dependent or Retired Participant, that the individual is prevented, by Illness or Injury, from performing the regular and customary activities usual for a person of similar age and family status.

Trust Agreement
The Trust Agreement establishing the Operating Engineers Public and Miscellaneous Employees Health and Welfare Trust Fund, dated September 1, 1998, including any amendments, extensions, or renewals.

Union

The Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Utilization Review Program or UR Program

A program where an Eligible Individual scheduled for confinement in a Hospital on an elective, non-Emergency basis is required to obtain Preadmission Review and Concurrent Review from the Professional Review Organization (PRO) under contract with the Fund as to the Medical Necessity of that confinement to receive unreduced benefit coverage for Covered Expenses incurred as a result of that Hospital confinement. For Emergency confinements, the review must be obtained retrospectively.

OPERATING ENGINEERS

PUBLIC AND MISCELLANEOUS EMPLOYEES

HEALTH AND WELFARE TRUST FUND

PLAN RULES AND REGULATIONS

FOR PLANS A, B and C

Restated Effective July 1, 2008

TABLE OF CONTENTS

CHAPTER 1. DEFINITIONS **1**

CHAPTER 2. ELIGIBILITY FOR BENEFITS **7**
Section 2.01. Eligibility Rules for Active Participants. 7
Section 2.02. Eligibility Rules for Retired Participants 7
Section 2.03. Dependents' Eligibility. 8
Section 2.04. Late Enrollment Provisions. 9
Section 2.05. Extension of Eligibility for Surviving Spouses 9
Section 2.06. Leave of Absence Due to Military Leave 9
Section 2.07. Extension of Health Benefits for Total Disability 10
Section 2.08. Certificate of Health Coverage 11
Section 2.09. Continuation Coverage Under COBRA 11
Section 2.10. Family and Medical Leave Act of 1993 13

CHAPTER 3. ELECTION OF COVERAGE **15**

CHAPTER 4. COMPREHENSIVE HEALTH PLAN BENEFITS **15**
Section 4.01. Schedule of Benefits 15
Section 4.02. Schedule of Benefits – Plan A 16
Section 4.03. Schedule of Benefits - Plan B 20
Section 4.04. Schedule of Benefits - Plan C. 24
Section 4.05. Lifetime Maximum Benefits 28
Section 4.06. Coinsurance Limit 28
Section 4.07. Copayments 28
Section 4.08. Preferred Provider Organization (PPO 29
Section 4.09. Utilization Review Program 30
Section 4.10. Covered Expenses 30
Section 4.11. Excluded Expenses 34

CHAPTER 5. PRESCRIPTION DRUG BENEFITS **37**
Section 5.01. Benefits 37
Section 5.02. Covered Expenses 38
Section 5.03. Exclusions 38

CHAPTER 6. CHEMICAL DEPENDENCY TREATMENT BENEFITS **40**
Section 6.01. Benefits 40
Section 6.02. Exclusions and Limitations 40

CHAPTER 7. HEARING AID BENEFIT **41**

CHAPTER 8. DENTAL BENEFITS **41**
Section 8.01. Definitions 41
Section 8.02. Benefits 42
Section 8.03. Schedule of Dental Services 42
Section 8.04. Dental Limitations 43
Section 8.05. Dental Exclusions 44

CHAPTER 9. ORTHODONTIC BENEFITS **45**

CHAPTER 10. VISION CARE BENEFITS **46**

CHAPTER 11. BURIAL EXPENSE BENEFIT **49**

CHAPTER 12. EXCLUSIONS, LIMITATIONS, AND REDUCTIONS **49**

Section 12.01. Exclusions and Limitations 49
Section 12.02. Third Party Liability 51
Section 12.03. Coordination of Benefits With Other Plans 53
Section 12.04. Coordination with Medicaid 55
Section 12.05. Coordination with Medicare 55
Section 12.06. Coordination with Other Government Programs 56

CHAPTER 13. GENERAL PROVISIONS 57

CHAPTER 14. AMENDMENT AND TERMINATION 61

CHAPTER 15. DISCLAIMER OF LIABILITY 62

CHAPTER 16. CLAIMS AND APPEALS PROCEDURES 62

OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH AND WELFARE TRUST FUND

RULES AND REGULATIONS
(Restated Effective July 1, 2008)

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 "Board" means the Board of Trustees established by the Trust Agreement.

