OPERATING ENGINEERS LOCAL 501

SECURITY FUND

(SOUTHERN CALIFORNIA)

SUMMARY PLAN DESCRIPTION AND

PLAN DOCUMENT

Effective January 1, 2023

ADMINISTRATION OFFICE:
Operating Engineers Local 501 Security Fund
BeneSys Administrators
1050 Lakes Drive, Suite 120, West Covina, CA 91790
P.O. Box 990, West Covina, CA 91793
(800) 320-0106 or (626) 646-1079

Noticia de Asistencia de Lenguaje Extrajero: Este folleto continene un sumario en ingles de sus derechos del plan y los beneficios de Operating Engineers Local 501 Security Fund (Plan). Si tiene alguna dificultad entendiendo cualquier parte de este folleto communiqués con el Administrador del Plan a su oficina en P.O. Box 990, West Covina, California 91793. Tambien se puede comunicar con el Administrador por telefono at (800) 320-0106.

BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT FOR THE OPERATING ENGINEERS LOCAL 501 SECURITY FUND

Dear Member:

This booklet, along with the detailed benefit information furnished by insurance providers, is your Summary Plan Description and Plan Document for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). This booklet provides the Operating Engineers Local 501 Security Fund's (Fund or Trust Fund) health and welfare benefit plan (Plan) eligibility rules and the benefits payable by the Plan, so please study the booklet carefully. Please put this booklet in a safe and convenient place. We hope it assists you in understanding your benefits and finding answers to your questions.

Employee contributions for the Plan are based on hours worked or paid for by active Employees under Collective Bargaining Agreements (or Participation Agreements) and by Retirees through monthly self-payments. These contributions and self-payments fund this Plan on a month-to-month basis. Should contributions and/or self-payments not provide sufficient funding to maintain the benefits, the Trustees reserve the right to change the eligibility rules, reduce the benefits, or eliminate the Plan, in whole or in part, as may be required by the circumstances.

If you have any questions concerning the Plan or you need assistance in securing your benefits, please call or write the Administrative Office at:

BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

The only parties authorized to answer any questions concerning the Trust Fund and the Plan are the Board of Trustees and the Plan's Administrative Office. No participating employer, employer association, or labor organization, nor any individual thereby, has any such authority.

Sincerely,

Board of Trustees

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IMPORTANT ADDRESSES AND PHONE NUMBERS

For information about **eligibility, benefits, or claims information:**

Trust Fund Administrative Office
Operating Engineers Local 501 Security Fund
c/o BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

For information about your **Indemnity Medical Plan Network Providers** and **for Medical and Mental Health/Substance Use Disorder Preauthorization Services Review:**

Call Anthem Blue Cross before any Hospital services are received, except for Emergency care.

Anthem Blue Cross Prudent Buyer PPO
Network and Managed Care Services
Medical and Mental Health/Substance Use Disorder Preauthorization Services:
Call the number on your membership card

Address:	21555 Oxnard Street Woodland Hills, CA 91365
Telephone:	(800) 274-7767
Website:	www.anthem.com/ca

For information about your Prescription Drug Program under the Indemnity Plan coverage and services:

OptumRx

Address:	2300 Main Street Irvine, CA 92614
Telephone:	(800) 797-9791 (866) 218-5445 *Specialty Drug Information* (800) 711-4555 *Specialty Drug Preauthorization* (select "Option 1" when prompted)
Website:	www.optumrx.com

Diplomat
Specialty Drug Adynovate

Address:	Diplomat Specialty Infusion Group Attention: Reimbursement Department 7177 E. Kemper Road Cincinnati, OH, 45249
Telephone:	(866) 442-4679
Website:	https://www.diplomatpharmacy.com/

For information regarding benefit claims and appeal procedures involving the drug Adynovate, please contact Diplomat directly by phone, mail, or through their website shown above.

For information about the **Employee Assistance Program (EAP)**:

Mental Health Network (MHN)
Address: 32 Hampden Street
Springfield, MA 01103
Telephone: (800) 444-4281
Website: www.mhn.com

For information about your **HMO Medical and Prescription Drug** coverage and services:

Kaiser
Address: 1 Kaiser Plaza
Oakland, CA 94612
Telephone: (800) 464-4000
Website: www.kp.org

For information about your **Dental** coverage and services:

Delta Dental
Address: P.O. Box 997330
Sacramento, CA 95899-7330
Telephone: HMO (800) 422-4234
PPO (800) 765-6003
Website: www.deltadental.com

For information about your **Vision** coverage and services:

Vision Service Plan (VSP)
Address: 101 California St., Suite 975
San Francisco, CA 94111
Telephone: (800) 877-7195
Website: www.vsp.com

For information about your **Telemedicine** coverage and services:

Telemedicine Management, Inc., d/b/a SwiftMD
Address: 801 Springdale Drive
Exton, PA 19341
Telephone: (833) 794-3863
Website: mySwiftMD.com (telemedicine services)

GENERAL DEFINITIONS

The following terms are used throughout this booklet, and their definitions will help you understand your benefit plan.

Calendar Month refers to any one of the twelve months of the year and means that month in its entirety, beginning with the first day.

Calendar Year means the period of twelve (12) consecutive months commencing January 1.

Collective Bargaining Agreement means an agreement in effect between the Employer and the Operating Engineers Local 501.

Contributing Employer or Employer means an Employer who makes contributions to theTrust Fund in accordance with a Collective Bargaining Agreement in effect between the Contributing Employer and the Operating Engineers Local 501, or in accordance with a Participation Agreement.

Contribution or Contributions are payments made to the Trust Fund for purposes of providing benefits as defined in the Trust Agreement.

Cosmetic means any surgery, procedure, service, drug, or supply designed to change or improve the appearance of an individual in the absence of specific functional deficit(s).

Course of Treatment means all periods of disability arising from the same or related causes, including all complications except: (1) in the case of an Employee, the Employee has completely recovered or returned to active full-time employment; and (2) in the case of a Dependent, the Dependent recovers for a period of six (6) months and also resumes normal activities.

Covered Charge(s) or Covered Expense(s) means the charges or expenses incurred by a person while eligible under the Plan, which are:

1. expressly covered under the applicable provisions of the Plan;

2. Medically Necessary; and

3. Usual, Customary, and Reasonable (UCR).

When a Covered Charge or Covered Expense is expressly provided under the Plan, reimbursement shall be limited to the lesser of the maximum reimbursement amount covered under the applicable provisions of the Plan or the amount charged.

Dental Emergency means the sudden onset of oral pain, swelling, or bleeding that requires immediate professional dental treatment.

Dental Hygienist means one who is educated and trained to evaluate the patient's oral health; expose, process, and interpret dental x-ray films; remove calculus deposits, stains, and plaque above and below the gumline; and apply preventive agents such as fluorides and sealants to teeth. Dental Hygienists also educate individuals and groups about oral health care, selecting toothbrushes, the use of dental floss, and oral health problems related to diet or use of tobacco products.

