OE3 Trust Funds

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OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND FOR UTAH

SUMMARY PLAN DESCRIPTION

EFFECTIVE
JULY 1, 2024

Operating Engineers
Health and Welfare Trust Fund for Utah

Health and Welfare Benefits
for Participants and Their Eligible Dependents
(including Medical, Prescription Drug, Dental, Vision, Weekly Disability, Life Insurance, Accidental Death and Dismemberment and Burial Expense)

Summary Plan Description (SPD) and Plan Document

EFFECTIVE
July 1, 2024

OPERATING ENGINEERS
HEALTH AND WELFARE TRUST FUND FOR UTAH
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Alameda, CA 94502

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OPERATING ENGINEERS
HEALTH AND WELFARE TRUST FUND FOR UTAH

TO OPERATING ENGINEERS AND THEIR FAMILIES:

We are pleased to provide you with this SPD/Plan Document describing your health care and insurance benefits under the Operating Engineers Health and Welfare Trust Fund of Utah as of July 1, 2024. This document supersedes all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

Here is what you'll find inside:

- An explanation about your benefits,
- Information on eligibility and enrollment,
- Chapters on the individual benefits (medical, prescription drug, dental, vision care, weekly disability benefits, life insurance, accidental death and dismemberment, burial expense); and
- Other important Plan information.

Participating Providers

You can make the most of your benefits and keep costs down by using participating health care providers. These providers have contract arrangements with the Plan's claims administrator for medical benefits that are designed to lower costs without reducing the level of care available to you. Contact the Trust Fund Office for more information.

About this Plan

The Board of Trustees has the right to amend, change, or discontinue this Plan and the types and amounts of benefits provided under this Plan. The Board of Trustees and its Appeals Subcommittee are granted the sole discretionary authority to make any and all determinations under the Plan, including who is eligible for benefits, the amount of benefits payable (if any) under any of the benefits funded directly by the Trust Fund, and the meaning and applicability of Plan provisions, including factual determinations regarding all aspects of the Plan and its benefits. No employer, union, individual trustee, or any representative of any employer or union is authorized to interpret this Plan on behalf of the Board of Trustees. Note:

- Your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits.
- The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage under Workers' Compensation insurance laws or similar legislation.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed lifetime benefits.

Emergency Medical Conditions and Urgent Care

Costs vary according to where you receive care for an emergency medical condition or for urgent care. Costs are usually highest at a hospital's emergency department, somewhat lower at an urgent care facility, and usually the lowest at a physician's office.

Questions?

We encourage you to read this booklet carefully and keep it handy for future reference. If you are married, please share the booklet with your spouse.

If you have questions about your benefits, contact the Trust Fund Office or the Fringe Benefits Service Center, where the staff will be pleased to assist you.

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 Trust Fund Office at 510-433-4422.

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 Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

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

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

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CONTACTS – QUICK REFERENCE CHART

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

Only the Trust Fund office in California can verify your eligibility.

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<tr><th colspan="2">QUICK REFERENCE CHART</th></tr>
<tr><th>Information Needed</th><th>Whom to Contact</th></tr>
<tr><td>Claims Processing Administration, Trust Fund Office
• Medical claims payment
• Medical Claims and Appeals
• Eligibility for Coverage
• Plan benefit information for medical, vision and hearing aid benefits
• Medicare Part D Notice of Creditable Coverage
• Eligibility for Coverage
• COBRA Administrator
• COBRA Continuation Coverage and notices
• Claims information for physical exam
• Substance use disorder benefits</td><td>Zenith American Solutions (Zenith)
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502

Or

P.O. Box 23190
Oakland, CA 94623-0190

Claims, Eligibility and COBRA:
(800) 251-5014 or (510) 433-4422 or (510) 271-0222
www.oe3trustfunds.org

Claims information for Physical exam or a Substance Use Disorder
(800) 251-5013</td></tr>
<tr><td>• Beneficiary designations for life insurance and burial expense benefits.</td><td>Fringe Benefits Service Center, Alameda, California
(800) 532-2105</td></tr>
<tr><td>Trust Fund Office – Salt Lake City, Utah
• Claim Forms and beneficiary designation forms
• Medical Claims and Appeals for life insurance, AD&D and weekly disability
• Eligibility for Coverage
• COBRA Continuation Coverage and notices
• Plan Benefit Information
• Information on PPO Providers</td><td>Utah Fringe Benefits Office
Operating Engineers Local Union No. 3 District 12
8805 South Sandy Parkway
Sandy, UT 84070-6460

(385) 326-2001</td></tr>
</table>

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
PPO Network • Medical Network Provider Directory • Additions/Deletions of Network Providers • Required pre-notification for Hospital admissions and admissions to a skilled nursing facility, surgery, organ or tissue transplants, home health care and home infusion therapy.	**Anthem Blue Cross** For Pre-notification, call (800) 274-7767 Website for Network Provider Directory: www.anthem.com Or www.bcbs.com **or call 1-800-810-2583.**
PPO Vision Network and Vision Claims Administrator • Vision Network Provider Directory • Additions/Deletions of Network Providers • Vision claims and appeals	**Anthem Blue Cross (Blue View Vision)** P.O. Box 8504 Mason, OH 45040-7111 Member Services: (866) 723-0515 To locate a participating network eye care doctor or location, you can log in at anthem.com, or from the Anthem home page menu under Care, select Find a Doctor.
Prescription Drug Program administered by the Prescription Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription drug information • Prior authorization of certain drugs • Direct member reimbursement (for Non-Network retail pharmacy use) • Specialty drug program: Prior authorization and ordering	**OptumRX** Main Corp Center 17900 Von Karman Avenue Irvine, CA 92614 • Retail, mail order and specialty pharmacy services, call 1-855-OPA-ENGI ((855) 672-3644) (TDD assistance: (855) 672-3644 (TTY 711)) • ***Mail order:*** For physicians to call in prescriptions: (800) 797-7658. For participants: (855) 672-3644 • ***Specialty pharmacy services***, call (855) 672-3644 or (866) 218-5445 Website: www.optumrx.com
PPO Dental Network and Dental Claims Administrator • Dental Network Provider Directory • Additions/deletions of Network Providers • For help in finding a participating dentist • Dental claims and appeals	**EMI Health – Group Number 002300** 5101 S. Commerce Dr. Murray UT 84107 Phone: (801) 262-7475 or (800) 662-5851 Fax: (801) 269-9734 www.emihealth.com
Substance Use Disorder Treatment • Pre-notification for inpatient substance use disorder treatment • Substance use disorder services and providers • Substance use disorder claims and appeals	**Assistance Recovery Program (ARP)** (800) 562-3277 **Send Substance Use Disorder claims to:** **Operating Engineers Assistance Recovery Program** 3920 Lennane Dr. Sacramento, CA 95834

QUICK REFERENCE CHART

<table>
<tr><th>Information Needed</th><th>Whom to Contact</th></tr>
<tr><td>Life Insurance and Accidental Death & Dismemberment benefits and Weekly Disability benefits</td><td>USAble Life Insurance Company
P.O. Box 1650
Little Rock, AR 72203-1650
800-370-5856
www.USAbleLife.com

Call Fringe Benefits Service Center in Alameda California for beneficiary designations for life insurance benefits at (800) 532-2105</td></tr>
<tr><td>Employee Burial Expense Benefit (for Employees only)

• Claims and appeals for the Burial Benefit</td><td>Union Labor Life Insurance Company

NOTE: If you are not eligible for the burial expense benefit under this Plan, the benefit may be provided for you through other contracts issued to the groups participating in the Operating Engineers Burial Expense Program. Your beneficiary should therefore contact the Union or the Trust Fund Office to ask about payment of this benefit in the case of your death.

Call Fringe Benefits Service Center in Alameda California for beneficiary designations for burial expense benefits at (800) 532-2105</td></tr>
<tr><td>HIPAA Privacy Officer and HIPAA Security Officer
• HIPAA Notice of Privacy Practices</td><td>Vice President HIPAA Services and Privacy Officer
Zenith American Solutions (Zenith)
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502

Phone (877) 217-2676</td></tr>
</table>

CHAPTER 1: OVERVIEW

Overview of Benefits Available	
Benefit	**Description**
Medical Benefits	The comprehensive medical Plan covers Medically Necessary treatment of Illness and injuries (including treatment of mental health and substance use disorders).
Substance Use Disorder Benefits	The Plan's substance use disorder benefits include benefits for substance use disorder rehabilitation treatment. If medical detoxification is needed in an acute care hospital, those hospital services are covered under the comprehensive medical benefits. **NOTE:** Benefits for treatment of substance use disorders are available **only to you and your spouse**, not to Dependent children.
Hearing Aids	The Plan pays 100%, up to $2,025 per ear every 4 years (deductible waived).
Prescription Drugs	The Plan covers generic and brand-name prescription drugs at retail pharmacies after you pay your share of costs. A participating pharmacy feature allows you to keep your share of the costs down. The Plan also offers a mail order service for medications you take on a long-term, continuous basis.
Dental	The Plan pays up to $1,500 per year in preventive, basic, and major restorative dental services per person. However, this maximum payment per Calendar Year does not apply to Dependent children under 19 years of age. A participating dentist feature allows you to keep your share of the costs down.
Vision Care	The Plan pays benefits for eye exams and glasses or visually necessary contact lenses.
Employee Weekly Disability Benefit	The Plan pays a weekly benefit of $200 for up to 26 weeks per disability if you are totally disabled and unable to work due to a non-occupational Illness or Injury.
Employee Life Insurance	Pays $4,000 to your beneficiary in the event of your death.
Dependent Life Insurance	Pays $1,000 to you if your spouse dies or $500 if your Dependent child dies.
Accidental Death and Dismemberment (AD&D)	Pays $2,000 to your beneficiary in the event of your death from an accident. Pays a benefit to you if you suffer the loss of certain body parts (e.g., foot, hand, eye) in an accident.
Employee Burial Expense	Pays $2,500 to your beneficiary to cover burial expenses in the event of your death.

Also, see Chapter 17, "Other Important Plan Information," for general provisions regarding your benefits.

HOW TO USE THIS SUMMARY PLAN DESCRIPTION (SPD)

As you read this SPD/Plan Document, keep in mind that references to "you" and "your" refer to both the Plan Participant, or Employee, and eligible Dependents (except when specifically noted that a benefit is for the Employees only, "you" and "your" refer to the Employee).

At the beginning of each chapter, you will find a summary of the benefits described in that chapter.

Unfamiliar Term?

If you see a word whose meaning you are unsure of, check the glossary at the end of this SPD/Plan Document. It contains definitions of words used throughout the document.

FOREIGN LANGUAGE ASSISTANCE

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Trust Fund en (800) 251-5014 or (510) 433 4422 or (510) 271-0222.

IDENTIFICATION CARDS

When you, the Plan Participant, become eligible under the Trust Fund, you will receive three identification cards - one card for medical services (including vision benefits), one for prescription drug benefits, and one for dental services.

You will receive an ID card from Anthem Blue Cross for comprehensive medical benefits and an ID card from OptumRx for your prescription drug benefits. The cards will include important information such as your identification number, your group number, your name and the names of your enrolled Dependents.

It is important that you keep your identification cards with you at all times. Be sure to present it to your provider before receiving care and when filling prescriptions at a pharmacy.

If you lose your card, you can get a new one simply by calling Anthem Blue Cross or OptumRx at the numbers listed on the Quick Reference Chart at the beginning of this document. If your coverage under the Plan terminates, your identification card will no longer be valid.

You will also receive a dental plan identification card from EMI Health, which you should present to the dental office whenever you receive dental care.

OTHER BENEFITS

Life Insurance and Accidental Death & Dismemberment benefits (Chapters 10, 11, and 12) and Weekly Disability benefits (Chapter 9) are fully insured by USAble Life Insurance Company, which pays the claims for these benefits.

The Employee Burial Expense Benefit (described in Chapter 13) is fully insured by the Union Labor Life Insurance Company, which pays the claims for this benefit.

Dental Benefits (described in Chapter 7) are self-funded by the Trust Fund and administered by EMI Health which pays the claims and provides a network of participating dentists.

FILING CLAIMS

Information on how to file claims is included at the end of each of the chapters describing the individual benefits. For information on what to do if you disagree with the decision made about your claim, see "Claims and Appeals Procedures" in Chapter 15.

CHAPTER 2: ELIGIBILITY AND ENROLLMENT

In this chapter you'll find:

- ✓ Employee eligibility
- ✓ Dependent eligibility
- ✓ Qualified Medical Child Support Orders
- ✓ Enrollment
- ✓ Coverage during a family and medical leave
- ✓ Coverage during military service

EMPLOYEE ELIGIBILITY

Three types of Employees are potentially eligible for the benefits described in this booklet:

- Hourly Employees,
- Flat-rate Employees (including non-bargaining unit office Employees and company officers), and
- Owner-Operators.

Coverage for Hourly and Flat-Rate Employees is provided through contributions made by Contributing Employers, under the terms of a collective bargaining agreement negotiated by Operating Engineers Local Union No. 3 or another agreement. Contributions are made according to hours worked for Hourly Employees and at a monthly flat rate for Flat-Rate Employees.

Owner-Operators who meet certain criteria and are not eligible through employment with Contributing Employers may make flat-rate contributions on their own behalf.

The eligibility rules for each group are described separately below.

Most collective bargaining unit Employees are Hourly Employees, but some are Flat-Rate Employees. If you are a bargaining unit Employee and unsure what group you are in, refer to your collective bargaining agreement or contact the Trust Fund Office.

Unless the context requires otherwise, the term "Employee" as used in this booklet includes an Owner-Operator who is eligible for benefits under the Plan.

Eligibility Rules for Hourly Employees

The hours you work for Contributing Employers are reported to the Fund and credited to an Hour Bank established for you.

You will become eligible for Plan benefits on the first day of the calendar month after Contributing Employers report at least 360 hours on your behalf during a period of three consecutive months or less which gives you 3 months of eligibility. For example, if you worked 110 hours in July, 130 hours in August, and 120 hours in September, you will have eligibility for October, November and December.

The hours worked during the 3-month qualifying period are recorded in your Hour Bank. 360 hours will be deducted for the first two months of eligibility. Once you have established eligibility, your eligibility will continue during any subsequent month for which the appropriate deduction (120 hours) is made from your Hour Bank.

See the explanation below for more information on Hour Banks and pro-rated hours if your Employer pays a non-standard contribution rate.

If you lose your eligibility for benefits, you may temporarily extend coverage by paying it for yourself. See "Extended Coverage by Self-Payment and COBRA Continuation of Health Care Coverage" in Chapter 3 for more information. (Note that under COBRA, you may continue only health care (medical, prescription drug, substance use disorder benefits, physical exam, and vision with or without dental) benefits—not life insurance, accidental death and dismemberment, burial expense benefits, or weekly disability benefits.)

Lag Month

To allow sufficient time for employer reports to be received and processed by the Fund Office, a "lag" month will be used in determining monthly eligibility. The lag month is the month between the payroll period in which the hours were worked and the month of eligibility provided by those hours. For example, hours worked in January are credited to your Hour Bank to provide eligibility for the month of March.

Freezing of Hour Bank – Non-qualifying Employment

You may not use your Hour Bank to extend coverage while you are working in Non-Qualifying Employment (work of the type covered by your collective bargaining agreement under which you earned your Hour Bank but performed for a non-contributing employer). During periods of such employment, you will not be eligible for Plan benefits. Your Hour Bank will be frozen until you are once again employed with a Contributing Employer, retire, or become unemployed. If you do not become employed with a Contributing Employer, retire, or become unemployed within 12 months after the freezing of your Hour Bank, any hours remaining in your Hour Bank will be cancelled.

Your Hour Bank will be frozen if:

- You become employed by a public or private employer who is not a Contributing Employer to the Fund;
- Your employer ceases to be a Contributing Employer;
- You perform Non-Qualifying Employment; or
- You are employed by an employer performing "public works" under which a public works project predetermined wage rate is applicable which your employer is duly committed and you receive a wage rate which includes the applicable health and welfare contribution as an agreed part of the compensation paid by the Employer.

If your Hour Bank is not reactivated within 12 months of being frozen, it will be cancelled. If your eligibility terminates due to the cancellation of your Hour Bank, you may not extend your coverage by making self-payments.

Pro-Rated Hours for Non-Standard Employer Contribution Rate

If your employer pays a contribution that is less than the standard industry rate, your hours will be credited in the proportion that rate bears to the standard rate. For example, if you worked 150 hours at a contribution rate of $4.25 when the standard contribution rate was $4.88, only 130 hours would be credited to your Hour Bank for those hours (150 x $4.25 = $637.50, divided by $4.88 = 130 hours).

This pro-rating of hours also applies to hours credited for the purpose of establishing initial eligibility.

Maximum Hour Bank Accumulation

Whenever you have more than 120 hours credited for a month, the excess hours will be accumulated in your Hour Bank to provide subsequent eligibility. Your Hour Bank hours may never be used to extend eligibility for any period in which you are working in Non-Qualifying Employment. Participants who become eligible on and after July 1, 2011 may accumulate up to 720 hours (6 months of eligibility). If you became eligible prior to June 1, 2011, and have not incurred a 12-month break in service, other rules may apply. Please refer to your prior SPD for those rules.

The hour bank maximum accumulation rules as of July 1, 2011 are summarized in the below chart.

Excess Hours Maximum Accumulation in Hour Bank	
Eligibility requirement	**Maximum Accumulation Allowed**
New Participants who become eligible on and after July 1, 2011…	720 hours (6 months of eligibility).
Any Participant with 660 hours or less in their Hour Bank as of June 30, 2011…	720 hours (6 months of eligibility).
If you had more than 660 hours in your bank as of June 30, 2011…	1,080 hours (9 months of eligibility). If your Hour Bank falls to 720 hours or less, your Hour Bank will be limited to a maximum of 720 hours.
If you had more than 990 hours in your bank as of June 30, 2011…	1,440 hours (12 months of eligibility). If your Hour Bank falls to 1,080 or less, your Hour Bank will be limited to a maximum of 1,080 hours.
Any Participant who retired in 2010 or 2011…	Will be able to run out their current Hour Bank under the rule of 110 hours for each month of eligibility.
Any Participant (upon application and approval) who was at or above 720 hours and who dropped below 720 hours because of a documented work-related accident…	Will be allowed to accumulate up to 1,080 hours (9 months of eligibility). This applies to participants who: 1. Had more than 660 hours prior to July 1, 2011; and 2. Are participants after January 1, 2014.

Reinstatement of Eligibility for Hourly Employees

If your eligibility terminates, it will be reinstated on the first day of the calendar month after your Hour Bank is credited with at least 120 hours, provided this occurs within the 12-month period immediately following the termination of eligibility. If you are not reinstated within the 12-month period, any hours in your Hour Bank will be cancelled and you will again need to meet the initial eligibility requirements described above.

For example, if you were last eligible for benefits in November 2023 and then next work 120 hours in September 2024, you would be eligible for health benefits in November 2024. However, if you

were last eligible in November 2023 but do not work 120 hours again until December 2024, you will need to re-establish eligibility by working 360 hours in 3 consecutive months or less.

Reciprocity

If your hours of employment are divided among different plans, reciprocity may help you meet benefits eligibility requirements.

The Operating Engineers Health and Welfare Trust Fund for Utah has reciprocal agreements covering engineers who work in more than one area of the Union, as well as with Southern California Operating Engineers, the Western Conference of Operating Engineers and the International Union of Operating Engineers & Pipeline Employers Health and Welfare Fund.

If you are available for work but ineligible for coverage because your hours were worked under two or more of the funds that have reciprocal agreements, please notify the Trust Fund Office or the administrator of the local Fund.

If you have any questions about reciprocity, please contact either the Trust Fund Office of this Plan or the administrative office of the plan under whose jurisdiction you are working.

Eligibility Rules for Flat-Rate Employees

You will be eligible for Plan benefits on the first day of the **second** month following the month in which your employer first reports a contribution to the Fund. For example, if your employer reports the first contribution for January, your eligibility would start March 1.

Each flat-rate contribution provides only a single month of eligibility. If you lose your eligibility for benefits, you may temporarily extend coverage by paying it for yourself. See “Extended Coverage by Self-Payment and COBRA Continuation of Health Care Coverage” in Chapter 3 for more information. (Note that under COBRA, you may continue only health care benefits—not, life insurance, accidental death and dismemberment, burial expense benefits or weekly disability benefits.)

Some Collective Bargaining Agreements may provide for Hour Bank accumulation for Flat-Rate Employees.

Eligibility Rules for Owner-Operators

If you are an Owner-Operator who is not eligible as a result of employment with Contributing Employers, you may elect to participate in the Plan by making the required monthly contribution to the Trust Fund on your own behalf, provided you are signatory to an approved Owner-Operator Agreement and are a dues-paying member or pay a service fee to Operating Engineers Local 3. The required contribution amount is determined by the Board of Trustees.

If this describes you, you will be eligible on the first day of the calendar month following receipt of your required contribution. Owner-Operator contributions do not provide an Hour Bank accumulation.

If you elect to go on a Contributing Employer’s payroll, the individual employer will be required to pay the full health and welfare contribution from the first day of employment.

DEPENDENT ELIGIBILITY

Eligible Dependents can be covered for medical, prescription drug, dental, and vision care benefits and for Dependent life insurance.

If you have eligible Dependents when you first become eligible for benefits, they will have the same eligibility date you do. If you acquire new Dependents after that time, you may enroll them as explained under "Enrollment" later in this chapter.

Your eligible Dependents are your:

- Legal spouse; and
- Natural child, stepchild, or a legally adopted child who is younger than 26 years of age, whether married or unmarried.
- Adopted children as of the date they are placed for adoption.
- Unmarried child younger than 26 years of age for whom you have been appointed legal guardian, provided the child is considered your Dependent for federal income tax purposes; or
- Unmarried child (or your Spouse's unmarried child) by birth, adoption or legal guardianship who is older than 26 years of age and incapable of self-supporting employment because of total and permanent disability, provided the child became disabled before reaching age 26 and while eligible under the Plan, and is considered your Dependent for federal income tax purposes. Written evidence of the individual's incapacity must be filed with the Trust Fund within 31 days after the individual attains age 26, and periodically thereafter as requested.

In accordance with ERISA Section 609(a)(2)(A), the Plan will provide coverage for an Employee's child under 26 years of age if required by a Qualified Medical Child Support Order, including a National Medical Support Order.

A spouse or child of a Dependent child is not eligible for coverage under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

This Plan will provide benefits in accordance with a **QMCSO or a National Medical Support Notice**. In this document, the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory

law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of your Dependent Children, the Trust Fund will determine if that order is a QMCSO as defined by federal law. That determination will be binding on you, the other parent, the child, and any other party acting on behalf of the child. The Trust Fund will notify the parents and each child if an order is determined to be a QMCSO, and if you are covered by the Plan, and advise you of the procedures to be followed to provide coverage of the Dependent Child(ren).

Enrollment Related to a Valid QMCSO

If the Trust Fund has determined that if an order is a valid QMCSO, it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Trust Fund determined the order was valid, without regard to typical enrollment restrictions.

If you are already a Plan Participant, the QMCSO may require the Plan to provide coverage for your Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Fund will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either you or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including limits on selection of provider and requirements for authorization of services, as permitted by applicable law.

Termination of Coverage

Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage.

Additional Information

For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Trust Fund Office.

RULES FOR REMOVING DEPENDENTS

After a dependent becomes eligible for coverage, you may remove them from coverage ONLY in accordance with the following provisions:

- If a covered child is under the age of 18, you must provide the Trust Fund with written consent to drop coverage from both you and your spouse;
- If a covered child is age 18 or older, you must provide the Trust Fund with written consent to drop coverage from both you and your child (age 18 or older);
- In order to drop your spouse from coverage, you must provide the Trust Fund with written consent from you and your spouse.

In addition, you may add an eligible child or spouse to your coverage after they have been removed from your coverage as follows:

- Any time after 12 months after the child or spouse's coverage has been terminated. Coverage is effective on the first day of the month following the date the enrollment in the Fund is requested, or
- In accordance with HIPAA Special Enrollment, if the child or spouse had other coverage at the time coverage with this Plan was terminated and loses that coverage, you may request enrollment in the Fund's plans if you request enrollment from the Fund Office within 90 days after loss of the other group coverage. Coverage then becomes effective on the first day of the month following the date the enrollment in the Fund is requested.

Contact the Trust Fund Office for proper enrollment procedures including but not limited to completing enrollment forms, showing proof of Dependent Status and, when applicable, making arrangement to pay any required contributions for coverage.

ENROLLMENT

The Employee may not decline coverage in this Plan subject to the special enrollment provisions.

The new member packet you receive when you first become eligible for benefits includes an enrollment form for providing information on yourself and your Dependents.

Please return your completed enrollment form to the Trust Fund Office within **2 weeks** of receiving your new member packet.

You should also submit a beneficiary designation form naming your beneficiary or beneficiaries for your life insurance, accidental death and dismemberment, and burial expense benefits. Beneficiary designation forms are available from the Utah Trust Fund Office or the Fringe Benefits Service Center.

DOCUMENTATION NEEDED TO ENROLL

The new member packet you receive when you first become eligible for benefits includes an enrollment form for providing information on yourself and your Dependents. You are required to notify the Trust Fund Office when ANY change occurs in the information provided on the enrollment form – for example, marriage, birth of a child, death, divorce, or any other change in your family status.

If you are enrolled for coverage under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your new Spouse and/or any newly eligible Dependent Child(ren) no later than 90 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.) The following documentation may be required in order to enroll a new dependent.

- **Marriage:** the certified marriage certificate. In addition, you may be asked to provide a divorce decree or remarriage documents.
- **Birth:** the certified birth certificate showing the biological child of employee. The Fund will accept the hospital birth document in lieu of the state issued birth certificate.
- **Stepchild:** the certified birth certificate, divorce decree or spouse death certificate (if applicable) and marriage certificate.

- **Adoption or placement for adoption**: court order paper signed by the judge showing that employee has adopted or intends to adopt the child, and certified birth certificate. The Fund will accept the hospital birth document in lieu of the state issued birth certificate.

- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate. In addition, the child must be considered your Dependent for federal income tax purposes.

- **Disabled Dependent Child:** Written evidence of the individual's incapacity must be filed with the Trust Fund within 31 days after the individual attains age 26, and periodically thereafter as requested.

- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.

If you have any questions, please contact the Trust Fund Office at the numbers listed above. You may also call the Fringe Benefits office at (800) 532-2105.

Keeping the Trust Fund Office Informed of Changes

You must notify the Trust Fund Office when ANY change occurs in the information provided on the enrollment form – for example, marriage, birth of a child, death, divorce, or any other change in your family status. You should also notify the Fund Office if you change your address.

It is very important that you notify the Trust Fund Office if you and your spouse divorce. **Any claims paid for expenses incurred by ineligible Dependents after the date of the divorce will become the responsibility of the Participant.** You will be required to reimburse the Trust Fund for these claims. In addition, if the Trust Fund Office is not notified of a divorce within 60 days, the former spouse may lose rights to COBRA continuation coverage.

Special Enrollment Provisions

The Employee may not decline coverage in this Plan subject to these special enrollment provisions.

