IUOE Stationary Engineers Local 39

Health & Welfare Plan

Summary Plan Description
2018 Edition

STATIONARY ENGINEERS LOCAL 39
HEALTH AND WELFARE PLAN

Plan Document/Summary Plan Description (SPD)

Effective June 1, 2018

Important Notice to Employees, Spouses and Dependents

From time to time, the Administrative Office (BeneSys Administrators) may mail you updated material to inform you and your Dependents of any change in benefits. It is important that you file all information received in the back pocket of this booklet and note any updates to affected sections of this document.

The **Board of Trustees** have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, interpret and or terminate any provisions of the Plan, this Summary Plan Description and any other Plan documents and to decide on all matters arising in connection with the operation or administration of the Plan. The Trustees have the sole and absolute discretionary authority:

- To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
- To formulate, interpret and apply rules and policies necessary to administer the Plan;
- To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- To resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan documents; and
- To process and approve or deny benefit claims and rule on any benefit exclusions to the extent allowed by any insurance policy or service agreement.

All determinations made by the **Board of Trustees** with respect to any matter arising under the Plan, this Summary Plan Description and any other Plan documents shall be final and binding on all parties.

Stationary Engineers Local 39 Health and Welfare Plan
P. O. Box 1737
San Ramon, CA 94583
Telephone: 925-208-2280

Dear Participant:

The **Board of Trustees** of the Stationary Engineers Local 39 Health and Welfare Plan is pleased to issue this Plan Document/Summary Plan Description (SPD). This SPD provides information about the self-funded benefits that are available to you through the Stationary Engineers Local 39 Health and Welfare Plan ("the Plan") and replaces all other Plan Document/Summary Plan Descriptions previously provided to you. Note that eligibility for certain benefits, such as life insurance and extended benefits upon loss of eligibility depends on the terms of the Collective Bargaining Agreement under which you work. The Administrative Office can advise you if you are eligible for those benefits.

This SPD has been designed to be easy to read and understand. Important contacts—phone numbers and websites for the Administrative Office and insurance vendors—appear on page 2. The "***Glossary of Defined Terms***" section of this booklet, beginning on page 86 provides definitions of terms that are capitalized throughout this booklet. ***"Fast Facts"*** appear at the beginning of each section to give you a quick overview of what is contained within that section. Useful information—such as quick tips and definitions—appear in the margin for quick reference.

We encourage you and your family to read this Plan Document/SPD carefully to make the best use of the benefits the Stationary Engineers Local 39 Health and Welfare Plan offers.

Employer contributions are remitted to the Trust Fund under the terms of the Collective Bargaining Agreement between your employer and Stationary Engineers Local 39. The contribution amount determines the benefits for which you are eligible.

If you have any questions concerning the benefits or your eligibility, please feel free to contact the Administrative Office by calling the numbers listed on page 2.

Sincerely,

Board of Trustees

Stationary Engineers Local 39 Health and Welfare Plan

Board of Trustees

Employer Trustees	Union Trustees
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Able Engineering Service 868 Folsom Street San Francisco, CA 94107	Stationary Engineers Local 39 1620 N. Market Boulevard Sacramento, CA 95834
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Important Notices

GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT)

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan administrator at 925-208-2280.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Administrative Office the Social Security Number (SSN) of your eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Important Contact Information

	Phone Number	Website
SELF-FUNDED MEDICAL PLAN		
Self-Funded Medical Claims, Eligibility, Benefits **BeneSys Administrators** P. O. Box 1737 San Ramon, CA 94583	**(925) 208-2280**	https://www.ourbenefitoffice.com/StationaryEngLocal39/Benefits/Home.aspx
Self-Funded Medical Plan PPO Provider **Anthem Blue Cross**	**(800) 810-BLUE** File Claims to: P.O. Box 60007 Los Angeles, CA 90060- 0007	www.anthem.com/ca or www.bluecares.com
Self-Funded Medical Plan Cost Management **Anthem Blue Cross**	For Hospitalizations and Services Requiring Prior Authorization (800) 274-7767	
Prescription Drugs for Self-Funded Medical Plan **Caremark**	**Customer Service** (888) 726-1629 **Mail Order Service** (866) 776-5677	www.caremark.com
HMO PLAN OPTIONS		
Kaiser Permanente	(800) 464-4000	www.kp.org
Anthem HMO	Member services (800) 227-3670 Pharmacy services (800) 824-0898	www.anthem.com/ca
DENTAL PLAN OPTIONS		
Delta Dental Plan of California	(888) 335-8227	www.deltadentalins.com
Met Life Dental	(800) 880-1800	www.metlife.com
VISION PLAN		
Eyemed	Provider Locator (866) 804-0982 For LASIK providers (877) 5LASER6	www.eyemed.com www.eyemedlasik.com
LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT		
ING Employee Benefits	Call the Administrative Office at number above for information.	

1. An Overview of Your Health and Welfare Plan

As a participating employee under the Local 39 Stationary Engineers Collective Bargaining Agreement (CBA), you and your covered family members are eligible for comprehensive coverage through the Health and Welfare Plan. Coverage includes medical, prescription drug, vision and dental care. If the terms of your CBA specify, the Plan includes life insurance and accidental death and dismemberment benefits for yourself and benefits in the event of your eligible Dependent's death.

FAST FACTS

- The Plan provides several options for medical and dental coverage.
- You may enroll yourself and your eligible family members when you first become eligible.
- Once you select a medical or dental plan, generally you may not change your coverage until a 12-month period has passed.

What is the Stationary Engineers Local 39 Health and Welfare Plan?

The Stationary Engineers Local 39 Health and Welfare Plan (sometimes referred to as "the Plan") was created in 1965 to provide benefits to members of Stationary Engineers Local 39. The Plan is adopted and controlled by the Trustees of the Trust Fund to which Employer contributions are made. The Trust Agreement under which the Plan operates allows for an equal number of Trustees designated by the Union Local and Trustees designated by the Employers.

The Trustees are authorized to change the Plan from time to time, consistent with the provisions of the Trust Agreement.

About the Trust Fund

Payment of the benefits described in this booklet is at all times subject to the availability of funds in the Trust to which Employers make contributions. Neither the Trust Fund nor the Trustees individually have any obligation to continue benefits if there are insufficient monies and assets in the Trust Fund to do so. The Trustees reserve the right to deny participation in the Trust Fund's benefit program to employers and unions whose agreements are in conflict with the rules and policies of the Trust Fund.

Day-to-day Operation of the Plan

The day-to-day operation of the Plan is handled by BeneSys, a contract administrator appointed by the Trustees. Although you may obtain assistance and information from your Employer, your Union representative or BeneSys Administrators about the Plan, final determination on all questions of benefits and eligibility can only be made by the full **Board of Trustees**.

Union representatives and employer personnel are not agents of the Trust and their statements about the functioning of the Plan are not binding on the Trustees.

What is Described in this Booklet

The Comprehensive Self-Funded Medical Plan, including prescription drug benefits and the Self-Funded Dental Plan and Vision Care Plan are described in this booklet. These benefits are provided under a self-funded program; that is, no insurance company or other outside organization "underwrites" or guarantees payment of these benefits. **The information in this booklet describes these benefits as of June 1, 2018, and supersedes all other information previously provided to you.**

The self-funded medical benefits are administered by the Administrative Office. Anthem Blue Cross provides Utilization Review services and access to a network of preferred hospitals, facilities and medical providers. Prescription drug benefits are administered by Caremark. Vision benefits are administered by Eyemed. Dental benefits are administered by Delta Dental Plan of California or MetLife.

This booklet also briefly describes the life insurance benefits provided through a group policy, which is issued to the Plan by ING Employee Benefits.

What the Stationary Engineers Local 39 Health and Welfare Plan Offers You

Employees eligible for benefits from this Trust can choose comprehensive medical benefits coverage through:

- The Comprehensive Self-Funded Medical Benefits Plan (which features the Anthem Blue Cross Blue Card PPO and includes prescription drugs through Caremark) or
- One of the following HMOs with which the Trust Fund contracts (you must live or work in the HMO service area in order to have HMO coverage):
  - Kaiser Permanente
  - Anthem HMO

You may choose comprehensive dental coverage through the Self-Funded Dental Plan administered by Delta Dental of California or the fully insured MetLife Dental Plan.

The Plan includes Vision and Life Insurance and Accidental Death and Dismemberment (AD&D) coverage only if such coverage specified in the terms of your CBA.

If you enroll in a medical HMO or in the MetLife Dental Plan, you will receive an "***Evidence of Coverage***" document from your benefits provider, which provides full details of the benefits coverage under your plan(s). Contact the HMO or MetLife Dental for more information. Contact numbers and websites are listed on page 2 of this document.

Foreign Language Assistance

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

Enrolling for Coverage

When you first become eligible for coverage, you should enroll yourself and your eligible Dependents in the medical and dental coverage option that you would like. When you are first eligible for benefits, the Administrative Office will advise you what HMO options are available to you based on where you live. Refer to the Eligibility and Enrollment for more information about enrollment.

If you are trying to decide between the Comprehensive Self-Funded Medical Benefits Plan and an HMO, contact the Administrative Office and ask for a copy of the Summary of Benefits and Coverage (SBC) for both plan options to review the differences between the two plans.

Changing Your Coverage

If you would like to change your coverage, you may not enroll in a different benefit option unless you have been covered under your current Plan for at least 12 months. For example, if you are first hired and enroll in benefits effective October 1, 2017, you will next have the opportunity to enroll in a different benefits option after September 30, 2018.

If you experience a Special Enrollment Event, such as a marriage or birth of a child, you may also be eligible to make certain additional changes to your benefits sooner than the 12-month period. See the sections called ***“Eligibility and Enrollment”*** and ***“Special Enrollment Events”*** for more details.

Special Notice to HMO Enrollees (Kaiser, Anthem HMO, or MetLife Dental)

Enrollment materials provide you with a summary of the benefits under your plan and may not completely describe your benefits. For specific details on your HMO coverage, refer to the HMO’s ***Evidence of Coverage***—the binding document between the insured HMO Plan and its members (or enrollees). All services and supplies must be provided, prescribed, authorized or directed by a provider in the HMO network. If there are any discrepancies between the HMO benefits represented through the dissemination of information by the Trust Fund and the HMO’s ***Evidence of Coverage***, the ***Evidence of Coverage*** will prevail.

2. Summary of Your Health and Welfare Benefits

Comprehensive Self-Funded Medical Benefits Plan

Please note that the summary below is for benefits under the Comprehensive Self-Funded Medical Plan. If you are enrolled in an HMO, refer to your HMO's ***Evidence of Coverage*** document for details on your medical and prescription drug coverage.

	Comprehensive Self-Funded Medical Benefits (Anthem Blue Cross PPO)	
	Anthem Blue Cross Contracted Provider (In-Network)	**Out-of-Network**[1]
Calendar Year Deductible	For any combination of In-Network and Out-of-Network providers: $170 per person; $340 per family before the Plan pays any benefits	
Coinsurance Limit	$1,000 of out-of-pocket Allowed Charges per person in a two calendar year period (in addition to the calendar year deductible each year)	
Office Visits	90% of negotiated rate, after deductible	70% of Allowed Charge after deductible
WELLNESS AND PREVENTIVE BENEFITS		
Physical Exams for Adults	90% of negotiated rate up to a maximum payment of $280 for each exam	70% of Allowed Charge up to a maximum payment of $280 for each exam
Well-Child Care	Routine exams covered up to a maximum payment of $280 for each exam for children three years and older. No limit for children under three years of age	
	90% of negotiated rate	70% of Allowed Charge
Mammograms	One baseline mammogram for women between ages 35 and 40, annually after age 40. For women with a documented genetic predisposition, annual mammogram covered beginning at age 35	
	90% of negotiated rate	70% of Allowed Charge
Pap Tests	90% of negotiated rate *(includes annual pelvic exam and pap test)*	70% of Allowed Charge
Colon Cancer Screening	A sigmoidoscopy every five years or a colonoscopy every 10 years beginning at age 50 (***virtual colonoscopy is not covered***)	

[1] Remember, when you see an out-of-network provider for care, the provider may balance bill you for any amount more than the Plan's Allowed Charge. If this is the case, you are responsible for paying the balance in addition to your coinsurance.

	Comprehensive Self-Funded Medical Benefits through Anthem Blue Cross	
	Anthem Blue Cross Contracted Provider (In-Network)	**Out-of-Network[1]**
Prostate Cancer Screening	Includes annual PSA blood test at age 50 for normal risk men, age 45 for African American men and age 40 for men with more than one first degree relative diagnosed with the disease	
	90% of negotiated rate	70% of Allowed Charge
MEDICAL AND HOSPITAL SERVICES		
Physician Services	90% of negotiated rate	70% of Allowed Charge
Lab and X-ray	90% of negotiated rate	70% of Allowed Charge
Chiropractic and Acupuncture	Maximum of 30 visits per person per calendar year for chiropractic and 30 visits per person per calendar year for acupuncture. Chiropractic supplies are not covered.	
	90% of negotiated rate	70% of Allowed Charge
Outpatient Surgery	Non-elective surgery: 100% of negotiated rate	Non-elective surgery: 100% of Allowed Charge
	Elective surgery: 80% of negotiated rate after deductible	Elective surgery: 80% of Allowed Charge after deductible
Inpatient hospitalization (except for certain maternity inpatient stays) must be authorized in advance under the Utilization Review program.		
Inpatient Hospital	100% of negotiated rate (deductible waived)	80% of Allowed Charge for semi-private room and ancillary services (deductible waived)
Outpatient Hospital	80% of negotiated rate after deductible (deductible waived only for emergency services)	80% of Allowed Charge after deductible (deductible waived only for emergency services)
Inpatient hospitalization must be authorized in advance under the Utilization Review program.		
Chemical Dependency (Employee only)		
• Inpatient	100% of negotiated rate (Deductible waived)	80% of Allowed Charge (Deductible waived)
• Outpatient	90% of negotiated rate	70% of Allowed Charge
Inpatient hospitalization must be authorized in advance under the Utilization Review program		
Mental Health		
• Inpatient	100% of negotiated rate (Deductible waived)	80% of Allowed Charge (Deductible waived)
• Outpatient	90% of negotiated rate	70% of Allowed Charge

[1] Remember, when you see an out-of-network provider for care, the provider may balance bill you for any amount more than the Plan’s Allowed Charge. If this is the case, you are responsible for paying the balance in addition to your coinsurance.

	Comprehensive Self-Funded Medical Benefits through Anthem Blue Cross	
	Anthem Blue Cross Contracted Provider (In-Network)	**Out-of-Network**[1]
Ambulance	80% of Allowed Charge	80% of Allowed Charge
Durable Medical Equipment	90% of negotiated rate	70% of Allowed Charge
Hospice Care	80% of negotiated rate	80% of Allowed Charge
	Bereavement counseling for immediate family members in the six-month period following a covered family member's death will be payable the same as any other outpatient counseling.	
Home Health Care	80% of Allowed Charge, home health aide services are limited to 100 visits per calendar year. One home health aide visit is four hours or less. Nutritional counseling limited to $50 maximum. Any Medically Necessary charges over the dollar maximum will be reimbursed at 10% of the Allowed Charge.	
Skilled Nursing Facility (SNF)	Plan covers eligible charges for up to 120 days per period of disability, (deductible waived)	
	80% of negotiated rate	80% of Allowed Charge
Physical Therapy	90% of negotiated rate	70% of Allowed Charge
Occupational Therapy	$40,000 per person per injury/illness limit	
	90% of negotiated rate	70% of Allowed Charge
Speech Therapy	Covered only following stroke, accident, injury or surgery	
	90% of negotiated rate	70% of Allowed Charge

Prescription Drugs Administered through Caremark (for Self-Funded Medical Plan Enrollees)	
CAREMARK RETAIL PHARMACY	
Generic	$4.00 copayment up to greater of 34-day or 100-tablet maximum
Brand Name	$7.00 copayment up to greater of 34-day or 100-tablet maximum
	If your doctor allows a generic substitution, but you request a brand name drug, you must pay the difference between the generic and brand name price, in addition to your copayment
CAREMARK MAIL SERVICE (Home Delivery)	
Generic	$4.00 copayment up to a 90-day supply
Brand Name	$7.00 copayment up to a 90-day supply
	If your doctor allows a generic substitution, but you request a brand name drug, you must pay the difference between the generic and brand name price, in addition to your brand name copayment.

[1] Remember, when you see an out-of-network provider for care, the provider may balance bill you for any amount more than the Plan's Allowed Charge. If this is the case, you are responsible for paying the balance in addition to your coinsurance.

Information About Medicare Part D Prescription Drug Plans for Individuals with Medicare

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. **It has been determined that the prescription drug benefits for all of the plan options offered by the Fund are creditable.** This means that the value of this Plan's prescription drug benefit is, on average, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

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

- If you are an active employee or dependent of an active employee and are eligible for Medicare, you do not have to do anything at this time.
- Upon retirement, former employees and family members not yet eligible for Medicare are allowed to continue their medical and prescription drug coverage through the Trust by self-paying the required monthly premiums.

When you become eligible for Medicare as a retiree and your Trust coverage is terminated, you will be able to sign up for Medicare Part D coverage without premium penalty as long as you enroll timely (within 63 days following your initial Medicare eligibility date).

Dental Benefits

Please note that the summary below is for benefits under the Delta Dental Self-Funded Plan. If you are enrolled in MetLife Dental, refer to your ***Evidence of Coverage*** document for details on your coverage.

Dental Self-Funded Benefits Administered by Delta Dental	
Plan Maximum	$2,000 per person per calendar year (does not apply to pediatric dental services for children under age 19). Does not include Diagnostic and Preventive services
Deductible	$30 per person, maximum of $60 per family, per calendar year
Diagnostic and Preventive Services (cleanings, exams)	100% of Covered Charges (deductible waived)[1]
Basic Benefits (X-rays, oral surgery, fillings)	85% of Covered Charges if provided by DeltaPreferred Option Dentist* 75% of Covered Charges if provided by any other dentist*
Restorative (crowns, inlays)	85% of Covered Charges if provided by DeltaPreferred Option Dentist* 75% of Covered Charges if provided by any other dentist*
Prosthodontic (fixed bridges, dentures)	85% of Covered Charges if provided by DeltaPreferred Option Dentist* 75% of Covered Charges if provided by any other dentist* (benefits limited to only once every 5 years to the same tooth; refer to page 53 for more information)
Orthodontia	Not covered

[1] Refer to the Dental section of the booklet beginning on page 51 for details of how the Delta Dental benefits are paid.

Vision Benefits

Please note that the summary below is for vision benefits if you are enrolled in the Comprehensive Self-Funded Medical Benefits Plan or Anthem HMO. If you are enrolled in Kaiser HMO, refer to your ***Kaiser Evidence of Coverage*** document for details on your vision coverage or call Kaiser. **This is a brief summary of your benefits if you use an Eyemed provider.** See the Vision section of this SPD for a more complete description of benefits available.

Vision Benefits Administered by Eyemed	
Plan Maximum	One exam, pair of lenses and frames every 12-month period (from your last date of service including dates of services prior to your effective date)
Exam	$10 copayment
Standard Plastic Lenses	$25 copayment
Frames	$140 allowance, 20% discount on balance over $140
Contacts	Up to $55 payment for standard contact lens fit and follow up. 10% discount off retail price for premium contact lens fit and follow up.
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price

Life Insurance and Accidental Death and Dismemberment Benefits

NOTE: This benefit is available to you only if specified in the terms of your Collective Bargaining Agreement. This benefit is fully insured with ING Benefits.

Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits		
Employee Life Insurance Benefit	• 500 times monthly dues rates (reduced to $2,000 at age 70) • Maximum benefit is $75,000	
Accidental Death and Dismemberment Benefits (Employees only)	Loss of: • Both hands, • Both feet, • Sight of both eyes, • One hand and one foot, • One hand and sight of one eye, or • One foot and sight of one eye	The full amount indicated above for the Loss of Life
	Loss of: one hand, one foot, or sight of one eye	One-half the amount indicated above for Loss of Life
Dependent Life Insurance	• Spouse: $1,500 • Unmarried Children: $100 for ages 14 days to six months; • $750 for ages six months to 19 years (or age 23 if full-time student)	

NOTE: Domestic partners and their dependents are not eligible for Life Insurance or AD&D benefits.

3. Eligibility and Enrollment

Employees are eligible for coverage if they work for an employer who has signed a Collective Bargaining Agreement with Stationary Engineers Local 39 agreeing to contribute to the Trust Fund on behalf of eligible employees who work a minimum of 80 hours each month. Depending on the terms of the Collective Bargaining Agreement, you can become eligible for coverage in one of two ways:

- On the first day of the second calendar month following the month in which you worked 80 hours or more for your employer; or
- On the first day of the calendar month immediately following the month in which you worked 80 hours or more for your employer.

You continue to be eligible for benefits provided you work the required 80 hours during a calendar month.

FAST FACTS

- You must work 80 hours or more per month to be eligible for coverage. The exact date of when coverage begins depends on your employer's Collective Bargaining Agreement. Check with the Administrative Office to confirm the exact date of your eligibility.
- You select the benefit coverages you want at the time you are first eligible. You may choose from several medical and dental options, depending on where you live.
- You have the opportunity to make changes to your health plan after 12 months of coverage, or if you experience a Special Enrollment event (see page 14).
- You continue to be eligible for benefits provided you work the required 80 hours during a calendar month.
- If you fail to work the required 80 hours in a month because of accident, illness or layoff, and if the terms of your Collective Bargaining Agreement provide for it, then your eligibility may be extended, usually up to a maximum of three consecutive months.

Eligibility for Your Spouse and Children

Your Dependents become eligible on the effective date of your eligibility once you complete the Plan's enrollment form. **However, if you are enrolled in an HMO, coverage for new Dependents may be delayed until the first day of the next month after you complete an enrollment form. You should contact the Administrative Office to request enrollment for new Dependents.**

Your eligible Dependents for health care benefits include your:

- Legal Spouse or Domestic Partner; and
- Your children (or those of your Domestic Partner) under age 26 who are natural children, legally adopted children, stepchildren, children who are required to be covered under a QMCSO, or children for whom you are the legal guardian. Legally adopted children are eligible when they are placed for adoption. A child is placed for adoption with you on the date you first become legally obligated to provide full or partial support of the child you plan to adopt.

Please note: Dependent children are eligible for medical, dental and vision coverage up to the end of the month in which the Dependent turns age 26 if the Employee is eligible for this coverage. Dependent children are eligible for life insurance up to age 19 (and 23 if a fulltime student) if the Employee is eligible for life insurance coverage and chooses to include coverage for Dependent Children

- **Disabled adult child:** An unmarried Dependent Child (as defined above) age 26 or older who is unable to earn a living because of mental retardation or physical disability is also considered an eligible Dependent, provided you remain eligible and the child:
  - Was both disabled and eligible under this Plan when he or she reached the limiting age; and
  - Is primarily dependent on you for support. You must send evidence of the child's dependence and incapacity to the Administrative Office within 31 days after the child attains the limiting age and periodically thereafter.

If your Domestic Partner (or a child of your Domestic Partner) do not qualify as tax dependents under IRC §152, your employer must include in your gross income the fair market value of the coverage provided to the Domestic Partner or child of your Domestic Partner. This is known as "imputed income." This will likely increase both the employee's taxable income and tax liability.

Qualified Medical Child Support Orders

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO), National Medical and Support Notice, or other court or administrative order. You may also enroll a child who is not in your custody if a QMCSO requires you to provide health coverage to that child. To be considered "qualified", a medical child support order must include:

- Your name and current address;
- Name and last known address of each child to be covered under this Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

QMCSOs should be sent to the Administrative Office. You will be notified of the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children who are not in your care under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA.

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

Eligibility for Domestic Partners (and his or her Dependents)

Your domestic partner (or his or her dependents) may be eligible to receive benefits through the Plan. A domestic partnership is defined as two persons who have an intimate, committed relationship of mutual caring, who live together and intend to do so indefinitely, who agree to be responsible for each other's basic living expenses, who are both 18 years of age or older, neither of whom is married, neither of whom is a close relative of the other, and neither of whom has a different domestic partner.

You and your domestic partner (or his or her dependents) must submit documentation in order to be eligible and meet eligibility requirements, as outlined below.

- You may submit a ***Certificate of Domestic Partnership*** from any city, county or state offering the ability to register a domestic partnership and such partnership has not been dissolved.
- Or, you may submit the following documentation:
    - Proof of joint residence (submit two):
        - A copy of current driver's license or identification card
        - A copy of mortgage in both of your names
        - A copy of lease or rental agreement in both of your names
    - Other documentation showing joint responsibility (submit one):
        - Copy of statement for joint bank account
        - Copy of utility statement in both of your names

Further, a notarized ***"Affidavit of Domestic Partnership"*** must be signed by the employee and domestic partner and filed with the Administrative Fund. The ***"Affidavit of Domestic Partnership"*** forms are available at the Administrative Office.

Termination of Domestic Partnership

It is your responsibility to notify the Administrative Office no later than 30 days after the termination of a domestic partnership. You will be responsible for any claims paid on behalf of your domestic partner after the date of termination. You cannot add a new domestic partner until six months have passed since the termination of an approved domestic partnership.

NOTE: Enrolling a Domestic Partner Might Increase Your Taxes

If a domestic partner (or the child of a domestic partner) are not considered your income tax dependent under applicable IRS rules, the value of the provided health care coverage must be added to your taxable earnings. Stationary Engineers Local 39 Health and Welfare Trust Fund will report to you the imputed taxable income value of the benefits provided to your enrolled domestic partner. It is your responsibility to report this income to the Internal Revenue Service. Although subject to federal taxation, some states, including California, do not tax the value of domestic partner health coverage provided to non-tax dependents. If you need further advice on this issue, please consult your tax advisor.

When Your Coverage Ends

Your employee coverage will end on the earliest of the following dates:

- The date the Plan terminates; or
- In accordance with the terms of the Collective Bargaining Agreement in effect between the Union and your employer, either the first day of the second calendar month following the month in which you fail to work 80 hours or the date that your Collective Bargaining Agreement is no longer in effect; or
- The date of entrance into full-time active duty with the Armed Services of the United States; or
- The date the Collective Bargaining Agreement between the Union and your employer ceases to be in effect. For example, if the CBA terminates in February, your coverage will terminate at the end of April.

Retroactive Cancellation of Coverage

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

When Coverage Can Be Extended

If you fail to work the required 80 hours in a month because of accident, injury, illness or layoff, and if the terms of your Collective Bargaining Agreement provide for it, then your eligibility may be extended, usually up to a maximum of three consecutive months. For more information about extending coverage, contact the Administrative Office.

When Your Dependent's Coverage Ends

Your Dependent's eligibility will terminate on the date your eligibility terminates or the end of the month following the date he or she no longer qualifies as a Dependent under the Plan, whichever is earliest. You are responsible for notifying the Administrative Office in writing within 60 days of the date any of your Dependents cease to qualify as a "Dependent" under the Plan's definition. ***If you fail to notify the Administrative Office, you may jeopardize the right to elect COBRA coverage and the Fund has the right to offset against future claims any amounts paid on behalf of ineligible dependents.***

Special Enrollment Rights

You are not permitted to make changes to your benefits more often than every 12 months unless you experience a Special Enrollment Event. Individuals enrolled during Special Enrollment have same benefit plan options and same cost and same enrollment requirements as other similarly situated individuals. Special Enrollment events include:

- Marriage (must request enrollment within 31 days) and If you get married, provide the Administrative Office with the original marriage certificate; (and, if applicable, an English translation), your spouse's date of birth and Social Security number; and a divorce decree or death certificate, if your new spouse is not your first spouse. If you acquire a new child through marriage, you must provide the Administrative Office with the child's birth certificate and the name of the parent who is eligible to participate in this Plan must appear on the birth certificate or adoption certificate.
- Acquire a new Dependent by birth, adoption, or placement for adoption of a child (must request enrollment within 90 days);
- Loss of Other Coverage - If, you did not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within **30 days** after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you, your Spouse and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; and you are eligible for coverage under this Plan, you may request enrollment for yourself and/or your Spouse and/or any Dependent Child(ren) within **31 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

If you get married…

You may wish to change your beneficiary for your Life and Accidental Death and Dismemberment insurance at this time.

If you have a baby…

If you have a baby, provide the Administrative Office with the following within 90 days of your child's birth:

- The baby's birth date;
- The baby's Social Security number;
- A copy of the baby's birth certificate with your name or your spouse's or domestic partner's name on it; and
- An English translation, if applicable.

- loss of eligibility for that coverage including loss resulting from divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered.

Exhaustion of COBRA Continuation Coverage

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

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

This Special Enrollment for loss of coverage does NOT apply to a retiree. Once a retiree loses coverage under this Plan, there is no opportunity for the retiree to re-enroll in the plan.

Medicaid or a State Children's Health Insurance Program (CHIP):

You and your dependents may also enroll in this Plan if you (or your eligible dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

In most cases, you have 30 days from the date of the event to request a change to your health care elections. However, if you are adding a new dependent child (due to birth, adoption or placement of adoption, losing eligibility for Medicaid or CHIP or becoming eligible for premium assistance through Medicaid or CHIP), you will have 90 days from the date of the event to request a change to your health care elections.

Benefit Options for Individuals Enrolled During a Special Enrollment period

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

Enrollment Forms

Every employee working for a contributing employer should complete an enrollment form. Enrollment forms are available at the Administrative Office and at the Local Union Offices.

After you have filed an enrollment form with the Administrative Office and upon establishing eligibility you will receive an identification card, either a Self-Funded Medical Plan Identification Card or an Identification Card from an HMO, whichever is appropriate.

You must notify the Administrative Office promptly in writing when ANY change occurs in the information provided on the enrollment form, for example marriage, birth of a child, death, divorce or any other change in dependent status or if you change your home address. You must also complete a new enrollment form to change your life insurance beneficiary.

If your enrollment form is not received within 60 days from the date you obtained initial eligibility, you will be enrolled in the Self-Funded Medical and Dental Plans. You may change this selection by completing an enrollment form and submitting it to the Administrative Office. Your change will be effective the first of the month following the month in which the enrollment form is received.

Enrolling a Dependent

You may request to enroll your eligible Dependents during the 90-day period after which they first became eligible and they will be eligible from the date they became your Dependent. Otherwise, if you add them at a later date, they will be eligible on the first of the month following the month in which the Administrative Office received all required enrollment materials.

If You Move

If you have a change of address, please notify the Administrative Office as soon as possible to make sure your records are up to date and to avoid a delay in payment of claims. Also, if you move out of an HMO's service area your coverage could be affected.

If You Have a Domestic Partner

Your same-sex or opposite-sex domestic partner and his or her eligible children may be covered through the Plan if they meet Plan eligibility requirements, shown on page 12. In addition, you must submit documentation—a notarized ***"Affidavit of Domestic Partnership"***—in order for your domestic partner and his or her Dependent children to be eligible for coverage. You must also submit birth certificates for your domestic partner and his or her Dependent children in order to enroll them. Contact the Administrative Office for the ***"Affidavit of Domestic Partnership"*** form.

Note that enrolling a domestic partner (and his or her eligible children) might increase your taxes because the value of the coverage must be reported as taxable income to the IRS. Refer to page 12 for more information about eligibility for a domestic partner (and his or her eligible children). Note also that domestic partners and their Dependents are not eligible for Dependent Life insurance coverage under the Plan.

If You Have a Baby

If you have a baby, your child is automatically covered by the Plan from the date of birth, provided you submit an updated enrollment form to the Administrative Office and the child's birth certificate and Social Security number when they become available.

Maternity benefits or any condition relating to pregnancy are payable under the hospital expense provisions of the Plan. PPO and Non-PPO routine nursery charges for a newborn infant during the mother's hospital stay following delivery are covered if the mother is the spouse of the Active Employee (or the Active Employee).

Note that a participant who is pregnant and enrolled in the Delta Dental Plan is entitled to one additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant during the pregnancy. Written confirmation of the pregnancy must be provided to Delta Dental when the claim is submitted, such as a note from your obstetrician.

What You Need To Do

If you have a baby, provide the Administrative Office with the following within 90 days of your child's birth:

- The baby's birth date;
- The baby's Social Security number;
- A copy of the baby's birth certificate with your name or your spouse's or domestic partner's name on it; and
- An English translation, if applicable.

If Your Dependent Child Has a Baby

If your Dependent child has a baby, the baby is **not** considered an eligible Dependent under the Plan since grandchildren are not eligible for coverage unless the employee is the legal guardian. This means that you may incur additional charges for the newborn during the mother's hospital stay following delivery at a non-PPO hospital. (PPO hospitals will usually cover routine nursery charges for the newborn as part of the covered maternity expenses.)

Required Documentation

You must provide the Administrative Office with the child's Social Security number and the child's birth certificate identifying at least one of the parents as a participant or spouse of the participant. If you are unable to get the paperwork to the Administrative Office within the 30-day period due to circumstances beyond your control, notify the Administrative Office immediately in writing to request an extension.

If You Adopt a Child

If you adopt a child (or have a child placed with you for adoption), contact the Administrative Office. You have 90 days from the date of the adoption (or placement for adoption) to enroll your child. If you are unable to get the paperwork to the Administrative Office within the 90-day period due to circumstances beyond your control, notify the Administrative Office immediately in writing to request an extension.

What You Need To Do

If you adopt a child or become the legal guardian of a child, you must provide the Administrative Office with the following within 90 days of the date of adoption placement:

- The child's birth certificate;
- The child's Social Security number; and
- The adoption agency official paperwork indicating the specific date that the child was placed in your home.

If You Become the Guardian of a Child

If you become the legal guardian of a child not otherwise eligible for benefits as a Dependent under this Plan, you may be able to add him or her as a Dependent provided you meet the requirements as the child's guardian. You must be able to demonstrate that you have been designated as the legal guardian for the child.

If You Take Family Medical Leave

If you are entitled to take Family Medical Leave to deal with a serious illness, birth of a child, or to care for a seriously ill parent or spouse, the Family Medical Leave Act (FMLA) allows you to continue coverage for the period of authorized leave (generally 12 weeks and in some cases, up to 26 weeks). The Trust Fund will provide continuing medical coverage so long as required monthly contributions are received from your contributing employer. Your employer should certify that you meet the requirements of FMLA and make the required contribution to the Administrative Office.

It is not the role of the Trustees or the Administrative Office to determine whether or not an individual employee is entitled to leave with continuing coverage under the federal statute, any state statute or the provisions of a Collective Bargaining Agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved between you, your employer and where applicable, the local union.

If You Become Disabled

If you become disabled you may be eligible for extended coverage if this has been provided for under the terms of your Collective Bargaining Agreement (refer to page 18). Otherwise, you may continue your coverage under the terms of the federal COBRA Continuation of Coverage regulations (refer to the section beginning on page 23).

If Your Employment is Terminated

If your coverage ends due to termination of your employment or insufficient hours, you may be eligible to purchase COBRA Continuation Coverage for you and your family. Your employer will notify the Administrative Office of your termination, but you are encouraged to inform the Administrative Office to avoid confusion in the event of a delay. For more information on COBRA, refer to the section beginning on page 23.

Extended Benefits Provision (Does not apply to HMOs)

If you or your Dependent are totally disabled when coverage ends due to loss of eligibility and you are under the treatment of a physician, comprehensive medical benefits may continue to be provided for treatment of the totally disabling illness or injury only. These extended benefits are provided until the first of the following occurs:

- The date the total disability ceases.
- Any Plan maximum that relates to the total disability has been paid.
- The date the person ceases to be under the continuous care of a physician for the total disability.
- A period of 12 consecutive months has passed since the date coverage ended.

IMPORTANT NOTE: Benefits are not extended for any person other than the person with the total disability and benefits are payable only for treatment of that totally disabling illness or injury. In addition, this **extended benefits provision is in lieu of COBRA** Continuation Coverage. This means that when this extension terminates, you may continue COBRA continuation for only an additional 6 months.

For purposes of this provision, ***total disability*** means:

- For the employee, that as a result of injury or illness, he is unable to engage in his or her usual occupation.

- For a Dependent, that as a result of injury or illness, he or she is prevented from engaging in all regular and customary activities usual for a person of similar age and family status.

If You Divorce

If you divorce, your former spouse may continue coverage under COBRA for up to 36 months. You must notify the Administrative Office within 60 days of the day that the divorce becomes final. The Administrative Office will then send a COBRA election notice and enrollment information to your former spouse. For more information, refer to the section beginning on page 23. If you remarry, you must present proof of divorce before you can add a new spouse.

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order, National Medical Support Order or other judgment or decree that recognizes that children residing with a custodial parent may be entitled to benefits under this Plan in the event of a divorce or other family law action. Orders must be submitted to the Administrative Office to determine whether the order is a QMCSO under federal law. The Plan will recognize a QMCSO that:

- Provides for health coverage to the child(ren) under state domestic relations law (including a community property law); and
- Relates to benefits under this Plan.

Please notify the Administrative Office if your situation involves a Medical Support Order. For information about how these orders are handled, you and/or your and beneficiary(ies) can obtain, without charge, a copy of the Plan's QMCSO procedures from the Administrative Office.

If You Enter Active Military Service

You must notify the Administrative Office if you are called to military leave in order to make any required payments to continue your health care coverage in your absence.

If your coverage ends under the Plan because you are absent from employment due to your service in the United States Armed Forces for less than 31 days, your coverage will be reinstated when you return to full-time employment as required by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If your coverage ends under this Plan because you are absent form employment due to your service in the United States Armed Forces for more than 30 days, you and your Dependents will be considered "Qualified Beneficiaries" for purposes of electing USERRA Continuation Coverage, which operates similar to COBRA continuation coverage, except as provided below. (See information beginning on page 23 for a full explanation of the COBRA coverage provisions, which may allow you to continue your health care coverage at your own expense.)

Contact the Administrative Office

Make sure you let the Administrative Office know if you are entering or returning from military service.

In addition, your Dependents may be eligible for health care coverage under a government health insurance program known as TRICARE. This Plan will coordinate with TRICARE in accordance with the requirements of federal regulations if you elect to continue coverage and make the required self-payments.

You and your eligible Dependents will receive a right to elect USERRA coverage for up to 24 months from the date on which your absence due to active duty begins. The maximum period of coverage will be shorter if your coverage ends before 24 months or if you fail to apply for or return to a position of covered employment within the timeframes allowed under USERRA. If you elect to continue coverage under this provision, the cost of your coverage will be up to 102% of the full cost of coverage. Payment must be received in a timely manner in order for coverage to continue. If you do not elect continuation coverage under USERRA, your Dependents may elect to continue coverage under COBRA.