Dentally Necessary and Dental Necessity means services and supplies that are determined by Delta Dental and/or the Trust Fund as Dentally Necessary. Dentally Necessary services are services that are:

1. appropriate and necessary for the symptoms, diagnosis, or direct treatment of teeth or gums;

2. not Experimental;

3. within the standards of good dental practice within the organized dental community;

4. not primarily for the convenience of the Participant, the Participant's Dentist, or any other provider; and

5. the most appropriate level of service that can be safely provided

Dentist is one who is skilled in and licensed to practice the prevention, diagnosis, and treatment of diseases, injuries, and malformations of the teeth, jaw, and mouth and who makes and inserts false teeth. A Dentist is a person who is currently licensed to practice dentistry by the governmental authority within the United States having jurisdiction over the licensing and practice of dentistry at the time and in the place services are performed. The term "Dentist" shall not include the Employee or his Dependent(s) or any person who is the Spouse, parent, child, brother, or sister of such Employee or Dependent.

Dependent means an individual who is:

1. the eligible legal Spouse or Registered Domestic Partner of the Employee;

2. any child of the Employee (which includes natural children, step-children, or legally adopted children or children placed with the Employee for the purpose of adoption as certified by the public or private agency making the placement) who is under age twenty-six (26);

3. any minor for whom a court has appointed the Employee or the Employee's eligible legal Spouse as guardian, so long as the guardianship is in effect;

4. any never-married child of the Employee who is twenty-six (26) years of age or older, who is incapable of self-support because of mental or physical incapacity or condition, that commenced while eligible and that existed prior to the date he/she would have otherwise ceased to be eligible due to age, and who is substantially dependent upon the Employee for support and maintenance, and is claimed as a Dependent on the Employee's most recent federal tax return, or resides in the Employee's household. The Employee must submit within thirty-one (31) days after the date he or she would normally cease to be eligible because of age, satisfactory proof of his/her incapacity. The Trust Fund may subsequently require periodic proof of his/her incapacity. This extension will continue until the earliest of (1) the date the child ceases to be eligible for reasons other than age, (2) the child ceases to be incapacitated, or (3) the end of the month in which the Employee fails to provide requested additional proof of incapacity; and

5. any unmarried child under age 19, whom the Employee is required to cover by a Qualified Medical Child Support Order (QMCSO).

The term Dependent shall not include foster children (unless otherwise eligible); or any person in the military, naval, or air service.

Employees are not entitled to Dependent coverage for any Dependents who are entitled to benefits as an Employee of a participating Employer.

DHMO means a Dental Health Management Organization. A DHMO is a prepaid dental health insurance plan.

Emergency means a medical condition with acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency medical condition means a medical condition manifesting itself 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 a condition described in Emergency Medical Treatment and Active Labor Act (EMTALA), including (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. This definition includes mental health conditions and substance use disorders.

Consistent with Section 1867 of the Social Security Act, "Emergency Services" shall mean (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, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; 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 required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished).

An "independent freestanding emergency department" is intended to include any health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that is licensed by a state to provide emergency services as described in § 149.110(c)(2)(i), even if the facility is not licensed under the term "independent freestanding emergency department."

No Surprises Act cost-sharing and balance billing protections continue from the emergency room to post-stabilization services in a hospital or freestanding emergency department until the attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition. Notice and consent as well as any additional state law requirements must also be met consistent with 45 CFR 149.410(b)(1), 45 CFR 149.410(b)(2), 45 CFR 149.420(c) through (g), 45 CFR 149.410(b)(3)and 45 CFR 149.410(b)(5).

Emergency Services means the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Employee means an Employee of an Employer or Union who is covered under the Plan pursuant to the terms of the eligibility rules.

Employer means any employer making contributions to the Trust Fund under the terms of the Collective Bargaining Agreement or a Participation Agreement.

Essential Health Benefits include the following to the extent otherwise covered under the terms of the Plan:

1. ambulatory patient services;

2. emergency services;

3. hospitalization;

4. maternity and newborn care;

5. mental health and substance use disorder services, including behavioral health treatment;

6. prescription drugs;

7. rehabilitative and habilitative services and devices;

8. laboratory services;

9. preventive and wellness services and chronic disease management; and

10. pediatric services, including oral and vision care.

Experimental or Investigational services are any services, procedures, devices, drugs, or equipment that are experimental or investigational in nature as determined by the Trust Fund. These services, procedures, devices, and drugs are generally those that:

1. are mainly limited to laboratory and/or animal research, but that are not generally accepted as proven and effective within the organized medical community;

2. have progressed to limited use on humans but that are not generally accepted as proven and effective within the organized medical community;

3. do not have final approval from the appropriate governmental regulatory body;

4. are not supported by scientific evidence that permits conclusions concerning the effect of the services, procedures, devices, or drugs on health outcomes;

5. do not improve the health outcome of the patient being treated;

6. are not as beneficial as any established alternative; or

7. are not generally approved or used by Physicians in the organized medical community within the United States of America.

Exclusion means any provision described in this document that provides that coverage for a specific condition is excluded.

Extended Care Facility means an institution that:

1. provides skilled nursing care under twenty-four (24) hour supervision of a Physician or graduate Registered Nurse (R.N.);

2. has available at all times the services of a Physician who is a staff member of a Hospital;

3. provides twenty-four (24) hour a day nursing service by a graduate Registered Nurse, licensed vocational nurse, or skilled practical nurse and has a graduate Registered Nurse on duty at least eight (8) hours per day;

4. maintains a daily medical record for each patient;

5. is not any of the following: a rest home, a home for the aged, a place for custodial care, a pain clinic, a hotel or similar facility; and

6. complies with all licensing and other legal requirements, and is recognized as an Extended Care Facility by the Secretary of Health and Human Services of the United States pursuant to Title XVII of the Social Security Act, as amended.

Health Plan, Plan, Trust Fund, or Fund means the Operating Engineers Local 501 Security Fund, as applicable, as created and established pursuant to the Revised Agreement and Declaration of Trust, effective January 1, 1976, and restated as of December 6, 1996, and any amendment thereto.

HMO means a health management organization as defined under state law. An HMO is a prepaid health insurance plan.

Home Health Care means intermittent Medically Necessary skilled health care services delivered in the home of an eligible Participant under orders of a Physician that is provided to Participants who are essentially homebound for medical reasons and physically unable to obtain necessary medical care on an outpatient basis.

Hospice means an establishment licensed by the state in which it is located that furnishes a centrally administered program of palliative and supportive service provided by an interdisciplinary team directed by a Physician, including physical, psychological, custodial, and spiritual care for patients who are terminally ill and their family members. For the purpose of this benefit only, “family member” includes the immediate family, the person who primarily cared for the patient, and other persons with significant personal ties to the patient, whether or not related by blood. Care may be provided in the home, at a Residential Treatment Facility/Substance Use Disorder Facility, or at a medical facility at any time of the day or night.