Newly Acquired Spouse and/or Dependent Child(ren) (as these terms are defined under this Plan)

- **If <u>you are enrolled</u> for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your new Spouse and/or any eligible Dependent Child(ren) no later than 90 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)

- **If <u>you are eligible for coverage but not enrolled</u> for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for yourself and/or your new Spouse and/or any eligible Dependent Child(ren) no later than 90 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.

- **If you did not enroll your Spouse for coverage** within 90 days of the date on which he or she became eligible for coverage under this Plan, and if you subsequently acquire a Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request

enrollment for your Spouse and/or your new Dependent Child(ren) and/or any eligible Dependent Child(ren) no later than 90 days after the date of your new Dependent Child(ren)'s birth, adoption or placement for adoption.

Loss of Other Coverage

If, you did not request enrollment under this Plan for yourself, your Spouse, and/or any Dependent Child(ren) within **90 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 eligible Dependent Child(ren) within **90 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- Loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or, termination of the other coverage for cause, such as making a fraudulent claim or intentional misrepresentation of a material fact); 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"** (explained below); or
- No longer residing, living, or working in 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 that includes the individual; 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 is offered by the other plan.

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.

Special Enrollment due to Medicaid or A State Children's Health Insurance Program (CHIP):

An eligible employee and their eligible dependents **may also enroll in this Plan** if that employee (or their eligible dependents):

- Have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (the employee) (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **90 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 **90 days** after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

If the individual requests Special Enrollment **within 90 days** of the date of the event that created the Special Enrollment opportunity, generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.

- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 90 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 90 days after birth, but within 90 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

Individuals enrolled during Special Enrollment must have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements.

If you Have Coverage Elsewhere

If you or your Dependents have health care coverage elsewhere, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage—you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your covered expenses. See "Coordination of Benefits" in Chapter 14 for more information.

COVERAGE DURING A FAMILY AND MEDICAL LEAVE

If your employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you and your eligible Dependents will continue to be covered under this Plan, provided you are eligible when the leave begins and provided your employer make the required contributions during the leave.

It is not the role of the Fund to determine whether or not you are entitled to FMLA leave with health and welfare coverage. Any question regarding entitlement to FMLA leave with continuing health coverage must be resolved with the Employer.

COVERAGE DURING MILITARY SERVICE

The Plan complies with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you enter military service with the uniformed services of the United States for a period of less than 31 days, your eligibility will be continued with no payment required from you

(unless you are an Owner-Operator required to make contributions on your own behalf), provided you were eligible under the Plan when the military leave began. The term “Uniformed Services” means the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

For military service lasting longer than 31 days, you may continue eligibility through self-payments for up to 24 months from the date the military leave began under USERRA. Unlike COBRA Continuation Coverage, if the Employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Trust Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

If you have an Hour Bank and you elect to self-pay for coverage during the military leave, or if you choose not to be covered by the Fund during the leave, your Hour Bank will be frozen and can be used when the leave ends. If you elect to use any accumulated Hour Bank eligibility for coverage during the leave, no charge will be made for the period of eligibility provided by the Hour Bank.

Requirement to Notify Fund Office

No later than 30 days after your military leave begins, you should notify the Fund Office in writing whether you wish to:

- Self-pay to continue Fund coverage during the military leave,
- Not be covered by the Fund during your leave, or
- Use any accumulated Hour Bank eligibility to continue Fund coverage during your leave (if you are an Hourly Employee).

After you return from Military Service

If you return to work or become available for work for a Contributing Employer within 90 days after separation from military service, you will be eligible for the balance of the calendar month in which you return to work and for the next calendar month, provided you give written notice to the Trust Fund Office within 10 days after your return to work. If you are hospitalized or convalescing from an Injury caused by active duty, these time limits are extended up to two years. After that, you will be entitled to eligibility based on any accumulated hours in your frozen Hour Bank.

CHAPTER 3: WHEN ELIGIBILITY ENDS

In this chapter you'll find:

- ✓ Termination of eligibility
- ✓ Extended self-payment coverage
- ✓ Options when you retire
- ✓ COBRA continuation coverage

TERMINATION OF ELIGIBILITY

Termination of your Eligibility

Your eligibility will terminate on the earliest of the following dates:

- The first day of the month following exhaustion of coverage provided by your Hour Bank, if you are an Hourly Employee, or
- The first day of the month your Hour Bank is frozen; or
- The first day of the second month following the month for which the last contribution was made on your behalf, if you are a Flat-Rate Employee, or
- The first day of the month for which the required contribution is not made, if you are an Owner-Operator, or
- The first day of the month in which you become eligible for coverage as a retired Employee (or, if later, the first day of the month following exhaustion of your Hour Bank and any extended eligibility, as described under “Options When you Retire" later in this chapter); or
- The last day of the second month following two consecutive months of no employer contributions paid to the Trust Fund on your behalf (regardless of any accumulated hours in your Hour Bank). This will NOT apply to Employees who are disabled, or to Employees on the Union's Out-of-Work list who are actively seeking employment with a Contributing Employer.

  Example: If no employer contributions are paid to the Trust Fund on your behalf in March and April (for February and March work months), and you are not disabled or on the Out-of-Work List, your coverage will end on the earlier of 1) May 31 or 2) the last day of the month in which your hour bank falls below 120 hours.

  If you are an Hour Bank Employee, and your coverage terminates under this rule, and you have a balance in your Hour Bank, your Hour Bank will be frozen until you once again are dispatched to, and employed by, a Contributing Employer, or until you retire. If you become employed by a Contributing Employer or retire within 12 months, notify the Fund Office right away and your Hour Bank will be reinstated on the first day of the month following the date of your employment by a Contributing Employer or retirement. Your eligibility will also be reinstated on this date if there are at least 120 hours in your unfrozen Hour Bank.

  If you do not become employed by a Contributing Employer or retire within 12 months after the date your Hour Bank is frozen, your Hour Bank will be cancelled.

An Employee whose eligibility terminates due to cancellation of his/her Hour Bank may not extend coverage by making self-payments for the 3-month self-pay period, but will be eligible for COBRA continuation coverage.

Termination of your Dependents' Eligibility

A Dependent's eligibility will terminate when your eligibility terminates or when the Dependent ceases to qualify as an eligible Dependent, whichever is sooner.

In the event of your death, if you are an Hourly Employee, your Dependents' coverage will continue until the last day of the month in which your Hour Bank balance falls below 120 hours.

Retroactive Termination of Coverage

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except in cases of fraud or intentional misrepresentation of material fact, provided that 30 days' advance notice is given.

Termination of for Non-payment

The Plan may terminate coverage when contributions are not timely paid.

EXTENSION OF MEDICAL BENEFITS FOR TREATMENT OF A DISABILITY

If you or your Dependent are totally disabled, as certified by a physician, when eligibility terminates for any reason, the disabled individual will remain eligible for comprehensive medical benefits **for that disability only** for up to 12 months following the date eligibility terminated.

For purposes of this provision, the terms "disabled" and "disability" mean that because of Illness or Injury, an individual is:

- Under a physician's care,
- Not able to perform substantially all the normal activities of a person of the same age and sex who is in good health, and
- Unable to engage in any occupation or business for income or profit (does not apply to children or unemployed spouses).

This extension of benefits will end when:

- The individual ceases to be disabled;
- 12 months have passed since eligibility terminated; or
- The disabled individual becomes eligible under another group plan or another plan's COBRA continuation coverage or any conversion policy, whichever occurs earliest.

If you elect this option (rather than COBRA Continuation Coverage), you will not be eligible to elect COBRA Continuation Coverage when this benefit expires.

EXTENDED COVERAGE BY SELF-PAYMENT

For Bargaining Unit Employees Only

If you are a bargaining-unit Employee, you may continue full benefits for yourself and your Dependents for up to 3 months after your eligibility terminates by making monthly payments to the Fund in the amount determined by the Board of Trustees.

The first monthly payment must be made to the Trust Fund Office no later than 45 days after the date you mail your COBRA election form. The two subsequent payments must be made by the 15th day of the month prior to the month of coverage. Payments must be continuous.

At the end of the 3-month period, you may continue your health care benefits under COBRA (as described below).

The 3-month self-payment continuation coverage will count toward the maximum duration of continuation coverage provided under COBRA.

You may not use this self-payment option to continue your coverage if your eligibility terminates because you are performing Non-Qualifying Employment (see the "Hour Banks" box in the eligibility section of Chapter 2) and your Hour Bank is cancelled.

Please note: The Fund is not responsible for your failure to take timely advantage of this self-payment provision.

OPTIONS WHEN YOU RETIRE

If you are an Hourly Employee, and your Hour Bank has enough hours for at least one month of eligibility when you retire, you will receive a total of 3 months of coverage under the Plan for active Employees. (This applies only if you qualify and enroll for retiree health coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund.)

For example: if you have accumulated 6 months of eligibility in your Hour Bank at the time of your retirement, and you qualify and enroll for retiree health coverage, you will continue to have coverage under the active Employees' Plan for a total of 9 months after you retire. You will not be required to pay contributions for coverage until your Hour Bank and the three additional months of coverage have been exhausted.

At the end of this period of extended coverage, you may be eligible to elect COBRA continuation coverage, as described in the section that follows. Once you have exhausted COBRA continuation coverage, you may enroll in retiree coverage, under the Pensioned Operating Engineers Health and Welfare Trust Fund (provided you are eligible), at the required self-pay rates. You also have the option of enrolling in retiree coverage (if you are eligible) without enrolling in COBRA continuation coverage first.

If you are a Flat-Rate Employee or an Owner-Operator, you will not have the Hour Bank option for extended coverage described above. When you retire, you may enroll in COBRA continuation coverage and then retiree coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund (provided you are eligible), or you may enroll in retiree coverage (if you are eligible) without enrolling in COBRA continuation coverage first.

The Pensioned Operating Engineers Health and Welfare Trust Fund is a separate plan that is described in another booklet. It has different benefits than the Plan covering active Employees, and specific conditions apply for eligibility. If you are anticipating retirement, you should request a copy of the booklet for the Pensioned Operating Engineers Health and Welfare Trust Fund from the Trust Fund Office, the Fringe Benefits Service Center or District Office of the Union. A booklet is also provided when a pension is awarded.

COBRA CONTINUATION OF HEALTH CARE COVERAGE

Have your Family Members Read This Section!

If you decide not to elect COBRA continuation coverage, your spouse and each eligible Dependent child will have a separate right to elect it independently. Therefore, it is important that you, your spouse, and your children all read this section of this booklet carefully.

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.

If your or your Dependents' coverage under the Operating Engineers Health and Welfare Trust Fund for Utah ends due to a "qualifying event," the Consolidated Omnibus Budget Reconciliation Act (commonly known as "COBRA") allows you to continue your health care coverage temporarily by paying for it yourself.

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, See your state Health Insurance Marketplace or www.healthcare.gov).

In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Medicare

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

- The month after the Eligible Individual's employment ends; or
- The month after group health plan coverage based on current employment ends.

If the Eligible Individual does not sign up for Medicare during the 8-month special enrollment period after he or she stops working, they will have to wait until the next general enrollment period.

If the Eligible Individual doesn't enroll in Medicare and elects COBRA continuation coverage instead, he or she may have to pay a Part B late enrollment penalty and may have a gap in coverage if they decide that they want Part B later. If the Eligible Individual elects COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate his or her continuation coverage. However, if Medicare Part A or B is

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

effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the Eligible Individual enrolls in the other part of Medicare after the date of the election of COBRA coverage.

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

Qualified Beneficiaries

Under the law, only "qualified beneficiaries" are entitled to COBRA continuation coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the COBRA qualifying event by virtue of being an Employee on that day, the spouse of an Employee, or the Dependent child of an Employee.

A child who becomes a Dependent child by birth, adoption, or placement for adoption with you during a period of COBRA continuation coverage and is enrolled within 30 days is also a qualified beneficiary and will have the same COBRA rights as a spouse or children who were covered by the Plan before the qualifying event that triggered the COBRA continuation coverage.

A spouse who becomes your spouse during a period of COBRA continuation coverage may be added to your coverage during the period you remain eligible for COBRA continuation coverage. (See "Special COBRA Enrollment Rights" later in this section.) However, such a new spouse would not be a qualified beneficiary (in other words, the spouse would not have any independent enrollment rights or be eligible for additional months of coverage if one of the "second qualifying events" described below occurred).

Qualifying Events

Qualifying events are shown in the chart below. You may only continue health care coverage that was in effect at the time of the qualifying event. COBRA continuation coverage does not include life insurance, accidental death and dismemberment benefits, or the burial expense benefit.

NOTE: The maximum duration for COBRA continuation coverage will be reduced by the number of months for which you extended benefits by self-payment if you elect the extension of benefits for a total disability.

<table>
<tr><th colspan="3">COBRA CONTINUATION COVERAGE</th></tr>
<tr><th>COBRA Qualifying Event</th><th>Who May Continue Benefits</th><th>Maximum Period of Continuation Coverage*</th></tr>
<tr><td>You lose eligibility due to
• A reduction in your Hour Bank below 120 hours,
• Termination of your employment for reasons other than gross misconduct, or
• Retirement</td><td>You, your spouse, and/or your Dependent children who were covered under the Plan on the day before the Qualifying event.</td><td>18 months**</td></tr>
<tr><td>You die</td><td>Your spouse and/or your Dependent children</td><td>36 months</td></tr>
<tr><td>You and your spouse divorce</td><td>Your former spouse and/or your Dependent children</td><td>36 months</td></tr>
<tr><td>Your child ceases to meet the Plan’s definition of an eligible Dependent (for example, because of marriage or age)</td><td>The affected Dependent child</td><td>36 months</td></tr>
<tr><td colspan="3">* Adjustment for extension of benefits by self-payment: The maximum duration for COBRA continuation coverage will be reduced by the number of months for which you extended benefits by self-payment (see “Extended Coverage by Self-Payment” above).
** Disability extension: Coverage for all enrolled family members may be continued an additional 11 months (for a total of 29 months) if you or a covered Dependent becomes totally disabled before or during the first 60 days of COBRA continuation coverage. See “Extended COBRA Period for Disability” later in this section.
Effect of prior Medicare enrollment: If the low hours, termination of employment, or retirement occurs less than 18 months after the date you become entitled to Medicare (Part A, Part B, or both), the maximum period of continuation coverage for your Dependents covered under the Plan will be 36 months after the date of your Medicare entitlement.</td></tr>
</table>

Extended COBRA Period for Disability

If you lose eligibility because of low hours or termination or retirement and you or one of your covered Dependents is determined by the Social Security Administration to have been totally disabled at the time of the qualifying event or within 60 days of the qualifying event, coverage may be extended for you and all enrolled Dependents beyond the original 18 months up to 29 months.

See “COBRA Notification Responsibilities” below for information on procedures and timeframes for notifying the Trust Fund Office of Social Security Administration determinations.

A higher premium will be charged for the additional 11 months of coverage.

If a Second COBRA Qualifying Event Occurs

If your Dependents are in an 18-month COBRA continuation coverage period because of your low hours or your termination of employment or retirement (or a 29-month period, in the case of

disability) and one of the following qualifying events occurs, the maximum COBRA continuation period for your Dependents will switch to 36 months (provided you and/or your Dependents notify the Trust Fund Office of the second qualifying event within the timeframe discussed in “Notification Responsibilities” below):

- You get divorced,
- You die,
- Your child ceases to meet the Plan’s definition of an eligible Dependent (in this case, only the child may extend coverage).

NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependents who are Qualified Beneficiaries.

For example: Tom stops working (the first COBRA qualifying event), and enrolls himself and his family in COBRA continuation coverage for 18 months. Three months after his COBRA continuation coverage begins, Tom’s child turns 26 and no longer qualifies as a Dependent child under the Plan’s definition. Tom’s child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

Employees are not entitled to COBRA continuation coverage for more than a total of 18 months (unless you are entitled to an additional 11 months’ continuation coverage because of a disability). Even if you experience a reduction in your work hours followed by retirement or termination of your employment, the retirement or termination is *not* treated as a second qualifying event and you may not extend your coverage.

Special Enrollment Rights

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

- Your Dependent must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage,
- Your Dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it, and
- You must enroll that Dependent within 31 days after the termination of the other coverage or contributions.

Adding a spouse or Dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

Notification Responsibilities

You and/or your Dependents are responsible for providing the Trust Fund Office with timely notice (see section “Deadline for Sending the Notice” below) of the following qualifying events:

- Your (the Employee’s) divorce from your spouse or
- A child ceasing to be eligible for coverage under the Plan as a “Dependent child.”

In addition, you and/or your Dependents are responsible for notifying the Trust Fund Office, within the timeframe noted below, of the following:

- A determination by the Social Security Administration that a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months is disabled, or
- A determination by the Social Security Administration that such a qualified beneficiary is no longer disabled, or
- The occurrence of a second qualifying event, as described under "If a Second COBRA Qualifying Event Occurs" above.

You must make sure that the Trust Fund Office is notified of any of the occurrences listed above. See the section below on "How to Provide Notice to the Trust Fund." Failure to provide this notice within the form and timeframes described below may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

Your employer is responsible for notifying the Trust Fund Office of your death, termination of employment, or retirement. Determinations of low hours will be the responsibility of the Trust Fund Office. However, you are encouraged to inform the Trust Fund Office of any qualifying event to assure prompt handling of your COBRA rights.

The Trust Fund Office will notify you and/or your Dependents of your rights to choose continuation coverage within 14 days of receiving notification of a qualifying event.

A notice sent to your spouse will be deemed to have also been sent to any eligible Dependent children residing with your spouse at the time.

How to Provide Notice to the Trust Fund Office

Notice of any of the five situations listed above must be provided in writing. Send a letter to the Trust Fund Office containing the following information:

- Your (the Employee's) name and Social Security number,
- The name of the Fund ("Operating Engineers Health and Welfare Trust Fund for Utah"),
- The event you are providing notice for,
- The date of the event, and
- The individual(s) affected by the qualifying event and their relationship to you.

If the qualifying event is a divorce from your spouse, you may be required to provide verification of the termination of your marriage.

Where to Send the Notice

Notice must be sent by U.S. mail to the Trust Fund Office in California at the following address:

COBRA Administrator
Operating Engineers Health and Welfare Trust Fund for Utah
P.O. Box 23190
Oakland, CA 94623-0190

Please keep a copy, for your records, of any notices you send to the Trust Fund Office.

Deadline for Sending the Notice

Assuming you have been furnished with a copy of this booklet or a general (initial) notice by the Plan informing you of the responsibility to provide these notices and these notice procedures, timeframes for providing notice are as follows:

- If you are providing notice of a divorce, a Dependent child is losing eligibility for coverage, or a second qualifying event, you must send the notice no later than **60 days after** the date of the relevant qualifying event.
- If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than **60 days after the latest of** (1) the date of the disability determination by the Social Security Administration, (2) the date of the qualifying event, or (3) the date on which the qualified beneficiary would lose coverage under the Plan due to the qualifying event.
- If you are providing notice of a Social Security Administration determination that you or your Dependent **is no longer** disabled, notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you or your Dependent is no longer disabled.

Who Can Provide Notice

Notice may be provided by the qualified beneficiary with respect to the qualifying event (you—the Employee—or your Dependents, as applicable) or any representative acting on behalf of the 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 you (the Employee), your spouse, and your child are all covered by the Plan and your child ceases to be a Dependent under the plan, a single notice sent by you or your spouse would satisfy this requirement.

If you or your Dependents send a notice to the Trust Fund Office as described above and the Trust Fund Office determines that you are not entitled to COBRA continuation coverage, the Trust Fund Office will send you a written notice stating the reason why you are not eligible for COBRA continuation coverage. This will be provided within 14 days after the Trust Fund Office receives your notice.

Electing Coverage

You and/or your covered Dependents have **60 days** to make your election from the later of:

- The date you would have lost coverage because of the qualifying event or
- The date you received the COBRA notice from the Trust Fund Office.

Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both you (the Employee) and your spouse may elect COBRA continuation coverage, or only one of you may elect COBRA continuation coverage.

A parent or legal guardian may elect COBRA continuation coverage for a minor child. If you or your spouse elects COBRA continuation coverage, you will be deemed to be electing it for your eligible Dependent children as well, unless you specify otherwise in the election. If you and your spouse do not elect COBRA continuation coverage, your Dependent children will be able to elect it or reject it independently of your rejection.

If you and/or your Dependents do not elect COBRA within the 60-day period allowed, you will forfeit all rights to COBRA continuation coverage and your health care coverage will end.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law: You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Coverage Options

You may elect to continue:

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

You may not elect any coverage you did not have immediately before the qualifying event. Your initial continuation coverage will be identical to coverage provided to eligible individuals who have not experienced a qualifying event. It may be modified if coverage later changes for other Participants.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that you or your Dependents are not entitled to the requested COBRA coverage, you will be sent, by the Trust Fund Office, an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

If you elect COBRA Continuation Coverage, you will have to pay the full cost of the coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the Fund's and your share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Sending in Payment

Premiums for COBRA continuation coverage are payable monthly, in amounts established by the Board of Trustees.

You have a maximum of 45 days from the date you mail your COBRA election form to the Trust Fund Office in which to submit your first payment. This first payment must include the cost of coverage retroactive to the first day your coverage would have otherwise terminated.

All subsequent monthly premium payments are due on the 15th day of the month prior to the month for which continuation coverage is elected. A 30-day grace period for premium payment will be allowed before coverage is terminated.

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

If the COBRA Administrator 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 COBRA Administrator will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

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

IMPORTANT
There will be no invoices or reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator whose address is listed on the Quick Reference Chart at the front of this document.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the earliest of the following dates:

- The last day of the maximum period of coverage (18, 29, or 36 months, as applicable)
- The date you or your Dependent fail to make the monthly payment on time (you will be allowed a 30-day grace period from the premium due date)
- The date the person receiving the coverage becomes covered under another group health plan
- The date the person receiving the coverage becomes covered under Part A or Part B of Medicare (after electing COBRA)
- The date your employer terminates its participation in the Plan (If your employer replaces the Plan, you may be entitled to coverage under the replacement plan)
- The date the Social Security Administration determines that an individual on extended disability coverage is no longer disabled (This applies only to the 19th through 29th month of an extended COBRA period for a disability)

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

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

Questions or Changes

If you have any questions regarding COBRA continuation coverage, please contact the COBRA Administrator at:

Operating Engineers Health and Welfare Trust Fund for Utah
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502

Telephone: (510) 433-4422 or (510) 271-0222 or (800) 251-5014.

If you change your marital status or add new Dependents, please notify the Trust Fund Office immediately. To protect your family's rights, you should also keep the Trust Fund Office informed of any changes in the addresses of family members.

Should Federal legislation alter the provisions of COBRA in existence at the time this Summary Plan Description is printed, you will be advised of any such modification as required.

CHAPTER 4: COMPREHENSIVE MEDICAL BENEFITS

In this chapter you'll find:
- ✓ Participating Network Providers
- ✓ Information about Medicare Part D
- ✓ Maximum benefit payments
- ✓ Deductible
- ✓ Percentage paid under the plan
- ✓ Coinsurance maximum
- ✓ Utilization Review program
- ✓ Covered services
- ✓ Exclusions from coverage
- ✓ Information on filing claims

Your comprehensive medical benefits provide coverage for diagnosis and treatment of non-occupational illnesses and injuries. Included are visits to the doctor, hospitalization, surgery, and diagnostic tests, among other services.

The Plan generally pays a percentage of Allowable Medical Expenses for covered services after the deductible is met.

The other key points about how the coverage under the Plan works, such as how the deductible works, Participating Providers, and how covered services are paid, are explained in detail in the sections following the Summary of Benefits chart.

It is important for you to understand how the Plan works before you need health care services. Please read this material carefully. If you have any questions about benefits or procedures, please contact the Trust Fund Office (see the phone number on the Quick Reference Chart at the front of this booklet).

YOU SELECT YOUR PROVIDER AND ARE ABLE TO CONTROL YOUR OUT-OF-POCKET EXPENSES

The Plan has a provider network. The reimbursement by the Plan is higher if you choose to receive services from a Participating Provider (rather than from a Non-Participating Provider).

Participating Provider: When you choose to see a Participating Provider, your out-of-pocket expenses will generally be lower than if you choose to see a Non-Participating Provider. Participating Providers have agreed to accept Allowable Medical Expenses as full compensation for covered services. Choosing to receive services from a Participating Provider means you will not be billed for balances beyond any Deductible, Copayment, and/or Coinsurance for covered services.

When obtaining services from a Participating Provider, you must present your Plan identification card and furnish any additional information requested. The Plan will pay the provider directly for covered services.

NOTE: The fact that a provider is a Participating Provider does not necessarily mean that all services you receive from that provider will be covered services under the Plan.

Non-Participating Provider: If you choose to see a provider that does not have a participating contract with Anthem Blue Cross, your out-of-pocket expenses will generally be higher. Except for

services covered by the NSA, choosing a Non-Participating Provider means you may be billed for balances beyond any Deductible, Copayment, and/or Coinsurance. This is sometimes referred to as Balance Billing.

Non-Participating Providers are under no obligation to limit their charges to the amounts considered "Allowed Charges" by the Plan. Before you will be entitled to payments under the Plan for covered services provided by a non-Participating Provider, the Claims Administrator must receive all forms and information necessary to process the claim. Most payments for covered services provided by a non-Participating Provider will be made directly to you. You will then be responsible to ensure that the non-Participating Provider is paid in full.

Nothing contained in the Plan will be construed to restrict you in exercising full freedom of choice in the selection of a provider for care or treatment of an Illness or Injury.

Participating Providers

The provider directory listing all Participating Providers is available online (at no cost to you) from Anthem Blue Cross at www.bcbs.com. The list of Participating Providers changes frequently so therefore you must call to confirm that a health care provider you have selected is currently a Participating Provider. You can do this by checking with the provider's office directly or by checking online or calling Anthem Blue Cross Customer Service at the numbers listed on the Quick Reference Chart at the beginning of this document.

You can find Blue Card providers in any state online at the website www.bcbs.com, or you can call (800) 810-2583.

For inpatient treatment of a substance use disorder, you should call the Assistance Recovery Program at (800) 562-3277 instead of the contacts above (*see Chapter 5*). We encourage you to contact ARP prior to receiving outpatient treatment in order to be directed to a contracted provider.

If you Have Coverage Elsewhere

If you or your Dependents have Medicare or other group medical coverage, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage—you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See "Coordination of Benefits" in Chapter 14 for more information.

INTER-PLAN ARRANGEMENTS

Anthem Blue Cross 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 Blue Cross (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 Blue Cross 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 (“non-Participating Providers”) don’t contract with the Host Blue. We explain below how we pay both kinds of Providers. The Plan covers only limited healthcare services received outside of the Anthem Blue Cross Service Area. For example, Emergency services obtained outside the Anthem Blue Cross Service Area is always covered

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 Blue Cross 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 Blue Cross 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 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 Blue Cross 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 Blue Cross 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 Blue Cross through average pricing or fee schedule adjustments.

If Anthem Blue Cross has entered into a negotiated arrangement with a Host Blue to provide value-based programs to the Plan on your behalf, Anthem Blue Cross 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 Blue Cross Service Area

1. **Allowed Amounts and Member Liability Calculation**

   When Covered Services are provided outside of Anthem Blue Cross'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 Blue Cross Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by non-Participating Providers. In these situations, you may be liable for the difference between the amount that the non-Participating Provider bills and the payment the Plan makes for the Covered Services as set forth in this paragraph.