Section 1.03. 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 1.04. 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 1.05. 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 1.06. 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 1.07. The term "Contract Physician" means a Physician who has a contract in effect with the Fund's Preferred Provider Organization.

Section 1.08. 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 1.09. The term "Contract Provider Area" means the geographic location that is within 30 miles of a Contract Provider.

Section 1.10. 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 1.11. 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 1.12. The term "Cosmetic" means surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Section 1.13. The term "Covered Expense(s)" or "Covered Service(s)" means only those charges which are Customary and Reasonable, or which are the negotiated charge from a 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). It shall also mean only those charges incurred by a Participant or Dependent while eligible for benefits under this Plan.

Section 1.14. The term "Customary and Reasonable Charge(s) means a charge which falls within the common range of fees billed by a majority of health care or dental providers for a procedure, service or supply in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case, as determined by Anthem Blue Cross for medical services and as determined by Delta Dental for dental services.

Section 1.15. 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 1.16. The term "Dentist" means a person licensed to practice dentistry in the state in which he/she or she provides treatment.

Section 1.17. The term "Dependent" means:

A. The Participant's lawful spouse or (or Domestic Partner if qualified under the rules of the Plan).

B. Unmarried children of the Participant if they are:

(1) Natural or legally adopted children younger than 23 years of age. Legally adopted children shall be considered eligible under this Plan when they are placed for adoption. Placed for adoption means the assumption and retention by a Participant of the legal duty for total or partial support of a child to be adopted; or

(2) Stepchildren or children for whom the Participant has been appointed legal guardian, provided the child is younger than 23 years of age, lives with the Participant, and can be claimed as a dependent on the participant's federal income tax return. However, if the Participant and natural parent of the stepchildren are legally separated, the stepchildren do not need to be living with the Participant to remain eligible under this Plan until the Participant's

divorce from their natural parent is finalized. Stepchildren are no longer eligible once there is a final dissolution of the marriage of their natural parent and the Participant; or

(3) Older than 23 years of age and prevented from earning a living because of mental or physical handicap (providing the disabled children were so handicapped and eligible as Dependents at the time they reached the limiting age), and are primarily dependent upon the Participant for support. Evidence of the child's dependence and incapacity must be filed with the Board within 31 days after attaining age 23, and periodically thereafter.

In accordance with ERISA Section 609(a), this Plan will provide coverage for a Dependent child of a Participant if required by a Qualified Medical Child Support Order.

Section 1.18. 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 1.19. 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 1.20. 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 1.21. The term "Eligible Individual" means each Participant and each of his eligible Dependents, if any.

Section 1.22. The term "Emergency" means the sudden onset of a medical condition that requires immediate treatment because it is either life threatening or it would cause a serious dysfunction or impairment of a body organ or part if not immediately treated.

Section 1.23. "Experimental or Investigational". See Section 12.01.J. for definition of Experimental or Investigational Procedures.

Section 1.24. The term "Fund" means the Operating Engineers Public And Miscellaneous Employees Health and Welfare Trust Fund .

Section 1.25. 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 1.26. 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 1.27. 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 1.28. The term "Illness" means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes.

Section 1.29. 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 1.30. 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 1.31. The term "Medicare" means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

Section 1.32. 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 1.33. 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 1.34. 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 1.35. 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 1.36. The term "Non-Contract Physician" means a Physician that does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.37. 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 1.38. The term "Out-of-Area" means a geographic area that is more than 30 miles from the nearest Contract Provider.

Section 1.39. 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 1.40. The term "Patient" means that Eligible Individual who is receiving medical treatment, services, or supplies covered by the Plan.

Section 1.41. 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 1.42. 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 1.43. The term "Plan Year" means January 1 through December 31 of any year.

Section 1.44. 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 1.45. 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 1.46. 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 1.47. The term "Retiree" or "Retired Employee" means each person who qualifies under the eligibility rules in Section 2.02.

Section 1.48. The term "Skilled Nursing Facility" means an institution as defined in Section 1861(j) of the Social Security Act.

Section 1.49. 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 1.50. 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 1.51. 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 1.52. The term "Union" means the Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Section 1.53. 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 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 have been covered under this Plan as an Active Employee for the 12 consecutive months prior to retirement;

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

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

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

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 1.17; or

(3) the date the full required contribution for the Dependent's coverage are not paid.