Hospital means a state or federal licensed acute care hospital that:

1. is engaged primarily in providing medical care and for the diagnosis and treatment of an Injury or Illness on an inpatient basis at the patient’s expense and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff of Physicians and routinely charges for such care;

2. continuously provides twenty-four (24) hour a day nursing service by or under the supervision of graduate Registered Nurses and is operated continuously with organized facilities for operative surgery on the premises;

3. is not, other than incidentally, a place of rest, a place for the aged, a nursing home, pain clinic, or other similar institution; and

4. is operating lawfully in the jurisdiction where it is located.

Hospital Care and Hospital Services mean a state or federally licensed Hospital that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Illness means any sickness or disease, including Mental Health or Substance Use Disorders, which requires treatment by a Physician. Illness includes pregnancy and all complications that arise therefrom for female Employees and Dependents (see also information on the Newborns' and Mothers' Health Protection Act on page 135 of this Plan booklet).

Injury means an accidental bodily injury that requires treatment by a Physician.

Lag Month means the period between work hours and eligibility and is usually one calendar month. For example, hours worked in January grant March Eligibility, this means that February is the lag month.

Limitation means any provision described in this document that provides that coverage for aspecific condition is limited.

Licensed Clinical Mental Health Professional means a person who holds a license with the state in which the services are being provided and has the appropriate education and training for the treatment of mental health or substance use disorders. No provider without current licensure will be covered. The practitioner must also have credentials and a license appropriate to the diagnosis and level of care required.

Medically Necessary and Medical Necessity means services and supplies that are determined by the Trust Fund to be:

1. appropriate and necessary for the symptoms, diagnosis, or direct treatment of an Illness or Injury;

2. not Experimental;

3. within the standards of good medical practice within the organized medical community;

4. not primarily for the convenience of the Participant, the Participant's Physician, or any other provider; and

5. the most appropriate supply or level of service that can be safely provided.

Medical (and Mental Health/Substance Use Disorder) Services Review Organization means an organization contracted with the Trust Fund to review the appropriateness and quality of care and to deliver results-oriented cost containment through preauthorization/pre-admission or procedure screening, second opinion referrals, medical case management, and retrospective review programs. Currently, the Medical (and Mental Health/Substance Use Disorder) Services Review Organization is Anthem Blue Cross under the Indemnity Medical Plan.

Medicare means Title XVIII of the Social Security Act, U.S. Public Law 8997, and any amendments thereto.

Mental Health means exhibiting a psychological condition as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV R or subsequent edition). To meet this diagnosis, the patient must exhibit behaviors as described as criteria.

Network Provider means a Hospital, Outpatient Surgical Facility, Dentist, or Physician, as defined in this section, under a PPO contract with the Trust Fund's PPO provider network(s) to provide care and treatment at a specified rate to Participants of the Plan.

New Unit means a group of Employees not previously covered, or who were previously covered and again become eligible under the terms of a new Collective Bargaining Agreement or a Participation Agreement with an Employer.

Non-Network Provider means a Hospital, Outpatient, Surgical Facility, Dentist, or Physician that does not have a PPO contract with the Trust Fund's PPO provider network(s) to provide services at a specified rate to Participants of the Plan.

Orthodontics means the process to correct a malocclusion. A malocclusion is an improper alignment of the teeth.

Orthodontist means those who examine, diagnose, and treat irregularities and malocclusions of teeth and mal relations of jaws. An Orthodontist is a specialist in dentistry who studies the alteration of the alignment of crooked teeth. An Orthodontist is a Dentist with additional specialist training in improving incorrect or unfavorable position (malocclusion) of the teeth and the underlying bone structure.

Orthodontic Treatment includes braces, plates, retainers, headgear, and other appliances. Braces are a collection of brackets (usually with a wire) that are used in orthodontics to correct the alignment of teeth in the jaws of humans. Braces are often used to correct underbites, overbites, crooked teeth, and various other functional flaws of teeth. They can be used on one or both jaws, depending on where the flaws occur.

Participant means an individual eligible for coverage under the Plan, including a regular Employee, Maintenance Attendant, eligible Retiree, and each of their eligible Dependents.

Participation Agreement means the written Agreement between a Contributing Employer and the Trust Fund requiring contributions to the Trust Fund for an Employer's bargaining unit or non-bargaining unit Employees.

Physician or Doctor means a Physician licensed as a medical doctor (M.D.), osteopath (D.O.), podiatrist (D.P.M.), chiropractor (D.C.), chiropodist (D.S.C.), dentist (D.D.S.), psychiatrist (M.D.), or other service provider practicing within the scope of their license or certification, as applicable and to the extent that benefits are provided.

For purposes of Mental Health and Substance Use Disorders treatment, a Physician or Doctor shall include any licensed psychologist, psychiatrist, or clinical social worker. The term shall include other mental health care providers if approved by the Medical (and Mental Health/Substance Use Disorder) Services Review Organization, such as a marriage, family, and child counselor, or a mental health nurse working individually or within a corporation, clinic, or group practice.

Dental services are reimbursable under the Dental Plan provisions only, except as described under Dental and Oral Surgical Services on page 49.

The term "Physician or Doctor" shall not include the Employee or his Dependent(s) or any person who is the Spouse, parent, child, brother, or sister of such Employee or Dependent.

Prescription Drug means a prescription medicine, which, to be dispensed, requires, by federal or state law, a written prescription of a Physician or Doctor for certain over-the-counter drug products with a written prescription of a Physician or Doctor. Prescription Drugs shall include insulin and diabetic supplies (syringes, chem strips, and lancets) if they are prescribed in writing by a Medical Doctor. A prescription drug shall include outpatient injectables and other specialty drugs provided that prior authorization is obtained.

Registered Domestic Partner means two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partnership is formed when persons file a Declaration of Domestic Partnership with the Secretary of State and, at the time of filing:

1. Neither person was married or in a domestic partnership with someone else;
2. The persons are not related by blood;
3. Both are at least 18 years of age (with exceptions);
4. Both are capable of consenting to the domestic partnership; and
5. Both are members of the same sex or one or both is eligible for social security benefits and over the age of 62.

Under California SB 30 both opposite-sex and same-sex couples under the age of 62 to be eligible to form domestic partnerships.

Registered Domestic Partnership means a Domestic Partnership that has been filed with and registered with the office of the California Secretary of State, or with a local agency of California or another state or local agency of another state in which the Domestic Partnership was created, and a copy of the certification of Domestic Partnership has been provided to the Trust Fund Administration Office.

A domestic partnership is formed when **BOTH** persons file a Declaration of Domestic Partnership with the Secretary of State, and, at the time of filing **ALL OF THE FOLLOWING REQUIREMENTS ARE MET:**

1. **Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.**

2. **The two persons are not related by blood in a way that would prevent them from being married to each other in this state.**

3. **Both persons are at least 18 years of age, except as provided in Section 297.1.**

4. **Both persons are capable of consenting to the domestic partnership.**

Registered Nurse means a person licensed under the appropriate laws which is not a relative by blood or marriage to the Employee, Spouse, or Dependent, and does not have the same legal address as the person receiving the nursing care.