E. BlueCard Global

If you plan to travel outside the United States, call customer service to find out your BlueCard Global benefits. **Only benefits for treatment of an Emergency Medical Condition are provided outside the United States.**

When you are traveling abroad and need medical care, you can call the BlueCard Global 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 Global

In most cases, when you arrange inpatient hospital care with BlueCard Global, 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 Global; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Global claim forms, you can get international claims forms in the following ways:

- Call the service center at the numbers above; or
- Online at www.bcbsglobalcore.com.

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

SCHEDULE OF MEDICAL BENEFITS

A schedule of the Plan's medical benefits appears on the following pages in a chart format. To determine the extent to which limitations apply to the benefits that are payable for any services or supplies you receive, you should also check the Exclusions chapter of this document to see if they are excluded.

Medical Plan Benefit Summary	
Deductible per calendar year (applies to most medical plan benefits except where noted that the Deductible is waived)	$350 Per Claimant $1,050 Per Family
Deductible carry-over applies. If covered expenses are incurred in the last 3 months of a calendar year and applied toward the deductible for that year, they will be carried forward and also applied toward the deductible for the following year.	
Maximum coinsurance per calendar year (note that certain expenses do not accumulate to this coinsurance maximum)	$5,000 per individual $10,000 per family
After the maximum coinsurance is met, the Plan pays	100% for the remainder of the calendar year except where noted

Covered Medical Services (Per Claimant)	Participating Provider	Non-Participating Provider [1]
Office Visits ▪ For Illness, Injury	You pay: 20%	You pay: 40%

Covered Medical Services (Per Claimant)	Participating Provider	Non-Participating Provider [1]
Routine Physical Examination (for Employee and Spouse) ✓ One exam and related diagnostic/x-rays per calendar year.	You pay: 0% (deductible waived)	You pay: 0% (deductible waived)
Child Preventive Care Office Visits (up to age 26)	You pay: 0% (deductible waived)	You pay: 40% (deductible waived)
Other Professional Services ▪ Laboratory, radiology and diagnostic procedures ▪ Surgery, inpatient visits and therapeutic injections	You pay: 20%	You pay: 40%
Routine Mammogram, Pap Smear, and Bone Density Scan	You pay: 0% (deductible waived)	You pay: 40% (deductible waived)
Routine Colonoscopy, Sigmoidoscopy	You pay: 0%	You pay: 0%
Ambulance Services	You pay: 20%	You pay: 40%
Blood Bank	You pay: 10%	You pay: 10%
Chiropractic Care ▪ 40 visits per calendar year	You pay: 20%	You pay: 40%
Durable Medical Equipment	You pay: 20%	You pay: 40%
Emergency Room (Including Professional Charges)	You pay: 20%	You pay: 40%
Hearing Aids ▪ Limited to one aid per ear every 4 years	The Plan pays up to $2,025 per ear (deductible waived)	
Home Health Care	You pay: 20%	You pay: 40%
Hospice Care	You pay: 20%	You pay: 40%
Hospital Care ▪ Inpatient, Outpatient and Ambulatory Service Facility	You pay: 20%	You pay: 40%
COVID-19 Vaccines and Boosters	You pay: 0% (deductible waived)	You pay: 40% (deductible waived)
Flu Immunization ▪ Flu shots from any provider reimbursable up to $25. (Must submit receipt to Trust Fund Office for reimbursement. This benefit is administered directly by the Trust Fund).	You pay: 0% (deductible waived)	You pay: 0% (deductible waived)

Covered Medical Services (Per Claimant)	Participating Provider	Non-Participating Provider [1]
Immunizations for Adults ▪ Limited to Tetanus and Rabies	You pay: 20%	You pay: 40%
Immunizations for Children ▪ Covered up to age 18	You pay: 0% (deductible waived)	You pay: 40% (deductible waived)
Maternity Care ▪ Covered for Employee and spouse only	You pay: 20%	You pay: 40%
Mental Health Services - Inpatient ▪ Includes Detoxification	You pay: 20%	You pay: 40%
Mental Health Services – Outpatient Benefits available for covered services provided by a psychiatrist, psychologist, a licensed Marriage, Family and Child Counselor (MFCC), or certified social worker	You pay: 20%	You pay: 40%
See Chapter 5 for a description of available substance use disorder benefits		
Orthotic Devices ▪ Foot orthotics are limited to one pair per Claimant per lifetime	You pay: 20%	You pay: 40%
Prosthetic Devices	You pay: 20%	You pay: 40%
Rehabilitation Services	You pay: 20%	You pay: 40%
Skilled Nursing Facility (SNF) Care	You pay: 20%	You pay: 40%
Transplants ▪ Transplants must be approved as Medically Necessary by Anthem Blue Cross to be covered.	You pay: 20%	You pay: 40%

1. The coinsurance percentage is based on the Allowed Medical Expense. Any amount over the Allowed Medical Expense is the Participant's responsibility.

Anthem BlueView Vision Benefits (Per Claimant)	In Network	Out-of-Network
Vision Examination ▪ Exam: 1 routine eye exam per calendar year	$10 copay	Up to $45 reimbursement

Anthem BlueView Vision Benefits (Per Claimant)	In Network	Out-of-Network
Eyeglass Lenses (instead of contact lenses): One pair of standard plastic prescription lenses: ▪ Single vision lenses ▪ Bifocal lenses ▪ Trifocal lenses ▪ Lenticular lenses	$0 copay $0 copay $0 copay $0 copay	Up to $30 reimbursement Up to $50 reimbursement Up to $70 reimbursement Up to $0 reimbursement
Frames ▪ Once every 2 calendar years	$140 allowance, then 20% off any balance	Up to $100 reimbursement
Contact Lenses (instead of eyeglasses) Once every calendar year		
▪ Elective conventional (non-disposable); OR	$140 allowance, 15% off any balance	Up to $100 reimbursement
▪ Elective disposable; OR	$100 allowance	Up to $100 reimbursement
▪ Non-elective (Medically Necessary)	Covered in full	Up to $210 reimbursement

Prescription Drug Benefits			
A nationwide network of Participating Pharmacies is available to you. Pharmacies that participate in this network submit claims electronically. You can find a list of Participating Pharmacies at the Claims Administrator Website, **www.OptumRx.com**.			
Calendar year deductible per Claimant	None		
Calendar year maximum coinsurance per Claimant	None		
	Claimant Responsibility		
Covered Prescription Drugs	Tier 1 Generic Medication	Tier 2 Preferred Brand Name Medications	Tier 3 Non-Preferred Brand Name Medications
Prescription Medications from a Pharmacy ▪ Up to a 34-day supply for each prescription	$10	$25 or 30%, whichever is greater, (maximum $60)	$25 or 30%, whichever is greater

Prescription Drug Benefits			
Injectable Medications from a Pharmacy ▪ Up to a 34-day supply for each injectable medication **Please note:** Injectables that are classified as Specialty medications may be obtained only through an OptumRx Specialty Pharmacy.	$10	$25 or 30%, whichever is greater, (maximum $60)	$25 or 30%, whichever is greater
Maintenance Medications from a Mail-Order Supplier ▪ Up to a 90-day supply for each prescription	$5	$20 or 30%, whichever is greater, (maximum $50)	$20 or 30%, whichever is greater
Prescription filled at a nonparticipating retail pharmacy (or if you fill your prescription at a participating pharmacy without a valid prescription drug ID card)	You pay the full cost of the drug and must file a claim for reimbursement. The Plan will reimburse 16.4% less than average wholesale price for the drug, plus a $.90 dispensing fee, less the applicable Copayments shown above for drugs from retail participating pharmacies.		
For any prescription drugs (whether from a Retail Pharmacy or a Mail Order Supplier) if the cost of the Prescription Drug is less than the Copayment, you will pay only the cost of the drug.			

If you currently (i.e. prior to October 2021) receive a specialty drug medication which falls within the current middle tier, the Brand Name medication when a Generic is Not Available tier, your specialty medication will be grandfathered into the new "Tier 1" effective January 1, 2022. As such, you will not experience an increased copayment for this medication.

DEDUCTIBLE

The Deductible is the amount you and your Dependents must pay each calendar year before the Plan begins to pay benefits. The deductible amount is $350 per covered person each calendar year. The Plan will not begin to pay benefits for your covered services in a calendar year until the deductible amount is satisfied.

The deductible applies separately to each covered person, but no more than $1,050 will be applied to deductibles for all members of a family in a calendar year, no matter how many Dependents are in the family.

There is a three-month deductible carry-over feature. If allowable expenses are incurred in the last 3 months of a calendar year, and are applied to the deductible for that year, they will also be applied to the deductible for the following year.

The Deductible does not apply to the Hearing Aid benefit, the Employee/Spouse Physical Exam benefit, the Substance Use Disorder benefits, the Child Preventive Care benefit, Flu Immunization, Routine Mammogram, Pap smear, and Bone Density Scan or the Retail/Mail Order Prescription Drug benefits.

PERCENTAGE PAID UNDER THE PLAN

Once the deductible amount is satisfied, the Plan pays a percentage of the Allowable Charge for covered services you receive, up to the maximum amount. See the glossary at the end of this SPD for a detailed description what Allowable Medical Expenses means. The remaining percentage not paid by the Plan is your Coinsurance. The percentage the Plan pays varies, depending on the kind

of service or supply and whether the provider is a Participating Provider or a Non-Participating Provider. Please refer to the Schedule of Benefits for an explanation of payments with a Participating Provider and a Non-Participating Provider.

Charges in excess of Allowable Medical Expenses are not reimbursable by the Plan. Participating Providers will not charge you for any balance beyond the deductible and Coinsurance amount for covered services. Non-Participating Providers, however, may bill you for any balances over the Plan payment level in addition to the deductible and/or coinsurance amount.

MAXIMUM COINSURANCE

The maximum Coinsurance is the calendar-year limit on your payments for covered services. Here's how it works.

The arrangement by which you and the Plan each pay a percentage of allowable expenses is called "Coinsurance." For example, the Plan pays 80% of the Allowable Medical Expenses for most covered services from a Traditional Participating Provider and you pay a Coinsurance amount of 20%.

The medical plan has a limit—or maximum Coinsurance—of $5,000 per person each calendar year. In addition, the plan has a maximum Coinsurance for your family of $10,000 each calendar year. Once you (or a Dependent) has met the maximum Coinsurance for the year, the Plan will pay 100% of Allowable Medical Expenses for the remainder of the calendar year for most types of covered services received by the claimant.

The following do not count toward the maximum Coinsurance:

- amounts you pay for services or supplies that are not covered by the Plan;
- amounts applied to the deductible;
- prescription drug copays or coinsurance; or
- any charges beyond benefit-specific maximums; or
- covered expenses for Employee/Spouse physical exams.

The Plan's benefit-specific limits continue to apply even after you have met the maximum Coinsurance.

The maximum Coinsurance applies only to the comprehensive medical benefits and mental health and substance use disorders, not to benefits described in other chapters of this booklet.

UTILIZATION REVIEW PROGRAM

The Plan uses Utilization Review to help ensure the services that you receive are Medically Necessary, appropriate and consistent with current medical practice. It is important to note that Medical Necessity does not make a service that is a specific exclusion of the Plan a covered service. Utilization Review consists of four methods of reviewing the health care you receive (pre-notification, concurrent review, post-service review, and case management), as described below.

Pre-notification

It is required that you notify Anthem Blue Cross before receiving any of the following services:

- home health care and home infusion therapy;
- transplants; and

- all inpatient admissions, including admissions to a Skilled Nursing Facility or Rehabilitation Facility, except as follows:

when your admission cannot be scheduled in advance (an emergency admission), Anthem Blue Cross should be notified of the admission no later than the next business day or the next business day following stabilization of the patient.

Pre-notification is not required for any maternity (delivery) admission having a duration of 48 hours or less following vaginal delivery or of 96 hours or less following cesarean delivery. Anthem Blue Cross should be notified of the continued stay if an admission will have a longer duration; and when this Plan is the secondary health plan.

NOTE: Even though you notify Anthem Blue Cross of the intent to receive a service, **it does not guarantee that the Plan will cover the service.** In the event the Plan determines that the service is not covered, the Plan will not provide any benefit for the service, regardless of whether notification was received.

You are also encouraged to contact Anthem Blue Cross when receiving the following services:

- high risk maternity care;
- cosmetic and reconstructive procedures;
- high cost Durable Medical Equipment, including prosthetics and orthotics; and
- certain prescription drugs. Please see the "Utilization Review Program for Prescription Drugs" outlined in Chapter 6.

The number to use for Pre-notification is (800) 274-7767.

It is required that you notify ARP before an admission for substance use disorder when your admission cannot be scheduled in advance (an emergency admission). ARP should be notified of the admission no later than the next business day or the next business day following stabilization of the patient. The number to use for Pre-notification is (800) 562-3277.

Concurrent Review

Anthem Blue Cross monitors and reviews certain services while they are being received. This is done to see if they meet Anthem Blue Cross medical guidelines. The program can also help you and your Provider plan for anticipated needs, such as physical therapy after you leave the hospital, and help coordinate these services.

Post Service Review

Anthem Blue Cross reviews some services already received to ensure they meet its criteria and that they were appropriate for your condition. This also helps Anthem Blue Cross monitor how care is being delivered by Providers in the community.

Case Management

Anthem Blue Cross or ARP are available to help you coordinate medical, mental health and substance use disorder needs for complex and catastrophic illnesses or injuries as well as certain chronic illnesses. Case management is designed to provide early detection, intervention and assistance in cases of serious or long-term Illness or Injury that have the potential for major continuing expense so that the appropriate level of care and treatment settings can be coordinated and a plan of care developed. Anthem Blue Cross (or ARP for a substance use disorder) may assess treatment methods and propose possible alternative health care to help promote positive treatment outcomes and maximize use of your benefits under the Plan.

COVERED SERVICES

Covered services and supplies include those described below. Exclusions and limits that apply to specific services and supplies are described with those services and supplies; others are described in the “Exclusions from Coverage” that follow the covered services and supplies.

To be covered, a service or supply must be Medically Necessary for the treatment of an Illness or Injury, as defined in the glossary of terms at the end of this SPD, and it must be rendered in accordance with generally accepted U.S. medical standards accepted by the medical community as a whole.

See the Schedule of Medical Benefits starting on page 31 for cost-sharing details related to covered services.

AMBULANCE SERVICES

The Plan covers ambulance services to the nearest appropriate Hospital when any other form of transportation is inadvisable and is not considered part of Hospital charges.

Specific Limitations and Exclusions

The Plan does not cover the following ambulance services:

- ambulance services when the patient could be safely transported by means other than ambulance, whether or not such other transportation is available; and
- air ambulance services when the patient could be safely transported by ground ambulance or by means other than ambulance.

CHIROPRACTIC CARE

The Plan covers chiropractic manipulative treatment (except for reduction of fractures and dislocations otherwise defined as surgical services). To be a Covered Service, chiropractic care must be due to an Illness or Injury with an identifiable onset and conclusion.

Specific Limitation

- Limited to 40 chiropractic visits per covered person each calendar year

DENTAL CARE

The Plan covers dental services as required as a result of damage to or loss of teeth due to an Accidental Injury (other than from chewing). Payment for dental services will be determined by where the services are received (for example, an office or an emergency department).

NOTE: *See Chapter 7 of this booklet for other dental benefits*.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, PROSTHETIC AND ORTHOTIC DEVICES

See “Utilization Review” earlier in this chapter for information on pre-notification requirements for high cost durable medical equipment and prosthetics.

The Plan covers Durable Medical Equipment, supplies, prosthetic and orthotic devices when ordered by the attending Provider for treatment of an Injury or Illness as follows:

Durable Medical Equipment

Durable Medical Equipment means medical equipment that is all of the following:

- intended only for the patient's use and benefit in the care and treatment of an Illness or Injury; and
- durable and usable over an extended period of time; and
- used primarily and customarily for a medical purpose, rather than for convenience or comfort; and
- prescribed for the patient by the attending Physician or Practitioner.

Durable Medical Equipment includes crutches, wheelchairs, hospital-type beds, insulin pumps (if certified as Medically Necessary by Anthem Blue Cross), and similar equipment.

Supplies

- Medical and surgical supplies including colostomy bags, catheters, surgical dressings, and syringes/needles for injection of prescribed medication.
- If the insulin pump has been determined to be Medically Necessary by Anthem Blue Cross, the Fund will also cover certain diabetic supplies including but not limited to insulin pump supplies, including tubing, dressings, infusion reservoirs, and power kits (batteries).
- Up to $150 per month for Medically Necessary diapers, incontinence supplies and disposable under-pads for disabled dependent children. This benefit may include up to but not exceeding a 31-day supply. If the disabled Dependent is over age 26, he or she must qualify as a Dependent as defined by the Fund.

Prosthetic devices

Prosthetic devices including artificial limbs, artificial eyes, breast prostheses, and eyeglasses or contact lenses required as replacements of natural lenses surgically removed (such as cataract surgery). This includes the professional services for fitting, adjusting, and repairing prosthetic devices and replacements together with professional services related to replacement.

Orthotic devices

Orthotic devices including braces, binders, and other orthopedic appliances or apparatuses used to support, align, or correct deformities or to improve the function of moving parts of the body. This also includes the professional services for fitting, adjusting, and repairing prosthetic devices and replacements together with professional services related to replacement.

Specific Limitations and Exclusions

No benefits are provided for the following:

- devices to increase vertical dimensions or restore occlusion;
- devices in connection with temporomandibular joint (TMJ) dysfunction;
- corrective shoes unless they are an integral part of a lower body brace, foot orthotics (in excess of one per lifetime), arch supports, and special shoe accessories;
- wigs, hairpieces, cosmetics, and other items of a similar nature;
- replacements required as a result of loss, theft, negligence, or of willful damage and replacements when the device being replaced is one that would continue to meet the patient's basic medical needs;

- air conditioners, air filtration units, humidifiers, vaporizers, hydrotherapy devices, water spas, exercise equipment and machines, communication devices, heating pads, lamps or other devices containing heating elements, contour chairs, vibrating chairs and beds, and other items which do not qualify as Durable Medical Equipment;
- modifications to vehicles or places of residence; and
- deluxe equipment when standard equipment is adequate to meet the patient's basic medical needs.

NOTE: The Allowed Charge will be limited to the lesser of the purchase price or the rental cost of Durable Medical Equipment.

When a custom or deluxe prosthetic device, orthotic device or piece of Durable Medical Equipment is prescribed for a condition for which a standard prosthetic device, orthotic device or piece of Durable Medical Equipment is Medically Necessary as determined by the Claims Administrator, the Allowable Medical Expenses for a standard prosthetic device, orthotic device or piece of Durable Medical Equipment will be allowed toward the cost of the custom or deluxe prosthetic device, orthotic device or Durable Medical Equipment.

EMERGENCY SERVICES

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care Provider furnishing the Emergency Services is a Participating Provider or a participating emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirements or limitations on out-of-network Emergency Services that are more restrictive than the requirements or limitations that apply to Emergency Services received from Participating Providers and participating emergency facilities;
- At 80% of the Allowed Charges when received from either a Participating or Non-Participating Provider (the Employee or Dependent is responsible for payment of 20% Coinsurance up to the Coinsurance maximum). Non-PPO ground ambulance services are payable at 60% of the Allowed Charge.
- By calculating the Cost-sharing requirement for Emergency Services provided by a Non-Participating Provider or facility as if the total amount charged for the services was equal to the Recognized Amount for the services; and
- By counting any Cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any PPO Deductible or PPO Out-of-Pocket Maximums applied under the Plan (and the PPO Deductible and PPO 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 Participating Provider or a Participating emergency facility.

In general, you cannot be Balance Billed for these items or services. The Cost-sharing amount for Emergency Services from Non-Participating Providers will be based on the lesser of billed charges from the Provider or the Qualified Payment Amount (“QPA").

<u>Non-Emergency Items or Services from a Non-Participating Provider at a Participating Facility</u>

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-Participating 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 Participating Provider;
- By calculating the Cost-sharing requirement as if the total amount that would have been charged for the items and services by a Participating Provider was equal to the Recognized Amount for the items and services;
- By counting any Cost-sharing payments made by the participant or beneficiary 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 Participating Provider; and
- In general, you cannot be Balance Billed for these items or services.

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

1. At least 72 hours before the day of the appointment (or three (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 that the Provider is a Non-Participating Provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any Participating Providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the Participating Providers listed; and
2. The participant or dependent gives informed consent to continued treatment by the Non-Participating Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or beneficiary.

The notice and consent exception for non-emergency items or services provided by a Non-Participating Provider at a participating facility 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-Participating 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 Participating Provider;
- With the Cost-sharing requirement calculated as if the total amount that would have been charged for such items and services by a Participating Provider was equal to the Recognized Amount for the items and services;
- With Cost-sharing for items and services so furnished counted toward any in-network Deductible and in-network Out-of-Pocket Maximums, as if such Cost-sharing payments were made for items and services furnished by a Participating Provider; and
- In general, you cannot be Balance Billed for these items or services.

The Cost-sharing Amount for non-emergency services at participating facilities by Non-Participating Providers will be based on the Recognized Amount, which is, generally, the lesser of the billed charges from the Non-Participating Provider or the QPA (i.e., the Plan's median of contracted rates for the item or service in that location).

AIR AMBULANCE SERVICES

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

- The Air Ambulance Services received from a Non-Participating Provider will be covered with a Cost-sharing requirement that is no greater than the Cost-sharing requirement that would apply if the services had been furnished by a Participating Provider;
- With the Cost-sharing requirement for the services calculated as if the total amount that would have been charged for the services by a Participating Provider of Air Ambulance Services was equal to the lesser of the QPA or the billed amount for the services;
- Any Cost-sharing payments you make with respect to covered Air Ambulance Services will count toward you PPO Deductible and PPO Out-of-Pocket Maximum in the same manner as if those services were received from a Participating Provider; and
- In general, you cannot be Balance Billed for these items or services.

HEARING SERVICES

The Plan covers audiometric (hearing) testing through your Anthem Blue Cross benefits. When the testing results in a determination that a Hearing Aid Device will improve hearing acuity, the Plan also covers services provided in connection with Hearing Aid Devices. A Hearing Aid Device means a device designed to be worn in, on, or by the external ear to enhance impaired human hearing and includes the devices specialized parts, attachments and accessories.

Expenses for Hearing Aid Devices are covered at 100% of Allowed Charge up to a maximum of $2,025 per ear every four (4) years (deductible waived). A replacement of a hearing aid device is not covered for any reason more often than once during any four-year period, or more than one hearing aid device for each ear during any four-year period. Hearing Aid Devices include both devices available with a prescription and devices approved by the FDA for over-the-counter purchase.

Please let your provider know that your claim (along with a hearing aid reimbursement form that you can request from Zenith) MUST be submitted to Zenith at the address below:

Zenith American Solutions (Zenith)
1141 Harbor Bay Parkway
Suite 100
Alameda, CA 94502

Specific Limitations and Exclusions

The Plan does not cover:

- The replacement of a hearing aid device for any reason more often than once during any 4-year period
- More than one hearing aid device for each ear

HOME HEALTH CARE

See "Utilization Review" earlier in this chapter for information on pre-notification requirements for home health care.

Home health care includes all professional services, technical and ancillary medical services, health aide services, and medical supplies and equipment which would be covered if the patient were a bed-patient in a Hospital or Skilled Nursing Facility. The Plan covers services provided in the home by a licensed community Home Health Care Agency or an approved Hospital program for home health care when the patient is essentially homebound for medical reasons, is physically unable to obtain necessary medical care on an outpatient basis and has a condition which requires the services of a licensed health care Provider, and is under the care of a Physician as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN);
- physical therapy, speech therapy, and occupational therapy (but not maintenance therapy) by a duly licensed therapist and one medical social service consultation;
- health aide services furnished to the patient while receiving skilled nursing services or therapy specified above;
- medical and surgical supplies which are customarily furnished by the Home Health Care Agency or program for its patients, including oxygen and its administration; and
- prescribed drugs furnished by the Home Health Care Agency or program. The administration of such drugs must require the professional skills of a nurse (RN, LPN or LVN) at the time the patient is receiving nursing services specified above and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

HOME INFUSION THERAPY SERVICES

See "Utilization Review" earlier in this chapter for information on pre-notification requirements for home infusion services.

The Plan covers home infusion therapy services provided in the home by a licensed Home Infusion Therapy Agency when the patient is under the care of a Physician as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN) required for: 1) training the patient and/or alternative care giver; 2) the administration of therapy; and 3) monitoring the intravenous therapy regimen;
- medical and surgical supplies which are customarily furnished by the Home Infusion Therapy Agency for its patients and which are necessary to administer the home infusion therapy regimen;
- non-replaced blood, blood plasma, blood derivatives, and their administration; and
- prescribed drugs furnished by the Home Infusion Therapy Agency which are part of the home infusion therapy regimen. The administration of such drugs must require the professional skills of a nurse (RN, LPN or LVN) and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

HOSPICE CARE

Hospice care includes palliative care and treatment of a patient with a life expectancy of 6 months or less, where the unit of care is the entire family and the focus of the interdisciplinary team is the acknowledgement of death, dealing with it in both its physical and psychological aspects. When provided prior to the death of the patient and in place of all other benefits, the Plan covers services

provided by a hospice or other facility under the direction of a hospice during a Hospice Benefit Period as follows:

- inpatient hospice care (i.e., respite care);
- Physician services;
- home health services;
- emotional support services;
- homemaker services; and
- prescription drugs and medications furnished by the hospice program. The administration of such drugs must require the professional skills of a nurse (RN, LPN or LVN) and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

NOTE: "Hospice Benefit Period" means a benefit period which begins on the date the attending Physician certifies in writing that a patient is terminally ill and ends at the earlier of the death of the patient or 6 months after the date of the attending Physician's certification, However, if the patient is living at the end of the 6-month period, a new 6-month period may begin when the attending Physician certifies in writing that the patient is still terminally ill.

HOSPITAL INPATIENT CARE

See "Utilization Review" earlier in this chapter for information on pre-notification requirements for hospital admissions.

Accommodations. The Plan covers the following accommodations (including bed, board and general nursing care) during an admission to a Hospital for acute care or intensive care:

- semi-private (or multi-bed unit) room; or
- private room accommodations but only when a severe medical condition, mental health or substance use disorder requires that you be placed in a private room, or the Hospital furnishes private rooms as the principal room accommodations for its patients.

  NOTE: The semi-private room rate will be allowed toward the private room rate when you are in a private room for reasons other than those specified above.

- intensive care unit (including cardiac care unit), special nursing care and ICU equipment.

Services and Supplies. The Plan covers the following services and supplies as customarily furnished by a Hospital:

- operating, recovery, and treatment rooms and delivery and labor rooms and their equipment;
- anesthesia materials and anesthesia administration by facility personnel;
- diagnostic and therapeutic radiological (x-ray), including radiation therapy, clinical pathology and laboratory, electrocardiograms (EKG), electroencephalograms (EEG), and other electronic diagnostic medical procedures required to diagnose an Illness, Injury, or other condition;
- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration and intravenous injections and solutions;

- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department as well as devices or appliances surgically inserted into the body;
- oxygen and its administration and non-replaced blood, blood plasma, blood derivatives, and their administration and processing; and
- inhalation therapy.