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

Section 2.04. Late Enrollment Provisions. In accordance with the Health Insurance Portability and Accountability Act of 1996, the following provisions will apply to Participants and Dependents who did not enroll in the Plan when first eligible:

A. If a Participant did not enroll himself or his Dependent(s) in the Plan when first eligible and the Participant subsequently acquires a new Spouse or Dependent child(ren) by marriage, birth, adoption, placement for adoption or legal guardianship, the Participant may request enrollment in the Plan for himself and his newly acquired Dependent(s) no later than 90 days after the date the new Dependent is acquired.

B. If a Participant did not enroll in the Plan on the date he/she first became eligible because the Participant or Dependent had other health coverage under any other health insurance policy or program (including COBRA Continuation Coverage, individual insurance, Medicaid or other public program) and the Participant and/or Dependent ceases to be covered by that other health coverage, the Participant may enroll himself and any eligible Dependents in this Plan within 31 days after termination of the other coverage if that other coverage terminated due to:

(1) The loss of eligibility for the other coverage as a result of termination of employment or reduction in the number of hours of employment, death, divorce or legal separation, or loss of dependent status under the other plan; or

(2) Termination of benefit package or the other plan ceases to offer coverage to a group of similarly situated individuals; or

(3) Moving out of an HMO service area if the other plan offers only an HMO; or

(4) Loss of eligibility under the other plan due to reaching the lifetime maximum on all benefits; or

(5) Termination of employer contributions toward the other coverage, or

(6) If the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is exhausted if it ceases for any reason other than the failure of the individual to pay the applicable COBRA premium on a timely basis.

Section 2.05. Extension of Eligibility for Surviving Spouses. In the event of the Active or Retired Participant's death, the surviving legal spouse will be given a one-time only opportunity to continue hospital, medical and prescription drug benefits for the spouse and eligible Dependent children by making the required self-payments to the Fund. The burial expense benefit is not included under this extension of eligibility provision. Self-payments must be continuous. If payment is not received for any month, coverage may not be reinstated at a later date.

Eligibility under this provision will terminate upon the surviving spouse's remarriage.

Section 2.06. Leave of Absence Due to Military Leave. A Participant who enters military service with the Uniformed Services of the United States will be provided continuation and reinstatement of eligibility rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

A. A Participant who is on active military duty for 31 days or less will continue to be eligible for up to 31 days with no self-payments required.

B. Participants whose period of military service is 31 days or more may continue their eligibility by self-payment for up to 18 months, as described in Section 2.09. Continuation Coverage Under

COBRA. Participants whose continuation period begins on and after December 10, 2004 may continue their eligibility for a total of 24 months. During the first 18 months of coverage the Participant will have all COBRA rights. However, COBRA rights, such as the right to elect additional months of coverage in the event of a second Qualifying Event or a Social Security disability determination, do not apply during the last 6 months of the 24-month period.

C. Coverage will not be provided for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

D. When the Participant is discharged from military service, eligibility will be reinstated on the day he/she returns to work with a Contributing Employer, provided that he/she returns to work within:

(1) Ninety (90) days from the date of discharge if the period of service was more than 180 days; or

(2) Fourteen (14) days from the date of discharge if the period of service was 31 days or more but less than 180 days; or

(3) On the first regularly scheduled work day following discharge if the period of service was less than 31 days.

If the Participant is hospitalized or convalescing from an Injury caused by active duty, the above time limits are extended up to 2 years.

Section 2.07. Extension of Health Benefits for Total Disability – For Active Participants and Dependents Only. This Extension of Benefits provision does not apply to individuals enrolled in an HMO plan.

A. If an Active Participant or Dependent is Totally Disabled when eligibility terminates, Comprehensive Health Plan benefits may be extended after termination, subject to the following conditions:

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

(2) The Eligible Individual remains Totally Disabled to the date the Covered Expense is incurred.

(3) Benefits will be payable subject to all comprehensive health Plan limitations and maximums that were in effect at the time eligibility terminated.

(4) A Physician's written certification of Total Disability is received by the Fund Office with 90 days after eligibility has terminated and at 90-day intervals thereafter to continue extended benefits.