Residential Treatment Facility means a psychiatric treatment facility accredited under the Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, which:

1. is mainly engaged in providing assistance in the treatment of mental health disorders;

2. is supervised by a staff of Physicians on the premises; and

3. provides on the premises 24-hour nursing services by graduate Registered Nurses.

Retiree or Senior Member means a retired Employee of an Employer or of the Union who meets the eligibility requirements.

Skilled Nursing Facility means an institution that is licensed by appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Spouse means an individual who has entered into a legal marriage as provided under state law.

Substance Use Disorders means exhibiting by use of chemical or alcohol behavior as described by the Manual of Mental Disorders (DSM IV R or subsequent edition). To meet this diagnosis, the patient must exhibit behaviors as described as criteria.

Substance Use Disorder Treatment Facility means an institution that provides inpatient care and meets the following requirements:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and eligible to receive payments under and in accordance with Medicare, and/or holds a state license as a facility able to provide care under the American Society of Addiction Medicine (ASAM) criteria for inpatient or transitional substance use disorder or mental health services;

2. provides organized facilities for diagnosis and treatment, either on its premises or at an institute with which it has a formal arrangement for the provision of such facilities; and

3. operates as a Substance Use Disorders or Mental Health specialty facility.

Surgical Center or Outpatient Surgical Facility means a state-licensed facility that is intended for outpatient surgical care and meets the following requirements:

1. is primarily engaged in providing diagnostic and surgical facilities for ambulatory, outpatient surgical care;

2. is equipped with permanent facilities for diagnosis and surgery and is staffed by Registered Nurses and Physicians and anesthetists licensed to practice medicine; and

3. is a place or facility other than a Doctor's office.

Total Disability or Totally Disabled means, with respect to an Employee or a Dependent Spouse, a disability which prevents the Employee or Dependent Spouse from engaging in any employment for remuneration or profit and, with respect to a Dependent child, such child is totally unable to engage in normal activities of a person of like age and sex as a result of the Illness or Injury.

Trust Agreement means the Revised Agreement and Declaration of Trust for the Operating Engineers Local 501 Security Fund, effective as of January 1, 1976, and restated as of December 6, 1996, and any amendment thereto.

Trustee(s) or Board of Trustees means the individual or individuals defined in this Plan booklet and the Revised Agreement and Declaration of Trust for the Operating Engineers Local 501 Security Fund.

Union means the International Union of Operating Engineers Local 501 as specified in the Trust Agreement.

Urgent Care Facility means a facility that is equipped and operated mainly to render immediate treatment for an acute Illness or Injury.

Usual, Customary, and Reasonable (UCR) Charge or Fee means the lesser of the fee usually charged for a Covered Service by a Hospital, Physician, or any other covered provider and the prevailing fee charged by similar providers in the geographic area where the Covered Service was rendered, and which in any case is reasonable under the circumstances. "Usual" or "prevailing" fees mean fees unreduced by any PPO contract, Medicare, Medicaid, or any other fee reduction arrangement. The determination of any UCR Charge or Fee shall be made by the Board of Trustees in its sole discretion and shall be binding upon all persons. However, for purposes of Non-Network Provider Emergency Services provided in an Emergency department of a Hospital, UCR shall mean the greater of the following amounts: (1) the median of negotiated in-network rates; (2) the generally applicable out-of-network costs (i.e., the UCR Charges or Fees); or (3) the Medicare rate.

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

Who is Eligible?
You are eligible for coverage under this Plan if you are:

1. working in a position covered by a Collective Bargaining Agreement that provides for contributions to be made to the Trust Fund on your behalf and that has been approved bythe Trustees;

2. an Employee of the Union;

3. an active Employee of an apprenticeship fund affiliated with Local 501 upon completion of a Participation Agreement and approved by the Trust Fund for participation in the Trust Fund;

4. active Employee(s) of a participating Employer working in a non-bargaining unit capacity, upon completion of a Participation Agreement, and approved by the Trust Fund for participation in the Trust Fund; or

5. an active Employee who is a Maintenance Attendant.

When Do I Become Eligible?
You become eligible for benefits on the first day of the second calendar month following any calendar month in which you work or are paid for at least 72 hours[1] for an Employer, and the Employer makes the required contributions. ***For example:*** *if you work or are paid for 72 or more hours in January and the required hours and contributions are received in a timely manner in February, you will become eligible for coverage on March 1st*. If you work for more than one Employer, you are not entitled to benefits greater than those that would apply if you worked for just one Employer.

If You Have 72 Hours Plus Contributions in:	You, Will, Be Covered During the Month of:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

However, if you are part of a New Unit on the effective date of the Collective Bargaining Agreement covering such New Unit, then you will be eligible for benefits on the first day of the calendar month next following the month in which you have worked or are paid for at least 72 hours in employment covered by the Collective Bargaining Agreement. You must contact the Trust Fund Administrative Office for verification of eligibility.

[1] Weekly contributions may also be remitted to the Fund for Employees who work less than 72 hours in a calendar month if required by the Collective Bargaining Agreement or the Participation Agreement.

When Does Coverage Begin?
You will become covered for medical benefits, dental benefits, vision benefits, prescription drug benefits, mental health, and substance use disorder benefits, EAP benefits, death benefits, and accidental death, dismemberment, and loss of sight (AD&D) benefits, as applicable, on the first day of the second calendar month following any calendar month in which you work or are paid for at least 72 hours for an Employer and the Employer makes the required contributions to the Trust Fund for such work.

Maintenance Attendants are eligible for all benefits and coverages offered to other eligible Employees. Coverage is available for Employees and their Dependents (Spouses and Dependent children) or Employees and their Dependent children only (no Spousal coverage), depending on the terms of the applicable Collective Bargaining Agreement.

How is Coverage Maintained?
To continue to be eligible for coverage under the Plan, you must work or be paid for at least 72 hours each month for an Employer, and your Employer must make the required contributions.

Transfer to Non-Bargaining Unit/Non-Covered Employment
If an active Employee of a participating Employer is transferred from performing bargaining unit work/covered employment to performing non-bargaining unit work/non-covered employment, the Employee may continue participation in the Plan, so long as the required monthly contributions are made by the Employer on a continuous and timely basis on that Employee's behalf in accordance with the Fund's Trust Agreement and all other active Employees transferred under these circumstances also continue participation in the Plan, and the required contributions are made by the Employer for these Employees based on the same terms and conditions. If the non-bargaining unit Employee at any time begins working for another participating Employer performing the same non-bargaining unit work/non-covered employment, then this provision will not apply unless the new participating Employer begins/continues contributions to the Fund on behalf of any other current Employee transferred (in the past, present, and/or future) from bargaining unit work/covered employment to non-bargaining unit work/non-covered employment with the new participating Employer.