Specific Limitations and Exclusions

The Plan does not cover vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient in connection with Hospital inpatient care.

HOSPITAL OUTPATIENT AND AMBULATORY SERVICE FACILITY CARE

The Plan covers the following services and supplies as customarily furnished to patients by a Hospital or Ambulatory Service Facility:

- operating, recovery, and treatment rooms and delivery and labor rooms and their equipment;
- anesthesia materials and anesthesia administration by facility personnel;
- diagnostic and therapeutic radiological (x-ray), clinical pathology and laboratory, electrocardiograms, electroencephalograms, and other electronic diagnostic medical procedures required to diagnose an Illness, Injury, or other condition;
- dialysis treatment, respiration therapy, radiation and chemotherapy, other than Myeloablative Therapy;
- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration and intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department as well as devices or appliances surgically inserted into the body;
- oxygen and its administration and non-replaced blood, blood plasma, blood derivatives, and their administration and processing; and
- inhalation therapy.

INPATIENT REHABILITATION SERVICES

See "Utilization Review" earlier in this chapter for information on pre-notification requirements for admissions to a rehabilitation facility.

The Plan covers inpatient rehabilitation services received in a Hospital, Skilled Nursing Facility or Rehabilitation Facility when part of an active rehabilitation program consisting of treatment directed toward the restoration of normal form and function after Illness or Injury. An acute condition must have stabilized to a level so that occupational therapy, physical therapy and/or speech therapy can be started with a realistically attainable goal for the patient.

Accommodations. The Plan covers semi-private or multi-bedroom accommodations (including bed, board and general nursing care) during an admission to a Hospital, Skilled Nursing Facility or Rehabilitation Facility for inpatient rehabilitation services:

Services and Supplies. In addition to the same services and supplies that would customarily be furnished to patients by a Hospital or Skilled Nursing Facility, the following services are also covered when provided to the patient during an admission for inpatient rehabilitation:

- occupational therapy, which is treatment to restore or improve functions impaired by Illness or Injury and to improve a Claimant's ability to satisfactorily accomplish daily living tasks;
- physical therapy, which is remedial treatment of an Injury or Illness by means of therapeutic massage and exercise, heat, light, and sound waves, electrical stimulation, hydrotherapy and manual traction; and
- speech therapy, which is treatment for the correction of a speech, voice or language impairment resulting from Illness, Injury, birth defect or previous therapeutic process.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with inpatient rehabilitation services:

- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items,
- late discharge billing for the convenience of the patient; and
- physical therapy, speech therapy and occupational therapy provided solely to maintain the patient's condition at the level to which it has been restored with no expectation of significant improvement.

MATERNITY CARE

Benefits for maternity care, childbirth and related conditions and/or complications are paid the same as any other illness for the Participant and spouse only. Routine nursery care for the newborn child of the Participant or spouse is also covered.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the physician), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In any case, a plan or issuer may not, under Federal law, require that a physician or other provider obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

Specific Limitations and Exclusions

The Plan does not cover the following:

- a Dependent daughter's pregnancy, maternity care or abortion; or
- abortion for the Participant or spouse except when the attending physician certifies that the mother's life is at risk or where medical complications arise from an abortion.

MENTAL HEALTH CONDITION SERVICES

Inpatient: The Plan covers inpatient mental health condition services. Benefits for inpatient treatment are paid at the percentage shown in the Summary of Benefits as applicable for the type of service (hospital charges, charges for inpatient doctor visits, etc.).

Outpatient: Outpatient mental health services are covered when the services are provided by a psychiatrist, psychologist, licensed MFCC (Marriage, Family and Child Counselor) or certified social worker.

TOBACCO CESSATION

The Plan covers counseling and interventions for tobacco use (both smoking and chewing tobacco) as a preventive care service (**with no cost sharing when a Participating Provider is used**) as follows:

- screening for tobacco use; and,
- for tobacco users, at least two (2) tobacco cessation attempts per year. Each "tobacco cessation attempt" includes coverage for **four (4) tobacco cessation counseling sessions** of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and all **FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications)** for a 90-day treatment regimen when prescribed by a Participating health care provider.

Additional medication prescribed for tobacco cessation will be available at the Plan's regular cost-sharing.

OFFICE OR CLINIC CARE

The Plan covers professional services by a Physician or Practitioner which are generally recognized and accepted procedures for diagnostic or therapeutic purposes as follows:

- direct physical or mental examination of the patient, patient's body or substance(s) from the body, and associated cognitive services for prescribing or administering treatment, but not counseling or patient education unless provided at no additional charge;
- diagnostic services including radiology, ultrasound, nuclear medicine, laboratory, pathology, diagnostic medical procedures; and
- other Covered Services when received as appropriate in an office or clinic but which may be specified elsewhere in this section, including but not limited to medical services, surgical services and consultations listed under Professional Services.

OUTPATIENT REHABILITATION SERVICES (PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY)

The Plan covers rehabilitative services by a Physician or Practitioner when received in an office, clinic or Hospital on an outpatient basis. Covered Services include only the following:

- physical therapy and occupational therapy when provided to restore or improve bodily function lost as a result of Illness or Injury; and

- speech therapy when provided to restore or improve speech function lost as a result of Illness or Injury.

Specific Limitations and Exclusions

The Plan does not cover the following rehabilitative services:

- physical therapy, speech therapy and occupational therapy provided solely to maintain the patient's condition at the level to which it has been restored with no expectation of significant improvement.

ROUTINE PHYSICAL EXAM – FOR THE EMPLOYEE AND SPOUSE ONLY

Regardless of Medical Necessity, the Plan will pay 100% for one routine physical examination per Calendar Year for the Employee and Dependent Spouse, including routine diagnostic tests or x-rays at the time of the exam. Exams required for employment are covered.

This benefit is not subject to the calendar year deductible and is not part of the maximum coinsurance feature.

If an abnormality is discovered during your physical exam or screening, subsequent services will be payable the same as any other Illness or Injury.

Specific Exclusions

The Plan does not cover the following under the Routine Physical Exam benefit:

- a physical exam or preventive care services provided to a Dependent child (see Well Child Care up to Age 26 below for services covered for a Dependent child).
- vision examinations covered under the Vision Care Benefit; and
- expenses incurred as a result of an Illness or Injury.

WELL CHILD CARE UP TO AGE 26

The Plan covers well childcare services for eligible Dependent children. Covered Well Child Care services include professional exams by a Physician, including routine diagnostic tests, vision and hearing exams up to age 26 and immunizations up to age 18.

OTHER PREVENTIVE SERVICES

The Plan provides coverage for the following preventive care services:

- **Colonoscopy or Sigmoidoscopy Screening.**
- **Routine Mammogram**.
- **Pap smear**.
- **Bone Density Scan**.
- **Flu Immunization.** The Plan covers 100%, not to exceed $25, for flu immunizations.

Please refer to the Schedule of Medical Benefits to find out the amount you will be responsible for if you go to a Participating Provider or a Non-Participating Provider.

PROFESSIONAL SERVICES

Reimbursement for some professional services may be included with the benefit for the facility services, as applicable. See the Schedule of Benefits for determination.

- **Anesthesia Services** – the administration of anesthetics to achieve general or regional (but not local) anesthesia and related resuscitative procedures.
- **Consultations** – the services of a Provider whose opinion or advice is requested by the attending Provider for further evaluation of an Illness or Injury.
- **Diabetic Education** – services for diabetic self-management training and education, including nutritional therapy, when requested by the attending Physician. Services must be provided by an accredited or certified program.
- **Family Planning** – basic evaluative services for family planning, birth control devices, injectable contraceptives and sterilization procedures.
- **Medical Services** – professional services by a Physician or Practitioner which are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:
    - ✓ direct physical or mental examination of the patient, patient's body or substance(s) from the body, and associated cognitive services for prescribing or administering treatment, but not counseling or patient education unless provided at no additional charge;
    - ✓ diagnostic services which are radiology, ultrasound, nuclear medicine, laboratory, pathology, and electronic diagnostic medical procedures;
    - ✓ non-replaced blood, blood plasma, blood derivatives, and their administration; and
    - ✓ dialysis treatment, respiration therapy, radiation and chemotherapy.
- **Surgical Assistants** – services of an assistant surgeon (if Medically Necessary) when performed in connection with a surgical procedure which is a Covered Service.
- **Surgical Services** – surgical services that are generally recognized and accepted procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:
    - ✓ cutting or laser operative procedures;
    - ✓ suturing of wounds and debridement of wounds, burns, or infections;
    - ✓ reduction of fractures or dislocations and orthopedic casting;
    - ✓ endoscopic examination of internal organs of the body;
    - ✓ use of a needle or cannula for biopsy, aspiration, or injection of a tendon sheath, joint, major body cavity, or blood vessel (vein or artery), but not routine venipuncture (drawing blood for laboratory tests is a medical service);
    - ✓ intra-arterial, intravenous, or intra-cardiac catheterization;
    - ✓ electrical, chemical, or mechanical destruction of tissue; and

- ✓ oral surgery, but not dental (teeth and gums) surgery (See Chapter 7 for the separate dental benefits of the Plan).

Specific Limitations and Exclusions

No benefits are payable for the following professional services:

- services of an assistant surgeon when the Hospital provides or makes available qualified staff personnel (including Physicians in training status) as surgical assistants; services of more than one assistant surgeon at one operative procedure; and services of an assistant surgeon when the complexity of the surgery does not warrant the services of an assistant;
- acupuncture, hypnosis, and administration of anesthesia by the primary or the assistant surgeon other than dental general anesthesia by a dentist or oral surgeon; and
- reversal of voluntary surgical sterilization or subsequent re-sterilization.

RECONSTRUCTIVE SERVICES AND SERVICES AFTER A MASTECTOMY

Under the Women's Health and Cancer Rights Act of 1998 (WHCRA), all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of all stages of mastectomy, including lymphedemas. These services are elective and are chosen by the patient in consultation with the attending physician. They are subject to the Plan's usual Coinsurance and Copay provisions. If you would like more information on WHCRA benefits, call Zenith at the number listed on the Quick Reference Chart.

SKILLED NURSING FACILITY CARE

See "Utilization Review" earlier in this chapter for information on pre-notification requirements for Skilled Nursing Facility admissions.

Accommodations

The Plan covers semi-private or multi-bedroom accommodations (including bed, board and general nursing care) during an admission to a Skilled Nursing Facility for extended care.

Services and Supplies

The Plan covers the following services and supplies as customarily furnished to patients by a Skilled Nursing Facility:

- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration and intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department;
- oxygen and its administration; and
- inhalation therapy.

Specific Exclusions

The Plan does not cover the following in connection with Skilled Nursing Facility care:

- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient.

TRANSPLANTS

See "Utilization Review" earlier in this chapter for information on pre-notification requirements for benefits for organ transplants.

The Plan covers transplant procedures when it is determined to be Medically Necessary by Anthem Blue Cross and **only** when the provisions of the Utilization Management Program have been followed before services are received.

EXCLUSIONS FROM MEDICAL COVERAGE

The exclusions described below also apply to other benefits described in other chapters of this booklet, as applicable. Other exclusions and limitations may apply as described elsewhere in this booklet for specific benefits.

No benefits are payable for any of the following (or for any direct complications or consequences of the following):

- **Alternative care:** The following types of alternative care:
    - acupuncture and acupressure;
    - holistic and homeopathic treatment;
    - massage or massage therapy;
    - naturopathy; faith healing, milieu therapy, hypnosis, or sensitivity training;
    - behavior modification, biofeedback;
    - electro-hypnosis, electro-sleep therapy, or electro-narcosis;
    - ecological or environmental medicine; and
    - other therapies: scream therapy; psychic surgery, channeling, sensory deprivation; rolfing; thermography; music, art, dance, or recreation therapy; crystal therapy; and hypertherapy (therapeutically induced fever) for the treatment of cancer.
- **Appliances or restorations necessary to increase vertical dimension or restore occlusion**
- **Benefits not stated:** Services and supplies provided for which there is no stated benefit under the Plan. When a non-covered service or supply is performed or received at the same time as a covered service, then only the portion of charges relating to the covered service will be considered eligible for payment under this Plan.
- **Birth control/infertility:** Services and supplies in connection with the following:
    - non-prescription contraceptives;
    - reversal of voluntary surgically performed sterilization or subsequent re-sterilization;
    - artificial insemination or in vitro fertilization;
    - infertility, except to the extent covered services are required to diagnose such condition; and fertility drugs and medications.

- **Charges that exceed the Allowed Charge**
- **Cosmetic/reconstructive services and supplies,** except for surgery that is:
  - performed to restore a physical bodily function;
  - related to an Accidental Injury; or
  - related to breast reconstruction following a Medically Necessary mastectomy to the extent required by law.

  Cosmetic means services or supplies that are applied to structures of the body primarily for the purpose of improving or changing appearance but not physical function.

  Reconstructive means services, procedures, and surgery performed to improve or correct a structure of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to restore function, but may also be done to approximate a normal appearance.

  For the purposes of this Plan, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.
- **Counseling:** Charges for counseling other than as specifically provided in the mental health and substance use disorder benefits, including educational services, counseling in the absence of Illness or Injury, and counseling with a patient's family, friend(s), employer, school counselor, or schoolteacher.
- **Court-ordered or court-related services/services in connection with legal proceedings:** Services, supplies, examinations, reports, or appearances in connection with legal proceedings or court ordered or court-related services unless the services are both Medically Necessary and a covered benefit of the Plan.
- **Custodial, domiciliary and convalescent care:** Custodial care, domiciliary care, convalescent care (other than as specifically provided under the Skilled Nursing Facility benefit of the Plan), rest cures, and services provided for or in connection with institutional care which is for the primary purpose of controlling or changing the patient's environment. This exclusion does not apply to Medically Necessary residential treatment.

  Custodial Care means care that mainly provides room and board (meals), or if it is for a physically or mentally disabled person who is not receiving care specifically to reduce the disability so that the person can live outside a medical care facility or skilled nursing facility. No matter where the person lives, care is considered Custodial Care if it is non-skilled nursing care, training in personal hygiene, other forms of self-care, supervisory care by a Provider, or care provided by a health care facility licensed by the state where the facility is located as an assisted living facility, hospice, small health care facility, or that is similarly licensed by the state in which it is located.

  Exception to Exclusion: the Plan may cover a stay at a long-term acute care facility when a patient is receiving rehabilitation therapy immediately after or instead of an acute inpatient hospitalization. For the Plan to consider such services, the stay must receive prior authorization and the patient must continue to make treatment progress as documented by patient notes.
- **Enteral feeding:** Services and supplies for or in connection to providing nourishment directly (e.g. feeding tube) to the digestive tract of a person who cannot ingest or digest an appropriate amount of calories and nutrients to maintain an acceptable nutritional status. Although a participant may need to ask for the liquid nutrition at a pharmacy, most

do not require a prescription from a Physician to obtain. **This includes the device that is used to deliver the food such as an enteral feeding tube.**

- **Erectile dysfunction:** Services and supplies for or in connection with erectile dysfunction, regardless of its origin.
- **Expenses incurred before Plan eligibility begins or after eligibility terminates.**
- **Experimental or investigational services:** Experimental or investigational treatments or procedures, services, supplies, and accommodations provided in connection with experimental or investigational treatments or procedures.
- **Fees, taxes, interest, etc.:** Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales, or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state, or local government, or by another entity, unless required by law.
- **Foot care** including but not limited to:
    - treatment of corns and calluses;
    - trimming of nails, except when Medically Necessary for diabetic patients (the Plan does cover surgery for ingrown toenails);
    - foot impression casting including x-rays;
    - nonsurgical treatment of bunions, flat feet, fallen arches, weak feet, chronic foot strain, or other symptomatic complaints of the foot;
    - arch supports, special shoe accessories; and
    - foot orthotics in excess of one per lifetime.
- **Gastric procedures:** Services and supplies for or in connection with gastric or intestinal bypass, gastric stapling, or other similar surgical procedure, or for or in connection with reversal or revision of such procedures.
- **Genetic services:** Services and supplies for, or in connection with, nucleic acid level genetic studies, or for genetic alteration. This exclusion does not apply to chromosomal analysis.
- **Growth hormone** therapy once bone growth is complete.
- **Cellular and/or Gene therapy or services to treat any complications resulting from 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 cellular and/or 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.
- **Hearing treatment**, except as specifically provided in the Plan.
- **Educational services:** Such as applied behavioral analysis, applied behavioral therapy or training, auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, synthesizers, auxiliary

aids such as communication boards, and listening systems), auditory perception or listening/learning skills and/or programs and services to remedy or enhance concentration, memory, motivation, reading or self-esteem.

- **Military service-related conditions:** Services and supplies for treatment of an Illness or Injury caused by or incurred during service in the armed forces of any state or country.
- **Obesity or weight reduction/control:** Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions. However, Medically Necessary treatment of an eating disorder may be covered under the mental health benefits of the Plan.
- **Orthognathic surgery:** Services and supplies to change the position (augmentation or reduction procedures) of a bone of the upper or lower jaw (orthognathic surgery).
- **Other party liability/ work related condition:** Services and supplies for treatment of Illness or Injury for which a third party is responsible, including:
  - Any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim settlement for which a covered person has or had a right to compensation; and
  - Any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to you, whether or not you, if eligible, file a claim for benefits under such coverage. Automobile personal injury protection coverage includes: 1) the minimum amount required by state or federal law, regardless of whether or not such coverage is in force, and 2) any amount of coverage carried in excess of the minimum amount required by law, regardless of whether or not you file a claim for benefits under the coverage.

  Any benefit provided contrary to this exclusion is not a waiver of the Plan's right to reimbursement or subrogation. (*See Third-Party Liability in Chapter 15 for more information.*)
- **Personal comfort items:** Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics, or other non-therapeutic purposes. For example, the Plan does not cover telephones, television, and guest meals while in a facility if they are charged separately from the cost of the room.
- **Physical exercise programs and equipment:** Physical exercise programs or equipment, including hot tubs, or membership fees at spas, health clubs, or other such facilities whether or not the program, equipment, or membership is recommended by your Provider.
- **Pregnancy of a Dependent daughter:** Services, supplies or treatment in connection with a Dependent daughter' pregnancy, maternity care or abortion unless deemed to be an emergency as mandated by the No Suprises Act – Consolidated Appropriations Act of 2021.
- **Preparation of forms/missed appointments:** Charges for preparing medical reports, itemized bills or claims forms; appointments scheduled and not kept ("missed appointments").
- **Prescription drugs and other medications:** Outpatient prescription drugs and over-the-counter drugs and medications (except as provided under Prescription Drug Benefits in

Chapter 6), vitamins, and minerals. Also excluded are special formulas, food supplements, or special diets, except as provided by a Hospital or Skilled Nursing Facility during a confinement for which benefits are available and as required for inborn metabolic errors.

- **Private duty nursing or hourly nursing services:** including ongoing hourly shift care in the home.
- **Psychoanalysis/psychotherapy** credited toward earning a degree or furthering a covered person's education or training unless such care is Medically Necessary and a covered benefit under the Plan.
- **Riot, rebellion, war and illegal acts:** Services and supplies for treatment of an Illness or Injury caused by your unlawful instigation and/or active participation in a riot or war, including an armed invasion or aggression, insurrection, or rebellion; or sustained by you while in the act of committing an illegal act unless such Illness or Injury is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor.
- **Routine physical examinations, tests, screening procedures, and immunizations:** Except as specifically provided by the Routine Physical Examination Benefit for Employees and Spouses or the Well Child Care benefit, routine physical examinations, including tests, screening procedures and immunizations when the individual has no symptoms of Illness or Injury (for example, cancer screening tests and general health screening tests). The Plan also covers flu vaccines at 100%, not to exceed $25.
- **Self-help, self-care, training, or instructional programs:** Self-help, non-medical self-care, training, educational, or instructional programs. Unless specifically described as a benefit, this includes diet and weight monitoring services, instruction programs including those to learn how to self-administer prescriptions or nutrition, and programs that explain how to use durable medical equipment or how to care for a person in the family. This exclusion does not apply to services for training or educating an individual when incidentally provided, without separate charge, in connection with Covered Services.
- **Services and supplies for negligent care:** Services and supplies provided as a result of negligent medical care or treatment.
- **Services and supplies that are not Medically Necessary** for the treatment of an Illness or Accidental Injury.
- **Services and supplies for which no charge is made or no charge is normally made:** Services and supplies for which you are not required to make payment or for charges that in the absence of this Plan there would be no obligation to pay. This includes but is not limited to:
  - services or supplies for which you cannot be held liable because of an agreement between the Provider rendering the service and another third party payor which has already paid for such service or supply;
  - services for which you incur no charge or have no legal obligation to pay.
- **Services and supplies otherwise available from a governmental agency or program:** Services and supplies to the extent benefits are provided or covered by any governmental agency (for example, a federal hospital or the Veterans Administration), unless reimbursement under the Plan is otherwise required by law. Also excluded are services covered by programs (such as Medicare) created by the laws of the United States, any state,

or any political subdivision of a state, or which would be so covered except for coverage under this Plan.

- **Services and supplies provided by a member of your family:** Services and supplies provided to you by a member of your immediate family. For purposes of this provision, “immediate family” means your parents, spouse, children, siblings, half-siblings, or in-laws, or any relative by blood or marriage who shares a residence with you.
- **Services and supplies provided by a school or halfway house:** Services and supplies provided by any public or private school or halfway house, or by their Employees and services provided solely to satisfy institutional requirements.
- **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions chapter of this document.
- **Sexual counseling, treatment, or surgery for minors:** Counseling, treatment (including drugs), or surgery for sexual dysfunction for minors, including but not limited to transsexualism, psychosexual identity disorder, psychosexual disorder or gender dysphoria unless otherwise required to be covered under Utah state law.
- **Temporomandibular Joint (TMJ) dysfunction treatment:** Services and supplies provided in connection with temporomandibular joint (TMJ) dysfunction other than surgical correction of the TMJ required as a result of an Accidental Injury.
- **Travel and transportation expenses**, other than covered Ambulance Services provided in the Plan.
- **Treatment, procedures, techniques or therapies outside accepted health care practice:** Treatment or prevention of an Illness or Injury by means of treatments, procedures, techniques or therapies outside generally accepted health care practice, as determined by the Claims Administrator.
- **Vision care:** Services and supplies related to vision care, except as specifically described under Vision Care Benefits in this SPD/Plan Document, including but not limited to:
    - routine examinations or assessment for refractive error, the fitting, provision, or replacement of eyeglasses;
    - contact lenses, including contact lens checks, except for the first intraocular lenses following cataract surgery;
    - visual therapy, training, and eye exercises, vision orthoptics;
    - vitamin therapy for vision;
    - fundus photography; and
    - surgical procedures to correct refractive errors/astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye are excluded.
- **Visits or consultations that are not in person:** Any telephone, internet (or other electronic communication, including tele-medicine) visits or consultations, whether initiated by you or your Provider,.

HOW TO FILE A CLAIM FOR MEDICAL BENEFITS

The Plan has the sole right to decide whether to pay you, the provider or you and the provider jointly.

Participating Provider Claims

When obtaining services from a Participating Provider in the Anthem Blue Cross network, you must show your Plan identification card and furnish the provider with any additional information requested. The Participating Provider will submit the claim for you and furnish Anthem Blue Cross with the necessary information needed to process your claim.

The Plan will pay Participating Providers directly for covered services.

Incorrect Participating Provider Information

A list of Participating Providers is available to you without charge on the website (www.anthem.com or www.bcbs.com) 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 provided by the Plan about whether a Provider is a Participating Provider from the Plan or its administrators, the Plan will apply the PPO Cost-sharing Amount to your claim, even if the Provider was a Non-Participating Provider when the service were received.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Participating Provider or facility terminates, or your benefits under the 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 right to elect continued transitional care from the Provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at the Participating Cost-sharing Amount to allow for a transition of care to a Participating Provider.

Nonparticipating Provider Claims

A non-Participating Provider may submit claims for you as well. If the non-Participating Provider will not submit your claims, you will need to file a claim yourself.

Before you will be entitled to payments for covered services provided by a non-Participating Provider, you must furnish or make sure the provider furnishes to Anthem Blue Cross all forms and information necessary to process your claims, including the following:

- The Employee's name and assigned ID number;
- claim information including your (the patient's) name, age, sex, and relationship to the Employee, medical or other records necessary to establish the medical services provided, the reason for the services, patient's condition prior to and at the time of treatment, the medical necessity of the treatment, the efficacy and non-investigational status of the treatment and similar facts and circumstances; and

- statements from the non-Participating Provider itemizing the diagnosis, the accommodations, services and supplies provided to you, the date on which each such item was provided, and the charge for each item. All statements furnished must be in the form and contain the information required by Anthem Blue Cross.

Payments to Non-Participating Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Participating Facilities by Non-Participating Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-Participating Provider or Air Ambulance Service 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 Amount under the Plan, and the Provider or facility is prohibited from billing the participant or dependent in excess of the required Cost-sharing Amount.

The Plan will pay a total Plan payment directly to the Non-Participating Provider that is equal to the amount of the Out-of-Network Rate for the services that exceeds the Cost-sharing Amount for the same services, less any initial payment amount.

Timely Filing of Claims

To be filed timely, Anthem Blue Cross must receive your claim **within 1 year** after the date the covered service to which the claim relates was provided to you. A claim that is not filed within 1 year after the date the service is provided will be denied.

Questions?

If you have any questions about submitting your claim, contact the Utah Fringe Benefits Office or the Trust Fund Office in Alameda at 800-251-5013.

For information on what to do if you disagree with the decision made in regard to your claim, and for additional information about claim payments, see "Claims and Appeals Procedures" in Chapter 15.

CHAPTER 5: SUBSTANCE USE DISORDER TREATMENT BENEFITS

In this chapter you'll find:

- ✓ Required pre-notification
- ✓ A quick-reference guide to substance use disorder benefits
- ✓ What the Plan covers
- ✓ Exclusions
- ✓ Information on filing claims

About This Chapter

The substance use disorder treatment program is provided through the Operating Engineers Assistance Recovery Program (ARP), not by Anthem BlueCross.

Your Assistance Recovery Program includes benefits for rehabilitation treatment for substance use disorders. If medical detoxification treatment is needed in an acute care hospital, those hospital services are covered under the comprehensive medical benefits described in Chapter 4.

NOTE: Benefits for treatment of substance use disorders are available **only to you and your spouse**, not to Dependent children.

REQUIRED PRE-NOTIFICATION

Before seeking inpatient treatment, you must notify the ARP office. The ARP coordinator will assist in making a referral to an appropriate authorized inpatient treatment program. All communication with the ARP will be strictly confidential.

In addition, we suggest you contact ARP prior to receiving any outpatient treatment so you can be directed to a network provider.

The ARP office can be contacted at (800) 562-3277.

The following chart is intended to provide a convenient reference guide to your substance use disorder benefits. More detailed information follows the chart.

Benefits for Covered Substance Use Disorder Treatment **REFERRAL THROUGH ASSISTANCE RECOVERY PROGRAM (ARP) RECOMMENDED** Not available for Dependent children	
Calendar-year deductible	None
Inpatient Substance Use Disorder (including residential treatment)	Inpatient services will be paid on the same basis as the medical plan. The Assistance Recovery Program (ARP) should be notified about the inpatient stay prior to the admission. For an emergency admission, ARP should be notified no later than the next business day or the next business day following stabilization of the patient.