When you are discharged (not less than honorably) from "service in the uniformed services," your full eligibility will be reinstated on the day you return to work, provided that you return to employment:

- Within 90 days from the date of discharge if the period of service was more than 180 days; or
- Within 14 days from the date of discharge if the period of service was 31 days or more but less than 181 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of services was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits may be extended up to two years.

Reinstatement of Coverage (for USERRA or FMLA)

If your coverage ends while you are on an approved leave of absence for family, medical or military leave, if you are benefits-eligible upon return, your coverage will be reinstated on the first day of the month following your return to active employment, if you return within 14 days after your leave of absence ends, and subject to all accumulated maximum plan benefits that were incurred prior to the leave of absence.

If You Retire

The Plan provides self-pay retiree medical and prescription drug coverage for yourself and your eligible Dependents if you are eligible for retiree benefits (see below) and not eligible for Medicare. **Dental, vision and life insurance coverage are not offered to retirees through this Plan.**

This program allows you to self-pay for continuing health coverage through an HMO option under the Plan until you are eligible for Medicare. The health plans currently offered are Kaiser and Anthem HMOs. A Self-Funded plan will only be offered if you live outside of Kaiser's and Anthem's service areas. Complete summaries of the benefits are available at the Administrative Office. Call the Administrative Office if you need more information.

Eligibility for Retiree Program

- You must be at least age 55 to participate in the Plan. You must also be receiving a retirement benefit from the Stationary Engineers Local 39 Pension Plan. The Plan covers eligible retirees until they are eligible for Medicare.
- To qualify, you must have been eligible and participating as an Active Employee in the Stationary Engineers Local 39 Health and Welfare Trust Fund for a minimum of five total years and at least 12 of the 24 months immediately preceding your retirement.
- You may cover Dependents under the self-pay retiree program who qualified as eligible Dependents under the Plan at the time you retire and are enrolled as Dependents under your active coverage. You may not add a dependent after your initial enrollment in the retiree plan.

Please note: the effective date of your Retiree health benefits will be the commencement date of your first pension check.

Making Self-payments for Coverage

Self-payments are to be made by a method of direct deposit only. Your premiums will automatically be deducted from your pension check or other account at the beginning of every month and transferred to a Stationary Engineers Local 39 Health & Welfare Trust Fund account. Payment must be received by the 10th day of the month of coverage. Late payments received between the 11th and 20th of the month will incur a 5% liquidated damages penalty. **Payment not received by the 20th of a month will result in permanent disenrollment.**

Self-pay rates are based on the expected experience of a group in this age category and will be adjusted at the beginning of each calendar year.

Enrolling in the Retiree Plan

Call the Administrative Office at least 30 days prior to your retirement date if you are interested in the retiree health insurance program. You will be required to complete a retiree health and welfare benefit program application before your initial eligibility becomes effective. Call the Administrative Office if you have any questions.

Once enrolled in the retiree program, you may later decide not to participate by disenrolling. ***Once you disenroll, you or your Dependents will not be allowed to re-enroll.***

After your initial retirement, you may decide to return to work under a related Collective Bargaining Agreement. You will still be eligible for the retiree program as long as your hours of covered employment do not exceed 80 in a month. If you work enough hours to trigger an employer contribution, you will return to active status. When you do not work the necessary hours to generate an employer contribution on your behalf, you will return to retiree status and any self-pay contribution will be deducted from your pension check once again.

The retiree program should not be construed as a promised or vested benefit. The Trustees reserve the right to modify or eliminate the program at any time.

If You Become Eligible for Medicare

If you are retired and you or your covered spouse becomes eligible for Social Security retirement benefits at age 65, or if you become eligible for Medicare due to disability, **you MUST enroll in Medicare and your coverage under this Trust Fund will terminate.** Medicare is the federally sponsored health care program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B). Medicare also offers prescription drug coverage (Part D).

What You Need To Do

To enroll in Medicare:

- Visit your local Social Security Office;
- Call 1-800-Medicare; or
- Visit Medicare online at www.medicare.gov.

WHEN TO ENROLL: Please note that you are not automatically enrolled in Medicare Parts A and B. If you are retired, you must enroll in Medicare as soon as you are eligible—three months before your 65th birthday or in certain cases when you become disabled—in order to avoid a gap in coverage.

If you are an Active Employee, you may wish to delay enrollment in Medicare Part B as that coverage may duplicate the benefits provided by the Plan; there is no penalty for delayed enrollment as long as you enroll in Medicare during the seven-month period immediately following termination of eligibility under the active Plan.

If you are an Active Employee, or the Dependent of an Active Employee, and you are eligible for Medicare due to having reached age 65 or because of disability, this Plan will be primary to Medicare. This means that Medicare may pick up whatever eligible expenses remain after the Plan has paid its share. You may also select Medicare as your primary coverage but in that case, this Plan will not pay for any services of the type covered by Medicare.

If you are entitled to Medicare because you have end-stage renal disease (ESRD), Medicare will become primary to the Plan after a period of up to 33 months after you begin treatment.

If You Die

If you die from any cause while you are covered under the Plan, your eligible Dependents may be able to continue coverage through COBRA. Surviving Dependents must make their COBRA contributions directly to the Administrative Office. Refer to the next section for more information on COBRA Continuation Coverage.

If you die while an Active Employee, your designated beneficiary may qualify for a benefit through the life insurance plan. In order to receive the benefit, your Collective Bargaining Agreement must provide this coverage. Refer to page 61 of this booklet for the Life Insurance and Accidental Death and Dismemberment section.

4. Continuing Your Coverage

FAST FACTS
• In certain circumstances, you and your Dependents may be eligible to temporarily continue coverage under COBRA. • Your children are eligible to temporarily continue coverage under COBRA when they no longer qualify as Dependents because of age. • To continue your COBRA coverage, you must make timely monthly payments to the Administrative Office. You are fully responsible for the payment of your benefits through COBRA.

COBRA Continuation Coverage

If your coverage under the Health and Welfare Plan ends due to a "Qualifying Event" (see below), you and/or your eligible Dependents may be eligible to continue your health care coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

By making monthly payments, you and/or your Dependents may continue the same medical, prescription drug, vision and dental coverage that you had before your coverage ended. Your coverage can last for up to 18, 29, or 36 months, depending on the Qualifying Event that resulted in your loss of coverage.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace** (the Marketplace helps people without health coverage find and enroll in a health plan, for California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov).

NOTE: Domestic Partners and children of Domestic Partners are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends (described in this chapter); however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary. This chapter describes in general how the Domestic Partner COBRA-like benefit will work. Contact the Administrative Office for questions.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

Qualifying Events

To be eligible to elect COBRA Continuation Coverage, you and/or your Dependent(s) must lose coverage due to any one of the Qualifying Events, shown on the next page.

Qualifying Event	Who May Purchase	Eligibility	Notification Requirements
TERMINATION Employee terminated for reason other than gross misconduct	Employee, spouse and/or Dependent children	18 months (24 months if due to military service)	Your Employer will notify the Administrative Office (Termination due to military service is the employee's responsibility to notify the Administrative Office.)
REDUCTION IN HOURS Employee's reduction in hours worked (making employee ineligible for coverage under the Plan). This includes if you retire.	Employee, spouse and/or Dependent children	18 months	Your Employer will notify the Administrative Office
DEATH of Employee	Spouse and/or Dependent children	36 months	Employer must notify the Administrative Office (A family member may also wish to do this)
DIVORCE Employee is divorced from spouse	Spouse and/or Dependent children	36 months	You or your spouse must notify the Administrative Office
CHILD IS NO LONGER ELIGIBLE FOR COVERAGE	Dependent child	36 months	You or your Dependent must notify the Administrative Office

Who May Elect COBRA?

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA Continuation Coverage. A Qualified Beneficiary is any employee or his or her spouse or Dependent child who was covered by the Health and Welfare Plan when a Qualifying Event occurs. You may add your newborn or adopted child(ren) to your continuation coverage, provided you request to add the child(ren) within 30 days of the birth or adoption and pay any additional premium. A child who becomes a Dependent child by birth, adoption or placement for adoption with the employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. However, a spouse you acquire as a spouse during COBRA Continuation Coverage is not a Qualified Beneficiary and has no rights to extended coverage in the event of a second Qualifying Event. Refer to page 14 under ***"Special Enrollment Rights"*** for more information.

One or more of your family members may elect COBRA even if you do not. Additionally, one member may elect COBRA for all Qualified Beneficiaries. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of Dependent children.

Withdrawal of Contributing Employer

You will not be able to elect COBRA Continuation Coverage under the Plan if you lose eligibility because your employer no longer contributes to the Plan.

If you experience a Qualifying Event as described in the table above, and you or your Dependents elect COBRA Continuation Coverage and your former employer later stops contributing to this Fund, you may continue your coverage under COBRA to the end of your continuation period (i.e., 18 months or 36 months). However, if your former employer has an existing plan or establishes a new plan to cover a class of Active Employees formerly covered under this Fund, your COBRA Continuation Coverage will be terminated under the Plan since your former employer is required to provide COBRA continuation coverage for you and/or your Dependents.

COBRA Notification Procedures

The Administrative Office must be notified of your Qualifying Event in order for you to elect COBRA Continuation Coverage.

Your employer is required notify the Administrative Office in the event of your termination of employment, reduction of your hours or your death.

If your spouse or child qualifies for continuation of coverage due to a Qualifying Event such as divorce or ceasing to meet the definition of a Dependent under the Plan, you or your spouse or child must notify the Administrative Office. This notice should be given no later than 60 days after the Qualifying Event.

If you fail to provide this notice within 60 days, your Dependent's right to continue coverage under COBRA will be lost.

What To Do If You Experience a Qualifying Event

Inform the Administrative Office of the Qualifying Event and request a COBRA election form:

- Complete and mail back the election form within 60 days.
- Make your first payment to the Administrative Office within 45 days of your election for COBRA coverage.
- Ongoing, pay for COBRA within 30 days of the due date, which is the first of the month.

When to Send Notice of the Qualifying Event

If you are providing notice due to a divorce, a Dependent losing eligibility for coverage or a second Qualifying Event (refer to page 27), you must send the notice no later than 60 days after the later of (1) the date upon which coverage would be lost under the Plan as a result of the Qualifying Event (2) the date of the Qualifying Event or (3) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Administrative Office.

If you are providing notice of a **Social Security Administration determination of disability**, notice must be sent no later than the end of the first 18 months of COBRA Continuation Coverage.

If you are providing notice of a Social Security Administration determination that you are **no longer disabled**, notice must be sent no later than 30 days after the later of (1) the date of the determination by the Social Security Administration that you are no longer disabled or (2) the date on which the Qualified Beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Administrative Office.

Who Should Send the Notice?

Your employer is required notify the Administrative Office in the event of your termination of employment, reduction of your hours or your death.

For all other Qualifying Events, notice may be provided by the covered employee, the Dependent who loses coverage, or any representative acting on behalf of the covered employee or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. For example, if an employee and his or her spouse and child are all covered by the Plan, and the child ceases to be a Dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

Keep the Plan Informed of Address Changes

In order to protect your rights, you should keep the Administrative Office informed of any changes in your address and the addresses of family members. You should also keep a copy for your records of any notices you send the Administrative Office.

How to Elect COBRA Continuation Coverage

You (or your employer) should contact the Administrative Office within 60 days from the date that the Qualifying Event occurs, or the date that you would lose coverage under the Plan because of the Qualifying Event, whichever is later. See the Notification Procedures below.

When the Administrative Office receives notice of the Qualifying Event, you will be mailed an election form, information about COBRA and confirmation of the date on which your coverage will end.

Under the law, you and/or your eligible Dependents have 60 days from the later of the date:

- You would have lost coverage because of the Qualifying Event; or
- You and/or your eligible Dependents received the election form and COBRA information,

to provide the Administrative Office with your completed election form.

If you and/or any of your eligible Dependents do not elect COBRA within 60 days of the Qualifying Event or the date you would lose coverage, you and/or your eligible Dependents will not have any group health coverage from the Health and Welfare Plan after your coverage ends.

Paying for COBRA Continuation Coverage

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your Dependents become eligible for this coverage, the Administrative Office will notify you of the COBRA premium amounts that you must pay.

Your COBRA premiums may be as high as 102% of the Plan's cost, except in the case of Social Security disability. (See ***"COBRA Continuation Coverage for Disabled Participants,"*** page 27)

You must send the **first COBRA payment** to the Administrative Office within **45 days** from the date you elect COBRA coverage. That first payment must include all payment due to cover the months from the date you lost coverage until the month in which the payment is made. There can be no gaps in coverage.

Late COBRA Payments

After the first premium, your monthly payments are due on the first day of each coverage month and will not be accepted if it is received more than 30 days after the due date (the grace period). ***Once coverage is terminated for non-payment, it cannot be reinstated.***

What If the Full COBRA Premium Payment Is Not Made When Due?

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

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

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

- If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred.

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

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Plan to inform your physician and health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the physician or provider is requesting confirmation of coverage when you are eligible for, but have not yet elected, COBRA coverage, or you have elected COBRA coverage but have not yet paid for it.

It is **recommended** that you make your payment by the 20th of the month prior to the coverage month. If your payment is not received by the 20th you may not be reported as eligible for coverage and claims may be denied or you may not be shown as eligible under your HMO Plan and be denied services. Your coverage will be reinstated if your payment is received by the Administrative Office by the end of the grace period.

How COBRA Can Be Extended When Original Eligibility Was for 18 Months

Qualifying Event	Who May Purchase	Eligibility	Notification Requirements
ELIGIBILITY FOR SOCIAL SECURITY DISABILITY Employee or a Dependent is determined by Social Security to be disabled before the 60th day of COBRA.	Employee, spouse and/or Dependent children	29 months (11 additional months)	You must notify the Administrative Office within 60 days of receiving Notice from Social Security and before the end of the first 18 months
MULTIPLE QUALIFYING EVENTS—Death, Divorce or Child No Longer Qualifying as Dependent	Spouse and/or Dependent Child(ren)	Up to 36 months from the original Qualifying Event	Employee, Spouse or Dependent Child must notify the Administrative Office within 60 days of the employee's death, divorce or the event that caused the child to no longer qualify as a Dependent
EMPLOYEE'S ELIGIBILITY FOR MEDICARE	Spouse and Dependent Children	Up to 36 months from the original Qualifying Event	You must notify the Administrative Office when you became entitled to Medicare

COBRA Continuation Coverage for Disabled Participants

If you are covered under COBRA for 18 months, and within the first 60 days of coverage you (or any of your Dependents) become disabled, you (and your Qualified Beneficiaries who elected COBRA) may be eligible to continue your COBRA coverage for an additional 11 months, for a total of 29 months (or until the person is no longer disabled).

To be eligible, the Social Security Administration must make a formal determination that you (or your Dependent) were disabled effective within the initial 60-day period of the start of your COBRA coverage and therefore entitled to Social Security Disability income benefits. You (or your Dependent) must notify the Administrative Office of the Social Security determination of disability before the end of the 18-month initial COBRA period and within 60 days of receiving the Notification from Social Security, if you wish to continue with the 11-month extension.

If you are eligible for the 11-month extension, your COBRA premiums may be as high as 150% of the Plan's cost for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month that occurs 30 days after Social Security has determined that you and/or your Dependent(s) are no longer disabled;
- The end of the 29 months COBRA Continuation Coverage;
- The date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Administrative Office within 30 days of:

- The date that you receive a final Social Security determination that you and/or your Dependent(s) are no longer disabled; or
- The date that the disabled person becomes entitled to Medicare.

Multiple Qualifying Events While Covered Under COBRA

The maximum period of coverage under COBRA is 36 months, even if you experience another Qualifying Event while you are already covered under COBRA. If you are covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected spouse or Dependent may extend coverage for another 18 months in the event of:

- Your death:
- You get divorced; or
- Your child is no longer a Dependent under the Plan's definition.

For example, you stop working (the first COBRA-Qualifying Event), and you enroll yourself and your Dependents for COBRA Continuation Coverage for 18 months. Three months after your COBRA Continuation Coverage begins, your child turns 26 and no longer qualifies as a Dependent child under the Plan's definition. Your child then can continue COBRA Continuation Coverage separately for an additional 33 months, for a total of 36 months COBRA Continuation Coverage.

You, as the employee, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless the 11-month Social Security Disability extension applies). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and you may not extend your coverage.

Special HIPAA Enrollment Rights

If you marry, have a newborn child, adopt a child or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage. You must request to enroll your new Dependent within 30 days of the marriage or within 90 days of birth, adoption or placement for adoption, with proper documentation.

In addition, if you are enrolled for COBRA Continuation Coverage and your spouse or Dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of your COBRA if you request enrollment within 30 days after the termination of the other coverage.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- You do not make all required payments on time;
- The person receiving the COBRA coverage becomes entitled to Medicare;
- The Trust Fund terminates its group health Plan and no longer provides group health coverage to its participants;
- Your former employer ceases to be a signatory to the Collective Bargaining Agreement and offers coverage to its active employees under another plan.
- During an extension of the maximum COBRA coverage period to 29 months due to the disability of a Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled.

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

California Cal-COBRA Rights (for HMO Participants only)

If you live in California and are enrolled in one of the fully insured HMOs, you can extend coverage beyond the 18 or 29 months permitted under federal COBRA under "Cal-COBRA". California law requires HMOs in the state to offer qualified beneficiaries who exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage, to a total of 36 months from the date federal COBRA began. This state law requirement does not apply to the self-funded Stationary Engineers medical Plan. Cal-COBRA coverage may cost more than federal COBRA coverage.

Conversion Privilege (for HMO Participants Only)

At the end of the COBRA Continuation Coverage period, HMO participants may be entitled to enroll in an individual conversion plan through your HMO. This plan may cost more and provide fewer benefits than your group health coverage.

Notice of Unavailability of COBRA Continuation Coverage

In the event the Administrative Office is notified of a Qualifying Event, but the Administrative Office determines that an individual is not entitled to the requested COBRA Continuation Coverage, the individual will be sent an explanation indicating why the COBRA Continuation Coverage is not available. This notice of the unavailability of COBRA Continuation Coverage will be sent according to the same timeframe as a COBRA election notice.

If You Have Questions

If you have questions concerning the Plan or your COBRA Continuation Coverage rights, contact the Administrative Office. For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

5. How Your Self-Funded Medical Plan Works

The Comprehensive Self-Funded Medical Benefits Plan (provided directly by the Trust Fund) covers office visits, hospitalization and surgery, wellness care and mental health and substance abuse treatment. If you prefer, you may elect to receive your medical coverage through one of the HMO options offered by the Plan.

Note that only the benefits of the Comprehensive Self-Funded Medical Benefits Plan are described in this booklet. For information on your HMO's coverage, refer to the ***Evidence of Coverage*** that you received from your HMO. Refer to the list of contacts on page 2 if you need to contact your HMO. A brief comparison between a Preferred Provider Organization (PPO) and HMO is offered below.

FAST FACTS

- You may change your health plan medical or dental options offered by the Plan no more frequently than every 12 months of coverage. Contact the Administrative Office for more information.
- Your eligible Dependents must be enrolled in the same plan as you.
- Compare the different costs and services of the different health care options carefully. For more information on HMOs, refer to the contact information on page 2.