When Does Dependent Coverage Begin?
Your Dependents will become covered on the date you become covered, provided your Dependents are enrolled in the Plan.

If you acquire any additional Dependents after you become covered under the Plan, each such Dependent will become eligible on the date he or she meets the eligibility requirements. You must notify the Trust Fund Administrative Office within 31 days of the date he or she becomes your Dependent. If notification is not received within 31 days of becoming an eligible Dependent, the Dependent's effective date of coverage will be the first day of the month following the date notification is received by the Trust Fund Administrative Office.

You will be required to submit supporting documentation to the Trust Fund Administrative Office of eligible Dependent status such as a marriage certificate in the case of a new marriage; a birth certificate in the case of a newborn; divorce and remarriage documents in the case of step-children; decree of adoption or certification of placement for adoption by a public or private agency making the placement in the case of adoption; or any other applicable supporting documentation that the Trustees may deem necessary to verify eligibility before coverage can become effective.

If you have a Dependent child who is also an eligible Employee, such person shall not be eligible as a Dependent.

When Does Coverage End?
Your coverage and/or your Dependent's coverage will end at 12:01 a.m. on the earliest of the following dates:

- ***Termination of Employment or Reduction in Hours Resulting in Loss of Eligibility***
  Your coverage and your Dependents' coverage will end the first day of the third calendar month following the month in which you last worked or were paid for at least 72 hours for an Employer. ***For example,*** *if you last worked or were paid for at least 72 hours for an Employer in January, your coverage will terminate on April 1st*. You may elect to continue your coverage and/or your Dependents' coverage under COBRA continuation coverage or USERRA coverage, if applicable. (Please refer to pages 17 to 24 for information on COBRA and USERRA coverage.)

  *Please note: If your Employer withdraws from the Fund for any reason, including its failure to have a signed Collective Bargaining Agreement in place with the Union or the health coverage is secured or negotiated, your eligibility will terminate the last day of the month in which you last worked or were paid for 72 hours or more hours before the date of the Employer withdrawal. This means no lag month, as described in the prior paragraph, is made available to you. Employer contributions, however, are due through the final work month.

- ***Loss of Dependent Status***
  Coverage under the Plan for your Dependent child will continue while you are covered but will end earlier if the child no longer meets the definition of Dependent. In such case, coverage will end the first day of the month following the date the child ceases to qualify as a Dependent. Your Dependent child may continue his or her coverage by electing COBRA continuation coverage and making the required monthly payments. (Please refer to pages 17 to 22 for information on COBRA coverage.)

- ***Divorce or Legal Separation***
  Coverage under the Plan for your eligible Spouse will continue while you are covered but will end earlier if you divorce or are legally separated. In such case, your eligible Spouse's coverage will end the first day of the month following the date of divorce or legal separation. Your eligible Spouse may elect to continue coverage under COBRA continuation coverage and make the required monthly payments. (Please refer to pages 17 to 22 for information on COBRA continuation coverage.)

- ***Death***
  In the event of your death, while covered under the Plan, your Dependents will continue to receive benefits for a six-month period following the date your coverage would otherwise have ended or, if earlier, until the date of remarriage of your eligible surviving Spouse. ***For example,*** if an Employee dies in October after completing at least 72 hours of work, benefits for his Dependents will continue through December and then six more months through June. Your Dependents may elect to continue coverage under COBRA continuation coverage and make the required monthly payments. (Please refer to pages 17 to 22 for information on COBRA continuation coverage.)

- ***Termination of the Plan***
  In the event the Plan terminates, your coverage will end on the date the Plan terminates.

- ***Special Rule for Anheuser-Busch Employees***
  If you are employed by Anheuser-Busch, and you are on a recognized leave of absence due to an occupational or non-occupational Illness or Injury, you and your Dependents' coverage will continue during such leave period, provided you are eligible for coverage when the leave began. If you work at least 72 hours in the month following the month in which you return to work, your coverage will be uninterrupted. However, you must return to work with Anheuser-Busch when your disability ends, and in no case later than two (2) years after your leave began. If you fail to return to work at such time, your coverage will end on the earliest of the first day of the third calendar month following the month in which you could have returned to work or in which the two-year period ends, whichever is applicable.

  There is no restriction on the number of leaves you may have while you are employed by Anheuser-Busch, so long as each leave is due to an occupational or non-occupational Illness or Injury.

  Please note that this special eligibility rule does not change the general exclusion for services received in connection with an occupational Injury or Illness. No benefits are payable for such services (see Exclusions and Limitations on pages 53 to 56 of the Plan booklet).

Disability Extension
After becoming covered under the Plan, if you cannot work because of a Total Disability, which exists continuously from the date last worked until the date eligibility for coverage under the Plan would terminate based on Employer contributions, you will have the right to choose one of the following options for continuation coverage:

a. You may elect COBRA continuation coverage. (See COBRA provisions on pages 20 to 26 in this Plan booklet.) You must pay the premium costs for this coverage. If you elect COBRA continuation coverage, you, your Spouse, and your Dependents may elect to continue coverage under all of the benefit packages you were enrolled in prior to your Total Disability except the death and AD&D benefits will not be included; or

b. Alternatively, you and your Spouse and your Dependents may extend medical coverage for up to three (3) months at no cost. When Total Disability extended coverage ends (see below), you, your Spouse, and your Dependents may elect COBRA continuation coverage, but coverage under COBRA will include only medical (including mental health and substance use disorder benefits) and prescription drug benefits. Also, the Total Disability extension period will be credited against your maximum period of COBRA continuation coverage.

If you do not timely elect COBRA continuation coverage as specified in the COBRA continuation coverage section of this booklet, you will be deemed to have elected the Total Disability extension under (b) above.

If you elect continuation coverage for medical (including mental health and substance use disorder) and prescription drug benefits only under the Total Disability extension, such coverage will terminate on the earliest of the following dates:

1. the date on which the Total Disability ceases;

2. the date on which coverage for such person becomes effective, under another employer's Employee benefit plan or under any medical benefit or service plan written on a group basis including Medicare and Medicaid;

3. the first day of the month following the date you receive your first check for retirement benefits from the Central Pension Fund;

4. the end of the period of three (3} months following the date on which the required contributions on behalf of the Employee ceased;

5. the date the Plan terminates; or

6. the date your Employer ceases to be a Contributing Employer to the Fund.

If you elect COBRA continuation coverage under (a} above, such coverage will terminate in accordance with the applicable COBRA termination event.

Total Disability means, with respect to an Employee or Dependent Spouse, a disability that prevents the Employee or Dependent Spouse from engaging in any employment for remuneration or profit, and, with respect to a Dependent child, such child is totally unable to engage in normal activities of a person of like age and sex as a result of the Illness or Injury. The determination of a Total Disability will be based solely on the finding made by an independent Physician (M.D.).