Benefits for Covered Substance Use Disorder Treatment **REFERRAL THROUGH ASSISTANCE RECOVERY PROGRAM (ARP) RECOMMENDED** Not available for Dependent children	
Outpatient Substance Use Disorder (including intensive outpatient treatment and partial hospitalization) and Recovery Home Treatment	Outpatient treatment is payable on the same basis as the physician office visit benefit in the case of professional services or on the same basis as the outpatient hospital benefit for services billed as a facility service (also known as "other outpatient services").

∗ Contract Charge(s) means the amount the provider has agreed to accept as payment in full. This amount is negotiated between the provider and the Operating Engineers Assistance Recovery Program.

Diversion Program (for the Employee only)

If you have tested positive in a drug or alcohol test but you do not require residential or outpatient substance use disorder treatment, the Plan will allow substance use disorder diversion treatment. Diversion program services include evaluation by a substance use disorder professional and any prescribed educational diversion program.

EXCLUSIONS FROM SUBSTANCE USE DISORDER COVERAGE

Substance use disorder treatment benefits are not payable for:

- Inpatient or outpatient care in an acute-care Hospital (Medically Necessary confinement in an acute-care Hospital will be covered under the medical benefits of the Plan);
- Services provided to a Dependent child.

If you Have Coverage Elsewhere

If you or your spouse have other group substance use disorder coverage, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage—you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See "Coordination of Benefits" in Chapter 14 for more information.

HOW TO FILE A CLAIM FOR SUBSTANCE USE DISORDER TREATMENT BENEFITS

To file a claim for substance use disorder treatment benefits, your provider should submit the claim directly to ARP at the following address:

Operating Engineers Health and Welfare Trust Fund for Utah Assistance Recovery Program
3000 Clayton Rd
Concord, CA 94519

CHAPTER 6: PRESCRIPTION DRUG BENEFITS

In this chapter you'll find:

- ✓ A guide to prescription drug benefits
- ✓ How the Plan works
- ✓ Drug purchases from retail pharmacies
- ✓ Mail order service
- ✓ What the Plan covers
- ✓ Exclusions and limitations
- ✓ Information on filing claims

About This Chapter

The prescription drug benefits described in this chapter are self-funded by the Trust Fund and administered for the Plan by OptumRx.

The prescription drug program provides benefits for drugs you purchase at a retail pharmacy. It also includes a mail service program for drugs you take on a longer-term basis.

Prescription drug benefits are provided through an arrangement with OptumRx which provides a network of participating pharmacies and a mail order service.

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

	Claimant Responsibility		
Covered Prescription Drugs	**Tier 1 Generic Medication**	**Tier 2 Preferred Brand Name Medications**	**Tier 3 Non-Preferred Brand Name Medications**
Prescription Medications from a Pharmacy ▪ Up to a 34-day supply for each prescription	$10	$25 or 30%, whichever is greater, (maximum $60)	$25 or 30%, whichever is greater
Injectable Medications from a Pharmacy ▪ Up to a 34-day supply for each injectable medication **Please note:** Injectables that are classified as Specialty medications may be obtained only through an OptumRx Specialty Pharmacy.	$10	$25 or 30%, whichever is greater, (maximum $60)	$25 or 30%, whichever is greater
Maintenance Medications from a Mail-Order Supplier ▪ Up to a 90-day supply for each prescription	$5	$20 or 30%, whichever is greater, (maximum $50)	$20 or 30%, whichever is greater

	Claimant Responsibility		
Covered Prescription Drugs	**Tier 1 Generic Medication**	**Tier 2 Preferred Brand Name Medications**	**Tier 3 Non-Preferred Brand Name Medications**
Prescription filled at a nonparticipating retail pharmacy (or if you fill your prescription at a participating pharmacy without a valid prescription drug ID card)	You pay the full cost of the drug and must file a claim for reimbursement. The Plan will reimburse the pharmacy contracted rate less the applicable Copays shown above for drugs from retail participating pharmacies.		
For any prescription drugs (whether from a Retail Pharmacy or a Mail Order Supplier) if the cost of the Prescription Drug is less than the Copayment, you will pay only the cost of the drug.			

If you currently (i.e. prior to October 2021) receive a specialty drug medication which falls within the current middle tier, the Brand Name medication when a Generic is Not Available tier, your specialty medication will be grandfathered into the new “Tier 1” effective January 1, 2022. As such, you will not experience an increased copayment for this medication.

If you Have Coverage Elsewhere

If you or your Dependents have prescription drug coverage elsewhere, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage—you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See “Coordination of Benefits” in Chapter 14 for more information.

HOW THE PLAN WORKS

Participating Pharmacy Network

The Plan has contracted with OptumRx to provide you with prescription drugs at negotiated contract rates when you use an In-Network pharmacy.

Using an In-Network pharmacy works to your advantage in two ways:

- Your copays are limited to the amounts shown in the benefits chart above.
- You do not have to worry about submitting a claim for reimbursement—you pay your copay at the time of purchase, and that’s it. The pharmacy bills the Plan for the remaining cost.

To take advantage of these features, you must present your prescription order and your prescription drug ID card to the pharmacy each time you have a prescription filled.

If you need to fill a prescription when you are without your ID card, provide the pharmacist with your name and Social Security number and ask him to call OptumRx for billing information at the telephone number listed on the Quick Reference Chart at the beginning of this booklet. If there is any problem with your eligibility, you will need to pay the full cost of the prescription and submit a claim to OptumRx for reimbursement.

NOTE: Copayments you make for prescription drugs do not count toward the calendar-year coinsurance maximum on your payments for allowable expenses (the “out-of-pocket limit”) for comprehensive medical benefits.

Participating Pharmacy List

The list of pharmacies participating in the OptumRx pharmacy network is updated periodically and is provided to you without charge. We also recommend that you call (or check on www.optumrx.com to confirm that a pharmacy you are intending to use is currently a participating pharmacy).

DRUG PURCHASES FROM RETAIL PHARMACIES

Participating Pharmacies

If you purchase your drugs at a participating retail pharmacy and show your prescription drug ID card, you pay your copay. If your prescription is filled with a brand-name drug when a generic is available, you will pay more.

Nonparticipating Pharmacies or no Prescription Drug Card

If you purchase your drugs from a non-participating pharmacy (or if you fail to show a valid prescription drug ID card at a participating pharmacy), you will have to pay the full cost of the prescription at the time of purchase, then file a claim for reimbursement.

Supply Limit

Prescriptions filled at a retail pharmacy cannot exceed a 34-day supply (except as noted immediately below). Copays are the same, whether your supply is for 1 day or 34 days.

Exceptions to Supply Limit

The Plan will cover up to 100 tablets of any of the following drugs at the Copays above:

- Nitroglycerine
- Oral anti-diabetic medications
- Phenobarbital
- Thyroid U.S.P.

MAIL ORDER SERVICE

The Plan's mail service program is intended for drugs you take on a longer-term basis. When you use this service, you may obtain up to a 90-day supply per prescription or refill (or 100 tablets of the drugs mentioned under "Exceptions to Supply Limit" above) from the mail order pharmacy. you pay the same Copayments for generic and brand-name drugs as described above under "Drugs Purchased from Retail Pharmacies.

If you need to start a long-term medication right away, have your physician write two prescriptions. The first prescription should be for at least a 7-day supply and should be taken to a participating retail pharmacy to fill. The second prescription should be for a 90-day supply and should be mailed to the mail order pharmacy for filling.

The website and telephone number for the mail order pharmacy is listed on the Quick Reference Chart at the beginning of this booklet.

WHAT THE PLAN COVERS

The Plan pays benefits for the following drugs and supplies when they are prescribed for the treatment of a non-occupational Illness or Injury:

- Prescription drugs or medicines that legally require a written or oral prescription order of a physician or practitioner within the scope of his or her professional license.
- Prescription Drugs, including drugs, biologicals, and compounded prescriptions used to treat an Illness or Injury.
- Compounded dermatological preparations such as ointments and lotions which must be prepared by a pharmacist according to your physician's prescription order.
- Therapeutic vitamins, cough mixtures, anti-acids, and eye and ear medications recommended by your physician to be used in the treatment of a specific illness or injury.
- Insulin and prescribed oral agents for controlling blood glucose levels.
- Diabetic supplies, including but not limited to lancets, swabs, syringes (hypodermic needles) and diabetic testing strips.
- Prescriptions dispensed by a physician or dentist in his or her office, which are not otherwise covered under the Plan and for which a separate charge is made.
- Oral or transdermal contraceptives that legally require the prescription order of a physician.
- for tobacco users, at least two (2) tobacco cessation attempts per year. Each "tobacco cessation attempt" includes coverage for all **FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications)** for a 90-day treatment regimen when prescribed by a Participating health care provider. Additional medication prescribed for tobacco cessation will be available at the Plan's regular cost-sharing.

NEW-TO-MARKET DRUGS

Any medication that is newly approved by the U.S. Food and Drug Administration (FDA) to enter the market is not covered by the Fund until after OptumRx has had a chance to review the evidence and overall clinical value when compared to other alternatives in the market. This means that if you attempt to fill a prescription for one of these "new to market" drugs, before OptumRx has completed its review, there will be no payment by the Fund.

Appeals

If your Physician feels that you must have access to this "new to market" medication before OptumRx completes its review, you may file an appeal with the Fund.

PREFERRED ALTERNATIVE DRUGS

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

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

You can search for medications and confirm coverage using the "Price a Medication" tool at www.optumrx.com or by calling the dedicated Operating Engineers Health and Welfare Trust Fund for Utah help desk at 1-855-OPA-ENGI (1-855-672-3644).

EXCLUSIONS AND LIMITATIONS FOR PRESCRIPTION DRUGS

In addition to the Exclusions from Coverage described in Chapter 4 of this booklet, the following limitations and exclusions apply to prescription drug benefits:

Exclusions

- Drugs for the treatment of substance use disorders for Dependent children
- Non-Legend patent or proprietary medicine
- Charges for the administration or injection of any drug
- Contraceptives, other than oral or transdermal, whether medication or device, regardless of intended use
- Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, or health and beauty aids
- Growth hormones
- Immunization agents, biological sera, blood or blood plasma
- Any drug for the treatment of infertility or the promotion of fertility
- Investigational or Experimental Drugs. Drugs labeled "Caution – limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication Dispensed by a Facility. Medication which is to be administered to an individual in whole or in part while he or she is a patient in a hospital or skilled nursing facility, rehabilitation facility, rest home, sanatorium, convalescent hospital, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals
- Medication not legally requiring a prescription, other than insulin
- Non-Medicinal Substances. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances, regardless of intended use (except as specifically provided for diabetic supplies under "What the Plan Covers.")
- Over-the-Counter Medications. Over-the-counter drugs and medications, whether or not prescribed, unless the over-the-counter drug or medication: 1) is approved by Optum Rx and expressly identified by Optum Rx in writing as a covered over-the-counter drug or medication; and 2) is accompanied by a prescription order. The fact that a particular over-the-counter drug or medication is covered does not require the Plan to cover or otherwise pay or reimburse you for any other over-the-counter drug or medication.

- Non-FDA Approved Purpose or Dosage. Any prescription drug prescribed for use other than its FDA-approved purpose or in other than the standard dosage for an FDA-approved purpose
- Prescription Drugs for Personal Enhancement. Any prescription drug for:
  - ✓ impotence;
  - ✓ enhancement of sexual performance, satisfaction or gratification;
  - ✓ enhancement of athletic or intellectual performance;
  - ✓ hair growth;
  - ✓ impedance of the aging process; and
  - ✓ weight management or weight reduction
- Progesterone suppositories
- Quantities in Excess of Supply Limit. Any prescription drug in excess of a 34-day supply from a retail pharmacy or a 90-day supply from the Mail Order Pharmacy, except as specified under "Exceptions to Supply Limit" above.
- Refills. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the physician's original prescription order.
- Retin-A for a person over 30 years of age, regardless of intended use

HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS

If you use a participating pharmacy and present your prescription drug ID card or you use the mail order service, you pay only your copay at the time of purchase, so you do not need to worry about filing claims.

For information on how to send prescriptions to the mail order pharmacy, see "Mail Order Service" earlier in this chapter.

If you use a non-participating pharmacy, you must pay the cost of the drug at the time of purchase and request reimbursement by following these steps:

- Obtain a claim form from the Utah Trust Fund Office or OptumRx.
- Complete your portion of the form (be sure to sign the claim form).
- Attach all original prescription receipts to the back of the claim form. (Store cash register receipts will NOT be accepted.) Prescription receipts **must** contain all of the following information:
  - Prescription number
  - Physician's name
  - Name of the drug, strength, and quantity
  - The date the prescription was filled
  - The charge for the prescription
- Check your completed claim to make sure it contains the following information:

    - Your (the Employee's) name Social Security number (or assigned ID number, if applicable)
    - The name and date of birth of the person for whom the prescription was filled
- Mail the completed claim form with your original prescription receipt(s) to OptumRx at the address listed on the Quick Reference Chart at the beginning of this booklet.

NOTE: You must submit your claim **within 1 year** from the date on which covered expenses were incurred. Benefits will not be allowed if you submit your claim more than 1 year after the date on which covered expenses were incurred.

If you have any questions about submitting your claim, contact the Utah Trust Fund Office or OtpumRx.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" in Chapter 15, "Appealing an Adverse Benefit Determination."

If you Have Other Insurance

Make sure you notify the Trust Fund Office if you have other insurance. If you do not notify the Trust Fund Office of other insurance, it will be unable to coordinate benefits, and this could result in a delay in the processing of your claim.

CHAPTER 7: DENTAL BENEFITS	In this chapter you'll find: ✓ A Schedule of Dental Benefits ✓ Participating Providers ✓ How the Plan works ✓ Plan maximums ✓ Recommended pre-determinations ✓ What the Plan covers ✓ Exclusions from coverage ✓ Extension of dental benefits ✓ Information on filing claims

About This Chapter

Dental Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Even though it is not required to do so, the Fund has decided to allow Dependent coverage up to age 26 for dental benefits.

The dental plan is administered by EMI Health, which processes dental claims for the Fund and provides a participating dental provider network. Dental benefits provide coverage for services ranging from checkups and cleanings to dentures.

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Schedule of Dental Benefits		
General Plan Features		
Maximum benefit **(does not apply to Dependent Children under 19 years of age)**	$1,500 per calendar year per individual	
Calendar-year deductible	None	
Preventive Services	**In-Network**	**Out-of-Network**
✓ Oral examination (including Periodontal) 2 per year ✓ Cleanings – 2 per year ✓ Fluoride - 2 per year for a child under age 14 ✓ X-rays ✓ Panoramic (or full mouth X-ray) once every 3-years	**80%**	**80%**

<table>
<tr><th colspan="3">Schedule of Dental Benefits</th></tr>
<tr><th>Basic Services</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>✓ Impacted teeth
✓ Anesthesia (or intravenous sedation) up to $150 maximum per calendar year
1. Maximum does not apply to children under 19 years of age
2. Age 8 and over for the extraction of impacted teeth only
3. For children age 7 and under, once per year
✓ Sealants – limited to every 3 years up to age 14
✓ Fillings (same surface – 1 every 18 months)
✓ Endodontics, Periodontics, Space maintainers
✓ Oral Surgery
✓ Crowns (when not part of a bridge, 1 every 5 years per tooth)
✓ Inlays (1 every 5 years per tooth)
✓ Onlays (1 every 5 years per tooth)</td><td>80%</td><td>80%</td></tr>
<tr><td>Major Services
✓ Bridges (including pontics, abutments and crowns when they are part of a bridge)
✓ Prosthodontics (dentures) 1 every 5 years per tooth</td><td>50%</td><td>50%</td></tr>
<tr><td>Specialists</td><td colspan="2">Paid the same as a General Dentist</td></tr>
<tr><td>Implants</td><td colspan="2">Not Covered</td></tr>
<tr><td>Orthodontics for Adults (ages 19 and over)</td><td>25% discount for Orthodontic Services when using a participating Orthodontist</td><td>Not Covered</td></tr>
<tr><td>Orthodontics (for Dependent Children ages 7-18)</td><td>Lifetime maximum benefit of $1,000. After the lifetime maximum is utilized, you will receive a 25% discount on any remaining network charges.</td><td>Not Covered</td></tr>
</table>

If you Have Coverage Elsewhere

If you or your Dependents have dental coverage elsewhere, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage—you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See "Coordination of Benefits" in Chapter 14 for more information.

PARTICIPATING PROVIDERS

Your dental plan includes a provider network of participating dentists through EMI Health. You are free to use any licensed dentist. However, using a participating dentist will save you and the Fund money because participating dentists are contracted to provide services to Plan Participants at special negotiated rates.

Services may be received from any licensed dental provider. However, this Plan will pay a percentage of the discounted fee when you use an In-Network Dental provider which saves you money. If you use an Out-of-Network dental provider, the Plan will pay a percentage of the Allowed Charge determined by the Dental Plan. Non-Network Providers may bill the Plan Participant for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called Balance Billing. **You can avoid Balance Billing by using In-Network providers.**

To find a participating In-Network dentist in your area:

- Call the PPO Dental Network at the number listed on the Quick Reference Chart at the beginning of this booklet for names and telephone numbers of participating dentists or to receive a provider directory at no cost; or
- Access the internet at the web site listed on the Quick Reference Chart at the beginning of this booklet.

Contract arrangements with dentists may change; it is always a good idea to confirm that a dentist is currently participating in the network by calling the PPO Dental Network.

***Note:* The fact that a dentist is a participating PPO provider does not necessarily mean that all services you receive from that dentist will be covered benefits under the Plan.**

HOW THE PLAN WORKS

The Plan pays percentages of the covered dental expense for an examination, treatment, or procedure, as shown in the chart on the preceding pages. If you use a participating In-Network dental provider, covered dental expense is the discounted contract rate specified in the contract between the provider and EMI Health. If you use a non-participating dentist, covered dental expense is the Allowed Charge determined by the Dental Network claims administrator.

If the amounts billed by a non-participating dental provider are lower than the Allowed Charge for the service provided, the Plan will pay percentages of the amounts billed instead.

If you have a question about the allowable amount for a specific dental service, you can call the Dental Claims Administrator.

DENTAL PLAN MAXIMUM

The Plan pays up to $1,500 in dental benefits per individual per calendar year. This maximum does not apply to Dependent Children up to age 19.

RECOMMENDED PRE-DETERMINATIONS FOR DENTAL SERVICES

Before treatment is received for the following dental services, it is recommended that the proposed treatment plan be submitted to EMI Health for review and an estimate of the benefits that will be payable.

- Treatment involving any type of prosthetic device, including dentures, bridges, crowns, jackets, and inlays; or
- Any type of procedure that might be considered cosmetic in nature.

Obtaining a pre-determination allows the Plan to advise you and your dentist ahead of time whether a procedure will be covered and, if so, the amount payable. This will also advise you of the amount that will be your obligation. Pre-determination need not be limited to those services described above. You may obtain a pre-determination on any proposed dental treatment plan.

WHAT THE DENTAL PLAN COVERS

Subject to the dental annual benefit maximum, the Plan pays the percentages shown below for the covered expenses of treatment received from a dentist or a dental hygienist working under the supervision of a dentist.

To be covered, services must be necessary and customary, as determined by the standard of generally accepted dental practice. Expenses are deemed to be incurred on the date the service or supply is provided.

NOTE: If you select a more expensive plan of treatment than is customarily provided, an allowance will be made for the least expensive alternative treatment. Examples are choosing a crown where a silver filling would restore the tooth or a precision denture where a standard denture would suffice.

Preventive Services

The Fund pays 80% of the applicable amount for the following:

- Diagnostic services—procedures to assist the dentist in evaluating existing conditions to determine the required dental treatment, including the following:
- Oral examination (including periodontal) limited to two exams in any Calendar year
- X-rays
- Panoramic or Full mouth x-rays (once every 3 years)
- Emergency palliative treatment
- Specialist consultation
- Preventive care:
  - Prophylaxis (cleaning) (first two treatments in any calendar year)
  - Fluoride treatment (first two treatments in any calendar year, for children under age 14)

Basic Services

The Fund pays 80% of the applicable amount for the following:

- Oral surgery—extractions for impacted teeth and certain other surgical procedures, including pre- and post-operative care;
- Restorative—amalgam, synthetic porcelain, and plastic restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay). Fillings on the same surface of the same tooth are limited to one every 18 months.
- Study models
- Space maintainers
- Dental sealants (for children under 14 years of age only). Sealants are covered services only for posterior molars that do not have restorations, and benefits for replacement sealants are limited to once every 3 years.
- Endodontics—treatment of the tooth pulp, root canal therapy;
- Periodontics—treatment of gums and bones supporting teeth;
- General anesthesia or intravenous sedation only for children age 7 and under once per calendar year, up to $150. It is also covered for people age 8 and over for the extraction of impacted teeth, based on necessity, not for anxiety management, up to $150 per calendar year. Please note that this maximum does not apply to children under 18 years of age;
- Crowns, inlays, onlays and cast restorations for treatment of carious lesions, (visible destruction of hard tooth structure resulting from the process of dental decay) which cannot be restored with amalgam, synthetic porcelain or plastic restorations.

  Crowns, jackets, and cast restorations can be replaced under this Plan only once every 5 years. (This limitation will not apply if the previous crown was a temporary stainless steel crown provided to children under 19 years of age.)

Major Services

- Bridges (including pontics, abutments and crowns when they are part of a bridge).
- Prosthodontics (dentures) - The Fund pays 50% of the applicable amount for procedures for construction or repair of fixed bridges or partial or complete dentures.

  Benefits will not be payable for a prosthodontic appliance more often than once in any 5-year period. A replacement appliance will be covered only if the existing appliance cannot be made serviceable or if there is such extensive loss of remaining teeth or change in supportive tissues that the existing appliance cannot be made satisfactory.

EXCLUSIONS FROM DENTAL COVERAGE

Dental benefits will not be paid for the following:

- The replacement of a lost, misplaced, or stolen appliance.
- Dental treatment involving the use of gold or more costly materials or specialized techniques if the treatment could have been provided by means of a less expensive, professionally acceptable alternative treatment plan.

- Oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs.
- Orthodontic services. See the Schedule of Dental Benefits for the benefits and discounts available from a PPO dentist.
- Implants; myofunctional therapy; athletic mouthguards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
- Any treatment program which began prior to the date you became eligible under the Plan.
- The replacement of crowns, bridges, onlays or prosthetic appliance within 5 years from the date of last placement.
- The replacement of crowns, bridges, dentures or onlays that can be restored to normal function.
- Care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision.
- For service or supplies payable under any medical expense, auto or no-fault plan.
- Cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
- Hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
- Drugs or the dispensing of drugs.
- General anesthesia, including intravenous sedation (except that general anesthesia or intravenous sedation is covered for children age 7 & under once per calendar year, up to $150. It is also covered for people age 8 and over for the extraction of impacted teeth, based on necessity, not for anxiety management, up to $150 per year). The $150 maximum does not apply to children under 18 years of age.
- Any services supplied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
- Any charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
- Composite, resin, or white fillings on posterior primary teeth. Benefit will be reduced to that of an amalgam or silver filling.
- For sealants not applied to permanent bicuspid or molar; applied at age 15 or older; applied 3 years from a previous sealant application; or applied to a decayed tooth.
- Lab fees for higher metals or porcelain crowns, bridges or onlays.
- Any services and supplies not listed or excluded in the coverage schedule under “What the Plan Covers”, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.

- For any condition covered under any Worker's Compensation Act or similar law.
- Any service or supply that is excluded under "Exclusions from Coverage" in Chapter 4.
- Night guards.

EXTENSION OF DENTAL BENEFITS

If you should lose eligibility for benefits, the Plan will pay normal dental benefits for the following items only:

- Delivery or placement of fixed bridgework or crowns provided the teeth were first prepared on a date when you were eligible for dental benefits and provided the bridgework or crowns are furnished within 60 days of when eligibility terminates.
- Delivery or placement of full or partial dentures, provided the final impression was taken on a date when you were eligible and provided the dentures are furnished within 60 days of when eligibility terminates.

Examinations, X-rays, or other services in connection with delivery and placement of prosthetic devices or crowns are not covered services under this extension of dental benefits provision.

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

To file a claim for dental benefits, follow these steps:

- Obtain a dental claim form from the Utah Trust Fund Office, District Office, or Local Union Office.
- Complete your portion of the form (be sure to sign the claim form).
- Have your dentist complete the rest of the form.
- Check your completed claim to make sure it contains the following information:
    - your (the Employee's) name and Social Security number (or assigned ID number, if applicable)
    - The patient's name and date of birth
    - The date of service
    - The codes for the dental procedures performed
    - The billed charge(s)
    - The Federal taxpayer identification number (TIN) of the provider
    - The dentist's billing name and address

Mail the completed claim form with your itemized bill(s) to the dental claims administrator at the address listed on the Quick Reference Chart at the front of this booklet.

NOTE: you must submit your claim **within 1 year** from the date on which covered expenses were incurred. Benefits will not be payable if you submit your claim more than 1 year after the date covered expenses were incurred.

If you have any questions about submitting your claim, contact EMI Health or the Trust Fund Office. For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" in Chapter 15, "Appealing an Adverse Benefit Determination."

If you Have Other Dental Insurance

Make sure you notify EMI Health if you have other dental insurance. If you do not notify EMI Health of other insurance, it will be unable to coordinate benefits, and this could result in a delay in the processing of your claim.

CHAPTER 8: VISION CARE BENEFITS

In this chapter you'll find:
- ✓ Schedule of Vision Care benefits
- ✓ Covered vision services
- ✓ Exclusions from coverage
- ✓ Information on filing claims

About This Chapter

Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. The Fund allows coverage for Dependents up to age 26 for vision benefits.

Your vision care benefits cover you and your enrolled Dependents for regular examinations and for lenses and frames necessary to correct your vision.

The chart below is intended to provide a convenient Schedule of Benefits for your Blue View Vision Plan Benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Schedule of Benefits **Blue View Vision Plan Benefits**	**In-Network**	**Out-of-Network**
A comprehensive eye exam (once every calendar year)	$10 copay	Reimburse up to $45
One pair of eyeglass frames (once every two calendar years)	$140 allowance, 20% off remaining balance	Reimburse up to $100
One pair of standard plastic prescription lenses: (once every calendar year) ✓ Single vision lenses ✓ Bifocal lenses ✓ Trifocal lenses ✓ Lenticular lenses	 $0 copay $0 copay $0 copay $0 copay	 Reimburse up to $30 Reimburse up to $50 Reimburse up to $70 Reimburse up to $0
Contact Lenses ***(instead of eyeglass lenses) once every calendar year*** Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.		
Elective conventional (non-disposable)	$140 allowance, then 15% off any remaining balance	Reimburse up to $100
Elective disposable; OR	$140 allowance *(no additional discount)*	Reimburse up to $100
Non-elective (Medically Necessary)	Covered in full	Reimburse up to $210
Laser Vision Correction Services	Participating LASIK/ photorefractive keratectomy (PRK) surgical centers offer a discounted rate for	Not covered

Schedule of Benefits Blue View Vision Plan Benefits	In-Network	Out-of-Network
	members	

COVERED VISION SERVICES

Vision Exams

The Plan covers a visual examination (regardless of Medical Necessity) by a duly licensed physician or optometrist once each calendar year. A comprehensive eye exam with dilation as needed is provided to check all aspects of your vision. An eye exam does not include a contact lens fitting fee. Your plan covers a refraction in conjunction with an eye exam.