Comparing the Self-Funded Medical Plan with a PPO to an HMO

Plan Comparison at a Glance

	Comprehensive Self-Funded Medical Benefits Plan: Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)
Description	A PPO is a network of preferred providers. You may visit preferred providers at a discounted rate, or visit out-of-network providers and pay higher coinsurance for covered services	You must visit providers in the HMO and select a primary care physician to coordinate your care
Restrictions	None	You must live in the HMO's service area
The Plan Pays	PPO-provider covered services are paid at a higher rate than out-of-network covered services	The full cost for covered services, minus your copayment, if applicable
You Pay	A percentage of the cost (your coinsurance). If you visit an out-of-network provider, you may also be responsible for paying the amount that the provider charges that is more than the Trust Fund's Allowed Charge	A copayment for services, if applicable
Deductible	$170 per individual or $340 per family, per calendar year (waived in specific circumstances)	None
Filing Claims	The PPO provider will file claims for you. You may have to file claims if you use an out-of-network provider	The HMO provider will file claims for you

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are managed health care programs that provide healthcare services through a network of healthcare facilities. If you enroll in an HMO, you select a primary care physician who becomes familiar with your health status and medical needs, then treats you or refers you to specialists within the network when necessary.

An HMO generally has lower out-of-pocket costs. If you elect an HMO, you can see only the physicians that are associated with the HMO plan to receive benefits. The Plan contracts with two separate HMO plans—refer to your enrollment materials for more information.

Preferred Provider Organization (PPO)

The Plan offers the **Anthem Blue Cross PPO BlueCard network** of doctors, specialists, hospitals and ancillary providers. Anthem Blue Cross contracts with these health care providers and offers services to employees at a discounted rates. This network of providers is called a Preferred Provider Organization. The PPO rate is called the "negotiated rate." The PPO is available in California and nationwide. Call (800) 810-BLUE for information on participating providers, or visit www.bluecares.com for a directory of providers. A directory of PPO providers is also available from the Administrative Office without charge.

> **Coinsurance**
>
> When you are required to share the cost for services by paying a percentage, your share is called "coinsurance." For example, if a covered service were covered at 90%, your coinsurance would be 10%.

When you visit a provider in the PPO (an **"in-network provider"**), you do not have to elect a primary care physician—you have the flexibility to see any doctor or specialist in the network without a referral.

If you choose to be covered under the Comprehensive Self-Funded Medical Benefits Plan, you are not required to visit a PPO provider. You can visit any provider you would like and you will still receive benefits for covered services. However, when you go out-of-network, your coinsurance costs are generally greater **and** you will pay the difference between the amount the out-of-network provider charges and the Fund's Allowed Charge, also called "balance billing." To avoid balance billing, choose in-network providers.

PPO Inter-Plan Arrangements

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area served by Anthem (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive covered services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for covered services through negotiated arrangements for national accounts.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or the negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments.

If Anthem has entered into a negotiated arrangement with a Host Blue to provide value-based programs to the Plan on your behalf, Anthem will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard Program.

D. Nonparticipating Providers Outside Anthem Service Area

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of Anthem's Service Area by non-participating providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for

the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. **Exceptions**

In certain situations, the Plan may use other pricing methods, such as billed charges the pricing it would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Plan makes for the Covered services as set forth in this paragraph.

E. BlueCard Worldwide® Program

If you plan to travel outside the United States, call customer service to find out your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency, including ambulance, outside of the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.
When you need BlueCard Worldwide claim forms you can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

You will find the address for mailing the claim on the form.

Annual Deductible

Before the Self-Funded Medical Plan begins to pay any benefits, unless specifically waived in the **Summary of Benefits**, you must satisfy an annual calendar-year deductible. The deductible is the dollar amount that you are responsible for paying for **Allowed Charges** you incur before the Plan will begin paying benefits for eligible covered services.

Each calendar year, the deductible applies to you and each member of your family, up to a maximum of $170 per individual or $340 per family. The deductible can be met by any number of family members. Once the out-of-pocket expenses for covered services for a family member reaches $170 in any calendar year, the Plan will begin to pay benefits for covered services for that family member.

Some services do not require you to meet a deductible before the Plan pays benefits. The deductible is waived for the following Allowed Charges:

- Hospital charges including outpatient hospital charges on the day of surgery, or for the emergency treatment of a non-occupational injury on the day of the accident, or the following day.
- Skilled Nursing Facility charges.
- Preoperative testing performed on an outpatient basis within seven days of a scheduled, covered surgery.
- Emergency outpatient surgery.

The $250 penalty that is required if you do not obtain pre-admission review prior to a hospital admission cannot be used toward satisfying the calendar year Deductible, nor does it count toward the Plan's coinsurance limit, described below. Refer to page 36 for more information on pre-admission review.

Deductible Carry-over Provision

Any Allowed Charges incurred in the last three months of the calendar year, which are applied toward meeting your annual deductible, will also be applied toward the deductible for the following year.

Coinsurance Limit / Out-of-Pocket Maximum

Once you and your family members have met your deductible, you share expenses with the Plan. Your portion of these expenses is called your "coinsurance"

Once the coinsurance expenses paid out of an individual's pocket reach $1,000 in a calendar year, the Plan will begin paying 100% of Allowed Charges for that person for the rest of the calendar year <u>and</u> the next calendar year (subject to the calendar-year deductible and any benefit maximums.) Note that the coinsurance limit does not apply to the following expenses, which are never covered at 100% and are unaffected by the coinsurance limit:

- Any non-covered services and supplies including any charges in excess of Allowed Charges.
- The additional $250 penalty incurred as a result of not obtaining a hospital preadmission review prior to a hospital admission.
- Copayments for Prescription Drugs administered by Caremark.

Allowed Charges

When you receive services from PPO providers, the Trust Fund (though its' contract with Anthem Blue Cross) has a negotiated payment rate that prevents the provider from billing you for any amounts that

exceed that rate. When you receive services from non-PPO doctors, hospitals and other health care providers, the Plan pays based on the Allowed Charge for the service (refer to the ***Glossary of Defined Terms***). You should be aware that these providers can bill you for their billed charges that exceed the Plan's Allowed Charge, in addition to your share of the Allowed Charge.

Certain Non-PPO Providers Paid at PPO Coinsurance

In certain limited circumstances the Plan will pay charges for services provided by a non-PPO physician at the PPO level of coinsurance. You may still be balance billed if the provider's charges exceed the Fund's Allowed Charge for the services.

The circumstances when your non-PPO provider charges will be paid at the PPO level of coinsurance are limited to the following:

- When you go to a PPO Hospital for a medical emergency and the emergency room physician is not contracted with Anthem Blue Cross.
- When you have surgery at a PPO Hospital or surgical facility and your primary surgeon is contracted with Anthem Blue Cross but an assistant surgeon and/or an anesthesiologist is not contracted with Anthem Blue Cross.
- When you are an inpatient at a PPO Hospital and you receive services from a specialist consultant upon request of your primary physician or you receive billed charges from a radiologist or a pathologist who is not on the staff of the Hospital and bills separately for their services.

6. Cost Management Programs

The Self-Funded Medical Plan requires you to certify certain kinds of care before you receive them—such as hospital stays (including mental health and substance abuse treatment), and surgeries. This is to ensure that you and the Fund are spending health care dollars wisely.

Please note: Precertification of a service does not guarantee that the Plan will pay benefits for that service because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during precertification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

FAST FACTS

- The Utilization Review Program requires you to call Anthem Blue Cross at **800-274-7767** before all inpatient hospital stays (including emergency admissions within 48 hours), or prior to admission to a mental health or substance abuse treatment facility.
- You must call the phone number on your ID card to authorize services such as transplant services, home health care and Skilled Nursing Facility care.
- The Plan provides personal case management for long-term serious medical care. Call Anthem Blue Cross for more information.

Utilization Review Program

You or your physician must call Anthem Blue Cross at **800-274-7767** to certify all inpatient hospital stays.

If you are admitted to the hospital in an emergency, you must notify Anthem Blue Cross within 48 hours by calling the number above.

NOTE: Hospital stays for maternity care of more than 48 hours following a normal delivery or more than 96 hours following a cesarean section need to be certified.

Admission to a Skilled Nursing Facility, all organ transplants, home health care and home infusion therapy are subject to additional authorization procedures described on page 36.

The Utilization Review program, which is managed by Anthem Blue Cross, evaluates hospital stays and surgeries and determines if they are Medically Necessary. The program is set up to review and certify care before you receive it, while you are receiving it and (if you do not pre-certify) retrospectively when the bill is submitted for payment.

Failure to Pre-Certify

If you do not follow the Utilization Review rules, your benefits will be affected. No benefits will be provided if you fail to pre-certify the above procedures in advance and it is later determined that the care was not considered Medically Necessary.

If you follow Utilization Review rules and proceed with any service that has been determined to be not Medically Necessary, benefits will not be provided for that service.

Payment for a covered inpatient hospital stay that is not approved by Anthem Blue Cross in advance will be subject to an additional deductible of $250.

In some cases, extraordinary circumstances may prevent you from certifying treatment in advance. This means that a condition was severe enough to prevent you from notifying Anthem Blue Cross or that a family member was not available to notify Anthem Blue Cross for you. In this case, you or a family member must notify Anthem Blue Cross within 48 hours of your admission.

Authorization Program

The following special services require authorization that the care is Medically Necessary and appropriate before care can be received. To obtain authorization, call the number on your plan identification card. In order to be authorized and covered under the Plan, the services must also be certified for other reasons, as explained below.

Organ and Tissue Transplants

For kidney or pancreas transplants to be approved, the physicians on the surgical team and the facility must be approved for the transplant requested.

For liver, heart, lung, double lung, heart-lung, kidney-pancreas or bone marrow (including Autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) or any multi-organ transplant, the providers of related preoperative and postoperative services must be approved and the transplant must be performed at a Center of Excellence.

Home Health Care

The attending physician must: certify that the services can be safely provided in your home; manage and direct the medical care at home; and establish a definitive treatment plan that must be consistent with your needs and must list the services to be provided by the home health agency. In order for home health care to be approved:

- The services must be performed by an agency recognized by CMS.
- The services must have been prescribed by a physician as Medically Necessary treatment of bodily injury, illness or pregnancy related conditions.
- In the absence of home health care, inpatient confinement in a Hospital or Skilled Nursing Facility would be necessary.
- The individual receiving the services must be homebound, so that leaving home would be detrimental to his or her health.

Home Infusion Therapy

The attending physician has submitted both a prescription and a plan of treatment prior to services being rendered.

Admissions to a Skilled Nursing Facility

You must require daily skilled nursing or rehabilitation, as certified by the attending physician; you were an inpatient in a hospital and are to be admitted to the Skilled Nursing Facility within 14 days of your hospital discharge; and you will be treated for the same condition for which you were hospitalized. The deductible is waived.

Personal Case Management

If you require extensive long-term treatment, Anthem Blue Cross will work with you to ensure that you obtain medically appropriate care in the most cost-effective and coordinated manner during prolonged periods of intensive medical care. A case manager may recommend an alternative treatment plan, which may include services not otherwise covered under this Plan.

You or your legal guardian and your physician must agree in a letter of agreement, with Anthem Blue Cross's recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Anthem Blue Cross makes alternative treatment recommendations only; any decision regarding treatment belongs to you and your physician. The Plan will, in no way, compromise your freedom to make such decisions.

Benefits are provided for an alternative treatment plan on a case-by-case basis only. Anthem Blue Cross has the discretion in deciding whether or not to authorize such services in lieu of standard benefits for any member, which alternatives may be offered and the terms of the offer.

The personal case management program does not prevent Anthem Blue Cross from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other member.

Members may be identified for possible personal case management through the Plan's utilization review procedures, by the attending physician, hospital staff, or Anthem Blue Cross claims report. You or your family member may also call Anthem Blue Cross regarding this provision.

7. What the Self-Funded Medical Plan Covers

FAST FACTS

- Refer to the ***Summary of Benefits*** beginning on page 6, which lists what the Plan pays for services and any limits on coverage.
- This section lists information about the services that are covered under the Plan, according to the amounts and limits listed in the ***Summary of Benefits*** beginning on page 6. Allowed Charges must be Medically Necessary, as defined by the Plan in the ***Glossary of Defined Terms***, page 86.
- Services and supplies that are not Medically Necessary, such as Custodial Care or a Cosmetic Procedure, are not covered by the Plan. The Plan does not pay benefits for charges that are determined to be more than the Allowed Charge

Wellness and Preventive Care Benefits

You and your Dependents are eligible for certain wellness and preventive care benefits through the Plan, as shown on the ***Summary of Benefits*** beginning on page 6 and described below.

Physical Examination Benefits

The Plan pays benefits for any routine physical examination, up to a maximum payment of $280 per exam for adults and children over three years of age. No benefits are payable under this preventive care benefit for:

- Services that are not performed by a physician or under a physician's direct supervision.
- Services received while confined in a hospital, Skilled Nursing Facility, nursing home, or similar institution.
- Vision, hearing or dental examinations.
- Medicines, drugs, appliances, equipment, materials or supplies.
- Psychiatric, psychological, and personality or emotional testing or examination.
- Pre-employment physical examinations or any physical examination related to employment.
- Premarital examinations.

Well Baby Care

For children under the age of three, the Plan pays benefits for routine well baby care, including examinations and screening laboratory tests, in accordance with the recommendations of the American Academy of Pediatrics. Immunizations recommended by the American Academy of Pediatrics are also covered.

Mammograms

The Plan pays benefits for a screening mammogram as follows:

- One baseline mammogram for women age 35 through 39;
- One mammogram each year for women age 35 through 39 with documentation that there is an inherited predisposition for breast cancer; and
- One mammogram each year for women age 40 and older.

Annual Pelvic Exam and Pap Test

The Plan pays benefits for one routine annual pelvic exam and pap test.

Prostate-Specific Antigen (PSA) Blood Test

The Plan pays benefits for a PSA blood test for men:

- Once every year beginning at age 50;
- African American men annually beginning at age 45; and
- Men with more than one first-degree relative diagnosed with prostate cancer annually beginning at age 40.

Colonoscopy and Sigmoidoscopy

The Plan pays benefits for adults age 50 and older who are at average risk for developing colorectal cancer with the following screening tests:

- A sigmoidoscopy every five years, OR
- Colonoscopy every 10 years.

Note that virtual colonoscopy is not covered.

Family Planning Benefits

The Plan pays benefits for office visits at 90% of negotiated rates for PPO providers and 70% of Allowed Charge for Non-PPO providers. Contraceptive devices and injectable contraceptives such as Depo Provera are covered at 50% of the Allowed Charge. Vasectomy and tubal ligation are covered as surgical benefits. Refer to the Prescription Drug section for coverage of other outpatient prescription contraceptives.

Immunizations

Immunizations recommended by the American Academy of Pediatrics for children over three years of age or for adults by the Center for Disease Control are covered.

Ambulance Services

Professional ambulance service from the place an emergency medical problem occurred to the closest hospital that is able to treat the problem is covered at 80% of Allowed Charges.

Inpatient Hospital Benefits

The Plan will cover:

- Room and board charges, up to an amount equal to the hospital's most common charge for its standard semiprivate accommodations;
- Intensive care unit accommodations when Medically Necessary;
- Therapy treatments;
- Surgical suite charges;
- Radiology/imaging charges and laboratory services;
- Anesthesia, oxygen, blood products and other ancillary services and supplies that are Medically Necessary for treatment of injury or sickness.

Hospital Preadmission Review

All hospitalizations (except emergency admissions and childbirth admissions) require a hospital preadmission review by Anthem Blue Cross (refer to page 36 for a description of how this program works).

PAYMENT FOR A HOSPITAL STAY THAT IS NOT APPROVED BY ANTHEM BLUE CROSS IN ADVANCE WILL BE SUBJECT TO AN ADDITIONAL DEDUCTIBLE OF $250.

Emergency inpatient admissions do not require a preadmission review; however, you or a family member must notify Anthem Blue Cross within 48 hours after an emergency admission.

Maternity and Obstetrical Benefits/Newborn Charges

Maternity benefits or any condition relating to pregnancy are payable under the hospital expense provisions of the Plan.

PPO and Non-PPO routine nursery charges for a newborn infant during the mother's hospital stay following delivery are covered if the mother is the employee or the spouse of the Active Employee. If the mother is the Dependent child of an Active Employee, only PPO routine nursery charges for a newborn infant during the mother's hospital confinement following delivery are covered.

Under the terms of the ***Newborn and Mother's Health Act of 1996***, the Plan generally may not restrict Allowed Charges for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the Newborn and Mother's Health Act of 1996 generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, the Plan may not require that a Provider obtain authorization from Anthem Blue Cross for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable.

Outpatient Hospital Services

Hospital outpatient charges for Medically Necessary services and supplies are covered according to the ***Summary of Benefits*** beginning on page 6. The deductible is waived for outpatient hospital charges for dislocated or broken bone being set, or for emergency treatment of a non-occupational injury on the day of the accident or on the following day.

If you or your eligible Dependent have non-elective surgery performed as an outpatient procedure when such surgery is generally performed on an inpatient basis, Plan benefits will be payable at 100% for such service.

Reconstructive Surgery

For reconstructive surgery following mastectomy, Federal law (the ***Women's Health and Cancer Rights Act of 1998***) requires a group health plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema (swelling associated with removal of lymph nodes).

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. (Refer to your HMO's ***Evidence of Coverage*** if you are enrolled in one of the HMOs.)

Organ and Tissue/Bone Marrow Transplants

Regular Plan benefits are payable for organ and tissue transplants which are approved by Anthem Blue Cross for you or your eligible Dependents, including patient screening, procurement and transportation of organ, surgery, follow-up care in home or hospital care and immunosuppressant drugs. Refer to pages 36 and 37 for details on the Utilization Review and Authorization Program. Benefits are not payable for any procedure that the Plan considers "Experimental." (Refer to the ***Glossary of Defined Terms***, beginning on page 86, for the Plan's definition of Experimental).

Second Surgical Opinion Benefit

If you or your eligible Dependent obtain a Second Surgical Opinion concerning a prescribed elective surgery, benefits shall be payable at 100% of the Allowed Charge for the medical examination and any necessary diagnostic laboratory or X-ray tests. The second opinion must be:

- Given by a physician who is Board Certified in the field of medical specialization concerned with the proposed surgery; and
- Given by a physician who has no financial interest in the outcome of his recommendation and who does not himself perform the surgery.

Skilled Nursing Facility (SNF) Benefits

Review the requirements to receive Skilled Nursing Facility benefits on page 37. Benefits will be paid according to and up to the limits stated in the ***Summary of Benefits*** schedule beginning on page 6. The following will be considered covered services:

- Room and board for semiprivate accommodations.
- Use of special treatment rooms, X-ray and laboratory examinations, physical, occupational or speech therapy, and other medical services customarily provided by a Skilled Nursing Facility except private duty or special nursing services or physician services.
- Drugs, biologicals, solutions, dressings and casts, but no other supplies.

Period of Disability. A period of disability begins on the first day of confinement in the Skilled Nursing Facility, and even though there may be several confinements in the Skilled Nursing Facility, the period of disability will continue until there has been a period of ninety (90) consecutive days during which the patient has been free of confinement in any type of institution providing nursing care.