You must obtain certification of Total Disability from a Physician (M.D.) and complete the necessary "Notice of Total Disability" form and file it with the Trust Fund Administrative Office in order to receive a Total Disability extension.

Reinstatement of Coverage
If you return to work with a participating Employer in the Fund within 12 months from the date your coverage under the Plan terminated, and the Employer makes the required contributions, your coverage will begin again on the first day of the calendar month following the calendar month you work at least 72 hours. If no contribution is made, your eligibility will be determined in accordance with the initial/normal eligibility rules.

Example: If you are rehired on January 1, and your Employer makes the required contributions at the time you are rehired (or no later than January 20th), your coverage will begin on February 1. Required contributions must still be made in February for hours worked in January in order to continue coverage in March, and so on.

HEALTH CONTINUATION COVERAGE UNDER COBRA

You and your eligible Dependents have the option to elect COBRA continuation coverage when your health coverage would otherwise terminate due to certain qualifying events. COBRA continuation coverage requires payments by the Employee or his or her eligible Dependents (or by any other third party). Set forth below, in summary, form, is an explanation of the COBRA continuation coverage rules. Contact the Administrative Office for further information.

Important Note: However, in lieu of COBRA, there may be other health coverage alternatives available to you and your family. Under the Patient Protection and Affordable Care Act, you are able to buy coverage through the Health Insurance Marketplace, also known as the Exchanges.

Through Exchanges, you could be eligible for a federal tax credit or subsidy that lowers your monthly premiums, and you can see what your premium, deductibles, and out-of-pocket costs will be before you enroll. Visit www.healthcare.gov for more information.

Eligibility and Coverage Periods

Participant
If you are:

1. an Employee participating in the Fund; and

2. you lose your health coverage because of one of the following qualifying events:

    a. a reduction in hours[1]; or

    b. termination of employment (other than for reasons of gross misconduct);

You are a Qualified Beneficiary and have the right to elect COBRA continuation coverage for up to 18 months from the date of the loss of coverage if you elect to continue the coverage during the election period. Any extended coverage you receive as a result of the Total Disability extension as described on pages 15 to 16 will count toward the 18-month maximum.

Spouse
If you are:

1. the Spouse of an Employee participating in the Fund; and

2. you are also covered by the Plan; and

3. you lose your health coverage because of one of the following qualifying events:

    a. a reduction of your Spouse's hours[1] or termination of your Spouse's employment (other than for reasons of gross misconduct);

    b. the death of your Spouse; or

    c. a divorce or legal separation from your Spouse;

You are a Qualified Beneficiary[2] and have the right to elect COBRA continuation coverage if you elect to continue the coverage during the election period. The maximum continuation coverage period is 18 months from the date of the loss of coverage in the event of a reduction of hours[1] or termination of employment. In the event of the Employee's death or a divorce or legal separation from the Employee, you have the right to elect COBRA continuation coverage for up to 36 months from the original date of loss of coverage. Any extended coverage you receive as a result of the Employee's Total Disability extension, as described on pages 15 to 16, will count toward the 18- and 36-month maximums. If the Employee became entitled to Medicare (Part A or B) prior to losing eligibility because of a reduction in hours or termination of employment (other than for reasons of gross misconduct), you may continue your coverage for the longer of:

1. 18 months (or 29 months in the event of a Total Disability extension) from the date of the Employee's reduction in hours[1] or termination of employment; or

2. 36 months from the date of your Spouse's entitlement to Medicare (actual enrollment in Part A or B).

The maximum COBRA continuation period is 36 months, even if multiple qualifying events occur.

Dependent Child
If you are:

1. the Dependent child of an Employee participating in the Fund; and

2. you are also covered by the Plan[3]; and

3. you lose your health coverage because of the following qualifying events:

    a. a reduction in hours[1] or termination of employment of the Employee parent (other than for reasons of gross misconduct);

    b. the death of the Employee parent;

    c. the Employee parent's divorce or legal separation; or

    d. loss of Dependent status under the Plan rules;

You are a Qualified Beneficiary and have the right to elect COBRA continuation coverage if you elect to continue the coverage during the election period. The maximum continuation coverage period is 18 months from the date of the loss of coverage in the event of a reduction of hours[1] or termination of employment by the Employee parent. In the event of your Employee parent's death, Employee parent's divorce or legal separation, or your loss of Dependent status, you have the right to elect COBRA continuation coverage for up to 36 months from the original date of loss of coverage. Any extended coverage you receive as a result of your Employee parent's Total Disability extension, as described on pages 15 to 16, will count toward the 18- and 36-month maximums. If your Employee parent became entitled to Medicare (Part A or B) prior to losing eligibility because of a reduction in hours[1] or termination of employment (other than for reasons of gross misconduct), you may continue your coverage for the longer of:

1. 18 months (or 29 months in the event of a Total Disability extension) from the date of the Employee's reduction in hours[1] or termination of employment; or

2. 36 months from the date of Employee parent's entitlement to Medicare (actual enrollment in Part A or B).

The maximum COBRA continuation period is 36 months, even if multiple qualifying events occur.

Domestic Partner and Dependent(s) of Domestic Partner
A Domestic Partner of an Employee participating in the Fund and the Dependent(s) of a Domestic Partner are not Qualified Beneficiaries and do not have the right to elect COBRA continuation coverage. Nevertheless, if you are a Domestic Partner of an Employee or a Dependent(s) of a Domestic Partner and you lose coverage as a result of the termination of a Domestic Partnership or other COBRA qualifying event discussed in this section under Spouse or Dependent, you may be eligible for COBRA-like continuation of coverage. Please contact the Administrative Office for information regarding the COBRA-like continuation of your coverage.

Second Qualifying Events
A second qualifying event, such as an Employee's entitlement to Medicare or an Employee's death, during the initial period of coverage may allow a Spouse or Dependent child who is a Qualified Beneficiary to receive up to 36 months of coverage, even though the initial coverage was 18 months. However, the maximum COBRA continuation period is 36 months, even if multiple qualifying events occur.

It is the responsibility of you (or your Dependents(s)) to inform the Administrative Office of a second qualifying event within 60 days from the date on which you (or your Dependent(s)) lose (or would lose) coverage under the Fund as a result of the second qualifying event.

Obligation to Notify the Fund
It is the responsibility of you (or your Dependent(s)) to inform the Administrative Office of a divorce, legal separation, or loss of Dependent status within 60 days of the later of the date of the loss of coverage or the date on which you (and/or your Dependent(s)) are informed through the furnishing of the Summary Plan Description and Plan Document booklet or the general COBRA notice of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Administrative Office. It is the responsibility of the Employee's Employer to inform the Administrative Office of an Employee's death or entitlement to Medicare within 60 days of these qualifying events. However, a family member should also contact the Administrative Office if these events occur. It is the responsibility of the Administrative Office of the Fund to determine when there has been an Employee reduction in hours or termination of employment within 60 days of these qualifying events.