Eyeglass Lenses

The Plan also covers eyeglass lenses that include factory scratch coating at no additional cost. Your *dependent* children under 19 may also receive polycarbonate and photochromic eyeglass lenses at no additional cost when received from a *network provider*.

Covered eyeglass lenses include plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- standard progressive lenses

Frames

You also have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance, then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

Contact Lenses

Your Plan also covers elective or non-elective contact lenses. You may receive a benefit for elective contact lenses or non-elective contact lenses, but not both. The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The Schedule of Benefits lists the contact lens allowance available under this plan.

- <u>Elective Contact Lenses.</u> Elective contact lenses are contacts that you choose for appearance or comfort.
- <u>Non-Elective Contact Lenses.</u> Non-elective contact lenses are prescribed by your provider for one of the diagnoses listed below:
  - ✓ Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
  - ✓ Keratoconus – unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
  - ✓ High Ametropia – unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
  - ✓ Anisometropia – when one eye requires a much different prescription than the other eye.

Important Note: The Plan will not reimburse for non-elective contact lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

EXCLUSIONS FROM VISION CARE COVERAGE

No vision care benefits will be payable for the following:

- **Not specifically listed**. Services not specifically listed as a covered service.
- **Sunglasses**. Sunglass lenses or accompanying frames.
- **Excess amounts**. Any amounts in excess of the maximum benefits stated in this certificate.
- **Premium contact lenses fittings**. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- **Cosmetic Options**. Cosmetic lens options not specifically listed in the Schedule of Benefits or the covered services section of this certificate. This includes non-prescription eyewear and lenses, plano lenses or lenses that have no refractive power.
- **Eye surgery**. Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. In addition, contact lenses or eyeglasses required as a result of this surgery are not covered.
- **Lost or broken lenses or frames**. Any lost or broken lenses or frames, unless you have reached a new benefit period.
- **Experimental or investigative**. Any experimental or investigative services or materials.
- **Uninsured**. Services received before your effective date or after your coverage ends.
- **Voluntary payment**. Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- **Work-related**. Vision services that have been paid under any Worker's Compensation law, federal Medicare program or federal Veteran's Administration program.
- **Government treatment**. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Non-licensed vision care providers**. Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by Blue View Vision.
- **Services of relatives**. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.
- **Hospital care**. Inpatient or outpatient hospital vision care.
- **Orthoptics**. Orthoptics or vision training and any associated supplemental testing.
- **Missed or Cancelled Appointments**. We will not pay for appointments a member has missed or cancelled.

- **Services or Supplies Combined with Discounts.** We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement. We will also not pay for certain brands of frames where the manufacturer does not allow discounts.

HOW TO FILE A CLAIM FOR VISION CARE BENEFITS

Notice of Claim: After you receive vision care you will need to Blue View Vision, either by phone or mail (see contact information listed below). You should contact Blue View Vision within 20 days of the date you received vision care so they can provide to you claim forms for filing. Notice given by someone on your behalf, or to any agent authorized by Blue View Vision, within\\ information to identify you will be deemed notice to us.

Claim Forms: Blue View Vision will provide claim forms within 15 days after you notify them. The claim form will have instructions on how to fill it out and where to submit. If you do not receive the claim form within 15 days of your notice, you may send written proof of your loss instead, such as an itemized bill from your provider. To make it easier to process your claim, the other proof of loss should include the following:

- The date of service
- The patient's name, date of birth, and identification number
- The type and place of service
- Your signature and the provider's signature

Proof of Loss: Your written proof of loss as described above should be provided to us within 90 days after the date of you received vision care. If it is not reasonably possible to provide your written proof of loss within this time, your claim will not be invalidated or reduced. However, you must send it as soon as reasonably possible, and in no event later than a year from when it was due, unless you are legally incapacitated.

Notice of claim, claim forms and other proof of loss can be sent to the following address:

Blue View Vision

P.O. Box 8504

Mason, OH 45040-7111

Phone: (866) 723-0515

Time of Payment of Claims: Claims will be paid immediately your written proof of your claim is received, but not later than days after your proper written proof of loss is received.

Payment of Claims: Your claims will be paid directly to providers if they have an assignment of benefits on file. If the provider does not have an assignment of benefits on file then Blue View Vision will pay claims to you. If you pass away, your claims will be paid to your designated beneficiary or to your estate if there is no assignment of benefits.

If you have any questions about submitting your claim, contact the Trust Fund Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" in Chapter 15, "Appealing an Adverse Benefit Determination."

CHAPTER 9: EMPLOYEE WEEKLY DISABILITY BENEFIT

In this chapter you'll find:

- ✓ A guide to your weekly disability benefits
- ✓ How the Plan works
- ✓ Exclusions
- ✓ Filing for reimbursement

About This Chapter

The Employee weekly disability benefits described in this chapter are provided through an insurance contract with USAble Life Insurance Company.

These benefits are provided for non-occupational disabilities only. Weekly disability benefits are not provided for Dependents.

The Plan will pay you a weekly benefit of $200 if you become disabled as a result of a non-occupational Injury or Illness and are unable to work at your regular occupation as a result of the disability.

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

Schedule of Weekly Disability Benefits	
General Plan Features	
Weekly benefit amount	$200
Maximum number of weeks payable	26 weeks for each period of disability
Benefit waiting period	None for Accidental Injury; 7 days for illness

HOW THE PLAN WORKS

Weekly disability benefits are payable if you become disabled due to an Illness or Accidental Injury that happened while you were eligible under the Plan, and you are unable to perform the major duties of your regular occupation as a result of your disability.

To be eligible for benefits, you must be seen and treated by a physician for the disabling condition and the physician must certify your disability in writing to the insurance company. The physician who certifies your disability cannot be a relative of yours.

For the purpose of this benefit:

- "Illness" means sickness, disease, pregnancy or complications of pregnancy

- "Accidental Injury" means immediate traumatic physical damage to the body which:
    - Results directly form an unexpected and unintentional event, and
    - Is independent of disease, bodily infirmity or any other cause.

Any disability that begins more than 90 days after the Accidental Injury will be considered an Illness for the purpose of determining the waiting period described below under *When Benefits Begin*.

When Benefits Begin

The Plan will begin paying benefits after a benefit waiting period. The waiting period is the number of days you must be continuously disabled before weekly disability benefits become payable. you must be under the care of a physician during the benefit waiting period.

If your disability is due to an illness, the benefit waiting period is 7 days. Benefits will begin on the 8th day of your disability.

If your disability is due to an Accidental Injury, there is no waiting period. Benefits will begin on the first day of your disability.

Maximum Benefit Period

Benefits are payable for a maximum of 26 weeks for any one period of disability, whether due to one or more causes.

If benefits are due for less than a full week of disability, you will receive one-seventh of the weekly benefit amount for each day you are disabled.

Any subsequent period of disability will be considered a new period of disability when:

- For disabilities resulting from the same cause, you return to active work at your regular occupation for a continuous period of 14 or more days; or
- For different and unrelated causes of disability, you return to active work at your regular occupation for at least one full day.

Benefit Reductions

Weekly disability benefits will be reduced by the amount of any benefit for loss of income you receive from the following sources, if they are provided as a result of the period of disability for which benefits are claimed under this Plan:

- Any state disability program
- Any federal Social Security benefits you, your spouse and/or your children receive or are eligible to receive because of your disability or retirement
- Any governmental law or program.

When Benefits End

Weekly disability benefits end on the **earliest** of the following dates:

- The end of the maximum benefit period (when you have received benefits for 26 weeks for a period of disability);

- The date your physician releases you to return to active employment at your regular occupation;
- The date you die;
- The date you fail to provide proof of continuing disability as required by the insurance company; or
- The date you become self-employed.

EXCLUSIONS FROM WEEKLY DISABILITY COVERAGE

Weekly disability benefits are not payable for disability that results from:

- Any Injury or Illness incurred in the course of any employment for wages or profit
- Any Injury or Illness for which you are entitled to benefits under any Workers' Compensation or occupational disease law
- A suicide attempt or any self-inflicted Injury
- Committing or attempting to commit an assault or felony
- Any Injury suffered while you were serving in the armed forces of any country

In addition, no weekly disability benefits will be paid for any period of disability during which you are:

- Not under the regular care of a physician;
- Incarcerated in a corrections facility; or
- Receiving Workers Compensation benefits, regardless of the cause of the disability.

HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS

If you become disabled, contact the Utah Trust Fund Office for assistance in filing a claim for weekly disability benefits. The Trust Fund Office will send you a claim form. The completed form and any required documentation should be returned to the Trust Fund Office at the following address.

Operating Engineers Utah Fringe Benefits Office
8805 South Sandy Parkway
Sandy, UT 84070-6460
(385) 326-2001

The Trust Fund Office will make sure all necessary information is included and will forward your claim to the insurance company for processing.

If you disagree with the payment decision made in regard to the claim, you can appeal it. See "Claims and Appeals Procedures" in Chapter 15 of this booklet.

CHAPTER 10: EMPLOYEE LIFE INSURANCE

In this chapter you'll find
- ✓ How the Plan works
- ✓ Conversion option
- ✓ Information on filing claims

About This Chapter

The Employee life insurance benefit described in this chapter is provided through an insurance contract with USAble Life Insurance Company.

Employee Life Insurance	$4,000 coverage

HOW THE PLAN WORKS

This Plan pays a $4,000 benefit in the event of your death - on the job or off - from any cause while you are insured under the Plan.

Payment of the Benefit

The $4,000 benefit will be paid to the beneficiary on file for you with the Fringe Benefits Service Center at the time of your death.

The beneficiary is the person you designated on the card you filled out when you joined the Union. You may change your beneficiary at any time without the consent of the previously named beneficiary.

If a beneficiary dies before you, the deceased beneficiary and his or her estate have no rights to the benefit. Two or more surviving beneficiaries will share the benefit equally unless you specified otherwise on your beneficiary designation card.

When There is No Surviving Beneficiary

If there is no designated beneficiary, or if your designated beneficiary does not survive you, the insurance company will pay the benefit in equal shares to your surviving relatives in the highest rank of the following: 1) spouse; 2) children; 3) parents; or 4) your estate.

NOTE: For the purpose of the above paragraph only, “children” means biological children and adopted children.

If the Beneficiary is a Minor or Incompetent

If your beneficiary is a minor or, in the opinion of the insurance company, incapable of giving a valid release for payment, the insurance company will pay the benefit to his or her legal guardian or, if there is no legal guardian, to the person or institution who has in its opinion custody and principal support of such beneficiary.

NOTE: The insurance company may, at its option, pay the benefit to any person who has incurred expenses in connection with your last illness, death or funeral. This is separate from the Employee burial expense benefit discussed in Chapter 13.

CONVERSION OPTION

If you Cease to Be Eligible for Group Life Insurance

If your coverage under this group life insurance plan ends because your eligibility terminates, your group life insurance will be continued for a period of 31 days. The life insurance benefit will be payable if you die within that period.

During the 31-day period, you may convert all or any part of the benefit to an individual life insurance policy with no need for a medical examination or evidence of insurability if you give the insurance company a written request to convert within the 31-day period. The premium for the first term of coverage must be paid before the individual policy will be issued. The new policy will take effect at the end of the 31-day conversion period.

You may choose any type of individual policy then customarily being issued by the insurance company, except term insurance or disability benefits. your cost will be based on the plan of insurance selected and your age at the time of conversion. The benefit amount on the conversion policy may not exceed the amount of group insurance in force on the last day of your coverage but must be at least $1,000.

If the benefit of the group life insurance plan was paid for your death that occurred during the 31-day conversion period, any individual conversion policy that was issued to you must be surrendered without a claim and any premiums paid for it will be refunded.

Conversion Option Under Other Circumstances

You will also be able to convert your benefit to an individual policy if you have been continuously covered for at least 5 years and your group life insurance terminates because the Fund's current group insurance policy is discontinued or amended. In such a case, the amount you may convert will be reduced by any amount for which you become eligible under any other group policy that replaces the Fund's policy.

Applying for A Conversion Policy

If you wish to take advantage of the conversion option, you must apply in writing to the insurance company and pay the first premium due within 31 days of the date your group insurance through the Fund terminates. The address is as follows:

USAble Life Insurance Company
P.O. Box 1650
Little Rock, AR 72203-1650
800-370-5856
www.USAbleLife.com

HOW TO FILE A CLAIM FOR EMPLOYEE LIFE INSURANCE BENEFITS

Your beneficiary should contact the Utah Trust Fund Office for assistance in filing a life insurance claim. The Trust Fund Office will confirm your beneficiary is the person you designated, and send him or her a claim form. The completed form should be submitted with any required documentation to the Trust Fund Office at the following address.

Operating Engineers Utah Fringe Benefits Office
8805 South Sandy Parkway
Sandy, UT 84070-6460

(385) 326-2001

The Trust Fund Office will forward the claim form and documentation to the insurance company for processing.

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she can request a review of the decision. Please alert your beneficiary to the claims and appeals information provided in Chapter 15 of this booklet.

CHAPTER 11: LIFE INSURANCE FOR DEPENDENTS

In this chapter you'll find:
- ✓ How the Plan works
- ✓ Conversion option
- ✓ Information on filing claims

About This Chapter

Like Employee life insurance, life insurance for your eligible Dependents is provided through an insurance contract with USAble Life Insurance Company.

Dependent Life Insurance Benefits	
Death of your spouse	$1,000
Death of your Dependent child (birth through age 26)*	$500

** See Chapter 2 for information on extended eligibility for disabled children unable to support themselves.*

HOW THE PLAN WORKS

The Plan will pay you, the Employee, a life insurance benefit if one of your eligible Dependents dies.

The amount of the benefit depends on whether the deceased was your spouse or a child. Benefit amounts are as shown in the chart above.

CONVERSION OPTION

If insurance terminates, the life insurance of your spouse and/or Dependent children may, as a one-time privilege, be converted to an individual policy.

(See "Conversion Option" in Chapter 10 about Employee Life Insurance for the conditions under which conversion may be available.)

Written application to the insurance company must be made within 31 days of termination of eligibility. The address is as follows:

USAble Life Insurance Company
P.O. Box 1650
Little Rock, AR 72203-1650
800-370-5856
www.USAbleLife.com

HOW TO FILE A CLAIM FOR DEPENDENT LIFE INSURANCE BENEFITS

If one of your covered Dependents dies, you should contact the Utah Fringe Benefits Office for assistance in filing a life insurance claim. The Fringe Benefits Office will send you a claim form and inform you of any documentation that may be required. The completed form and any required documentation should be sent to the Fringe Benefits Office at the following address.

Operating Engineers Utah Fringe Benefits Office
8805 South Sandy Parkway
Sandy, UT 84070-6460
(385) 326-2001

The Fringe Benefits Office will make sure the claim form is complete and then will forward it to the insurance company. If you have any questions about submitting your claim, contact the Fringe Benefits Office.

If you disagree with the payment decision made in regard to the claim, you can appeal it. See “Claims and Appeals Procedures” in Chapter 15 of this booklet.

CHAPTER 12: EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

In this chapter you'll find:
- ✓ How the Plan works
- ✓ Extra seat belt benefit
- ✓ Exclusions from coverage
- ✓ Information on filing claims

About This Chapter

Like Employee and Dependent life insurance, Employee AD&D benefits are provided through an insurance contract with USAble Life Insurance Company. AD&D coverage is not provided for Dependents.

Schedule of Employee AD&D Benefits	
Description of Loss	**Benefit Payable**
Your death	Plan pays $2,000 to your beneficiary
Quadriplegia	Plan pays $2,000 to you
Loss of one hand, one foot, or sight in one eye	Plan pays $1,000 to you
Paraplegia or hemiplegia	Plan pays $1,000 to you
Two or more of the above losses	Plan pays $2,000 to you

- Quadriplegia means the complete and irreversible loss of the use (paralysis) of both upper and both lower limbs.
- Loss of hands or feet means the complete severance through or above the wrist or ankle joint.
- Loss of sight means entire and unrecoverable loss of sight.
- Paraplegia means the complete and irreversible loss of the use (paralysis) of both lower limbs.
- Hemiplegia means the complete and irreversible loss of the use (paralysis) of the upper and lower limbs on one side of the body.

HOW THE PLAN WORKS

The Plan insures you for up to $2,000 against death or dismemberment, loss of sight, or some types of paralysis, which result from an accident. The amount payable depends on the nature of the loss, as shown in the chart above.

The loss must be the result of an accident (on or off the job) and must occur at the time of the accident or within 365 days after the accident. The Injury causing the loss must be sustained while you are insured under the Plan. If you suffer more than one loss in a single accident, the maximum combined benefit for all losses will be $2,000, except as specifically provided below under *Seat Belt Benefit*.

For the purposes of this benefit, "accident" means immediate traumatic physical damage to the body which:

- results directly from an unexpected and unintentional event; and
- is independent of disease, bodily infirmity or any other cause.

If the loss is your death, the $2,000 benefit will be paid to the designated beneficiary you have on file with the Fringe Benefits Service Center at the time of your death. This benefit is in addition to the $4,000 Employee life insurance benefit described in Chapter 10.

The benefit for any other AD&D loss will be paid to you, the Employee.

Seat Belt Benefit

If you die as a result on an automobile accident in which you were wearing a seat belt, as evidenced by a police accident report, the Plan will pay an extra $2,000 benefit in addition to the $2,000 Accidental Death benefit.

- "Automobile" means a motor vehicle licensed for use on public highways, with four or more wheels and with seats designed for two or more persons.
- "Seat Belt" means a properly installed seat belt or lap and shoulder restraint used as approved by the National Highway Traffic Safety Administration.

The additional seat belt benefit is payable only if an Accidental death benefit is payable under the policy.

EXCLUSIONS FROM AD&D COVERAGE

No AD&D benefit is paid for a loss resulting from any of the following:

- Suicide, self-inflicted Injury, or any attempt to injure yourself, regardless of whether you are sane or insane at the time
- Active participation in a riot. "Active participation" does not include being at the scene of a riot during the performance of official duties
- War or any act of war, whether declared or undeclared
- Injury suffered while serving in the military forces of any country
- Committing or attempting to commit an assault or felony
- Any sickness or pregnancy existing at the time of the accident
- Voluntary use or consumption of any poison, chemical compound or drug, except a prescription drug used or consumed in accordance with the directions of your prescribing physician
- Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebrovascular accident)
- Bodily infirmity or disease from bacterial or viral infections, other than infection caused from a bodily Injury sustained in an accident while you were covered under the Plan
- Any diagnostic test or medical or surgical treatment

HOW TO FILE A CLAIM FOR AD&D BENEFITS

If you suffer one of the losses described in this chapter, you or your beneficiary should obtain an AD&D claim form from the Utah Fringe Benefits Office. The completed form should be submitted with any required documentation to the Fringe Benefits Office at the following address:

Operating Engineers Utah Fringe Benefits Office
8805 South Sandy Parkway
Sandy, UT 84070-6460
(385) 326-2001

If you have any questions about submitting your claim, contact the Fringe Benefits Office.

If you or your beneficiary disagrees with the payment decision made in regard to the claim, it can be appealed as explained in "Claims and Appeals Procedures" in Chapter 15 of this booklet. Please alert your beneficiary to the existence of that information in this booklet.

CHAPTER 13: EMPLOYEE BURIAL EXPENSE BENEFIT

In this chapter you'll find:
- ✓ How the Plan works
- ✓ Exclusions from coverage
- ✓ Information on filing claims

About This Chapter

The Employee burial expense benefit is provided through an insurance contract with Union Labor Life Insurance Company. The burial expense benefit is not provided for Dependents.

Burial Expense Benefit for an Employee	$2,500

HOW THE PLAN WORKS

The Plan pays a burial expense benefit in the amount of $2,500 in the event of your death from any cause—on the job or off—while you are insured for this benefit. This burial benefit does not apply to the death of a Dependent.

The burial expense benefit will be paid to your beneficiary. This benefit is payable in addition to the $4,000 Employee life insurance benefit and, if death is caused by an accident, the $2,000 benefit payable under Employee accidental death and dismemberment benefit.

NOTE: If you are not eligible for the burial expense benefit under this Plan, the benefit may be provided for you through other contracts issued to the groups participating in the Operating Engineers Health and Welfare Trust Fund for Utah Burial Expense Program. Your beneficiary should therefore contact the Union or the Trust Fund Office to ask about payment of this benefit in the case of your death.

BENEFICIARY DESIGNATION

You may name anyone as the designated beneficiary, and you may change the designation at any time by filling out the proper form. To designate or change your beneficiary, complete a new beneficiary designation form (available from the Utah Fringe Benefits Office, the Fringe Benefits Service Center or your local Union office). The beneficiary change will not be effective until your new signed and dated form is received by Fringe Benefits Service Center.

If you have not designated a beneficiary or your beneficiary predeceases you, payment will be made to the first of the following that survives you: your lawful spouse, your children, your parents, or your brothers and sisters. If none of these individuals survives you, the benefit will be paid to your executor or administrator.

HOW TO FILE A CLAIM FOR THE BURIAL EXPENSE BENEFIT

Your beneficiary should contact the Utah Fringe Benefits Office to obtain a burial expense benefit claim form. The Fringe Benefits Office will confirm your beneficiary is the person you designated, and send him or her a claim form The completed form should be submitted with any required documentation to the Fringe Benefits Office at the following address.

Operating Engineers Utah Fringe Benefits Office
8805 South Sandy Parkway
Sandy, UT 84070-6460
(385) 326-2001

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she can request a review of the decision. Please refer your beneficiary to the claims and appeals information provided in Chapter 15 of this booklet.

CHAPTER 14: COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

This chapter includes:

- ✓ Coordination of benefits
- ✓ Other party liability

COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

This Plan does not coordinate benefits with an individual plan. This means that when you are 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.

If you or a Dependent are entitled to benefits from another Group Plan as well as benefits from this Fund, then the benefits provided by this Fund will be paid in accordance with the following provisions, not to exceed the total amount of benefits which would have been paid for the calendar year in the absence of other group coverage, or 100% of Covered Expenses incurred.

a) If the Covered Person is the Employee, Fund benefits will be provided for Covered Expenses without reduction by this Plan.

b) The benefits of a Group Plan which covers the Covered Person other than as a Dependent will be determined before the benefits of a Group Plan which covers the person as a Dependent.

c) If the Covered Person for whom claim is made is a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan which covers the Covered Person as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, will be determined before the benefits of the Group Plan which covers the Covered Person as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year. If either Group Plan does not have the provisions of this rule c. regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule will not apply, and the rule set forth in the Plan which does not have the provisions of this rule c. will determine the order of benefits.

d) In the case of a Covered Person for whom claim is made as a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Group Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Group Plan which covers the child as a dependent of the parent without custody.

e) In the case of a Covered Person for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Group Plan which covers the child as a dependent of the natural parent with custody will be determined before the benefits of a Group Plan which covers that child as a dependent of the stepparent, and the benefits of a Group Plan which covers the child as a dependent of the stepparent will be determined before the benefits of a Group Plan which covers the child as a dependent of the natural parent without custody.

f) In the case of a Covered Person for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree which would otherwise

establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d. and e. above, the benefits of a Group Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other Group Plan which covers the child as a dependent child.

g) In the case of a dependent child who is covered under more than one plan one of which is of an individual who is not the parent of the child, the order of benefits will be determined using the longer/shorter length of coverage and if length of coverage is the same, then the birthday rule applies between the dependent child's parent's coverage and the dependent spouse's coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to the longer/shorter length of coverage rule first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

h) When rules a., b., c., d., e., or f. do not establish an order of benefit determination, Fund benefits will be provided without reduction if the Covered Person has been eligible continuously for benefits from this Fund for a longer period of time than he or she has been continuously eligible for benefits from the other Group Plan, provided that:

   (1) The benefits of a Plan covering the Covered Person as a laid-off or retired employee will be determined after the benefits of any other Plan covering the person as an active employee.

   (2) If either Plan does not have a provision regarding laid off or retired employees, which results in each Plan determining its benefits after the other, then the provision of Subsection (1) above will not apply

COORDINATION OF BENEFITS WITH MEDICARE

A. **Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).

B. **Coverage Under Medicare and This Plan When Totally Disabled:** If an eligible employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.

C. **Coverage Under Medicare and This Plan for End-Stage Renal Disease:** If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY TO MEDICARE

When Covered by this Plan and also by Medicare Parts A and B: When an eligible individual under this Plan is also covered by Medicare Parts A and B and this Plan is secondary to Medicare,

this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.

When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits: If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.

Also, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, Case Management or utilization of Network provider requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract: Under the law a Medicare beneficiary (meaning an individual who is determined by the Social Security Administration to be eligible for and has actually enrolled in Medicare benefits) is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare beneficiary enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare beneficiary receives pursuant to it.

WHEN COVERED BY THIS PLAN AND ALSO BY A MEDICARE PART D DRUG PLAN

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 coverage of the Medical Plan outlined in this document is "creditable."** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare 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 enrollment 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 have dual coverage under both this Plan and Medicare Part D, this group health plan pays primary and Medicare Part D coverage is secondary for:

- Medicare eligible Active Employees (and their Medicare eligible Dependents); and
- individuals no longer actively employed but still receiving benefits based on hours accumulated when they were working.

For more information on Medicare Part D refer to www.medicare.gov or contact the Fund Office.

COORDINATION OF BENEFITS WITH PREPAID PLANS

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event a Covered Person (i) has coverage under this Plan, and (ii) has

coverage under a prepaid program under another Group Plan (regardless of whether the Covered Person must pay a portion of the premium for that plan), and (iii) uses the prepaid program for services covered by this Plan, then this Plan will only reimburse the copayments required of the Covered Person under the prepaid plan, and only if those copayments are required of every person covered by that program. Except for the copayments specified above, the Plan will not pay expenses of eligible participants or dependents covered by prepaid programs of other plans. For purposes of this Plan, the term "prepaid program" will include health maintenance organizations, individual practice associations, and any other programs that the Board in its sole discretion deems to be essentially similar to prepaid arrangements.

COORDINATION OF BENEFITS WITH MEDICAID

Payments by this Plan for benefits with respect to a Covered Person will be made in compliance with any assignment of rights made by or on behalf of the Covered 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). Where payment has been made by the State under Medicaid for medical assistance in any case where this Plan has a legal liability to make payment for that assistance, payment for the benefits will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person to the payment for that assistance. In no event will payment be made by this Plan, under this provision, for claims submitted more than one year from the date expenses were incurred. Reimbursement to the State, like any other entity which has made payment for medical assistance where this Plan has a legal liability to make payment, will be equal to Plan benefits or the amount actually paid, whichever is less.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

A. **TRICARE**: If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to 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.