B. **Termination of Extended Benefits**. Benefits will continue until the earliest of the following occurrences:

(1) the date the Eligible Individual is no longer Totally Disabled,

(2) the date the Eligible Individual becomes covered under another health plan which provides similar benefits; or

(3) the end of a period of 12 months following the date eligibility under this Plan terminated

Section 2.08. 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 2.09. Continuation Coverage Under COBRA. COBRA requires that under specific circumstances when coverage terminates, certain health plan benefits available to Eligible Individuals must be offered for extension through self-payments. To the extent that COBRA applies to any Eligible Individual under this Plan, these required benefits shall be offered in accordance with this Section 2.09.

A. **General.** Participants and Dependents who lose eligibility under the Plan may continue Plan coverage subject to the terms of this Section. This Chapter is intended to comply with the health care continuation provisions of COBRA. Those provisions are incorporated by reference in the Plan and shall be controlling in the event of any conflict between those provisions and the terms of this Section.

B. **Continuation Coverage.** Eligible Individuals who would otherwise lose Plan coverage because of a "qualifying event" may continue coverage (except the Burial Expense benefit) under COBRA.

A "qualifying event" is defined as any of the following:

(1) Termination of Employment or reduction in hours which results in a loss of coverage;

(2) Death of the Participant;

(3) Divorce of the Participant from his Dependent Spouse;

(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) Second Qualifying Event. The 18-month period described in paragraph (1) above, or the 29-month period under the disability extension described in paragraph (4) below, may be extended to a maximum of 36 months from the date of the Qualifying Event if a second Qualifying Event (other than a termination of employment or reduction in hours) occurs with respect to that Qualified Beneficiary during the original 18 or 29-month period, and while the Qualified Beneficiary is covered under the Plan.

(4) Extension of Coverage Period for Disability. A Qualified Beneficiary who is entitled to continuation coverage because of a termination of employment or reduction in hours may extend coverage beyond the original 18 months to a total of 29 months if he/she is determined by Social Security to be totally disabled as of the date of the Qualifying Event or during the first 60 days of COBRA continuation coverage. Other Qualified Beneficiaries in the disabled person's family are also eligible for the 29 month extended coverage period.

To qualify for the additional 11 months of continuation coverage, a Qualified Beneficiary must report the Social Security disability determination to the Fund Office in writing before the original 18-month period expires and within 60 days after the date of the Social Security determination.

(5) Entitlement to Medicare. If a Participant loses coverage due to a termination of employment or reduction in hours *after* he/she became entitled to Medicare, the Participant may continue coverage under COBRA for 18 months from the date of the Qualifying Event. However, the Dependents of the Participant may continue coverage under COBRA until the later of:

a. 18 months from the date of the Qualifying Event; or

b. 36 months form the date the Participant became entitled to Medicare.

G. **Termination of COBRA Continuation Coverage.** Notwithstanding the maximum duration of coverage described in Section 2.09.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 2.10. Family and Medical Leave Act of 1993. If an Active Employee's Employer approves taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Employee and eligible Dependents will continue to be eligible under this Plan during the leave subject to the following conditions:

(1) The Employee was eligible when the leave began, and

(2) The Employer properly grants the leave under the Family and Medical Leave Act, and

(3) 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 4.10.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. Three schedules of comprehensive health plan benefits are provided by the Fund, as described in Sections 4.02, 4.03 and 4.04. "Plan A" means the plan of health benefits available to Employees who are employed by Employers who are subject to a Collective Bargaining Agreement requiring contributions to the Fund to provide Plan A benefits. "Plan B" means the plan of benefits available to Employees who are employed by Employers who are subject to a Collective Bargaining Agreement requiring contributions to provide Plan B benefits. "Plan C" means the plan of benefits available to Employees who are employed by Employers who are subject to a Collective Bargaining Agreement requiring contributions to provide Plan C benefits.