Any notice that you (or your Dependent(s)) are required to make under the COBRA section of this booklet must be in writing and sent to the Administrative Office at the address listed in the COBRA "Change in Address" section. The notice(s) must be furnished within the applicable time period defined above for qualifying events and below for Social Security Administration (SSA) disability determinations and contain the name of the Plan, your name, and the name(s) of your Dependent(s), the qualifying event(s) (or other events such as an SSA disability award or recovery from an SSA disability), the date(s) of the event, and your (and/or your Dependent's(s')) address(es).

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[1] A reduction in hours due to a leave under the Family and Medical Leave Act (FMLA) does not constitute a qualifying event under COBRA. If the Employee, however, does not return to employment with his Employer at the end of the FMLA leave, a COBRA qualifying event will occur on the date the Employee would otherwise lose coverage following the end of the FMLA leave. A reduction of hours due to any other leave of absence, strike, walkout, or layoff will be considered a qualifying event.

[2] Only you or your Spouse or Dependent(s) who are covered under the Plan the day before the qualifying event (and a Dependent child described under (iii) below) are considered Qualified Beneficiaries. Other Dependents added during the period of COBRA coverage do not become Qualified Beneficiaries. For example, if a second qualifying event occurs, these Dependents are not entitled to extend their COBRA coverage to 29 or 36 months as would a Qualified Beneficiary.

[3] If you become a Dependent child of an Employee by reason of birth or placement for adoption during a period when the Employee is receiving COBRA continuation coverage, you also have the right to elect COBRA continuation coverage. For purposes of determining the extension period, the qualifying event for this type of child is the same qualifying event as the Employee parent.

Any notice that your Employer is required to make under the COBRA section of this booklet must be in writing and sent to the Administrative Office at the address listed in the COBRA "Change in Address" section. The notice must be furnished within the applicable COBRA time period and contain the name of the Plan, the name and address of the Employee, the name(s) of the Dependent(s) (if known), the qualifying event, and the date of the qualifying event.

Notices of a qualifying event (or any extension thereof due to a second qualifying event, or an SSA disability determination, and if SSA determines you have recovered from the disability) may be made by you, your Dependent(s), or a representative acting on behalf of you (and/or your Dependent(s)).

COBRA Notices
When the Administrative Office has received information or determines that a qualifying event has occurred, the Employee and/or Dependent will be sent a COBRA notice explaining their rights to COBRA continuation coverage along with a COBRA continuation coverage election form. This COBRA notice will provide information on the coverages available and their costs. If you desire COBRA continuation coverage, you are required to send the COBRA election form to the Administrative Office within 60 days of the later of (i) the date you receive the COBRA notice and election form, or (ii) the date you would otherwise lose coverage. If you waive COBRA coverage during this 60-day period, you may revoke your waiver at any time during the same 60-day period.

If you choose to elect COBRA continuation coverage, the Fund will provide you with the same health care coverage you have had (medical, prescription drug, dental, and vision), but death and AD&D benefits are not provided. You will, however, be required to elect all of the health care coverages you had prior to your qualifying event. If you move out of the area of a region-specific HMO medical plan, the Fund will offer its corresponding Indemnity Medical Plan coverage, if any, with the applicable reimbursement limitations.

You do not have to show that you are insurable to choose COBRA continuation coverage. You or your Dependents (or any other third party) will have 45 days to make the initial payment after the date you elect the coverage (including any retroactive amount that may be due) until you are no longer eligible for COBRA continuation coverage. Coverage will be canceled if no payment is sent to the Fund within 31 days of the due date. If you make an insignificant underpayment in the amount of the monthly COBRA premium, you will be notified by the Administrative Office of the deficiency. You must pay the amount of the underpayment within 30 days of the original due date, or your COBRA coverage will be canceled. An insignificant underpayment is defined as less than $50.00 under the total COBRA premium (or 10% of the amount due if the COBRA premium is less than $50.00).

When the Administrative Office has reviewed information under the notice procedures specified above and determines that a qualifying event or a determination of disability by the Social Security Administration regarding you (and/or your Dependent(s)) has not occurred, the Administrative Office will furnish you (and/or your Dependent(s)) with an explanation in writing as to why you (and/or your Dependent(s)) are not entitled to COBRA coverage (or an extension thereof) not later than 30 days from the receipt of the notice you (and/or your Dependent(s)) provided.

Termination of COBRA Coverage
COBRA continuation coverage will be terminated for any of the following reasons:

1. you (or your Spouse or Dependent(s) or other third party) fail to pay the premiums for your continuation coverage in a timely fashion as defined in the preceding section;

2. you (or your Spouse or Dependent(s)) first become covered under another group health plan as an Employee or as a Dependent after the date of your COBRA election (however, should the other group health plan exclude or limit your coverage under this Plan until the date the other group health plan can no longer exclude or limit coverage for your pre-existing condition as set out in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) unless the exclusion or limitation may be disregarded under HIPAA and as further set out in the Patient Protection and Affordable Care Act (PPACA)); but only to the end of the maximum COBRA periods, e.g., 18, 29, or 36 months, as applicable;

3. the Trust Fund is terminated, except that if you or your eligible Dependent(s) are on COBRA and your present/former Employer withdraws from the Plan for any reason, you and your eligible Dependent(s) will not be entitled to continued coverage under this Plan if your Employer makes available either existing or new health coverage to a class of the Employer's Employees formerly covered under the Trust Fund;

4. you (or your Spouse or Dependent(s), if applicable) first become entitled to Medicare (actual enrollment in Part A or B) after the date of the COBRA election (however, non-Employee Qualified Beneficiaries who are covered at the time that you are entitled to Medicare may elect to continue their COBRA extension for up to a total of 36 months);

5. you (or your Spouse or Dependent(s), if applicable) have extended continuation coverage due to a disability and then are determined by the Social Security Administration to be no longer disabled;

6. the maximum required COBRA continuation period expires; or

7. for cause (such as a fraudulent claim submission) that would result in the termination of coverage for non-COBRA participants.

If your (and/or your Dependent's(s')) COBRA coverage is subject to early termination; the Administrative Office will furnish you (and/or your Dependent(s)) with written notice as soon as practicable providing the reason that the COBRA coverage has terminated earlier than the maximum COBRA period applicable to the qualifying event, the date of termination and any rights you (and/or your Dependent(s)) may have under the Fund or under applicable law to elect an alternative group or individual coverage (see "Conversion Coverage" on page 22).