B. **Veterans Affairs/Military Medical Facility Services**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.

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

D. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

E. **Other Coverage Provided by State or Federal Law**: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is

provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

THIRD-PARTY LIABILITY

If you or your dependent (any Eligible Individual) are injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

1. The Eligible Individual, or anyone receiving any Plan benefits as a result of the injury to the Eligible Individual, shall be required to pay to the Plan any and all proceeds whatsoever, including but not limited to proceeds designated as being punitive damages or for pain and suffering, received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage) arising out of any claims for money or other damages by the Eligible Individual or his or her heirs, parents, or legal guardians, or anyone else acting on his or her behalf, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. This obligation to pay the Plan applies whether the individual has been made whole or not. The assets so recovered shall be considered Plan assets and the recipient shall be under a fiduciary duty to pay them over to the Plan. In addition to any other remedy provided hereunder, the Plan shall be entitled to enforce this requirement by way of restitution or constructive trust, equitable lien by agreement or any other remedy permitted by law.

2. Any Eligible Individual, or anyone acting on his or her behalf, who accepts payments from the Plan, or authorizes Plan payments to be made to anyone else, or on whose behalf any benefits are paid with respect to the Eligible Individual's injuries, agrees that a present assignment of the Eligible Individual's rights against such third party is automatically made to the extent of the payments made by the Plan.

3. These rules are automatic, but the Plan may require that any Eligible Individual or his or her representative sign and complete a questionnaire as well as a third party lien acknowledgement form, an Agreement to Reimburse and Assignment of Recovery. If an Eligible Individual, or his or her representative, within 1 year from the date of the injury, fails to submit to the Plan a completed and signed questionnaire, third party lien acknowledgement form, an Agreement to Reimburse and Assignment of Recovery as requested by the Plan and in forms satisfactory to the Plan, or fails to provide a form or other documentation establishing that the injury was not caused by a third party, the Eligible Individual shall not be eligible for Plan benefit payments related to the injury involved. This remedy is in addition to all other remedies the Plan may have.

4. If Plan benefits are paid on behalf of an Eligible Individual and upon recovery of any proceeds from or on behalf of the third party such benefits are not reimbursed to the Plan as set forth above, then the Eligible Individual will be ineligible for any future Plan benefit payment until the Plan has withheld an amount equal to the amount which has not been reimbursed. This remedy is in addition to all other remedies the Plan may have.

5. Any Eligible Individual on whose behalf the Plan pays benefits agrees that the Plan may intervene in any legal action brought against a third party or any insurance company, including the Eligible Individual's own carrier for uninsured motorist’s coverage.

6. An equitable lien by agreement shall exist in favor of the Plan upon all sums of money recovered collectively by the Eligible Individual from all sources as a result of the injuries to the eligible employee. The lien may, but is not required to, be filed with the third party, the third party's agents, or the court. The Eligible Individual, and those acting on his or her behalf, shall do nothing to prejudice the Plan's rights as described above without the Plan's written

consent. The Eligible Individual agrees to waive any defense based upon an inability of the Plan to trace the amounts recovered and agrees that the lien may be satisfied by any assets of the Eligible Individual.

7. If an Eligible Individual settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then the Eligible Individual shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim, unless the Plan or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.

8. In addition to all other remedies the Plan may have, the Plan shall be subrogated to the rights of the Eligible Individual against the responsible third party or its insurer.

9. By accepting benefits under the Plan, a Participant and any Eligible Individual on whose behalf benefits are paid, agrees as a contractual matter enforceable under state or federal law, that upon receipt of recovery from the responsible third party, the person receiving the payment shall reimburse the Plan the amount of benefits it has paid to the Eligible Individual caused by the responsible third party.

CHAPTER 15: CLAIMS AND APPEALS

This chapter includes:
- ✓ Procedures on Filing Claims and Appeals

CLAIMS AND APPEALS PROCEDURES

Discussed below are the various types of claims associated with Plan benefits, procedures for filing claims, and the steps involved in appealing a decision with which you disagree. The processing times mentioned in the discussion are summarized in the charts at the end of the discussion.

NOTE: If you have a medical claim that is denied by Anthem Blue Cross, a substance use disorder service claim denied by Operating Engineers Assistance Recovery Program (ARP), a prescription drug claim denied by Optum Rx, or a dental claim that is denied by EMI Health, you must first exhaust the appeals processes of Anthem Blue Cross, ARP, Optum Rx or EMI Health before filing an appeal with the Board of Trustees.

Likewise, if you have a weekly disability claim that is denied by USAble, you must first exhaust the appeals process of USAble before filing an appeal with the Board of Trustees.

Any appeal for a vision claim should be submitted to BlueView Vision before filing an appeal with the Board of Trustees.

In this Chapter, all references to "you" include all of your Covered Dependents.

Definitions specific to this Chapter

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

- a payment of less than 100% of a Claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible);
- a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;
- a failure to cover an item or service because the Plan considers it to be experimental, investigational, not Medically Necessary or not medically appropriate;
- a decision that denies a benefit based on a determination that a Claimant is not eligible to participate in the Plan;
- a rescission of coverage, whether or not there is an adverse effect on any particular benefit.

If you bring a prescription to the pharmacy and the pharmacy refuses to fill the prescription (unless you pay the entire cost), this is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Plan).

Claim. The term "Claim" means a request for a benefit made by you in accordance with the Plan's reasonable procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if you file a Claim for specific benefits and the Claim is denied because you are not eligible under the terms of the Plan, that coverage determination is considered a Claim.

Filling a prescription order at a pharmacy does not constitute a Claim (to the extent benefits are determined based on cost and coverage rules predetermined by the Plan). If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless you pay the entire cost, you should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

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

Claims are Categorized as Follows:

- **Pre-Service Claim.** The term "Pre-Service Claim" means a Claim for a benefit for which the Plan requires Pre-notification before medical care (or substance abuse) is obtained in order to receive the maximum benefits allowed under the Plan.
- **Urgent Care Claim.** The term "Urgent Care Claim" means a Claim for medical care (or substance abuse) or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.
- **Concurrent Claim.** The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of the previously approved benefit.
- **Post-Service Claim.** The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent Care or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered. A claim regarding rescission of coverage will be treated as a post-service claim.
- **Disability Claim**. The term "Disability Claim" means a claim for which the plan must make a determination of disability in order for the participant to receive the benefit. For example, the Operating Engineers Health & Welfare Trust Fund for Utah provides an extension of medical coverage based on disability and eligibility for a dependent over age 26 based on disability, which involves the Plan's review of a claimant's or dependent's disability.

Relevant Documents. "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

Rescission: "Rescission" means a cancellation or discontinuance of coverage that has a retroactive effect (including a retroactive cancelation or discontinuance of disability benefits), except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

Claim Procedures

Timely Filing of Claims. Benefits will be paid by the Plan only if notice of claim is made within 1 year after the date the Covered Service to which the claim relates was provided to you.

Pre-Service Claims. Under the terms of this Plan, you are required to provide Pre-notification to the Operating Engineers Health and Welfare Trust Fund for Utah Assistance Recovery Program (ARP) for substance use disorder services. In addition, you are required to notify Anthem Blue Cross before you receive home health care, home infusion therapy, transplants and other inpatient admissions.

- The Operating Engineers Health and Welfare Trust Fund for Utah Assistance Recovery Program (ARP), Optum Rx, or Anthem Blue Cross will notify the Participant of an improperly filed Pre-Service Claim as soon as possible, but no later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. The Participant will only receive notice of an improperly filed Pre-Service Claim if the claim is submitted to the appropriate office and includes: (i) Claimant's name, (ii) Claimant's specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.
- For properly filed Pre-Service Claims, you (and your Physician) will be notified of a decision within 15 days after receipt of the claim unless additional time is needed. The time for response may be extended for up to an additional 15 days if necessary due to matters beyond the control of Anthem Blue Cross, Optum Rx or ARP. If an extension is necessary, you will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.
- If an extension is required because additional information is needed from you, Anthem Blue Cross, Optum Rx or ARP will issue a request for additional information that specifies the information needed. You will have 45 days from the date of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the request for additional information until the earlier of: (i) 45 days; or (ii) the date the Participant responds to the request. ARP, Optum Rx or Anthem Blue Cross then has 15 days to make a determination on the claim.

Urgent Care Claims. ARP, Optum Rx or Anthem Blue Cross will determine whether a Claim is an Urgent Care Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Care Claim, and notifies ARP, Optum Rx or Anthem Blue Cross of such, it will be treated as an Urgent Care Claim.

- Urgent Care Claims must be submitted to Anthem Blue Cross, Optum Rx or ARP by telephone. You should indicate that the claim should be handled as an Urgent Care Claim. Urgent Care Claims may not be submitted via the US Postal service.
- For properly filed Urgent Care Claims, Anthem Blue Cross, Optum Rx or ARP will respond to you and your Physician with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.
- If an Urgent Care Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, Anthem Blue Cross, Optum Rx or ARP

will notify you as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. you must provide the specified information within 2 business days after receiving the request for additional information. If the information is not provided within that time, the Claim will be denied.

- During the period in which you are allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 2 business days or the date you respond to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information.
- If you improperly file an Urgent Care Claim, Anthem Blue Cross, Optum Rx or ARP will notify you as soon as possible but not later than 24 hours after receipt of the Claim of the proper procedures required to file an Urgent Care Claim. Improperly filed claims include, but are not limited to: (i) claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or (ii) claims that do not name a specific patient, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. The notification may be oral unless you or your authorized representative requests written notification. Unless refiled properly, it will not constitute a Claim.

Concurrent Claims. Any request by you to extend an approved Urgent Care Claim will be acted upon within 72 hours of receipt of the Claim, provided the Claim is received at least 72 hours prior to the expiration of the approved Urgent Care Claim. A request to continue a plan of treatment that is in progress that does not involve an Urgent Care Claim will be decided according to Pre-Service or Post-Service timeframes, whichever applies.

In the event that Anthem Blue Cross, Optum Rx or ARP has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, and a determination is made to terminate or reduce such treatment (other than by Plan amendment or termination), the Participant will be notified as soon as possible, but in any event early enough for the Participant to have the appeal decided before the benefit is reduced or terminated.

Post-Service Claims. Post-Service Claims must be submitted within 1 year after the date on which covered services were received. Benefits will not be allowed if the claim is submitted more than 1 year after the date on which covered services were received. If your identification card is presented to a Participating Provider, the Participating Provider will furnish Anthem Blue Cross, Optum Rx, ARP or EMI with the necessary forms and information necessary to process the Claim. For services from a Nonparticipating Provider, you must furnish or caused to be furnished to Anthem Blue Cross, Optum Rx, ARP or EMI all information necessary to process the Claim. The Provider may file the claim on your behalf.

A Post-Service Claim is considered to have been filed upon receipt of the claim by Anthem Blue Cross, Optum Rx, ARP or EMI.

Timing of Decisions on Post Service Claims

Ordinarily, you will be notified of decisions on Post-Service Claims within 30 days after the receipt of the Claim. Anthem Blue Cross, Optum Rx, ARP or EMI may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of Anthem Blue Cross, Optum Rx ARP or EMI. If an extension is necessary, you will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which Anthem Blue Cross, ARP or EMI expects to render a decision.

- If an extension is required because Anthem Blue Cross, Optum Rx, ARP or EMI need additional information from you, the Claims Administrator or ARP will request additional information from the Provider and/or you via fax, telephone, Explanation of Benefits (EOB) or letter. The request shall specify the information needed. You will then have 45 days from receipt of the request to supply the additional information. If the information is not provided within that time, the Claim will be denied. The deadline for making a decision on the Claim will be suspended from the date of the request for additional information until the earlier of: (i) 45 days after the request is sent; or (ii) the date you respond to the request. Anthem Blue Cross, Optum Rx, ARP or EMI then has 15 days to make a decision and notify you of its determination.
- If Anthem Blue Cross, Optum Rx, ARP or EMI determines that additional information is required from you, and you fail to provide any requested information within 45 days, a notice of adverse benefit determination will be issued.

Disability Claim: A Disability Claim must be submitted to the Trust Fund Office within 90 days after the date of the onset of the disability. 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.

Timing of Decisions on Disability Claims

The Fund or Insurer will make a decision on the Disability Claim and notify the Eligible Individual of the decision within 45 days after receipt of the Claim by the Trust Fund Office. If the Fund requires an extension of time due to matters beyond the control of the Plan, the Trust Fund Office will notify Eligible Individual of the reason for the delay and the date by which the Fund expects to render a decision. This notification 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 Fund notifies the Eligible Individual of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund notifies the Eligible Individual, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from the Eligible Individual, 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 the Eligible Individual is 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 the Eligible Individual responds to the request. Once the Eligible Individual responds to the Plan's request for the information, the Eligible Individual will be notified of the Plan's decision on the Claim within 30 days.

For Disability Claims, the Fund reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

Authorized Representatives

Your authorized representative, such as a spouse or an adult child, may submit a Claim or appeal on your behalf if you have previously designated the individual to act on your behalf through a

form available at the Fund Office. Additional information may be requested to verify that the designated person is authorized to act on your behalf. Even if you have designated an authorized representative, you must personally sign an authorization claim form and file it with the Fund Office at least annually.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim without you having to designate an authorized representative.

Notice of Initial Benefit Determination (for a Non-Disability Claim)

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

- the specific reason(s) for the determination;
- reference to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
- a description of the appeal procedures and applicable time limits;
- a statement of your right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;
- if an internal rule, guideline or protocol was relied upon in deciding the Claim, either a copy of the rule or a statement that a copy is available upon request at no charge;
- if the determination was based on the absence of Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
- for Urgent Care Claims, a description of the expedited review process applicable to Urgent Care Claims (for Urgent Care Claims, the notice may be provided orally and followed with written notification).

Notice of initial benefit determination for disability claims

The Eligible Individual will be provided with written notice of the initial benefit determination. If the determination is an adverse benefit determination, the notice will include all of the above in addition to the following:

(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 the claimant is entitled to receive relevant documents upon request; and

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

APPEAL PROCEDURES

Appealing an Adverse Benefit Determination

If any Claim is denied in whole or in part, or if you disagree with the decision made on a Claim, you may appeal the decision in the manner specified below. Appeals must be submitted to the Trust Fund Office or ARP within 180 days after you receive the notice of Adverse Benefit Determination. Failure to appeal within this time period will preclude all further rights to appeal. The appeal must be accompanied by any pertinent material not already furnished to the Plan, and must state why you believe the Claim should not have been denied. In the case of a Concurrent Claim, the appeal must be submitted within a reasonable time give the medical circumstances.

- **Pre-Service Claims.** Appeals of Adverse Benefit Determinations regarding Pre-Service Claims must be in writing via mail or by telephone. A Pre-Service Claim appeal that is received with additional information which, upon review, allows additional benefits to be approved by Anthem Blue Cross or ARP in accordance with Plan provisions will not be considered an appeal, but a new Pre-Service Claim.
- **Urgent Care Claims.** Appeals of Adverse Benefit Determinations regarding Urgent Care Claims must be made by following the First Level Appeals Process with Anthem Blue Cross for medical, Optum Rx for prescription drug and EMI for dental claims as outlined in the Summary Plan Description furnished to Participants.
- **Concurrent Claims.** Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Care Claims.
- **Post-Service, Life, Burial, AD&D and Disability Claims.** The appeal must be submitted in writing to the Claims Administrator within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:
  1. the patient's name and address;
  2. the Participant's name and address, if different;
  3. a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
  4. the date of the Adverse Benefit Determination from the Claims Administrator or ARP; and
  5. the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

The First Level Appeal Process for Appeals of Medical, Prescription Drug, Vision and Dental Claim Denials

For medical appeals, you must first exhaust the First Level Appeal process of Anthem Blue Cross. This First Level Appeal process consists of Complaint / Grievance / Reconsideration or First Level – Expedited Appeal (for Urgent Care Claims).

For **prescription drug appeals,** you must first exhaust the First Level Appeal process of Optum Rx.

For **substance abuse appeals,** you must first exhaust the First Level Appeal process of ARP.

For dental claims appeals, you must first submit the appeal to EMI before submitting the appeal to the Board of Trustees.

For **vision claim appeals**, you must first file an appeal for a vision claim to BlueView Vision before filing an appeal with the Board of Trustees.

For eligibility claims related to disability (a claim for which the plan must make a determination of disability in order for the participant to receive the benefit), you should appeal directly to the Board of Trustees.

If you disagree with the decision made in the First Level Appeal Process, you may then appeal to the Board of Trustees. The appeal to the Board of Trustees must be made in writing within 180 days after you receive notice of denial. Failure to appeal to the Board of Trustees within this time period will preclude your right to further appeal of the decision made in the First Level Appeal Process.

The Appeals Process to Board of Trustees

You will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. You will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents pertaining to your Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

For claims based on a finding of disability only, the claimant 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 final notice of appeal determination is required to be provided by the Plan) to give claimant a reasonable opportunity to respond prior to that date. The Plan will extend the deadline for the final notice of appeal determination as may be necessary in order to provide a claimant a reasonable opportunity to respond to new or additional evidence and/or additional rationale pursuant to the time frames for sending notices of appeal determinations set forth below.

Timeframes for Sending Notices of Appeal Determinations.

Pre-Service Claim Appeals. Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal by Anthem Blue Cross, Optum Rx or ARP.

Urgent Care Claim Appeals. Notice of the appeal determination for Urgent Care Claims will be sent within 72 hours of receipt of the appeal by Anthem Blue Cross, Optum Rx or ARP.

Concurrent Claim Appeals. Notice of the appeal determination for a Concurrent Claim will be sent by Anthem Blue Cross, Optum Rx or ARP prior to the termination of the benefit.

Post-Service, Life, AD&D and Burial Expense and Disability Second Level of Appeal. Ordinarily, decisions on appeals involving Post Service, Life, AD&D, Burial Expense or Disability

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

Content of Appeal Determination Notices

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

- the specific reason(s) for the determination;
- reference to the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
- if an internal rule, guideline or protocol was relied upon, either a copy of the rule or a statement that a copy is available upon request at no charge; and
- 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, applying the terms of the Plan to your claim, is available upon request at no charge.

The determination of a Disability appeal will include all of the above in addition to the following:

- A discussion of the decision, including the basis for disagreeing with or not following:
  - a) The view of a treating physician or vocational professional who evaluated the claimant;
  - b) The views of medical or vocational experts obtained by the plan, and
  - c) Any disability determination by the Social Security Administration.
- 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;
- 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;
- 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.
- A statement that if a Participant is not proficient in English, and has questions about a claim denial, they should contact the Fund Office to find out if assistance is available. If a Participant's address is in a county where ten percent or more of the population residing in the county is literate only in the same non-English language then the Plan shall (i) provide oral language services (such as a telephone customer assistance hotline) in any applicable

non-English language and provide assistance with filing claims and appeals in any applicable non-English language; (ii) provide, upon request, a notice in any applicable non-English language; and (iii) include in the English version, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

EXTERNAL REVIEW OF EMERGENCY SERVICES, AIR AMBULANCE SERVICES, AND SERVICES PROVIDED BY NON-PARTICIPATING PROVIDERS AT PARTICIPATING FACILITIES

This voluntary External Review process is intended to comply with the No Surprises Act external review requirements. 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 the 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 a 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 an appeal.

External Review of Standard (Non-Urgent) Claims

You may request External Review of a standard (not urgent) claim in writing, within four (4) months of the date that a notice of a Claim Appeal Benefit Determination is received. For convenience, these determinations are referred to below as an "Adverse Determination."

Preliminary Review of Standard Claims. Within five (5) business days of the Plan's receipt of your request for External Review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- ✓ You 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 requirements for External Review;
- ✓ You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations you are 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 the request for External Review meets the above requirements. This notification will inform you:

- ✓ If the request is complete and eligible for External Review; or

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

- ✓ If the request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow 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 External Review, the Plan will assign the request to an IRO. 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 to submit additional information regarding the claim (generally, you are allowed to submit such information within ten (10) business days).

- ✓ Within five (5) business days after the External Review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

- ✓ If you submit additional information related to the claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the External Review. Reconsideration by the Plan will not delay the External Review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to 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 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 include:

  1) 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);

  2) The date that the IRO received the request to conduct the External Review and the date of the IRO decision;

  3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

  4) 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;

  5) 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);

  6) A statement that judicial review may be available to you; and

  7) 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 life or health, or would jeopardize the 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 the 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 the claimant 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 the claimant (e.g. telephonically, via fax) as to whether the 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 the claimant is dissatisfied with the External Review determination, they may seek judicial review as permitted under ERISA Section 502(a).

WHEN A LAWSUIT MAY BE STARTED

No Participant, Dependent, beneficiary or other person shall have any right or claim to benefits under this Plan or any right or claim to payments from the Fund, other than as specified herein. No action may be filed (or started) more than three (3) years after the end of the year in which services were provided, or, if the claim is for short term disability benefits, more than three (3) years after the start of the disability. This three (3) year limitation period applies to all legal and equitable actions arising out of or relating to a claim for benefits, including, but not limited to any legal or equitable action under ERISA.

You may not start a lawsuit to obtain benefits until after either:

1. You have submitted a Claim pursuant to the Plan, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or
2. The appropriate timeframe described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

For disability appeals, administrative procedures will not be deemed to be exhausted if:

1. The plan's violation of the disability claims procedures was de minimis and did not cause, and is not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information with the claimant;
2. This exception is not available if the violation is part of a pattern or practice of violations;
3. The plan must provide a written explanation of the violation with 10 days or receipt of a request.

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

Maximum Times for Processing of Health Care Claims and Appeals (Times are suspended during waits for additional information requested of you)				
	Pre-Service Claims	**Urgent Claims**	**Concurrent Claims**	**Post-Service Claims**
Anthem Blue Cross, ARP, EMI Health or Trust Fund Office makes initial determination (provided all necessary information is submitted)	Within 15 days of claim's receipt (can be extended for another 15 days)	Within 72 hours of claim's receipt	In time for you to appeal before benefit is reduced or terminated Within 24 hours of request for extension of urgent claim care	Within 30 days of claim's receipt (can be extended for another 15 days)

Maximum Times for Processing of Health Care Claims and Appeals (Times are suspended during waits for additional information requested of you)				
	Pre-Service Claims	**Urgent Claims**	**Concurrent Claims**	**Post-Service Claims**
Anthem Blue Cross, ARP, EMI Health or Trust Fund Office notifies you claim has been improperly filed	Within 5 days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Not applicable
Anthem Blue Cross, ARP, EMI Health or Trust Fund Office requests additional information	Within 15 days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Within 30 days of claim's receipt
You respond to request for information	Within 45 days of request	Within 48 hours of request	Not applicable	Within 45 days of request
Anthem Blue Cross, ARP, EMI Health or Trust Fund Office makes determination after requesting information	Within 15 days of your response or expiration of time allowed	Within 48 hours of your response or expiration of time allowed	Not applicable	Within 15 days of your response or expiration of time allowed
You make request for appeal	Within 180 days of receiving notice of denial	Within 180 days of receiving notice of denial	Within a reasonable time for your situation	Within 180 days of receiving notice of denial
Anthem Blue Cross, EMI Health, Trust Fund Office, or the Board makes decision on appeal	Within 30 days of your requesting appeal	Within 72 hours of your requesting appeal	Within a reasonable time for type of care decision	At next regular Board meeting or, if appeal is received less than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)

Eligibility Disputes

If your claim is denied because you are not shown as eligible in the records of the Trust Fund Office, your eligibility status will be resolved by the Trust Fund Office working with Anthem Blue Cross, the ARP, EMI Health or any other service provider, as necessary, to resolve your claim in accordance with the timelines described under "Notice of Decision on Appeal" below.

CHAPTER 16: OTHER IMPORTANT PLAN INFORMATION

This chapter includes:
- ✓ Use and Disclosure of PHI
- ✓ Factors that Could Affect your Receipt of Benefits
- ✓ Patient Protections

USE AND DISCLOSURE OF HIPAA PROTECTED HEALTH INFORMATION

The Plan will use Protected Health Information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

1. **Payment.** "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
   a. Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and Copayments as determined for an individual's claim),
   b. Coordination of benefits,
   c. Adjudication of health benefit claims (including appeals and other payment disputes),
   d. Subrogation of health benefit claims,
   e. Establishing Employee contributions,
   f. Risk adjusting amounts due based on enrollee health status and demographic characteristics,
   g. Billing, collection activities and related health care data processing,
   h. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments,
   i. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).
   j. Medical Necessity reviews, or reviews of appropriateness of care or justification of charges,
   k. Utilization review, including Pre-notification, Preauthorization, concurrent review and retrospective review,
   l. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the Provider and/or health Plan), and
   m. Reimbursement to the Plan.
2. **Health Care Operations.** "Health Care Operations" include, but are not limited to, the following activities:
   a. Quality Assessment,
   b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management,

contacting of health care Providers and patients with information about treatment alternatives and related functions,

c. Rating Provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
d. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
e. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
f. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,
g. Business management and general administrative activities of the entity, including, but not limited to:
h. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
i. Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,
j. Resolution of internal grievances, and
k. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.
l. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to the pension plan for purposes related to administration of that plan.

The Board of Trustees of the Operating Engineers Health and Welfare Trust Fund for Utah is the "Plan Sponsor." The Board of Trustees, through adoption of this Summary Pan Description/Plan Document, hereby agrees to the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information,
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual,
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
8. Make available the information required to provide an accounting of disclosures,
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA, and
10. If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

1. The Plan Administrator, and
2. The following staff designated by the Plan Administrator:
3. Claims adjustors
4. Clerical staff
5. Team leaders and managers
6. Data processing staff
7. Billing and eligibility staff
8. Other staff as designated by the Plan Administrator as needed

The persons described in section may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described in the above section do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

The Board of Trustees of the Operating Engineers Health and Welfare Trust Fund for Utah, who are the Plan Sponsor:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;
2. Ensure that the adequate separation 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.

FACTORS THAT COULD AFFECT YOUR RECEIPT OF BENEFITS

Certain factors could interfere with payment of benefits from the Plan (result in your disqualification or ineligibility, denial of your claim, or loss, forfeiture, or suspension of benefits you might reasonably expect). Examples of such factors include the following:

- **Failure to follow the Plan's provisions for pre-notification.** For the Plan's comprehensive medical and prescription drug benefits, it is recommended that you follow the procedures described beginning on page 38 for certain services/drugs to ensure coverage; however, there is no benefit penalty for not following those procedures.
- **Failure to submit claims in a timely way.** You must submit your health care claims **within 1 year** from the date covered expenses were incurred. Benefits will not be allowed if you submit your claim more than 1 year after the date on which covered expenses were incurred. AD&D claims should be submitted within 90 days after the date of loss which is covered by the policy or as soon as reasonably possible, but no later than 1 year from the date of loss.
- **The Plan's coordination of benefits provisions.** If you or a Dependent has health care benefits under another group plan, payment of benefits by the Fund will be coordinated with payment of benefits by that other plan. See "Coordination of Benefits" earlier in this chapter for more information.
- **The Plan's other party liability provision.** You must reimburse the Plan for any benefits you receive for an Illness or Injury caused by a third party if you are compensated for that Illness or Injury by the third party or an insurer. See "Other Party Liability" earlier in this chapter for more information.
- **Performance of Non-Qualifying Employment.** If you are an Hourly Employee, you will not be eligible for Plan benefits during any period you perform work of the type covered by your collective bargaining agreement but performed for a non-contributing employer. Your Hour Bank will be frozen until you once again become employed with a Contributing Employer, retire, or become unemployed, and any hours remaining in your Hour Bank will be cancelled if you do not do so within 12 months after the Hour Bank is frozen.
- **Previous overpayment of benefits.** If benefits were overpaid or paid in duplicate, or if benefits were paid for a person not entitled to the benefits, the Plan may offset the overpaid amounts against future benefit payments. The Plan may also bring legal action against you or any other recipient of the inappropriate payments to collect any duplicate or overpaid benefits.
- **Failure to update your address or enrollment information.** If you move, it is your responsibility to keep the Trust Fund Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits. In addition, you must contact the Trust Fund Office regarding any changes in your family status. You will be held liable for benefit payments based on incorrect information about family members (for example, if you fail to notify the Trust Fund Office that you have divorced or an adoption has been rescinded). In addition, you may be liable for other costs incurred by the Fund as a result of the incorrect information. These costs include (but are not limited to) attorneys' fees, administrative costs, and reasonable interest.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Utah Fringe Benefits Office at (385) 326-2001 or the claims administrator at (800) 251-5014.