Section 4.02. Schedule of Benefits - Plan A. All benefits shown in the following Plan A Schedule of Benefits are based on Covered Expenses, as defined in Section 1.13. The benefit percentages shown are based on the negotiated fee for Contract Providers, or on the Customary and Reasonable 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			
Lifetime Maximum	$1,000,000 per person		
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
Outpatient Hospital/Emergency Room for Emergency, Surgery, or Accidental Injury (within 72 hours)	Plan pays 90%; subject to coinsurance limit	Plan pays 80%	Plan pays 90%; subject to coinsurance limit
Outpatient Hospital/Emergency Room for Non-Emergencies	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility	Plan pays 90%; subject to coinsurance limit	Plan pays 80%	Plan pays 90%; 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
Adult Routine Physical Exam Calendar Year Maximum: $150	Plan pays 100%	Plan pays 100%	Plan pays 100%

+ All payments for Non-Contract Providers are based on Customary and Reasonable charges.

Well Child Care for children through age 16	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit

Benefit Description — Plan A	Contract Provider	Non-Contract Provider+	Out-of-Area+
Adult Immunizations	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Mammograms	Plan pays 90%; subject to coinsurance limit	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 Health Calendar Year Maximum: 30 days	Plan pays 90%	Plan pays 60%	Plan pays 90%
Outpatient Mental Illness Weekly Maximum: 1 visit Calendar Year Maximum: 50 visits, for covered providers only	Plan pays 50%	Plan pays 50%	Plan pays 50%
Other Covered Expenses Not Shown Above	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit

+ All payments for Non-Contract Providers are based on Customary and Reasonable charges.

[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.

Section 4.03. Schedule of Benefits - Plan B. All benefits shown in the following Plan B Schedule of Benefits are based on Covered Expenses, as defined in Section 1.13. The benefit percentages shown are based on the negotiated fee for Contract Providers, or on the Customary and Reasonable 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 Medical Benefits — Plan B			
Lifetime Maximum	$1,000,000 per person		
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
Outpatient Hospital/Emergency Room for Emergency, Surgery, or Accidental Injury (within 72 hours)	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Outpatient Hospital/Emergency Room for Non-Emergencies	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	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
Adult Routine Physical Exam Calendar Year Maximum: $150	Plan pays 100%	Plan pays 100%	Plan pays 100%

+ All payments for Non-Contract Providers are based on Customary and Reasonable charges.

Well Child Care (for children through age 16)	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit

Benefit Description — Plan B	Contract Provider	Non-Contract Provider+	Out-of-Area+
Adult Immunizations	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Mammograms	Plan pays 80%; subject to coinsurance limit	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 Health Calendar Year Maximum: 30 days	Plan pays 80%	Plan pays 60%	Plan pays 80%
Outpatient Mental Illness Weekly Maximum: 1 visit Calendar Year Maximum: 50 visits for covered providers only	Plan pays 50%	Plan pays 50%	Plan pays 50%
Other Covered Expenses Not Shown Above	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit

+ All payments for Non-Contract Providers are based on Customary and Reasonable charges.

[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.

Section 4.04. Schedule of Benefits - Plan C. All benefits shown in the following Plan C Schedule 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 Customary and Reasonable 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 Medical Benefits — Plan C			
Lifetime Maximum	$1,000,000 per person		
Annual Deductible	$750 per person; $2,250 family maximum Deductible does not apply to Contract Provider and Out-of-Area office visits, adult physical exam benefits, or Hospital Emergency Room charges for emergencies and accidental injuries within 72 hours of Injury.		
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
Outpatient Hospital/Emergency Room for Emergency, Surgery, or Accidental Injury (within 72 hours)	Plan pays 80%, no deductible; subject to coinsurance limit	Plan pays 80%, no deductible	Plan pays 80%, no deductible; subject to coinsurance limit
Outpatient Hospital/Emergency Room for Non-Emergencies	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 Customary and Reasonable charges.

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

Benefit Description — Plan C	Contract Provider	Non-Contract Provider+	Out-of-Area+
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
Adult Routine Physical Exam Calendar Year Maximum: $150	Plan pays 100%	Plan pays 100%	Plan pays 100%
Well Child Care (for children through age 16)	After $15 Copayment per visit, Plan pays 100%; no deductible	After deductible, Plan pays 60%	After $15 Copayment per visit, Plan pays 80%; subject to coinsurance limit; no deductible
Adult Immunizations and Mammograms	After deductible, Plan pays 80%; subject to coinsurance limit	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
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

+ All payments for Non-Contract Providers are based on Customary and Reasonable charges.