Hospice Benefits

If you (or one of your family members) are diagnosed by a physician as being terminally ill with a life expectancy of six months or less, and incur charges for physician prescribed services and supplies furnished directly by a Hospice, the Plan will pay the following covered charges:

- Room and board for confinement in a hospice.
- Services and supplies furnished by the hospice during confinement.
- Home hospice care, including part-time nursing care by or under the supervision of a registered nurse (R.N.).
- Home health aide services.
- Special meals.
- Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for family members.

For purposes of this benefit, "Hospice" means an agency that provides counseling and medical services and may provide room and board to a terminally ill individual and which meets all of the following tests:

- It has obtained any required state or governmental licensure.
- It provides service 24 hours a day, 7 days a week.
- It is under the direct supervision of a physician.
- It has a nurse coordinator who is a registered nurse (R.N.).

Home Health Care Benefits

The following services are covered subject to prior authorization by Anthem Blue Cross (refer to page 36):

- Skilled home health care provided by licensed home health nurses.
- Services of a home health aide on a part-time or intermittent basis. (Refer to the ***Summary of Benefits***.)
- Nutrition counseling up to a maximum shown on the ***Summary of Benefits***.
- Infusion therapy.
- Psychiatric treatment by a licensed social worker who is practicing within the scope of their license.
- **Durable Medical Equipment** and other medical supplies are covered to the same extent that they would be covered outside of this Home Health Care Benefit.

Limitations. The following services would not be covered under this benefit:

- Services performed by a member of your immediate family or a person who normally lives in your home.
- Charges for Custodial Care (refer to the ***Glossary of Defined Terms***).
- Charges for private duty nursing.

Dental Surgery Benefits

Covered services include:

- The treatment of accidentally injured teeth within two years of the accident (applied without respect to when the individual is enrolled in the plan).
- Temporomandibular joint (TMJ) surgery may be covered with pre-certification by Anthem Blue Cross. Refer to page 36 for more information on obtaining precertification.

Mental Health Benefits

Mental health services are limited to conditions which, in the judgment of the attending Physician, is Medically Necessary. No benefits are provided for pervasive developmental delay, learning disabilities or services that are primarily provided to enhance the academic achievement of a Dependent child. Mental Health services are covered as follows:

- ***Outpatient Visits:*** Expenses incurred for treatment of mental health conditions while not confined in a hospital are payable according to the ***Summary of Benefits***.
- ***Inpatient Benefits:*** If you or your eligible Dependents are confined in a hospital for the treatment of a mental health-condition, the Plan will pay according to the ***Summary of Benefits***. Pre-certification by Anthem Blue Cross is required—refer to page 36.

Chemical Dependency Benefits (Employees Only)

If you receive inpatient hospital treatment for chemical dependency, the Deductible will be waived, and benefits will be payable according to the ***Summary of Benefits*** beginning on page 6. Benefits are not provided for Dependents.

- ***Outpatient Visits:*** Expenses incurred for treatment of substance abuse while not confined in a hospital are payable according to the ***Summary of Benefits***.
- ***Inpatient Benefits:*** If you are confined in a hospital for the treatment of substance abuse, the Plan will pay according to the ***Summary of Benefits***. Pre-certification by Anthem Blue Cross is required—refer to page 36.

Chiropractic and Acupuncture Benefits

Covered services are paid according to the ***Summary of Benefits*** on page 6. The following limitations apply:

- You or your eligible Dependents would have been reimbursed had a physician provided such treatment.
- The Medical Necessity for such services may be subject to Plan review.
- Acupuncture is only covered with a physician’s referral.
- Chiropractic supplies are not covered.

Rehabilitation Therapy

The Plan will cover Medically Necessary outpatient rehabilitation therapy, including physical, occupational and speech therapy, according to the limits and schedule set forth in the ***Summary of***

Benefits. No benefits are provided for pervasive developmental delay or learning disabilities of a Dependent child. Speech therapy is payable only when treatment is following stroke, accidental injury or surgery. Occupational therapy is limited to $40,000 per person per injury or illness.

Charges for habilitation services are not covered. Habilitation services refer to services to attain certain functions a person has never acquired including delays in childhood speech and physical therapy. Habilitation services are not covered eve if the delay in development is a direct result of an injury, surgery or as a result of a treatment that is the type that is covered by this Fund. For example, therapy for a child who isn't walking or talking at the expected age would not be covered.

Durable Medical Equipment and Prosthetics

The Plan will cover monthly rental charges of oxygen, Medically Necessary medical supplies and Durable Medical Equipment (refer to the ***Glossary of Defined Terms***) not to exceed the reasonable purchase price. The Plan covers these prosthetic devices: artificial limbs and eyes and post-mastectomy breast prosthesis. Note that glasses, hearing aids, orthopedic shoes, foot orthotics or other supportive devices for the feet are not considered an Allowed Charge by the Plan.

Other Services

The Plan will provide benefits for Allowed Charges at 90% of negotiated rate for PPO providers or 70% of the Allowed Charges for non-PPO providers for the following:

- Diagnostic X-ray and laboratory examinations. (**Exception:** preoperative testing performed on an outpatient basis within seven days of a scheduled covered surgery will be payable at 100%, and the deductible will be waived.)
- Radiation therapy and chemotherapy.
- Autologous blood donation (blood donated for use by oneself) or family donated blood.
- Nutritional counseling limited to $100 lifetime for diabetic nutritional program. Any eligible charges over the $100 lifetime maximum will be reimbursed at 10%.
- Allergy serum and allergy injections.

Limitations and Exclusions

In addition to the General Limitations and Exclusions listed on page 64 and any limitations or exclusions specifically contained in the benefit descriptions, Comprehensive Self-Funded Medical Plan Benefits are not payable for expenses incurred in connection with:

a. Custodial Care (refer to the ***Glossary of Defined Terms***).

b. Any services in connection with or related to pervasive developmental delay, learning disabilities, services to enhance educational achievement or for social or behavioral problems.

c. Speech therapy (except when treatment is following stroke, accidental injury or surgery).

d. Occupational therapy is limited to $40,000 per person, per injury or illness.

e. Vision care services not in connection with an active illness or injury.

f. Vision therapy such as orthoptics (vision training). (See page 58 for Vision Benefits).

g. Driver's physical exams or any physical exam related to employment.

h. Acupuncture (except when referred by a licensed physician).

i. Biofeedback training (except with Prior Authorization from Anthem Blue Cross).

j. Cosmetic Surgery or Treatment (refer to the ***Glossary of Defined Terms***), except when needed to repair damage caused by a non-occupational injury and performed within two years of the date of injury applied without respect to when the individual is enrolled in the plan.

k. Personal comfort, beautification, or convenience items or services.

l. Services rendered by a Family and Child Counselor, Marriage Counselor or a Licensed Clinical Social Worker except when referred by a licensed Physician. Refer to page 44 for more information on covered outpatient mental health services.

m. Hearing aids.

n. Orthopedic shoes, orthotics or other supportive devices for the feet.

o. Services or supplies rendered by a provider not recognized by the Plan (refer to the ***Glossary of Defined Terms*** for the definition of Physician.); or services received by a patient that are performed by the spouse, child, brother, sister or parent of the patient or of the patient's spouse or an individual who resides with the patient.

p. Vitamins and nutritional supplements.

q. Nonprescription drugs and supplies.

r. Fertility drug therapy, in vitro fertilization, artificial insemination, infertility treatment or any charges associated with the inducement of pregnancy (however, initial services to diagnose infertility are covered).

s. Reversal of sterilization procedures.

t. Elective abortion (except when the attending Physician certifies that the female Employee's or Spouse's health would be endangered if the fetus were carried to term, or where medical complications arise from an abortion).

u. Genetic testing (except that amniocentesis is covered for a patient over age 35 or if the patient had a previous child with a congenitally inherited disease).

v. Any services or supplies in connection with Experimental or Investigational procedures. Refer to the ***Glossary of Defined Terms*** for a definition of Experimental.

w. Insurance billing fees, special reports, mailing and handling charges, late charges, charges for missed appointment, etc.

x. Supplies of a chiropractor.

y. Smoking cessation and weight loss programs.

z. Massage therapy.

aa. Charges for the purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators, elevators, swimming pools, waterbeds, exercise equipment, or other similar items or equipment.

bb. Appliances for treatment of temporomandibular joint dysfunction (TMJ) and services related to the fitting of such appliances.

cc. Dental surgery except within two years of accidental injury to teeth (applied without respect to when the individual is enrolled in the Plan).

dd. Services received outside of the United States, except in an Emergency (refer to the ***Glossary of Defined Terms*** for the definition of Emergency).

8. Prescription Drugs

The Comprehensive Self-Funded Medical Benefits Plan offers out-patient prescription drug coverage through Caremark. You can purchase your prescription medications at a participating retail pharmacy or through a mail order program. If you are covered through an HMO, refer to your HMO's ***Evidence of Coverage*** document for more information on the prescription drug coverage offered through that HMO.

FAST FACTS

- The Comprehensive Self-Funded Medical Benefits Plan offers prescription drug coverage through Caremark that provides pharmacy and home delivery options for you.
- You'll save yourself and the Fund money if you use the Caremark mail service for long-term medications and ask for generics when available.

Caremark: Administrator of Out-Patient Prescription Drug Program

Pharmacy	Your Copayment
Participating Retail Pharmacy	$4 for generic / $7 for brand name[1] for up to 34-day supply or 100 tablets, whichever is greater
Mail Order Program (Home Delivery)	$4 for generic / $7 for brand name* for up to 90-day supply

Purchasing Your Medications

To purchase your medications at a pharmacy, you'll need to present your ID card and make your copayment at the time you receive your medication. You'll pay less if you select a generic drug rather than a brand name drug.

Most pharmacies participate in the Caremark program, such as Albertson's, Costco, Longs Drugs, Raley's, Rite Aid, Safeway, Save Mart, Sav-On, Vons and Walgreens. If a pharmacy does not participate, you must pay the full cost for the prescription and submit the receipt to Caremark. Caremark will reimburse you, minus the copayment.

Save with Generics

Generic drugs are a less expensive alternative to brand name drugs. These drugs contain identical active chemical ingredients of the brand name drugs they replace. For most people, most of the time, a generic will give them the same results as a brand name drug.

Your Cost for a Brand Name Drug When a Generic is Available

When a generic drug is available but the pharmacy dispenses a brand name drug for any reason other than the physician indicates "dispense as written," you will pay the difference between the brand name drug and the generic plus the brand copayment. If your doctor does indicate "dispense as written" when prescribing you a brand name drug, you will pay only the brand name copayment.

[1] Note that if your doctor writes a prescription to allow for a generic drug but you request a brand name drug, you must pay the difference between the generic and brand name drug price in addition to your copayment.

Mail Order Program (Home Delivery)

You may choose to take advantage of the mail order program for a less expensive and convenient way to receive your "maintenance" drugs. Maintenance drugs are those medications that you take on a regular basis, such as medicine for diabetes, high blood pressure, arthritis, or heart conditions.

The mail order program allows you to receive up to a 90-day supply of your medication delivered right to your door. Medications are mailed within 10 to 14 days of your order.

Get started in the program by calling **(866) 776-5677**. You will speak with a "FastStart" representative who will help you get started with the Mail Service program and avoid a trip to your doctor's office. Just provide your ID card information, the names of the long-term medications you take, your doctor's name and phone number and your mailing address. Once your doctor authorizes the prescription, your medication will be mailed 10 to 14 days from the time your order is placed.

For more information about Mail Service, call Caremark's FastStart program at **(866) 776-5677**.

What the Plan Covers

The Prescription Drug Plan covers most federal legend drugs (any medicinal substance that bears the legend, "Caution: Federal law prohibits dispensing without a prescription) including;

- Oral contraceptives/birth control pills.
- Insulin, insulin syringes and needles, blood glucose test strips and tablets, lancets.
- Self-injectable medication and the needles and syringes required to administer the medication.
- Dermatological acne products, including, but not limited to Retin A, Azelex, Differin, up to age 25.
- Anaphylaxis prevention kits (bee sting kits and diabetic rescue kits) including Ana-Kit, Ana-Kit Jr., Epipen / Epipen Jr., Glucagon and Glucagon Emergency Kit.
- Oral erectile dysfunction drug treatment (includes only coverage for Staxyn, Viagra and Cialis). Levitra is not covered. Covered erectile dysfunction drugs have a quantity limit of 6 for a 30-day supply and 18 for a 90-day supply.

What the Plan Does Not Cover

a. Medication available without a prescription (over-the-counter) or prescription medications for which there is a non-prescription equivalent available, even if ordered by a physician via a prescription, except as listed under Covered Drugs;

b. Medical devices, therapeutic devices or appliances including support garments, ostomy supplies and other non-medicinal substances (unless listed as covered);

c. Smoking cessation products, including, but not limited to Zyban and nicotine gum; nicotine patches and nicotine nasal spray;

d. Oral and injectable infertility medications;

e. Dietary supplements, including vitamins;

f. Human immunoglobulin injections;

g. Prescription birth control/contraceptives such as Depo-Provera, diaphragms, emergency contraceptive pills and kit, etc., except as listed under Covered Drugs;

h. All non-prescription birth control/contraceptive jellies, ointments, foams or devices;

i. Medications for the treatment of sexual dysfunction (including, but not limited to M.U.S.E., Yohimbine, Viagra);

j. Medication used for diagnostic purposes;

k. Medication for which the cost is recoverable under the Workers' Compensation or Occupational Disease Law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the patient;

l. Any charge for the administration of a medication;

m. Medications prescribed for experimental or non-FDA approved indications;

n. Medications received/consumed in connection with medical or dental services that are not covered by the Plan;

o. Immunization agents, biological sera, blood or plasma products (may be covered under the medical portion of the Plan);

p. Growth hormone;

q. Infused medication (may be covered under Home Health Care—refer to page 43);

r. Anorexiants (weight loss medications);

s. Medications received/consumed while in a licensed Hospital or Skilled Nursing Facility or medications to be taken or administered to the eligible member while he or she is a patient in a Hospital, Skilled Nursing Facility, rest home, sanitarium, etc.;

t. Medications used for cosmetic purposes including, but not limited to Renova, Rogaine, Vaniqua, Penlac, pigmenting and depigmenting agents;

u. Drugs or medicines delivered or administered to the member by a prescriber or prescriber's staff; and

v. All homeopathic medications.

Filing Claims (for Use of a Non-Network Retail Pharmacy)

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 (888) 790-4258.

If you fill a prescription at an Out-of-Network pharmacy, you will need to pay for the drug at the time of purchase. You can then send your drug receipt to Caremark using the Direct Member Reimbursement process.

9. Dental Care

Dental plan benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA). Even though the Fund is not required to do so, it allows coverage for Dependent children up to the end of the month in which they turn age 26.

Children of Non-Medicare Retirees are not eligible for dental benefits.

Healthy teeth and gums are an important part of your overall health. That is why your Health and Welfare Plan offers dental benefits for you and your family. This section describes the benefits provided by the Self-Funded Dental Plan, which is administered by Delta Dental. You may also request a more detailed ***Evidence of Coverage*** brochure from the Administrative Office.

FAST FACTS

- Retirees may not participate in the dental plan.
- This section describes your benefits if you select the Self-Funded Dental Plan. If you enroll in the MetLife Pre-Paid Dental Plan you should refer to the ***Evidence of Coverage*** brochure from MetLife and be sure your dentist is contracted with MetLife each time you receive services.

Dental Plan Deductible

The deductible is the annual amount each covered person pays before the Plan begins paying benefits. The annual deductible does not apply to Diagnostic and Preventive services such as exams and cleanings.

The annual deductible is $30 for each enrollee in your family, up to a limit of $60 per family. Credit will be given for deductibles met under prior dental insurance carriers, when payment of such deductibles can be documented.

Coinsurance and Annual Dental Plan Maximum

Once you have met your annual deductible, you share expenses with the Plan. This is called your Coinsurance. The Plan pays benefits up to $2,000 per person per calendar year for Basic, Restorative and prosthodontic services (does not include pediatric dental services for children under age 19). Refer to the ***Summary of Benefits*** on page 6 for more information.

Choice of Dentists

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

You can locate participating dental providers by calling Delta Dental toll-free at (**800) 765-6003** or on the Web at www.deltadentalins.com

Nearly 29,000 dentists in active practice in California are Delta Dental Dentists. About 16,500 of these Delta Dental Dentists are also Delta Dental PPO Dentists. While covered under the PPO plan, you are free to choose any dentist for treatment, but it is to your advantage to choose a Delta Dental Dentist. This is because his or her fees are approved in advance by Delta Dental. Delta Dental Dentists have treatment forms on hand and will complete and submit the forms to Delta Dental free of charge.

Need To Find a Delta Provider?

The Administrative Office can provide you with a Delta Dental directory of providers. Or, visit www.deltadentalins.com to find a provider online or call Customer Services at (800) 765-6003.

If you choose a **Delta Dental PPO Dentist**, you will receive all of the advantages of going to a Delta Dental Dentist, and you may have a higher level of Benefits for certain services.

Payment to a **Delta Dental PPO Dentist** will be based on the applicable percentage of the lesser of the Fee Actually Charged, the dentist's accepted Allowed Charge on file with Delta Dental, or a fee which the dentist has contractually agreed upon with Delta Dental to accept for treating enrollees under this plan.

Payment to a **Delta Dental Dentist** who is not a PPO dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the accepted fee that the dentist has on file with Delta Dental.

If you go to a non-**Delta Dental Dentist**, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330.

Payment for services by a California dentist, or an out-of-state dentist, who is **not a Delta Dental Dentist** will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee that satisfies the majority of Delta Dental Dentists.

Predetermination of Dental Benefits

If you or a covered family member need dental treatment that the dentist estimates will cost $300 or more, you should ask the dentist to file a predetermination of benefits with Delta Dental before treatment begins. Determining what Delta Dental will pay in advance helps prevent any misunderstandings about your financial responsibilities.

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

Payment for claims exceeding $500 for services provided by dentists located outside the U.S. may at Delta's option, be conditioned upon a clinical evaluation at Delta's request. Delta will not pay benefits for such services if they are found to be unsatisfactory.

Continuity of Care

If you are undergoing a course of treatment and your dentist no longer is a DeltaPreferred Option Dentist or Delta Dentist, you may continue to receive treatment from that dentist. Payment will be based on the dentist's status on the date the treatment plan is completed.

What the Dental Plan Covers

Diagnostic and Preventive Benefits

These services do not count toward the dental plan annual maximum benefit.

- Oral examinations (including initial exams and periodic exams)

- Diagnostic X-rays
- Cleanings (maximum four per calendar year)
- One additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant for a participant who is pregnant. Written confirmation of the pregnancy must be provided to Delta Dental when the claim is submitted, e.g., a note from your obstetrician.

Basic Benefits

- Fluoride treatment to age 15
- Oral surgery—extractions and certain other surgical procedures, including pre-and post-operative care
- Restorative—amalgam, silicate or composite (resin) fillings for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
- Endodontic—treatment of tooth pulp
- Periodontic—treatment of gums and bones that support the teeth; periodontal prophylaxis
- Sealants—topically applied acrylic, plastic or composite material to seal developmental grooves and pits in teeth for the purpose of preventing dental decay
- Space maintainers
- Adjunctive general services—general anesthesia, office visit for observation, office visit after regularly scheduled hours, therapeutic drug injection, treatment of post-surgical complications (unusual circumstances), limited occlusal adjustment
- Emergency exams, exams of biopsied tissue; palliative (emergency) treatment of dental pain, specialist consultation

Restorative

Crowns, jackets, inlays, onlays and cast restoration benefits are provided only if services are to treat cavities that cannot be restored with amalgam, silicate or direct composite (resin) restorations.