PATIENT PROTECTIONS

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

You do not need prior authorization from the Fund, Anthem Blue Cross, 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 Anthem Blue Cross at (800) 274-7767.

CHAPTER 17: YOUR RIGHTS UNDER ERISA

This chapter includes
- ✓ General Plan Information
- ✓ Plan Facts
- ✓ Statement of ERISA Rights

GENERAL PLAN INFORMATION

Non-Assignment

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

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

Right to Freedom from Liability for Payment

There is no liability on the Board or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for such purpose. Any benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for payment.

No Liability for Provider-Related Loss or Injury

The Fund has no control over any diagnosis, treatment, care, or other services delivered by a health care provider, whether the provider is a contract provider or a non-contract provider, and disclaims liability for any loss or injury caused by any provider by reason of negligence, failure to provide treatment, or otherwise.

No Replacement for Workers' Compensation

The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage under Workers' Compensation insurance laws or similar legislation.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan have been delegated and have discretionary authority to interpret the terms of the Plan including, but not limited to the discretionary authority to resolve ambiguities or inconsistencies in the Plan and to

determine the extent to which a person is eligible and entitled to any Plan benefits. The Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Facility of Payment

In the event that it is determined that the Participant or a beneficiary is incompetent or incapable of handling his own affairs and no guardian has been appointed, or in the event the Participant has not provided the Fund with an address at which he can be located for payment, the Fund may, during the lifetime of the Participant or beneficiary, pay any amount otherwise payable to the Participant or beneficiary, to the husband or wife or relative by blood of the Participant or beneficiary, 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 Participant or beneficiary before all amounts have been paid, the Fund may pay any amount to one or more of the following surviving relatives of the Participant or beneficiary: lawful spouse, child or children, mother, father, brothers, or sisters, or to the Participant's or beneficiary's estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Fund.

Transfer of Rights or Obligations

Except to the extent otherwise specifically provided below or elsewhere in the Plan, each Participant, Dependent or other beneficiary is restrained from selling, transferring, anticipating or otherwise disposing of any benefit payable by the Plan, or any other right or interest under the Plan, and the Fund will not be required to recognize any sale, transfer, anticipation, assignment, alienation, hypothecation or other disposition. Any benefit, right or interest is not subject in any manner to voluntary transfer or transfer by operation of law or otherwise, and is exempt from the claims of creditors or other claimants and from all orders, decrees, garnishments, executions or other legal process or proceedings not expressly authorized by federal law.

Overpayment Recovery

In the event that through mistake or any other circumstance, a Participant, Dependent or other beneficiary has been paid or credited with more than he is entitled to under the Plan or under the law, or has become obligated to the Fund under an indemnity agreement or an Other Party Liability agreement or in any other way, the Fund may offset, recoup and recover the amount of the overpayment, excess credit or obligation from benefits accrued or thereafter accruing to the Participant, Dependent or beneficiary, and not yet distributed, through the Fund's collection procedures, in any installments and to the extent determined by the Board. The foregoing shall not limit any other remedies available to the Fund to recoup overpayments whether at law or in equity.

PLAN FACTS

Name of Plan	Operating Engineers Health and Welfare Trust Fund for Utah
Type of Plan	Employee welfare benefit plan maintained for the purpose of providing comprehensive medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment, weekly disability and burial expense benefits to Employees and their eligible Dependents.
Plan Number	501

Funding Medium	Benefits are provided from the Trust Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and are held for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. Health care benefits (including medical, prescription drug and dental) are paid directly from the Fund and are not insured by any contract of insurance. Life insurance, accidental death and dismemberment, weekly disability, substance use disorders and burial expense benefits are provided through carriers and are fully insured or otherwise guaranteed. For more information, see "Organizations Through Which Benefits Are Provided" below.
Source of Contributions	Contributions to the Plan are made by employers in accordance with their collective bargaining agreements with Operating Engineers Local Union No. 3 and by certain other employers pursuant to the provisions of the Trust Agreement. The collective bargaining agreements require contributions to the Plan at fixed rates. Contributions for continuing coverage after eligibility ends are made by Participants in an amount determined by the Board of Trustees.
Plan Administrator	The Board of Trustees Operating Engineers Health and Welfare Trust Fund for Utah 1141 Harbor Bay Parkway, Suite 100 Alameda, CA 94502 P.O. Box 23190 Oakland, CA 94623-0190 Telephone: (800) 251-5014 Names and addresses of the Trustees (as of the date this booklet was issued) are shown later in this section.
Plan Sponsors	On written request, the Fund Office will provide information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.
Plan Year	The date of the end of the Plan year is December 31.
Employer Identification Number (EIN)	94-2784001
Agent for Service of Legal Process	Greg Trento Operating Engineers Health and Welfare Trust Fund for Utah 1141 Harbor Bay Parkway, Suite 100 Alameda, CA 94502 Telephone: (800) 251-5014 Service of legal process may also be made upon a Fund Trustee or the Board of Trustees.

Administration of the Plan

The Plan is administered and maintained by a joint labor-management Board of Trustees, with the assistance of a contract Fund administrator. The Fund administrator and the address of the administrative office are as follows:

Zenith American Solutions
Operating Engineers Health and Welfare Trust Fund for Utah
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502

Telephone: (800) 251-5014

The Board of Trustees and the Utah Committee Trustees are responsible for the operation of the Fund and has full power to interpret the Plan (including all Plan documents and agreements) and to decide all questions and facts concerning the Plan.

The Fund administrator's office is staffed with persons competent in the fields of accounting, data processing, and claims processing. The Fund administrator bills all participating employers monthly, receives the employer contributions, maintains complete financial records, produces a monthly financial statement, maintains work records and eligibility records, and receives claims for substance use disorders and the physical exam.

Trustees

The names and addresses of the Utah Committee and the Trustees (as of the date of this booklet) are listed below:

Employee Trustees

Justin Diston
Co-Chairman
Operating Engineers Local 3
3000 Clayton Road
Concord, CA 94519

Brandon Dew
Union Trustee
Operating Engineers Local 3
8805 South Sandy Parkway
Sandy, UT 84070

Jason Madsen
Union Trustee
Operating Engineers Local 3
8805 South Sandy Parkway
Sandy, UT 84070

Employer Trustees

Marie Neff
Accountant
Mountain Crane
393 South 2650 West
Salt Lake City, UT 84104

Andy Anderson
Regional Safety/HR Manager
Ames Construction, Inc.
3737 West 2100 South
West Valley, UT 84120

Clint Fischer
HR Director
Campbell Companies
4901 West 2100 So.
Salt Lake City, UT 84120

Employee Trustees

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

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

Employer Trustees

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

Organizations Through Which Benefits Are Provided

The complete terms of the benefits provided directly by the Fund are set forth in this Plan Document/Summary Plan Description. The complete terms of the benefits provided through insurance companies are set forth in the contracts with those organizations.

Organizations through which benefits are provided are as follows:

Zenith American Solutions (Zenith)
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502
(The Claims Administrator for the comprehensive medical and vision benefits under the Plan (does not insure these benefits).

Anthem Blue Cross
Provides the Participating Provider network and Utilization Management program for comprehensive medical benefits)

Optum Rx
Provides the Participating Provider network and certain review programs for prescription drug benefits.

Operating Engineers Health and Welfare Trust Fund for Utah Assistance Recovery Program
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502
(Administers the substance use disorder treatment benefits; does not insure these benefits)

EMI Health
5101 S Commerce Dr.
Murray UT 8410765
(The Claims Administrator for dental benefits under the Plan (and provides the Participating Provider dental network), does not insure the dental benefits)

USAble Life Insurance Company
P.O. Box 1650
Little Rock, AR 72203-1650

(Fully insures the life insurance, accidental death and dismemberment benefits and weekly disability benefits)

Union Labor Life Insurance Company
Attention: Group Life Claims Unit
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
(Fully insures the burial expense benefit)

Trust Fund Consultants

In accordance with prudent management standards, the following professional consultants are retained by the Fund to assist the Board of Trustees and the Fund administrator in the operation of the Fund:

- A benefit plans consultant, who assists the Board of Trustees in technical matters relating to the operations of the Fund, such as the design of benefit programs and eligibility provisions, analysis of emerging loss experience and projections of anticipated benefit costs, preparation of specifications for competitive bids when necessary, etc.
- A Certified Public Accountant, who is responsible for auditing the records of the Trust Fund.
- Legal Counsel, who assists and counsels the Board of Trustees on all legal matters, including interpretations of the many laws and regulations under which the Trust Fund operates.

Authority

Although the Trustees, Union representatives, and other persons familiar with the Plan may be able to answer certain questions for you, the Plan cannot be bound to any inaccurate information they may give. At the direction of the Board of Trustees, the Trust Fund Office is authorized to give you answers to your questions, but only if you have furnished in writing full and accurate information concerning your situation. If you wish to be certain of your right to any particular benefit, contact the Trust Fund Office and obtain written confirmation of the right with which you are concerned.

Only the Board of Trustees is authorized to interpret and make factual determinations regarding the Plan and the benefits described in this booklet. No employer or local union or any representative of an employer or union is authorized to interpret this Plan on behalf of the Board.

Any dispute as to eligibility, type, amount, or duration of benefits or any right or claim to payments from the Fund shall be resolved by the Board or its duly authorized designee in accordance with the Plan Document/Summary Plan Description and the Trust Agreement. Any decisions will be binding on all parties, subject only to such judicial review as may be in harmony with Federal labor law.

See "Claims and Appeals Procedures" in Chapter 16 for information on what to do if you disagree with the decision made regarding a claim you have filed.

Plan Documents

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Trust Fund Office during regular business hours. Upon written request, copies of these documents will be provided.

The Trustees may make a reasonable charge for the copies. The Fund administrator will state the charge for specific documents on request, so you may know the cost before ordering.

Collective Bargaining Agreements

This program is maintained pursuant to collective bargaining agreements between Local Union No. 3 Operating Engineers and the employers who are parties to these bargaining agreements. A copy of the bargaining agreements may be obtained by making written request to the Trust Fund Office, and the agreements are available for inspection at the Trust Fund Office. A copy of any of the collective bargaining agreements will also be available for inspection within 10 calendar days after written request at any of the local union offices or at the office of any contributing employer to which at least 50 Plan Participants report each day.

Plan Amendment or Termination

In furtherance of its commitment to provide benefits to Employees, the Board reserves the right, solely at its discretion, to amend, modify or terminate the Plan at any time.

This right includes, but is not limited to,

- the right to terminate or change covered expenses, benefit payments and Coinsurance or Copayment amounts, Deductibles, and annual maximum,
- the right to alter or postpone the method of payment of any benefit, and
- the right to change the Plan to implement various cost control measures.

Such termination or amendment may affect the amount of any benefit payable for charges incurred before the effective date of such changes or termination.

In the event the Trust Fund is terminated, all assets remaining in the Trust Fund, after payment of expenses, will be used to continue the benefits provided by the then-existing benefit plans, until such assets have been exhausted.

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan of the Operating Engineers Health and Welfare Trust Fund for Utah, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights:

Receive Information About your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse, or your Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration

U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at (800) 998-7542 or contacting the EBSA field office nearest you. You may also find answers to your plan questions and a list of EBSA field offices at the website of EBSA at www.dol.gov/ebsa.

CHAPTER 18: GLOSSARY

This chapter includes:

- ✓ Definitions of words used in this SPD/Plan Document

Accidental Injury means an Injury that is the direct result of an accident, independent of Illness or any other cause. Accidental Injury does not mean bodily injury caused by routine nor normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Air Ambulance Service means medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605.

Allowed Medical Expense/Allowed Charge/Allowed Amount/Allowable Charge means:

1. For Emergency Services provided by Non-Participating Providers, for Non-Emergency Services provided by a Non-Participating Provider at a participating facility, and for Air Ambulance Services, the Out-of-Network Rate, as defined below.

2. For all other services, the lesser of:

   a. The dollar amount this Plan has determined it will allow for covered Medically Necessary services or supplies provided by Non-Participating Providers as determined by the Plan's Preferred Provider Organization (PPO) based on appropriate and reasonable charges for the services in the geographical area where the services are provided. With respect to Non-Participating Hospitals or facilities within the PPO service area for items and services other than Emergency Services, the allowed charge will be the negotiated contract rate of the PPO Hospital or facility that is geographically nearest to the Hospital or Facility where treatment was received. The Plan's Allowed Charge is not based on or intended to be reflective of fees that have traditionally been described as usual and customary (U&C); usual, customary, and reasonable (UCR); or any other traditional term. Non-Participating Providers' bills often exceed the Plan's Allowed Charge, and in such cases the Plan's benefits will be based on the Allowed Charge, not the Non-Participating Provider's billed rate. When the patient has not had a reasonable opportunity to select a Participating Provider, the Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the Allowed Charge for the submitted claim.

   b. The Non-Participating Provider's actual billed charge.

3. When using Non-Participating Providers, except for No Surprises Act Services, the Participant or Dependent is responsible for any difference between the actual billed charge and the Plan's Allowed Charge (a practice called "Balance Billing"), in addition to any Copayment and percentage coinsurance required by the Plan.

Ambulatory Surgical Facility means a health facility licensed by the State of Utah or the state in which it is located, which is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

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 subject to exceptions specified by the Secretary;
- Items and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and
- Items and services provided by a Non-Participating Provider if there is no Participating Provider who can furnish such item or service at such facility.

Assistance Recovery Program (ARP) means that program adopted by the Fund which coordinates and authorizes services for the treatment of substance use disorders for Participants and Dependent Spouses.

Balance Billing. A bill from a health care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the Provider actually charged (the billed charges). Amounts associated with Balance Billing are not covered by this Plan, even if the Plan's Coinsurance Maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's Coinsurance Maximum and may result in Balance Billing to you. **Non-Participating Providers commonly engage in Balance Billing.** This means a Plan participant may be billed for any balance that may be due in addition to the amount payable by the Plan. **Generally, you can avoid Balance Billing by using Participating Providers**.

Pursuant to the No Surprises Act, you may not be Balance Billed for Emergency Services, Air Ambulance Services, and, unless appropriate notice and consent criteria are met, Non-Emergency Services performed by Non-Participating Providers at a participating facility. For these No Surprises Services, Cost-sharing payments shall count toward any in-network Deductible and in-network Out-of-Pocket Maximum.

Board means the Board of Trustees of the Operating Engineers Health and Welfare Trust Fund for Utah.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Covered Person's Effective Date.

Claimant is the Employee or eligible Dependent.

Coinsurance means an amount, expressed as a percentage, that the Claimant must pay for Covered Services.

Coinsurance Maximum is the maximum amount of coinsurance each covered person or family is responsible for paying during a Calendar Year before the coinsurance required by the Plan ceases to apply (for most but not all services). When the Coinsurance Maximum is reached, the Plan will pay 100% of additional coinsurance related to most covered expenses for the remainder of the Calendar Year.

Continuing Care Patient means an individual who, with respect to a Provider or facility—

- Is undergoing a course of treatment for a Serious and Complex Condition from the Provider or facility;
- Is undergoing a course of institutional or inpatient care from the Provider or facility;

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

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.

Contributing Employer or Employer means any employer who is required by a collective bargaining agreement, or by an Agreement to Train Apprentices, to make payments into the Fund, and who does in fact make one or more payments into the Fund. The term "Contributing Employer" also includes the Union, a Joint Labor-Management Fund or Joint Apprenticeship Committee or Committees on which the Union is represented and the Operating Engineers Local Union No. 3 Credit Union, provided that any of these entities will be a Contributing Employer solely for the purpose of making payments with respect to the work of its Employees and will have no other rights or privileges under the Trust Agreement as a Contributing Employer.

Copayment or Copay means the fixed amount that you must pay for a service, supply or prescription drug before the Plan pays its share of the cost.

Cost-sharing means the amount a participant or beneficiary 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-Participating 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 Participating Facilities performed by Non-Participating Providers, and Air Ambulance Services from Non-Participating Providers will be based on the Recognized Amount.

Covered Person means the Employee and each eligible Dependent.

Covered Dental Expense means only expenses incurred for necessary treatment, as determined by standards of generally accepted dental practice, that are received by a Covered Person from a Dentist or a dental hygienist under the supervision of a Dentist. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is obtained. Covered Dental Expense is limited to:

- ***for a Participating Provider:*** the contract rate specified in the contract between the dental care provider and the Dental Care Provider Network.
- ***for a Non-Participating Provider:*** the lesser of the Reasonable and Customary Charge, or the provider's usual charge for the service provided.

Covered Service means a service, supply, treatment or accommodation that is listed in the Covered Services section of the Plan.

Deductible means the amount of Allowable Expenses that you must pay each Calendar Year before the Plan will provide payment for Covered Services.

Dental Care Provider Network means a network of dental providers that has contracted with EMI Health, which has contracted with the Fund to provide a dental provider network for Covered Persons.

Dental Services means services or supplies provided to prevent, diagnose or treat diseases or conditions of the teeth and supporting tissues or structures, including but not limited to services or supplies rendered:

- to repair defects which have developed because of tooth loss;
- to restore the ability to chew; or
- to control bruxism

Dentist means an individual licensed to practice dentistry in the state which he or she is providing services.

Dependent means a Participant's eligible legal spouse and children who meet the eligibility rules of the Fund.

Disabled and Disability means:

- for an Employee, that the Employee is under a Physician's care and is unable to work at his regular occupation due to Illness or Injury; (loss of a license does not, in and of itself, constitute Disability); and
- for a Dependent, that due to Illness or Injury, the Dependent is prevented from performing all regular and customary activities usual for a person of similar age and family status.

Effective Date means the date eligibility for Plan benefits begins for the Employee or Dependent.

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

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
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 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-Participating Provider or Non-Participating Emergency Facility (regardless of the department of the hospital in which such items or services are furnished) also include post-stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services were furnished until:

1. The attending emergency physician or treating Provider determines that the patient is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and

2. The patient or their authorized representative is supplied with a written notice of the following:

    a. The Provider is a Non-Participating Provider with respect to the Plan,
    b. An estimate of the charges for treatment and any advance limitations that the Plan may put on treatment,
    c. The names of any Participating Providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the Participating Providers listed; and
    d. The patient or their authorized representative gives informed voluntary consent to continued treatment by the Non-Participating Provider, acknowledging that the patient (or their authorized representative) understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or beneficiary.

Employee and Participant mean an individual who meets the eligibility requirements of the Trust Fund based on employment with contributing employers to the Fund.

Employer or Contributing Employer means any employer who is required by a collective bargaining agreement, or by an Agreement to Train Apprentices, to make payments into the Fund, and who does in fact make one or more payments into the Fund. The term "Contributing Employer" also includes the Union, a Joint Labor-Management Fund or Joint Apprenticeship Committee or Committees on which the Union is represented and the Operating Engineers Local Union No. 3 Credit Union, provided that any of these entities will be a Contributing Employer solely for the purpose of making payments with respect to the work of its Employees and will have no other rights or privileges under the Trust Agreement as a Contributing Employer.

Experimental or Investigational Services means a treatment or procedure for which reasonable and substantial scientific evaluation has not been completed, effectiveness has not been established, or the procedure or treatment has not been accepted and generally used by the medical provider community for a period of 5 years. The Claims Administrator's Medical Director will determine whether a treatment or procedure is experimental or investigational. The absence of any alternative treatment or procedure or any effective non-experimental or non-investigational treatment or procedure for an Illness or Injury shall not make or be deemed to make an experimental or investigational treatment or procedure a Covered Service.

Flat Rate Employee means a person who is an Employee (including a non-bargaining unit office employee or a company officer) for whom contributions are made to the Fund at a monthly flat rate, as determined by the Board.

Fund means the Operating Engineers Health and Welfare Trust Fund of Utah.

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

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

Home Health Care Agency means an agency that is duly licensed by the state in which it is located to provide home health care.

Home Infusion Therapy Agency means an agency that is duly licensed by the state in which it is located to provide home infusion therapy services.

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

Hour Bank means the account that is established for each Employee. Contributing Employers make contributions to the Fund based on hours worked by the Employee.

Hourly (or Hour Bank) Employees means a person who is an employee of one or more Contributing Employers with respect to whose work contributions are made to the Fund.

Illness means a congenital malformation which causes functional impairment, a condition, disease, ailment, or bodily disorder, other than an Injury. **Pregnancy of a covered Employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan.**

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.

Injury means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

Lifetime means the period of time a Covered Person is eligible under the Plan.

Mail Order Pharmacy means the Participating Pharmacy that has agreed to process mail order claims submitted by Covered Persons under the Prescription Drug Program.

Maximum Benefit means that when payments equal the specified amount or when benefits have been provided for a specified number of days, visits, or services, no more payments will be made by the Plan. When the Maximum Benefit is for a specified time period such as a Calendar Year, no more payments will be made during the remainder of the specified time period.

Medically Necessary means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness, Injury, disease or its symptoms in a manner that is:

- In accordance with generally accepted standards of medical practice in the United States;
- Clinically appropriate in terms of type, frequency, extent, site, and duration;
- Provided for the diagnosis or direct care and treatment of the Illness or Injury,
- Not primarily for the convenience of the patient, the patient's Physician, the patients' family, or another provider or caregiver, and
- Covered under the Plan.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and that is known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established interventions, the effectiveness shall be based first on Scientific Evidence; then professional standards; and then expert opinion.

For the purpose of this definition, Scientific Evidence will shall mean scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Mental Health Condition means a pathological state of mind (whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement) producing clinically significant psychological or physiological symptoms together with impairment in one or more major areas of functioning when improvement can reasonably be anticipated with therapy.

Non-Participating Pharmacy means a pharmacy that has no agreement with the Prescription Drug Program listed on the Quick Reference Chart.

Non-Participating Provider means a Provider who does not have an effective participating contract with the medical or dental PPO Network listed on the Quick Reference Chart to provide services and supplies to Covered Persons.

Non-Qualifying Employment means work for a:

- Non-contributing employer of the type covered by the collective bargaining agreement under which an Hour Bank was earned; or
- Contributing Employer in a classification not covered by a collective bargaining agreement with the Union, which requires contributions to the Fund.

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

No Surprises Services means the following, to the extent covered under the Plan:

- Emergency Services by a Non-Participating Provider or facility;
- Air Ambulance Services by a Non-Participating Provider;
- Non-emergency Ancillary Services for anesthesiology, pathology, radiology, and diagnostics, when performed by a Non-Participating Provider at a participating facility; and
- Other non-emergency services performed by a Non-Participating Provider at a participating health care facility for which the Non-Participating Provider does not meet the federal notice and consent requirements required under the No Surprises Act.

Non-Participating 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.

Out-of-Network Rate. With respect to Emergency Services provided by a Non-PPO Provider, non-emergency services furnished by a Non-Participating Provider at a participating facility, and Air Ambulance Services by a Non-Participating Provider, **Out-of-Network Rate** means, in order of priority, one of the following:

- If the state has an All-Payer Model Agreement, the amount that the state approves under that system;

- Applicable state law;
- The amount negotiated by the parties; or
- The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

Out-of-Pocket Maximum or Limit. The No Surprises Act modifies the Maximum Coinsurance, an Out-of-Pocket Limit, provided in Chapter 4 of the 2018 SPD for Emergency Services, non-emergency services furnished by a Non-Participating Provider at a PPO facility, and Air Ambulance Services. Any Cost-sharing payments (e.g., copayments, coinsurance, and deductible) made by the participant or beneficiary are counted towards any in-network deductible or Out-of-Pocket Limit.

Owner-Operator means a person who is not an employee of a Contributing Employer, but who is signatory to an approved Owner-Operator Agreement with the Operating Engineers Local Union Number 3 requiring flat rate contributions to this Fund, and is a dues paying member or service fees payor of the Union. Owner-Operator contributions do not provide an Hour Bank accumulation.

Participant mean an individual who meets the eligibility requirements of the Trust Fund based on employment with contributing employers to the Fund.

Participating Pharmacy means a duly licensed pharmacy that has an agreement with the Prescription Drug Program to furnish Prescription Drugs to Covered Persons.

Participating Provider means, for Medical Benefits, a Provider who has an effective participating contract with the medical PPO Network (listed on the Quick Reference Chart at the beginning of this document) to provide services and supplies to Covered Persons at negotiated contract rates under its Tier 2 network of Traditional Participating Providers.

For Dental Benefits, Participating Provider means a dental care provider included in the dental PPO network listed on the Quick Reference Chart at the beginning of this document.

Period of Disability will be considered separate for an Employee if the causes of the disabilities are entirely unrelated or if the Employee returns to work or is available for work. Periods of Disability for a Dependent will be considered separate if separated by a period of 3 months.

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches (M.D.) or to practice as an osteopathic physician and surgeon (D.O.).

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists, and other professionals practicing within the scope of their respective licenses.

Preferred Provider Organization (PPO), also known as a Participating Provider organization, is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of Participating Providers. The providers contract with the network to provide health care services and items at a reduced rate to the plan’s participants. The Plan’s PPO is Anthem Blue Cross.

Prescription Drug means a drug or medicine which can only be obtained by a Prescription Drug Order and bears the legend “Caution, Federal Law prohibits dispensing without a prescription” or which is restricted by State law, or insulin.

Prescription Drug Order means a written or oral order for a Prescription Drug issued by a Physician or Practitioner within the scope of his or her professional license.

Provider means a Hospital, Skilled Nursing Facility, Ambulatory Service Facility, Physician, Practitioner, or other individual or organization that is duly licensed to provide medical or surgical services.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the Plan or issuer for the item or service in the area.

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

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

For Air Ambulance Services furnished by Non-Participating Providers, the **Recognized Amount** is the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

Reciprocity Agreement means the agreement which establishes the administrative procedures for reciprocity between the funds signatory to the Western Conference of Operating Engineers Health and Welfare Reciprocity Agreement, including any amendment, extension or renewal of that Agreement.

Rehabilitation Facility means a facility or distinct part of a facility which is licensed by the State as a rehabilitation facility, or is similarly licensed by the state in which it is located, and which provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

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

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- 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.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the State as a nursing care facility, or is similarly licensed by the state in which it is located, and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Trust Agreement means the Trust Agreement establishing the Operating Engineers Health and Welfare Trust Fund for Utah, including any amendment, extension or renewal.

Union means Operating Engineers Local Union No. 3 of the International Union of Operating Engineers, a labor organization as defined in the Labor Management Relations Act, 1947 (29 U.S.C. § 141 et seq.).

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