Benefit Description — Plan C	Contract Provider	Non-Contract Provider+	Out-of-Area+
Inpatient Mental Health Calendar Year Maximum: 30 days	After deductible, Plan pays 80%	After deductible, Plan pays 60%	After deductible, Plan pays 80%
Outpatient Mental Illness Weekly Maximum: 1 visit Calendar Year Maximum: 50 visits for covered providers only	After deductible, Plan pays 50%	After deductible, Plan pays 50%	After deductible, Plan pays 50%
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.			

[+] All payments for Non-Contract Providers are based on Customary and Reasonable charges.

Section 4.05. Lifetime Maximum Benefits. The Maximum Benefit shown in the Schedule of Benefits in Sections 4.02, 4.03 and 4.04 may be paid for each Eligible Individual for Covered Expenses, except that certain medical expenses shown in the Schedule of Benefits may be subject to a lower Limited or Annual Maximum Benefit. The Lifetime Maximum is the maximum amount of benefits payable by the Plan during the entire time an Eligible Individual is covered under this Plan, regardless of whether there is a break in coverage. The Plan will not pay any further Comprehensive Health Plan Benefits on account of an Eligible Individual once the Lifetime Maximum Benefit has been paid. The Plan has no obligation to pay any benefits during the lifetime of the Eligible Individual after coverage terminates, except as provided in the Extension of Health Benefits for Total Disability provision as described in Section 2.07.

Section 4.06. Coinsurance Limit.

A. Plan A and Plan B: 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) Charges from Non-Contract Providers within the Contract Provider Area;

(4) Mental Illness benefits;

(5) Charges in excess of any Plan maximums or that are not Covered Expenses; and

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

Section 4.07. 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

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, immunizations

(5) X-ray and laboratory services

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

Section 4.08. 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 Customary and Reasonable 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

Section 4.09. 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 4.10. 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 and 4.04:

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) Hospital confinements due to Mental Illness are limited to 30 days per calendar year.

(3) Well baby nursery care is covered on the same basis as other Hospital care.

(4) 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 4.07.

(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.**

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) Adult Routine Physical Examination Benefit (for the Participant, Dependent Spouse and Dependent Children age 17 and over). The Plan will pay up to $150 per calendar year, for the exam and any related routine diagnostic tests.

a. No benefits will be payable for any 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.

(2) Immunizations. Payable in accordance with the Schedule of Benefits.

(3) 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:

a. Ages 35 through 39: one baseline mammogram.

b. Ages 40 through 49: one mammogram every 2 years, or more frequently if recommended by a Physician.

c. Age 50 and over: one mammogram every year.

(4) Well-Child Care Benefits. Benefits are payable in accordance with the Schedule of Benefits for children age 16 and younger 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:

(1) Outpatient Treatment or services if provided by a Physician, psychologist or licensed clinical social worker. Outpatient benefits are limited to a maximum of 50 outpatient visits per calendar year and no more than 1 visit per week.

(2) Inpatient: Hospital charges for inpatient treatment of Mental Illness are limited to a maximum of 30 days per calendar year.

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 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,** limited to 180 days per calendar year. Admission to a skilled nursing facility must begin within 14 days of discharge from a covered inpatient stay in an acute care Hospital.

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 Customary and Reasonable Charges 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) The Patient is admitted to a transplant center program in a major medical center approved either by the federal government or the appropriate state agency of the state in which the center is located.

(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.

In no case will the Plan cover expenses for transportation of the donor, surgeons or family members.

Section 4.11. 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 4.10.

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, mental retardation, or autistic disease, except that the exclusion of developmental delay will not apply to benefits payable under Section 4.10.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 4.10.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, nutritional counseling, food supplements or substitutes. (Except that the initial Diabetes instruction visit is covered.)

K. Services or supplies which are primarily for weight loss, health club membership, spas, exercise and physical fitness programs or equipment.

L. Hypnotism, stress management, biofeedback, and any goal oriented behavior modification therapy, such as to quit smoking, lose weight or control pain.

M. A Dependent daughter's pregnancy, maternity care or abortion, except for complications of pregnancy.

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 4.10.W. and 4.10.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

4.10.K. Routine Preventive Care Services and except for well baby nursery care as described in Section 4.10.A.(3).

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.

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.** 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:** 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.