Prosthodontic Benefits

Construction or repair of fixed bridges, partial dentures and complete dentures are benefits if provided to replace missing natural teeth.

Limitations

a. Only the first two oral examinations, including office visits for observation and specialist consultations, or combination thereof, in a calendar year are Benefits while you are eligible under any Delta Dental plan. See Diagnostic and Preventive Benefits above for additional Benefits during pregnancy.

b. Full-mouth x-rays are a Benefit once in a five-year period while you are eligible under any Delta Dental plan.

c. Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over, while you are eligible under any Delta Dental plan.

d. The Plan pays for four cleanings or a dental procedure that includes a cleaning each calendar year under any Delta Dental plan. If you are pregnant during this time, the Plan may pay for an additional cleaning (see Diagnostic and Preventive Benefits above).

   Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit.

e. Fluoride treatments are covered to age 15 twice each calendar year under any Delta Dental plan.

f. Periodontal scaling and root planing is a Benefit once for each quadrant each 24-month period. See Diagnostic and Preventive Benefits above for additional Benefits during pregnancy.

g. Sealant Benefits include the application of sealants only to permanent first molars through age eight 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.

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

i. Crowns, Inlays, Onlays and Cast Restorations are benefits on the same tooth only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

j. Prosthodontic appliances and implants are benefits only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactory. The Plan may replace an implant, a prosthodontic appliance or an implant supported prosthesis you received under another dental plan if Delta determines it is unsatisfactory and cannot be made satisfactory. The Plan will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

k. The Plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth that are made from accepted materials and by conventional methods.

l. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. 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.

What the Dental Plan Does Not Cover

a. Services for injuries covered by Workers' Compensation or employer's liability laws.

b. Services that are provided to the enrollee by any federal or state governmental agency or are provided without cost to the enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.

c. Services for cosmetic purposes or for teeth that are discolored or lacking enamel.

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

e. Any single procedure, bridge, denture or other prosthodontic service that was started before the enrollee was covered by this Plan.

f. Prescribed drugs or applied therapeutic drugs, premedication or analgesia.

g. Experimental procedures.

h. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.

i. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures and other dental services when deemed Medically Necessary.

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

k. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.

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

m. Intravenous sedation, occlusal guards and complete occlusal adjustment.

n. Orthodontic services (treatment of mal-alignment of teeth and/or jaws).

o. Diagnostic casts.

If You Have Questions About Services You Receive from a Delta Dentist

If you have questions about the services you receive from a Delta Dentist, Delta recommends that you first discuss the matter with your dentist. If you continue to have concerns, call Delta's Quality Review department at (800) 765-6003. If appropriate, Delta can arrange for you to be examined by one of Delta's consulting dentists in your area. If the consultant recommends the work be replaced or corrected, Delta will intervene with the original dentist to have the services replaced or corrected at no additional cost to you or obtain a refund. In the latter case, you are free to choose another dentist to receive your full benefit.

Second Opinions for Dental Treatments

Delta obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions and evaluate treatment that is proposed. Delta will authorize such an examination prior to treatment when necessary to make a benefit determination in response to a request for a Predetermination of treatment cost by a dentist. Delta will authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta to perform the clinical examination at Delta's expense.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examinations may be submitted to Delta for payment. Delta will pay such claims in accordance with the benefits of the plan.

This is only a summary of Delta's policy on second opinions. A copy of Delta's formal policy is available from Delta's Customer and Member Services upon request.

Dental Plan Grievance Procedure and Claims Appeal

If you have any questions about the services received from a Delta Dental Dentist, we recommend that you first discuss the matter with your Dentist. If you continue to have concerns, you may call or write Delta. Delta will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. **Any questions of ineligibility should first be handled directly between you and your group.** If you have any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, you may call toll-free at 800-765-6003, contact Delta on their web site at: www.deltadentalins.com or write Delta at P. O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

If your claim has been denied or modified, you may file a request for review (a grievance) with Delta within 180 days after receipt of the denial or modification. If in writing, the correspondence must include your group name and number, the Primary Enrollee's name and ID number, the inquirer's telephone number and any additional information that would support the claim for benefits. Your correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, Delta will provide you with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Delta's review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of Delta's regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Delta's review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Delta will provide the Enrollee a written acknowledgement within five calendar days of receipt of the request for review. Delta will make a written decision within 30 calendar days of receipt of the request for review. Delta will respond, within three calendar days of receipt, to complaints involving severe pain and imminent and serious threat to an Enrollee's health. You may file a complaint with the **Board of Trustees** only after you have completed Delta Dental's grievance procedure. Refer to the section of this booklet titled ***Claims and Appeals Procedures***.

If You Have Additional Dental Coverage

It is to your advantage to let your dentist and Delta know if you have dental coverage in addition to this Delta plan. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both plans—sometimes paying 100% of your dental bill. For example, you might have some fillings that cost $100. If the primary carrier usually pays 80% for these services, it would pay $80. The secondary carrier might usually pay 50% for this service. In this case, since payment is not to exceed the entire fee charged, the secondary carrier pays the remaining $20 only. Since this method pays 100% of the bill, you have not out-of-pocket expense.

For more information, contact Delta Customer and Member Services.

Filing Dental Claims

If you go to a non-Delta Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330.

10. Vision Care

Vision plan benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA). Even though the Fund is not required to do so, it allows coverage for Dependent children up to the end of the month in which they turn age 26.

Children of Non-Medicare Retirees are not eligible for Vision Benefits. Also, there are no vision benefits available for Medicare Retirees or their Dependents.

If you are enrolled in Kaiser HMO, you and your eligible Dependents will receive your vision benefits through Kaiser.

If you are enrolled in the Comprehensive Self-Funded Medical Plan or the Anthem HMO, you and your eligible Dependents are able to participate in the Vision Care Plan provided through Eyemed

FAST FACTS

- Vision benefits include eye exams, frames, lenses for glasses and/or contact lenses.
- The vision plans offer annual eye exams for you and your family.
- You should obtain care through an Eyemed doctor in order to maximize your plan benefits.

What the Vision Plan Covers

The Vision Plan is designed to provide for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. Not every vision care service or supply is covered by the Vision Plan, even if prescribed, recommended, or approved by your physician or optical provider. The Plan covers only those services and supplies that are medically necessary and included as a covered benefit. The Plan will not reimburse any expenses that are not eligible vision expenses.

Schedule of Vision Benefits		
Covered Vision Benefits	**Eyemed Provider**	**Non-Eyemed Provider**
Vision Exam (with dilation as necessary) One vision exam is payable every 12 months	100% after a $10 copay per exam.	Up to maximum of $50
Retinal Imaging	Up to $39	Not Covered
Contact Lens Fit and Follow-up (available after a comprehensive eye exam)	*Standard:* up to $55 *Premium:* 10% off retail	Not Covered

Schedule of Vision Benefits		
Covered Vision Benefits	**Eyemed Provider**	**Non-Eyemed Provider**
Frames for Eyeglasses One frame is payable every 12 months	100% up to $140. 20% discount on any amount over $140	Up to maximum of $105
Lenses for Eyeglasses • Standard lenses are covered (basic plastic lenses). • A single vision, lined bifocal, lined trifocal, lined lenticular or progressive lens is payable once every 12 months.	***Single Vision***: 100% after a $25 copay ***Bifocal:*** 100% after a $25 copay ***Trifocals:*** 100% after a $25 copay ***Lenticular***: 100% after a $25 copay ***Standard Progressive:*** 100% after a $25 copay ***Premium Progressive:*** 100% after a $45-$70 copay (Tier 1 - $57 copay, Tier 2 - $68 copay, Tier 3 - 70 copay, Tier 4 - $25 copay and 80% of charge less $120 allowance)	***Single Vision***: up to $50 ***Bifocal:*** up to $70 ***Trifocals:*** up to $90 ***Lenticular***: up to $90 ***Standard Progressive:*** up to $70 ***Premium Progressive:*** Up to $70 (Tier 1 through Tier 4)
Lens Options	***UV Treatment:*** 100% ***Tint (Solid and gradient):*** 100% ***Standard Plastic Scratch Coating:*** 100% ***Standard Polycarbonate adults:*** $40 copay ***Standard Polycarbonate kids under 19:*** 100% ***Standard Anti-Reflective Coating:*** $45 copay ***Premium Anti-Reflective Coating:*** Tier 1 - $57, Tier 2 - $68, Tier 3 – 80% ***Photochronic/Transitions:*** 100% ***Polarized:*** 20% off retail ***Other Add-Ons and Services:*** 20% off retail	***UV Treatment:*** up to $11 ***Tint (Solid and gradient):*** up to $11 ***Standard Plastic Scratch Coating:*** up to $11 ***Standard Polycarbonate adults:*** Not Covered ***Standard Polycarbonate kids under 19:*** up to $28 ***Standard Anti-Reflective Coating:*** Not Covered ***Premium Anti-Reflective Coating:*** Not Covered ***Photochronic/Transitions:*** up to $53 ***Polarized:*** Not Covered ***Other Add-Ons and Services:*** Not Covered
Contact Lenses Allowance includes materials only	***Conventional Contact Lenses*** 100% up to $105, 15% discount for amount over $105 ***Disposable Contact Lenses*** 100% up to $105 ***Medically Necessary Contact Lenses*** 100%	***Conventional Contact Lenses*** up to $105 ***Disposable Contact Lenses*** up to $105 ***Medically Necessary Contact Lenses*** Up to $210
LASIK or PRK from U.S. Laser Network	15% off the retail price of 5% off the promotional price	Not covered

How to Use the Vision Plan

Step One: Call your Eyemed doctor to make an appointment. To locate an Eyemed doctor, call Eyemed at 1-866-804-0982 or visit the Eyemed website at www.eyemed.com.

Step Two: Let the doctor know you are an Eyemed member when you call. The doctor will then verify your eligibility with Eyemed. You may need to provide your ID number (usually the employee's Social Security number) and the group name.

Step Three: You are responsible for paying the doctor your copayments for services received and any additional costs or amounts that are not covered under the Plan.

If You Use a Non-Eyemed Provider

If you obtain services through an out-of-network provider, you must pay the provider in full and submit an itemized receipt to Eyemed. Eyemed will reimburse you up to the amounts allowed under your plan's out-of-network benefits schedule. The reimbursement schedule does not guarantee full payment nor can Eyemed guarantee patient satisfaction when services are received from an out-of-network provider.

All claims for reimbursement must be filed within six months of the date services were completed. Reimbursement benefits are made to you and are not assignable to the provider. See the ***Important Contact Information*** on page 2 for Eyemed's website and phone number if you need to file a claim.

Vision Plan Limitations and Exclusions

EyeMed benefits do not include services or materials arising from:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes, or supporting structures;
- Any eye or vision examination, or any corrective eyewear required as a condition of employment, and safety eyewear;
- Services provided as a result of any Worker's Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses (except for 20% discount);
- Two pair of glasses in lieu of bifocals;
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order;
- Services or materials provided by any other group benefit plan providing vision care; and
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

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

Please note: A Dependent child may be covered for life insurance benefits to a maximum age of 19 (or age 23 if he or she meets the requirements of full time student status).

Most members who have health coverage through the Stationary Engineers Local 39 Health and Welfare Plan also have Life Insurance and Accidental Death and Dismemberment (AD&D) benefits. Some Collective Bargaining Agreements, however, do not provide for these benefits. You should check with the Administrative Office to confirm whether you have these benefits.

Life Insurance provides coverage to your beneficiary in the event of your death. AD&D pays the full benefit amount to your beneficiary in case of accidental death; a partial benefit is paid to you for certain covered losses. Benefits from AD&D are payable in addition to benefits from life insurance.

The Plan also provides you with benefits in the event of the death of an insured Dependent.

FAST FACTS

- Active Employees under age 70 are generally covered in the amount of 500 times their monthly dues rates, up to a maximum of $75,000. Some members have different amounts of coverage or no coverage as specified in their Collective Bargaining Agreements.
- Your designated beneficiary is eligible to receive a lump-sum benefit upon your death.
- To change your beneficiary designation, contact the Administrative Office.

Life Insurance Benefits

Active Employees under age 70 are generally covered in the amount of 500 times their monthly dues rates, up to a maximum of $75,000. Some members have different amounts of coverage or no coverage as specified in their Collective Bargaining Agreements.

Active Employees age 70 and over are generally covered at $2,000. Coverage terminates upon retirement.

Designating a Beneficiary

You may name anyone you wish as your beneficiary. Beneficiary cards are kept on file in the Administrative Office. You may request a change of beneficiary at any time. The latest signed and dated beneficiary form on file will be the one honored in the event of your death. Your beneficiary should contact the Administrative Office in the event of your death for assistance in claiming benefits.

If you do not designate a beneficiary or if your beneficiary does not outlive you, the amount of the life insurance benefit will be payable as follows:

- To your legal spouse if living; if none,
- In equal shares to your then living natural and adopted children if any; if none,
- In equal shares to your father and mother if living; if not,
- To your estate.

Coverage During Total Disability

Group Life Insurance can be continued without cost to you if you are eligible under the Plan and you become totally disabled before age 60. In order to continue coverage while you are disabled, you must notify the Administrative Office promptly of your total disability. You will need to complete forms to extend your coverage.

Proof that your total disability has continued for at least six months must be received by the life insurance company within 12 months from the date of your disability. You will be required to submit evidence of your continuing disability periodically.

Converting Your Coverage

You may be able to convert your life insurance coverage to an individual policy under certain circumstances. The conversion privilege applies if your life insurance coverage ceases because:

- Your employment ceases; or
- You are no longer in a class eligible for insurance.

In order to convert your coverage, you must apply and pay your first premium within 31 days of becoming eligible to convert your policy.

If coverage ends because the plan terminates, and the plan has been in force for at least five consecutive years, you may be able to convert your coverage to an individual policy (the amount of coverage less any amount that you may become eligible for within 31 days of discontinuance). In order to convert, written application must be made for an individual policy and the first premium must be paid on it within 31 days after cessation of insurance for any of the aforementioned reasons. No evidence of insurability will be required.

Your converted policy may be any kind of individual policy then customarily being issued by the Company at the age and for the amount applied for, but such amount shall not exceed the amount of life insurance in force at the date of termination.

The individual policy will become effective at the end of the 31-day period during which conversion is possible. The premium for the converted policy will be at the Insurance Company's then customary rate for that same policy issued to any other person of the same class of risk and age at the time the converted policy is to become effective.

After an individual policy becomes effective for any person, that policy will be in exchange for all benefits and privileges under the group policy as regards the person involved and the amount that could have been converted.

Dependent Life Insurance

The Plan provides Dependent life insurance coverage, as shown in the ***Summary of Benefits*** on page 10.

The amount of life insurance on the life of any one of your Dependents cannot exceed 50% of the life insurance on your life.

The following Dependents are not eligible for this insurance:

- Any dependent who is not at least 14 days of age.
- Any dependent who is in active fulltime military service.
- Any dependent child who is over the dependent age as specified by the Plan.

Benefits for the death of any insured Dependent are paid to the insured employee. If the employee is not living at the time of payment, payment will be made to his or her estate or, at the option of the Plan, to the employee's spouse.

Conversion Privilege for Dependent Life

If your insurance terminates, the insurance on your Dependents will also terminate. However, your spouse may convert his or her life insurance to an individual policy in a similar manner as described for employees. This conversion privilege does not apply to dependent children.

Accidental Death and Dismemberment (AD&D) Benefits

Your Accidental Death and Dismemberment Insurance will be paid for any of the following losses as the result of an accident, on or off the job. The injury must be sustained while you are insured and the loss must occur within 90 days after such injury. Payment will be made regardless of any other benefits you may receive.

The loss of hands and feet means the loss of their use by severance at or above the wrist or ankle and the loss of sight means the total and irrevocable loss of sight.

The Plan provides Accidental Death and Dismemberment coverage, as shown in the ***Summary of Benefits*** on page 10. In the case of accidental dismemberment, benefits will be paid to you.

In the event of loss of life, benefits will be payable to your beneficiary (who may be any person or persons you name. You may request a change of beneficiary at any time by submitting a Change of Beneficiary form to the Administrative Office.

The payment for all losses caused by any one accident may not be more than the full amount of your insurance, but the benefits paid on account of one loss will not prevent further payment for losses resulting from subsequent accidents.

What's Not Covered Under the Accidental Death and Dismemberment Plan

Insurance does not cover any loss resulting from:

- Sickness, bodily or mental infirmity, or treatment thereof;
- Suicide or attempted suicide, while sane or insane;
- Ptomaines or any infection, other than a pyogenic infections occurring through, and at the time of, an accidental cut or wound;
- Bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment;
- Committing an assault or felony;
- Inciting or taking part in any form of public violence;
- Declared or undeclared war, or act of war; or
- Voluntary or involuntary acts such as:
  - Taking of drugs, except drugs taken as prescribed by doctor (M.D.) or doctor of osteopathy (D.O.);
  - Taking of poison; or
  - Inhaling of gas.

Please note: any appeals of Life Insurance or AD&D decisions will follow the post-service group health claim procedures and timing.

12. General Exclusions and Limitations

In addition to any other limitations or exclusions listed in this booklet, the Plan will not provide benefits for:

a. Any accidental bodily injury arising out of, or in the course of, the patient's employment.

b. Any bodily injury or illness or disease for which the patient is entitled to indemnification in accordance with the provisions of any **Workers' Compensation** or similar law

This exclusion applies:

- even if you or your covered Dependent were not covered by workers' compensation insurance, or
- if the covered individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified, or
- if the covered individual's rights under workers' compensation or occupational disease or similar law would have been available but are not because of some action or inaction the covered individual did or did not take.

c. To the extent permitted by Federal law, any period of confinement in, or any medical care and treatment received from, a **Veteran's Administration hospital**.

d. To the extent permitted by Federal law, any condition for which **care or treatment is obtained from a federal government agency** or from any state or political subdivision where such care or treatment is available without cost to the patient. Furthermore, such confinement or care obtained in a hospital owned or operated by a state or political subdivision thereof, is excluded, unless there is an unconditional requirement to pay for such confinement or care without regard to any rights against others, contractual or otherwise.

e. To the extent permitted by Federal law, any hospital, medical, dental or vision services or supplies provided by or **paid for by any governmental program**—national, state, county or municipal including any expenses reimbursed by Federal Medicare.

f. Conditions caused by or arising out of an act of war, armed invasion or aggression, or civil disturbance, or while committing or attempting to commit a felony. This felony provision does not apply if the condition, injury or disability results from being the victim of domestic violence, or if the commission or attempted commission of the felony was a direct result of an underlying health factor.

g. A condition for which the patient is **not under the care of a Physician**.

h. Services or supplies for which no **charge is made**. Charges which you or your Dependents are not legally required to pay, or would not be required to pay in absence of this Plan.

i. **Any expense not specifically adopted by the Trustees as a covered expense** under the Plan, until specifically adopted by the Trustees as a covered expense.

j. Charges **incurred on or after the date eligibility terminates** (except to the extent allowed in the Extended Benefits provision described on page 18).

k. Charges for any services, treatments or supplies which:

- Are **not Medically Necessary** for the treatment of an injury or illness (See the ***Glossary of Defined Terms*** for a definition of Medically Necessary).
- Are **not recommended by a Physician**.
- Are considered to be **Experimental, or Investigational**. (See the ***Glossary of Defined Terms*** for a definition of Experimental and Investigational.)