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 treatment that has been pre-authorized by the Assistance Recovery Program. Chemical dependency treatment benefits are subject to the Comprehensive Health Plan Benefits lifetime maximum as described in Chapter 4.

A. **Inpatient Residential Treatment.** Coverage is provided for up to 2 inpatient treatment programs in a lifetime, not to exceed 30 days per treatment program. Benefits are payable according to the following schedule:

   (1) First admission: 100% of negotiated charges

   (2) Second admission: 80% of negotiated charges

B. **Outpatient Treatment.** The Plan will pay 80% of negotiated charges, to a maximum benefit of $2,000 per calendar year, for treatment and counseling received on an outpatient basis, not to exceed 50 visits per calendar year.

C. **Recovery Home Treatment**. The Plan will pay the lesser of $20 per day or actual charges incurred for up to 30 days per calendar year for residential treatment in an approved recovery home (halfway or three-quarter way home) subsequent to confinement in an ARP approved inpatient facility. Plan benefits are limited to an overall lifetime maximum of 60 days per person.

Section 6.02. Exclusions and Limitations. No benefits will be provided for the following:

A. Any treatment that has not been pre-authorized by the Assistance Recovery Program and provided by a facility or provider approved by the Assistance Recovery Program.

B. More than 2 inpatient treatment programs during the individual's lifetime.

C. More than 50 outpatient visits per calendar year.

D. More than 30 days per calendar year, or 60 days per lifetime, of recovery home treatment.

E. 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. The hearing aid benefit is subject to the Comprehensive Health Plan Benefits lifetime maximum as described in Chapter 4.

Section 7.02. Benefit. Upon certification by a Physician that an Eligible Individual has a hearing loss, and that the loss may be lessened by the use of a hearing aid, the Fund will, subject to the provisions of this Chapter 7, pay 80% of the Customary and Reasonable Charges incurred for the examination and the hearing aid up to a maximum payment of $450 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, 2008 dental benefits are provided under an insured 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 Customary and Reasonable Charge for the treatment, examination or procedure, or b) the Dentist’s usual, customary and reasonable 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.

Section 8.03. Schedule of Dental Services. Subject to the Limitations and Exclusions described in Sections 8.04 and 8.05, benefits for Covered Dental Expenses will be paid in accordance with the following Schedule of Services.

A. **Diagnostic and Preventive Benefits**. **Payable at 100% of Covered Dental Expenses**.

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

(2) Preventive. Prophylaxis, fluoride treatment and sealants.

B. **Basic Benefits. Payable at 85% of Covered Dental Expenses**.

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

(2) Oral surgery, including extractions and certain other surgical procedures, including pre- and postoperative care.

(3) Restorative. Amalgam, synthetic porcelain and plastic restorations (fillings) for treatment of carious lesions.

(4) Endodontic. Treatment of the tooth pulp.

(5) Periodontic. Treatment of gums and bones supporting teeth.

C. **Crowns and Cast Restoration Benefits**. **Payable at 85% of Covered Dental Expenses**.

Crowns and cast restorations for treatment of carious lesions which cannot be restored with amalgam, synthetic porcelain or plastic restorations.

D. **Prosthodontic Benefits**. **Payable at 60% of Covered Dental Expenses**.

Procedures for construction or repair of fixed bridges, partial and complete dentures, if provided to replace missing natural teeth. Benefits are payable for implant surgical placement and removal and for implant supported prosthetics, including implant repair and re-cementation.

E. **Additional Benefits During Pregnancy.** Additional services are covered during pregnancy. The additional services each calendar year include: one additional oral examination and either one additional routine prophylaxis or one additional periodontal scaling and root planning per quadrant. Written confirmation of pregnancy must be provided by the Patient or Dentist when the claim is submitted. The additional services are payable at the applicable percentage payable for Diagnostic and Preventive Benefits or Basic Benefits.

Section 8.04. Dental Limitations. The benefits described in Section 8.03. are subject to the following limitations:

A. Bitewing x-rays are covered twice each calendar year. Full mouth x-rays are limited to once every 3 years

B. Prophylaxis is limited to 2 treatments in a calendar year. Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit. See Additional Benefits During Pregnancy in Section 8.03.E.

C. Fluoride treatments are covered twice each calendar year.

D. Only the first two oral examinations in a calendar year, including office visits for observation and specialist consultations, or any combination of these, are benefits while the individual is eligible under any Delta Dental plan. See Additional Benefits During Pregnancy in Section 8.03.E.