13. Coordination of Benefits (COB)

You and your Dependents may be entitled to benefits under this Plan as well as benefits under another plan. In such cases, this Plan will coordinate its benefits with those provided by other employment-related group plans. Co-payments and deductibles required by a prepaid medical plan (such as an HMO) will also be coordinated with benefits provided by this Plan.

FAST FACTS
• You must report any duplicate group health coverage for yourself and/or your eligible Dependents on any claim you submit to the Administrative Office.
• This Plan will coordinate benefits with coverage that you receive from other sources, including Medicare.

With coordination of benefits, a combination of payments up to, but not to exceed, 100% of the Allowed Charge allowed under this Plan (and that were actually incurred) may be paid. In no event will the benefit paid by this Fund exceed the amount that would have been paid if there were no other plans involved.

One of the two or more plans involved is the primary plan while the others are secondary plans. The primary plan pays benefits first without regard to the other plans involved. The secondary plan then pays the difference between the amount paid by the primary plan and the covered expense allowed under its plan rules. If one plan has no coordination of benefits provision, it is automatically primary.

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

Effect on Benefits

In order to determine which plan will be primary, and which will be secondary, the following rules will apply:

Employees and Dependents. The plan that covers the person as an employee will be primary, and pay benefits first. The plan that covers the person as a Dependent will be secondary, and will pay benefits second.

Active/Retired or Laid-Off Employee. The plan that covers the person who is neither laid-off nor retired (or as that person's Dependent) pays benefits first. The plan that covers that person as a laid-off or retired employee pays benefits last.

Dependent Children of Parents NOT Separated or Divorced. The plan covering the parent whose birthday falls earlier in the calendar year, regardless of birth year, will be primary. If both parents have the same birthday, the plan that has covered the parent the longest shall be primary. The plan covering the parent for the shorter period of time pays benefits second.

Dependent Children of Parents Separated or Divorced. Subject to contrary provisions in a QMCSO, the following order shall apply:

a. the plan of the parent with custody pays first;

b. the plan of the spouse of the parent with custody (the stepparent) pays next; and

c. the plan of the parent without custody pays last.

d. However, if the divorce decree clearly places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent shall be primary.

Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering the person for the shorter period of time pays second.

Adult dependent child. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined by the longer/shorter length of coverage described above. If the length of coverage is the same, then the birthday rule applies between the dependent child's parent's coverage and the dependent's spouse coverage.

Coordination with Medicare

The Plan will provide normal hospital and medical benefits under the Comprehensive Medical Benefits Plan for eligible Employees and their dependents. If an expense is covered by both this Plan and Medicare (except for charges incurred after the first 33 months of treatment for end-stage renal disease), this Plan will pay its benefits without regard to Medicare, and Medicare may then pay the remainder of the charge subject to its applicable limitations.

Once you retire and you become eligible to enroll in Medicare due to age or disability, you will no longer be eligible for benefits from this Trust Fund.

Coordination with Medicaid or Tricare

Benefits payable by this Plan will be made in compliance with any assignment of rights made by or on behalf of such eligible person as required by California's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second. If the State has provided medical assistance (under Medicaid) where this Plan has a legal liability to make payment for such services, payment will be made by this Plan for claims submitted within one year from the date expenses were incurred.

If a Dependent is covered by both this Plan and the TRICARE Program (formerly known as the Civilian Health and Medical Program of the Uniformed Service or CHAMPUS) that provides health care services to Uniformed Service members, retirees and their families worldwide, 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 this Plan.

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 Dependent (i) has coverage under the Self-Funded portion of this Plan, and (ii) has coverage under a prepaid program (as hereafter defined) under another group plan (regardless of whether the Dependent must pay a portion of the premium for such plan), and (iii) incurs expenses normally covered under the prepaid program, then this Plan will only reimburse the co-

payments required of the eligible Dependents under the prepaid program, and only if such co-payments are required of every person covered by that program. <u>This includes copays for prescription drugs</u>.

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

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

Coordination with Preferred Provider Agreements

In addition to any other limitations applicable to this Plan or its Coordination of Benefits provisions, 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:

- The lesser of: (1) the normal charges billed for the expenses by the provider; (2) the contractual rate for such expense under the preferred provider agreement between the provider and the plan that this Plan is coordinating with, or (3) this Plan's contractual rate with its preferred provider; and
- The amount that the other plan pays as "primary."

Right to Information, Payment and Recovery of Payment

Whenever payments that should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this Plan and, to the extent of such payment, the Plan will be fully released from any liability regarding the person for whom payment was made.

Whenever payments have been made by this Plan which should not have been paid or for which you were not eligible, <u>the Plan may recover and collect those payments from you or your Dependents or such other organization(s) that may be liable to the Plan for such repayments</u>.

Information Gathering. In order to implement the provisions in this "Coordination of Benefits" section, the Trustees or the Administrative Office may, without the consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Trustees or to the Administrative Office such information as may be necessary to implement the provisions of this section or to determine their applicability.

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.

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.

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 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.

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:

a. To prosecute any claim for damages diligently;

b. 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;

c. 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;

d. 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;

e. To provide the Fund with all relevant information or documents requested;

f. 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;

g. 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;

h. To execute any documents necessary to secure reimbursement;

i. 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;

j. 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 motorist's coverage;

k. 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;

l. 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 and pay the reimbursement amount. If the Eligible Individual breaches this agreement 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.

14. Filing Your Claims

Please note: any appeals of Life Insurance or AD&D decisions will follow the post-service group health claim procedures and timing.

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. Information on how to file dental, prescription drug and vision claims is shown at the end of each section describing those benefits earlier in this booklet. For insured Dental Plan claims (with Met Life) or Vision Plan claims, you must first exhaust the appeals procedures of Delta Dental or Eyemed before filing a voluntary appeal directly to the Trustees.

Throughout this section, “you” and “your” may refer to you, your Dependent(s), and/or your authorized representative, as applicable. If you are eligible for other coverage and that coverage should pay first, you must submit your claim to the other plan first.

Contract hospitals will usually send your claim electronically to Anthem Blue Cross.

Your PPO providers will generally submit claims on your behalf; however, it is your responsibility to ensure that claims are properly submitted to the Administrative Office at the following address:

Stationary Engineers Local 39 Health and Welfare Trust Fund
P. O. Box 1737
San Ramon, CA 94583

Important Note

The submission of claim forms containing intentionally false statement or omissions or the listing of persons as Dependents who do not meet the Fund’s eligibility provisions for Dependent coverage, may constitute a criminal act, and may subject you to criminal prosecution. If is extremely important that the information stated on any claim form is complete and entirely accurate.

Appeals of HMO and Insured Benefits

The following procedures apply to claims and appeals on matters within the discretion of the **Board of Trustees**. Please note that the **Board of Trustees** does not hear appeals regarding adverse actions taken by an HMO or insurance carrier. If an HMO or insurance carrier denies a claim for benefits, other than eligibility under the Plan, the claimant must appeal directly to the HMO or carrier.

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. In addition, Any retroactive cancelation or discontinuance of disability benefits (except if due to failure to pay a required contribution) is considered a claim.

Filing Medical 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. If your provider does not file your claims, do the following:

- Obtain the appropriate claim form from the Administrative 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 the Administrative Office at the address shown above.

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 code (the code for Physician services and other health care services found in the Current Procedural Terminology, as maintained and distributed by the American Medical Association) or HCPC code;
- ICD (the diagnosis code found in the most current edition of the International Classification of Diseases, 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) or National Provider Number (NPI) of the provider; and
- Provider's billing name, address, and phone number.

Types of Claims

Health care claims are divided into four basic types of claims.

- **Urgent Care Claim** 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, in the opinion of a Physician with knowledge of your condition:

- 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.

➢ **Pre-Service Claim** is a non-urgent claim for benefits where pre-approval is required before you obtain care (see pages 36 and 37 for information on when approval is required).

➢ **Concurrent Care Claim** 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 Claim** is a claim for benefits that for services that have already been received.

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:

➢ **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.

➢ **Pre-Service Claims.** The Plan will notify you of its initial determination within 15 days from receipt of your claim. 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. 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.

➢ **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.

➢ **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.

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.

If a Health Care 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 written 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 written request.

Appealing a Denied Health Care Claim

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Administrative 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 appeal must begin within 180 days of the date the Plan provides an adverse appeal determination.

In general, you should send your written request for an appeal to the **Board of Trustees** at the Administrative 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.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Administrative 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.

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:

- **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 15 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. 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 receive, upon written request and free of charge, reasonable access to, or copies of, all documents, records, or other information relevant to your claim;

- 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 written 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 written request.

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 written request, of the identity of any medical experts consulted in making a determination of your appeal.

Following Exhaustion of 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 of Trustees** 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 claim for 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, 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.

No legal action may be commenced or maintained against the Trust Fund or the Board of Trustees more than 180 days after a claim has been denied.

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.

Elimination of Conflict of Interest

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

Filing Disability Claims

A disability claim is a claim for which the plan must make a determination of disability in order for the Participant to receive the benefit (such as a claim for a disability eligibility extension or a request to cover a disabled dependent past the limiting age) and must be submitted to the Plan within 90 days after the date of the onset of the disability.

Disability Claim Decisions

To ensure that the persons involved with adjudicating disability claims and disability appeals (such as claim adjudicators and medical or vocational experts) act independently and impartially, decisions regarding hiring, compensation, promotion, termination or retention or other similar matters with respect to those individuals, will not be made based upon the likelihood that the individual will support the denial of benefits. The Plan will make a decision and notify you of the decision within 45 days after receipt of the claim.

- If the Plan requires *an extension of time due to matters beyond its control*, you will be notified of the reason for the delay and the date by which the Plan expects to render a decision. This notice will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

  A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date the Plan expects to render a decision.
- If an *extension is needed because the Plan needs additional information from you,* the extension notice will specify the information needed. If the information is not provided within the 45-day period, the claim will be denied. During the 45-day period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date you respond to the request. Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

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

If Your Disability Claim is Denied

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

(a) A discussion of the decision, including the basis for disagreeing with or not following:
    1. The views of a treating physician or vocational professional who evaluated the claimant;
    2. The views of medical or vocational experts obtained by the Plan, and
    3. Any disability determination by the Social Security Administration.

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

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

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

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

Appealing a Disability Denial

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

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

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

When filing an appeal, you may:

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

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

Timeframes for Sending Notices of Appeal Determinations for Disability Claims

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

If the decision on review is not furnished to the Participant within the time specified in this section, the claim shall be deemed denied upon review. 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 of Trustees** with respect to a petition for review is final and binding upon all parties, including the claimant or the petitioner, is subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the **Board** on an appeal, there is no further right of appeal to the **Board** or right to arbitration.

The Plan's claims and appeals provisions apply to and include any and every claim for 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, 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.

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before courts or administrative agencies, until after all administrative procedures have been exhausted (including this Plan's claim appeal review procedures described in this document) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. No legal action may be commenced or maintained against the Trust Fund or the Board of Trustees more than 180 days after a claim has been denied.

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

- Was de minimis and did not cause and is not likely to cause, prejudice or harm to you;
- Was for good cause or due to matters beyond the control of the Plan;
- Occurred in the context of an ongoing, good faith exchange of information with you; and
- Was not part of a pattern or practice of violations.

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

Content of Appeal Determination Notices for Disability appeals

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

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

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

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

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

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

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

    1) The view of a treating physician or vocational professional who evaluated the claimant;

    2) The views of medical or vocational experts obtained by the plan, and

    3) Any disability determination by the Social Security Administration.

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

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

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

15. Your ERISA Rights

As a Participant in the I.U.O.E. Stationary Engineers Local 39 Health and Welfare 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 shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by plan with the U.S. Department of Labor.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself 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 the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health and welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them with 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 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. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim and exhaust the Plan's appeal process before filing a lawsuit. 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 a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA, formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also find answers to your plan question and a list of EBSA field offices at the website www.dol.gov/ebsa

16. Information Required by ERISA

Name of Plan	The IUOE Stationary Engineers Local 39 Health and Welfare Plan
Type of Plan	An Employee Health and Welfare Benefit Plan that provides coverage for medical, prescription drugs, dental care, vision care, life insurance and accidental death and dismemberment benefits to eligible members and their qualified Dependents.
Plan Sponsor	A joint labor-management Board of Trustees
Collective Bargaining Agreements	The Plan is maintained pursuant to various Collective Bargaining Agreements. Copies of any of the Collective Bargaining Agreements may be obtained upon written request to the Fund Office and are available for examination at the Administrative Office and Local Union Offices during regular office hours.
Health and Welfare Plan Administrative Office Address	Stationary Engineers Local 39 Health and Welfare Plan c/o BeneSys Administrators P. O. Box 1737 San Ramon, CA 94583 The Administrative Office will provide, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreement and the employer's address.
Agent for Service of Legal Process	The Plan designated as agent for service of legal process is: Bonnie L. Maraia c/o BeneSys Administrators 7180 Koll Center Parkway Suite 200 Pleasanton, CA 94566 (800) 622-0547 or (925) 208-2280 Service of legal process may also be made upon any Trustee.
Plan Administrator	The **Board of Trustees** is the Plan Administrator. This means that the **Board of Trustees** is responsible for seeing that information regarding the Plan is reported to governmental agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security of 1974. The **Board of Trustees** has engaged the contract administrator named below to provide routine administrative services to the Plan: BeneSys Administrators P. O. Box 1737 San Ramon, CA 94583
IRS Employer Identification Number	(EIN) 946171641
Plan Number	501
Plan Fiscal Year	The date of the end of the Plan's fiscal year is December 31.
Sources of Financing	Contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements in force with Stationary Engineers Local 39 at fixed monthly per capita amounts. In addition, employees and Dependents eligible for COBRA may extend their coverage through self-payment.

Name of Plan	The IUOE Stationary Engineers Local 39 Health and Welfare Plan
Sources of Plan Benefits	Hospital and medical benefits are paid by the Trust Fund unless you have enrolled in an HMO. If you are enrolled in an HMO, the Trust Fund pays a monthly premium to the HMO and the HMO is financially responsible for your claims. Prescription drug benefits are administered by Caremark and paid by the Trust Fund. Dental benefits administered through Delta Dental are the financial responsibility of the Trust. MetLife Dental Plan is funded through monthly premiums paid to it, and it assumes the financial responsibility for your claims. Vision care benefits are administered by Vision Service Plan and paid by the Trust Fund. Life Insurance and Accidental Death and Dismemberment insurance benefits are paid through an insurance policy between the Trust Fund and ING Employee Benefits.
Plan Amendment and Termination of the Plan	The **Board of Trustees** may amend and/or terminate the Plan pursuant to its authority under the Trust Agreement. If the Plan is terminated, its remaining assets will be used to continue to provide its benefits for so long as Plan assets permit, or else they will be transferred to a successor plan providing health care benefits. However, the Trustees would have the right to revise, reduce or otherwise adjust benefits in any reasonable manner in connection with such termination. In no event will the termination of the Plan or Trust result in a reversion of any assets to a Contributing Employer.
Discretionary Authority of the **Board of Trustees**	The **Board of Trustees** has final discretionary authority to interpret the Plan.

The Board of Trustees

The **Board of Trustees** is made up of an equal number of Employer Representatives and Union Representatives, who serve without compensation.

Employer Trustees	Union Trustees
Jim Johnson Able Engineering Service 868 Folsom Street San Francisco, CA 94107	**Jerry Kalmar** Stationary Engineers Local 39 1620 N. Market Boulevard Sacramento, CA 95834
Danny Murtagh Boston Properties, LP Four Embarcadero Center Lobby Level, Suite One San Francisco, CA 94111	**Bart Florence** Stationary Engineers Local 39 1620 N. Market Boulevard Sacramento, CA 95834

Organizations Through Which Plan Benefits are Provided or Administered

Routine Administrative Services to the Plan and Self-Funded Medical Claims Processing	BeneSys Administrators P. O. Box 1737 San Ramon, CA 94583
Medical Plan PPO Network Access	**Anthem Blue Cross and Blue Card** 2155 Oxnard Street Woodland Hills, CA 91367
Utilization Review Vendor	**Anthem Blue Cross** P. O. Box 60007 Los Angeles, CA 90060-0007
HMO Providers	**Kaiser Permanente** 1800 Harrison Street, 9th Floor Oakland, CA 94612 **Anthem HMO** 2155 Oxnard Street Woodland Hills, CA 91367
Prescription Drugs	**CVS Caremark** 9501 East Shea Blvd. Scottsdale, AZ 85260
Dental Plan Providers and Claims Administration	**Delta Dental** Delta Tower 100 First Street San Francisco, CA 94105 **MetLife Dental Plan** 1990 North California Blvd., Suite 21 Walnut Creek, CA 94596
Vision Plan Providers and Claims Administration	**Eyemed**
Life and AD&D Insurance	**ING/ReliaStar Life Insurance Company**

Privacy, Confidentiality, Release of Records or Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that the Health and Welfare Plan protect the confidentiality of your private health information. The Plan maintains a Notice of Privacy Practices that provides a complete description of your rights under HIPAA's privacy rules. You will receive a copy of the Notice when you enroll in the Plan or you may request an advance copy from the Administrative Office. This summary is not intended and cannot be construed as the Plan's Notice of Privacy Practices. In the event of any inconsistency between this summary and the Notice of Privacy Practices, the terms of the Notice control.

Once you are enrolled in the Plan, the Administrative Office and the **Board of Trustees** will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations, or as permitted or required by law. In particular, they will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan provided by the Plan

Sponsor. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization.

The **Board of Trustees** hires professionals and other companies to assist it in providing health care benefits. The **Board of Trustees** has required these entities, called, "Business Associates," to observe HIPAA's privacy rules. In some cases, you will receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that organization.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

In compliance with **HIPAA Security** regulations, the Plan Sponsor will:

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 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.

If you have questions about the privacy of your health information, or if you wish to file a privacy violation complaint once you are covered under the Plan, please contact the Plan's Privacy Official at the Administrative Office.

17. Glossary of Defined Terms

Active Employee means each person who meets the eligibility rules described in Section 3 of this Summary Plan Description.

Allowed Charges Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. With respect to an In-Network provider, the negotiated fee/rate set forth in the agreement between the participating network provider/facility and the network or the Plan; or
2. With respect to a Non-Network provider, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers.

   The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. or
3. For an In-Network Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim; or
4. The provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Limit. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

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

Collective Bargaining Agreement is a written agreement between Stationary Engineers Local 39 and an employer that requires the employer to make contributions to the Plan on behalf of its employees. To inquire about whether a particular employer contributes to this Plan, or to request a copy of the Collective Bargaining Agreement, contact the Administrative Office.

Cosmetic Surgery or Treatment means any 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, dental, or surgical treatment intended to restore or improve physical appearance without significantly improving physiological function, as determined by the Plan Administrator or its designee.

Custodial Care means care and/or services which are provided to help a person to perform activities of daily living, including personal hygiene. Custodial care services include personal care, homemaking services, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered. Such services will be considered custodial regardless of who recommends, orders, provides or directs the care or of the setting the care is provided in.

Dentist means a dentist licensed to practice dentistry in the state in which he renders treatment.

Durable Medical Equipment (DME) means equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness, is not disposable or non-durable and is appropriate for use in the patient’s home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Eligible Individual means each Active or Retired Employee and each of his Dependents (refer to Section 3 of ***this Summary Plan Description***), if any.

Emergency means an accidental injury or unforeseen sudden onset of a medical condition with symptoms so severe, including severe pain, that without immediate medical attention the Eligible Individual could reasonably expect:

- that his health would be in serious jeopardy;
- that a body organ or part would be seriously damaged;
- that permanent disability or prolonged temporary disability could result;
- that prolongation or more complex or hazardous treatment could result; or
- that inordinate physical or psychological suffering could result.

Final determination as to whether services were rendered in connection with an Emergency will be made by the Plan Administrator or its designee.

Experimental means any of the following:

a. Any medical procedure, equipment, treatment or course of treatment, drug or medicine which is not normally and regularly used or prescribed by the medical community for the reason that it remains under clinical or laboratory investigation or has not been exposed to clinical/laboratory investigation; or

b. Any drug, device or medical treatment or procedure which is the subject of on-going phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

c. Reliable Evidence shows that the consensus among experts regarding the drug, device, or 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 the standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the 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 or medical treatment or procedure; or the

written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

The Plan Administrator or its designee has the discretion and authority to make the final determination as to whether services are “Experimental.” The Board of Trustees or its designee may rely on the advice of medical consultants in determining whether a service or supply is “Experimental” under this definition.

Fund means the IUOE Stationary Engineers Local 39 Health and Welfare Trust Fund.

Hospital means any acute care hospital that is licensed under any applicable state statute and must provide: (a) 24-hour inpatient care, and (b) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services.

Illness(es) means a bodily disorder, infection or disease and all related symptoms and recurrent conditions resulting from the same causes. Pregnancy is covered the same as an illness.

Injury(ies) means physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Medically Necessary with respect to services and supplies received for treatment of an illness or injury means those services or supplies determined by the Plan Administrator or its designee 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,
d. not primarily for the convenience of the patient, the patient’s Physician or another provider, and
e. the most appropriate and cost efficient 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.

Final determination as to whether services are “Medically Necessary” will be made by the Plan Administrator or its designee. The Trustees may rely on the advice of medical consultants in determining whether a service or supply is “Medically Necessary” under this definition.

Medicare means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

Non-PPO Provider means a Hospital or other health care provider which does not have a contract in effect with the Fund under a Preferred Provider Organization.

Physician means Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.) or Acupuncturist, Behavioral Health Practitioner, Chiropractor, Dentist, Nurse (RN, LVN, LPN), Licensed Midwife, Certified Nurse Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master’s prepared Audiologist, Optometrist, Optician for vision plan benefits, Anesthesia provided by a Physician or a Certified Registered Nurse Anesthetists; who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice. The term Physician shall not include any person who is the spouse, Domestic Partner, child, brother, sister, or parent of the employee.

PPO Provider means a hospital or other health care provider which has a contract in effect with the Fund under the Preferred Provider Organization that is under contract to the Fund.

Placed for Adoption occurs on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Plan Year means January 1 to December 31.

Pre-Admission Review means the process whereby the Professional Review Organization (PRO) under contract to the Plan determines the medical necessity of an Eligible Individual’s elective confinement in a Hospital, and if Medically Necessary, the number of pre-authorized days eligible for unreduced benefit

coverage according to the terms of the Plan, prior to such elective Hospital confinement actually occurring.

Preferred Provider Organization (PPO) means a program / network whereby Hospitals and health care providers contract with an independent PPO organization which has a contract with the Fund to provide any and all necessary hospitalization and other medical services to Eligible Individuals payable on the basis of a negotiated rate, approved by the Board and amended from time to time. The plan also contracts with Delta Dental and Vision Service Plan for preferred dental and vision providers.

Prescription Drugs are 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.

Professional Review Organization (PRO) means an organization, under contract to the Plan, which is responsible to determine whether the elective confinement of an Eligible Individual to a Hospital is Medically Necessary, and if Medically Necessary, to determine the number of Medically Necessary days for such confinement solely for the purpose of determining whether such Eligible Individual is to receive unreduced benefit coverage according to the terms of the Plan for covered expenses incurred as a result of such Hospital confinement.

Skilled Nursing Facility (SNF) means a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets the following requirements:

- It is accredited by The Joint Commission (TJC) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
- It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis.

A Skilled Nursing Facility that is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of the Self-Funded Medical Plan.

Trust Agreement means the Trust Agreement establishing the Stationary Engineers Welfare Fund dated July 1, 1965, and any modification, amendment, extension or renewal thereof.

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 from the Professional Review Organization (PRO) under contract to the Plan, as to the medical necessity of such confinement in order to receive unreduced benefit coverage for covered expenses incurred as a result of such Hospital confinement. For emergency confinements, such review must be obtained retrospectively.

Amendment No. 1
to the June 1, 2018 Plan Document/Summary Plan Description
of the
Stationary Engineers Local 39 Health and Welfare Plan

Effective June 1, 2018 (except as otherwise indicated), the following changes have been made to the Summary Plan Description as noted below:

Page 6, Section 2, Summary of Your Health and Welfare Benefits, the row titled "Calendar Year Deductible" has been restated as follows:

	Comprehensive Self-Funded Medical Benefits (Anthem Blue Cross PPO)	
	Anthem Blue Cross Contracted Provider (In-Network)	Out-of-Network[1]
Calendar Year Deductible	For any combination of In-Network and Out-of-Network providers: $170 per person; $340 per family before the Plan pays any benefits. The deductible is waived for: • hospital charges including outpatient hospital charges on the day of surgery, or for the emergency treatment of a non-occupational injury on the day of the accident, or the following day, • skilled nursing facility charges, • preoperative testing performed on an outpatient basis within seven days of a scheduled, covered surgery and • emergency outpatient surgery.	

Section 7, Medical Plan Benefits, in the Section titled "Limitations and Exclusions" beginning on page 46, a new exclusion ee. is added at the end of the list of Limitations and Exclusions as follows:

(ee) Charges related to gene therapy. Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Fund does not cover any charges related to gene therapy, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Illustrative examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well and Luxturna and Zolgensma, but new applications for gene therapies are submitted every year. In addition, treatment received due to complications from gene therapy are not covered.

Section 8, Prescription Plan Benefits, in the Section titled "What the Plan Does Not Cover," beginning on page 49, exclusion (i) is deleted in its entirety. Exclusions (j) through (v) are renamed (i) through (u), respectively. A new exclusion v. is added stating as follows:

v. Charges related to gene therapy.

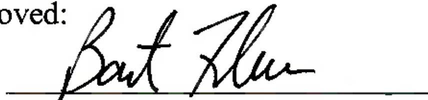
____

Effective January 1, 2019, the following changes have been made to the Summary Plan Description as noted below:

All references to Caremark throughout the SPD/Plan Document have replaced with OptumRx.

Page 2, Important Contact Information, the row titled "Caremark" has been restated to reflect "OptumRx" as follows.:

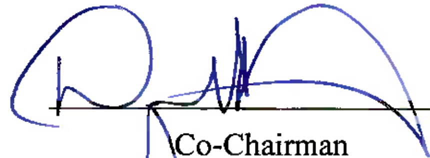
	Phone Number	Website
SELF-FUNDED MEDICAL PLAN		
Prescription Drugs for Self-Funded Medical Plan OptumRx	**Customer Service** (855) 295-9140 **Mail Order Service** (855) 295-9140 Specialty Pharmacy Briova Rx (855) 295-9140	www.optumrx.com

Approved: 

Chairman

3/5/20

Date



Co-Chairman

3-5-2020

Date

Board of Trustees
Stationary Engineers
Local 39 Health and Welfare Plan

5627961v6/01695.005

Amendment No. 2
to the June 1, 2018 Plan Document/Summary Plan Description
of the
Stationary Engineers Local 39 Health and Welfare Plan

Effective August 1, 2020, the following changes have been made to the Summary Plan Description as noted below:

Page 20, Section 3, Eligibility and Enrollment, the Subsection titled "Eligibility for Retiree Program" has been restated as follows:

Eligibility for Retiree Program

- You must be at least age 55 to participate in the Plan. You must also be receiving a retirement benefit from the Stationary Engineers Local 39 Pension Plan. The Plan covers eligible retirees until they are eligible for Medicare.
- To qualify, you must have been eligible and participating as an Active Employee in the Stationary Engineers Local 39 Health and Welfare Trust Fund for a minimum of five total years and at least 12 of the 24 months immediately preceding your retirement.
- You may cover Dependents under the self-pay retiree program who qualified as eligible Dependents under the Plan at the time you retire and are enrolled as Dependents under your active coverage. You may not add a dependent after your initial enrollment in the retiree plan unless you have a Special Enrollment event as outlined on page 14.

Please note: the effective date of your Retiree health benefits will be the commencement date of your first pension check. If, however, you were previously eligible and participating as an Active Employee in this Plan with active coverage ("Active Coverage"), your Retiree health benefits will begin upon exhaustion of Active Coverage. Coverage under a plan other than this Plan does not qualify as Active Coverage.

Page 38, Section 6, Cost Management Programs, the section titled "Personal Case Management" has been restated as follows:

Personal Case Management

If you require extensive long-term treatment, Anthem Blue Cross will work with you to ensure that you obtain medically appropriate care in the most cost-effective and coordinated manner during prolonged periods of intensive medical care.

Members may be identified for possible personal case management through the Plan's utilization review procedures, by the attending physician, hospital staff, or Anthem Blue Cross claims report. You or your family member may also call Anthem Blue Cross regarding this provision.
The Plan will only pay for benefits as described in this booklet. There is no substitution of benefits allowed under this Plan.

Approved:

Chairman

10/22/2020

Date

Co-Chairman

10-14-20

Date

Board of Trustees
Stationary Engineers
Local 39 Health and Welfare Plan

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Amendment No. 3
to the June 1, 2018 Plan Document/Summary Plan Description
of the
Stationary Engineers Local 39 Health and Welfare Plan

Effective January 1, 2022, the following changes are made to the Summary Plan Description as noted below:

Section 17, Glossary of Defined Terms, the following definition for Allowed Charges is restated as follows with the additions in italics:

Allowed Charges Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies.

For Emergency Services, non-Emergency Services provided by Non-PPO Providers at PPO facilities, and Air Ambulance services, the Allowed Charge is the Recognized Amount.

For all other services, the Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. With respect to an In-Network provider, the negotiated fee/rate set forth in the agreement between the participating network provider/facility and the network or the Plan; or
2. With respect to a Non-Network provider, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers.

   The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary, and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. or
3. For an In-Network Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third-party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim; or
4. The provider's/facilities actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Limit. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan *except for Emergency Services, non-Emergency Services furnished by a Non-PPO provider at a PPO facility, or Air Ambulance.*

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

Section 17, Glossary of Defined Terms, the definition of "Emergency" is repealed and replaced with the following:

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of an individual or, with respect to a pregnant women, her unborn child in serious jeopardy.

Emergency Services means the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names

of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and

- The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or dependent understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or dependent.

Section 17, Glossary of Defined Terms, the following new definitions are added, stating as follows:

Ancillary services are, with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Cost sharing means the amount a participant or dependent is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

The **Cost Sharing Amount** for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Continuing Care Patient means an individual who, with respect to a provider or facility-

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Health Care Facility (for non-emergency services) is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Independent Freestanding Emergency Department is a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Non-PPO emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

Non-PPO provider means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Out-of-Network Rate with respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process;
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system; or
- If applicable, if a State law is in effect and applies, the amount determined in accordance with such law.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 45 CFR § 149.140(a)(16).

Recognized Amount means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Serious and Complex Condition means with respect to a participant, dependent, or enrollee under the Plan one of the following:

1. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent;
2. in the case of a chronic illness or condition, a condition that is—
   a. is life-threatening, degenerative, potentially disabling, or congenital; and
   b. requires specialized medical care over a prolonged period of time.

In the context of Continuity of Care, **Termination** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Chapter 5, How Your Self-Funded Medical Plan Works, is amended to add the following new subsections above the subsection entitled "Preferred Provider Organization (PPO)" stating as follows:

Designation of a Primary Care Provider

The Kaiser HMO Plan option generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. You have the right to designate a pediatrician as the primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser designates one for you.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser Permanente at the number listed at the front of this document.

Patient Access to Obstetrical and Gynecological Care

You do not need prior authorization from *the Fund, Anthem, Kaiser,* or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office, Anthem, or Kaiser at the numbers listed at the front of this document.

Chapter 5, How Your Self-Funded Medical Plan Works, the subsection entitled "Preferred Provider Organization (PPO)" is restated as follows with additions in italics and deletions in strikeout:

Preferred Provider Organization (PPO)

The Plan offers the **Anthem Blue Cross PPO BlueCard network** of doctors, specialists, hospitals, and ancillary providers. Anthem Blue Cross contracts with these health care providers and offers services to employees at a discounted rate. This network of providers is called a Preferred Provider Organization. The PPO rate is called the "negotiated rate." The PPO is available in California and nationwide. Call (800) 810-BLUE for information on participating providers or visit www.bluecares.com for a directory of providers.

> **Coinsurance**
> When you are required to share the cost for services by paying a percentage, your share is called "coinsurance." For example, if a covered service were covered at 90%, your coinsurance would be 10%.

A list of network providers is available to you without charge from the Administrative Office, or by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.

When you visit a provider in the PPO (an **"in-network provider"**), you do not have to elect a primary care physician—you have the flexibility to see any doctor or specialist in the network without a referral.

If you choose to be covered under the Comprehensive Self-Funded Medical Benefits Plan, you are not required to visit a PPO provider. You can visit any provider you would like and you will still receive benefits for covered services. However, when you go out-of-network, your coinsurance costs are generally greater **and** you will pay the difference between the amounts the out-of-network provider charges and the Fund's Allowed Charge, also called "balance billing." To avoid balance billing, choose in-network providers.

Continuing Care

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed continued coverage at Network cost sharing to allow for a transition of care to a Network provider until the earlier of a) ninety (90) days or b) the date on which you are no longer considered a continuing care patient with respect to that provider.

Chapter 5, How Your Self-Funded Medical Plan Works, the section entitled "Certain Non-PPO Providers Paid at PPO Coinsurance" has been restated as follows with additions in italics and deletions in strikeout:

Certain Non-PPO Providers Paid *under the No Surprises Act*

In certain limited circumstances the *Self-funded* Plan will pay charges for services provided by a non-PPO physician at *the in-network Rate under the No Surprises Act. Payment rules may be different for the fully insured HMO*.

Emergency Services are covered:

- *Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;*
- *Without regard to whether the health care provider furnishing the Emergency Services is a PPO Provider or a PPO emergency facility, as applicable, with respect to the services;*
- *If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility:*
  - Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO Providers and PPO emergency facilities;
  - Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO Provider or a PPO emergency facility;
  - By calculating the Cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
  - By counting any Cost-sharing payments made by the participant or dependent with respect to the Emergency Services toward any in-network deductible or in-network out-of- pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the Cost-sharing payments were made with respect to Emergency Services furnished by a PPO Provider or a PPO emergency facility.

Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition are covered, until:

- *The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; and*
- *The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and*
- *The participant or dependent is in a condition to receive the written notice, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable State law.*
- *The participant or dependent gives informed consent to continued treatment that is not considered Emergency Services by the non-PPO provider, acknowledging that the participant*

or dependent understands that continued treatment by the non-PPO provider may result in greater cost to the participant or dependent and balance billing.

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a non-PPO provider at a PPO facility, the items or services are covered by the plan:

- *With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,*
- *By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such PPO provider were equal to the Recognized Amount for the items and services.*
- *By counting any cost-sharing payments made by the participant or dependent toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a -PPO Provider.*

Non-emergency items or services performed by a Non-PPO Provider at a PPO facility will be covered based on your out-of-network coverage if:

- *At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment; and*
- *The participant or dependent gives informed consent to continued treatment by the Non-PPO Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-PPO Provider may result in greater cost to the participant or dependent, that the payment of such charge might not accrue toward meeting any limitation of the plan on cost-sharing (such as deductible or out-of-pocket maximum), and that the participant or dependent may be balance billed.*

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

- *With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO Provider,*
- *With cost-sharing requirements calculated as if the total amount charged for the items and services by such PPO provider were equal to the Recognized Amount for the items and services, and*
- *With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO Provider.*

Chapter 14, Filing Your Claims, is amended to include a new subsection immediately before the subsection entitled "If a Health Care Claim is denied" stating as follows:

Timing Requirement for payment of Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the non-PPO provider. The 30 day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

If an Out-of-Network provider or facility and the plan enter into the Independent Dispute Resolution (IDR) process under the federal No Surprises Act (Public Law 116-260, Division BB) and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service, the allowable amount is the amount of such determination. The participant or dependent has no right nor obligation to participate in any IDR process under the federal No Surprises Act.

Chapter 14, Filing Your Claims, is amended to include a new subsection immediately preceding the subsection entitled "Payment in Event of Incompetency or Lack of Address" stating as follows:

EXTERNAL REVIEW OF CERTAIN CLAIMS FOR EMERGENCY SERVICES, NON-EMERGENCY SERVICES FROM NON-PPO PROVIDER AT PPO FACILITY, AND AIR AMBULANCE SERVICES

This voluntary External Review process is intended to comply with the No Surprises Act external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

External Review is only applicable in certain cases. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim is denied and is a claim for emergency services, non-emergency services from a Non-PPO provider at a PPO facility, or air ambulance.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

Generally, you may only request external review after you have exhausted the Plan's internal claims and appeals process described above. This means that, generally, you may only seek external review after a final determination has been made on your appeal.

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

External Review of Standard (Non-Urgent) Claims.

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of a Claim Appeal Benefit Determination. For convenience, these Determinations are referred to below as an “Adverse Determination,” unless it is necessary to address them separately.

Preliminary Review of Standard Claims.

Within five (5) business days of the Plan’s receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan.
- You have exhausted the Plan’s internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and
- You have provided all of the information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

- If your request is complete and eligible for external review; or
- If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
- If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

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

If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

- The assigned IRO will timely notify you in writing of the request’s eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

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- Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
- If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

  In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- The assigned IRO will provide written notice of its final external review decision to you and the Plan **within 45 days** after the IRO receives the request for the external review.

  If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

  If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. [If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).
- The assigned IRO's decision notice will contain:
  - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
  - The date that the IRO received the request to conduct the external review and the date of the IRO decision;
  - References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

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- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

External Review of Expedited Urgent Care Claims.

You may request an expedited external review if:

- you receive an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Claim Appeal Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review for an Expedited Claim.

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

Review of Expedited Claim by an Independent Review Organization (IRO).

Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

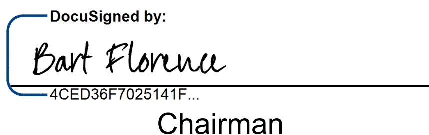
- If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at 925-208-2280. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

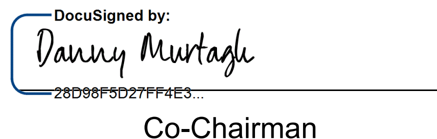
Approved:



Chairman

12/22/2021 | 9:02 AM PST

Date



Co-Chairman

12/14/2021 | 5:35 PM PST

Date

Board of Trustees
Stationary Engineers
Local 39 Health and Welfare Plan