E. Sealant benefits include the application of sealants only to permanent first molars through age 8 and second molars through age 15 if they are without caries (decay), or restorations on the occlusal surface. Sealant benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.

F. Direct composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspids. Any other posterior or direct composite (resin) restorations are optional services and the Plan's payment is limited to the cost of the equivalent amalgam restoration.

G. Periodontal scaling and root planning is covered once for each quadrant each 24-month period. See Additional Benefits During Pregnancy in Section 8.03.E.

H. Crowns, inlays, onlays, and cast restorations are covered on the same tooth only once every 5 years while eligible under the Delta Dental plan or the prior Trust Fund Plan, unless Delta determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the placement of the restoration.

I. Prosthodontic appliances and implants (including fixed bridges and partial or complete dentures) are covered only once every 5 years, while eligible under this Delta Dental plan or the prior Trust Fund Plan, unless Delta determines there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of an

implant, a prosthetic appliance or an implant supported prosthesis received under another plan will be covered if Delta determines it is unsatisfactory and cannot be made satisfactory.

J. The Plan pays the applicable percentage of the Dentist's fee for a standard partial or complete denture. A standard partial or complete denture is one made from accepted materials and by conventional methods.

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

Section 8.05. Dental Exclusions. Dental benefits are not payable for:

A. Expense incurred for missed appointments.

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

C. Orthodontic services, except as otherwise specified in Chapter 9.

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

E. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, and teeth that are discolored or lacking enamel.

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

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

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

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

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

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

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

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

N. Intraveneous sedation.

O. Complete occlusal adjustment.

P. Any services excluded under the General Exclusions, Limitations and Reductions listed in Chapter 12.

CHAPTER 9. ORTHODONTIC BENEFITS

Effective July 1, 2008 orthodontic benefits are provided under an insured 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 Customary and Reasonable Charges 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 9.04. 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.

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 ±.50 diopter power); or 2 pair of glasses in lieu of bifocals.

(2) Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.

(3) Medical or surgical treatment of the eyes, including any refractive vision surgery.

(4) Corrective vision treatment of an Experimental nature.

Section 10.04. Low Vision Benefit. The Low Vision benefit is available to Eligible Individuals who have severe visual problems that are not correctable with regular lenses. The following services under this benefit require prior approval from VSP.

A. **Supplementary Testing** includes a comprehensive examination of visual function and the prescription of corrective eyewear or vision aids where indicated. The Plan pays 100% for VSP Signature Choice Plan providers, or up to a maximum of $125 when provided by an Out-of-Network provider.

B. **Supplemental Care, including subsequent low vision aids.** The Plan will pay 50% of the cost for supplemental care provided by a VSP Signature Choice Plan provider or an out-of-network provider.

C. **Benefit Maximum.** The maximum benefit payable for all low vision benefits is $500 per Eligible Individual every 2 years.

D. **Out-of-Network Provider Benefit.** Services received from an out-of-network provider are subject to the same time limits, benefit maximum and payment provisions described above except that supplementary testing is limited to a maximum of $125. The Eligible Individual must pay the out-of-network provider his full fee and will be reimbursed in an amount not to

exceed what VSP would pay a VSP Doctor for the service.

CHAPTER 11. BURIAL EXPENSE BENEFIT

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 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 Customary and Reasonable Charges or any services not considered to be customary and reasonable.

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 customary and reasonable 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 Participants 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.

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 Customary and Reasonable 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 Customary and Reasonable.

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. CLAIMS AND APPEALS PROCEDURES

A. **Definitions.**

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

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

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

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

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

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the participant pays the entire cost, is not considered an Adverse Benefit

Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Plan).

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

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.

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

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

c. A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;

d. A description of the appeal procedures and applicable time limits;

e. A statement of the participant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;

f. If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;

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

h. For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

C. Appeal Procedures.

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

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

b. Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made either by calling the designated Review Organization or by other available similarly expeditious method, including electronic means. Appeals of Urgent Claims may **not** be submitted via the US Postal service.

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

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. the specific reason(s) for the determination;

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

c. a statement that the participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;

d. a statement of the participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

e. if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and

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

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

193676v1/03532.001