Special Extension of COBRA Continuation Coverage Based on Disability as Determined by the Social Security Administration

A special COBRA extension applies in the event that the Employee (or Dependent) applies for Social Security disability benefits and if the Social Security Administration determines that the eligible Employee (or Dependent) was disabled as of the time of or within 60 days of the Employee's reduction in hours or termination of employment (or in the case of a child born to or placed for adoption with a covered Employee during a COBRA coverage period, during the first 60 days after the child's birth or placement for adoption) and the disability lasts at least until the end of the 18-month initial period of continuation coverage. The Employee (or Dependents) will be entitled to an additional 11 months of COBRA continuation coverage beyond the initial 18-month entitlement for a total of 29 months of COBRA continuation coverage. If the disabled Employee or Dependent has non-disabled family members who were covered under COBRA for the first 18 months, they will also be entitled to the additional 11 months if the COBRA premium is paid. The premium charged for this additional 11 months of coverage will be 150% of the COBRA rate set annually by the Board of Trustees (see below). However, if a disabled Dependent experiences a second qualifying event within the original 18-month period, COBRA coverage may be extended up to 36 months, and the premium charged to the disabled Dependent and non-disabled Dependents will be 102% for the entire extended period. If the second qualifying event occurs after the original 18-month period, the premium charged will be 150% through the end of the extension period. Even if the disabled Employee or Dependent does not elect or pay for COBRA coverage, the non-disabled members who elected COBRA are entitled to the additional 11 months of coverage. The premium charged in this case will be 102%.

You (or your Dependent(s)) or other representative acting on your behalf) are responsible for notifying the Administrative Office within 60 days after the later of the date of the disability determination by the Social Security Administration (SSA), the date on which (or Your Dependent(s)) lose (or would lose) coverage under the Plan as a result of a qualifying event; or the date on which you (or your Dependent(s)) are informed through the furnishing of the Summary Plan Description and Plan Document booklet or the general COBRA notice of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Administrative Office.

You (or your Dependent(s)) are also obligated to notify the Administrative Office within 30 days after the later of the date of a final determination by the SSA under Title II or XVI of the Social Security Act, that you (or your Dependent(s)) are no longer disabled; or the date on which you (or your Dependent(s)) are informed through the Summary Plan Description and Plan Document booklet or the general COBRA notice of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Administrative Office. Upon such determination, COBRA continuation coverage will be terminated for the disabled individual (and any non-disabled family members) if the initial 18 months of COBRA continuation coverage had been exceeded.

The COBRA termination will occur 30 days after the month in which the SSA determined you (or your Dependent(s)) were no longer totally disabled or earlier if the SSA determined you (or your Dependent(s)) recovered from the disability within the initial 18-month period. Please note that a disabled individual's COBRA coverage terminates, even in disability situations, when the eligible individual's Medicare coverage begins.

COBRA Payment Rates
The COBRA continuation coverage payment rates are set annually by the Board of Trustees. Information on the rates is available from the Administrative Office.

Conversion Coverage
At the end of the applicable COBRA continuation coverage period, you will be allowed to enroll in whatever individual conversion health plan is available under the Fund rules. Currently, there are no conversion programs for the Indemnity Medical Plan. The Fund's HMO(s), however, continue to offer conversion privileges. Please call them for details. If your Spouse has other coverage or if you believe you (and/or your Dependent(s)) are eligible for state or federal assistance, you may also want to contact these plan(s) and agency(ies) as well.

Termination of COBRA by an HMO
If you (your Spouse and/or your Dependent(s)) have COBRA continuation coverage through the Fund's HMO program and you are terminated from the program because you move out of the HMO's service area before the applicable COBRA period expires and the Fund does not have a contract with an HMO in that area, you (your Spouse and/or Dependent(s)) will be allowed to enroll in the Indemnity Medical Plan so long as payment of COBRA premiums are continuous and timely and the other COBRA requirements are met for the continuation of health coverage. Please call the Administrative Office for additional details.

Change in Address
It is important that you (your Spouse and/or your Dependent(s)) notify the Fund in writing if you change your address. This information should be sent to:

Operating Engineers Local 501 Security Fund
c/o BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793

Compliance with Law
The Board of Trustees has adopted procedures for complying with COBRA based on their interpretation of the law. The Board reserves the right to make any changes they deem appropriate or as required by law. Any oversights and/or omissions will be interpreted in accordance with the applicable law and corresponding regulations.

HEALTH CONTINUATION COVERAGE UNDER USERRA

If you are on a leave of absence from your employment to perform service in the U.S. Uniformed Services, you may elect to continue your coverage (and coverage for your eligible Spouse and Dependents) under the Uniformed Services Employment and Reemployment Rights Act of 1974 (USERRA). Such coverage is separate from and in addition to COBRA continuation coverage. Participants have a right to elect USERRA continuation coverage for themselves, their covered Spouses, and their covered Dependent children. Unlike COBRA, Spouses and Dependent children do not have independent election rights. If you elect both USERRA and COBRA continuation coverage, they will run concurrently, and you will be provided with the coverage that is most favorable to you.

Coverage will continue until the earlier of (a) 24 months from the date your absence begins, or the date you return or should have returned to active employment, or, if applicable, applied for re-employment. Unlike COBRA, there are no additional Qualifying Events or disability extensions available to extend coverage. However, in certain cases, USERRA leave may be extended for up to two years for an individual hospitalized for or recovering from an illness or injury incurred or aggravated during military service. Participants must provide required notices and documentation regarding their service as provided under USERRA.

USERRA continuation coverage terminates when any one of the following events occurs:

1. the date on which you fail to return from military service to active employment or apply, if applicable, for re-employment as required under USERRA;

2. the end of the maximum 24-month period, beginning on the date on which your military leave of absence began;

3. you fail to make timely payment for your continuation coverage;

4. the date on which you are discharged from military service under other than honorable conditions, or under conditions that prohibit your reinstatement under USERRA; or

5. the Employer no longer provides group health coverage to any Employee.

The monthly payment for USERRA continuation coverage if Uniformed Service lasts more than 30 days is the same as the monthly payment for COBRA continuation coverage; Participants and their Dependents are under the same election and payment requirements as are the other Participants and Dependents under COBRA continuation coverage. (See pages 17 to 22.) No payment will be required if your period of service is 30 days or fewer. Like COBRA, you must elect USERRA continuation coverage by returning the election form to the Trust Fund Administrative Office within the 60-day period identified in the election form. If you fail to return the election form during this time period, with limited exceptions, you will lose the right to continuation coverage under USERRA.

If you (your Spouse and/or Dependent(s)) have USERRA continuation coverage through the Trust Fund HMO(s) program and you are terminated from the program because you move out of the HMO service area before the applicable USERRA period expires and the Trust Fund does not have a contract with your HMO in that area, you (your Spouse and/or your Dependent(s)) will be allowed to enroll in the Indemnity Medical Plan until the expiration of the applicable USERRA period, so long as payment of USERRA premiums are continuous and timely and the other USERRA requirements are met for the continuation of health coverage.

If you want USERRA coverage, you must contact the Trust Fund Administrative Office before your military leave of absence begins, unless it was impossible or unreasonable for you to do so. In that case, you must contact the Trust Fund Administrative Office as soon as it is reasonably practicable for you to do so. The Trust Fund Administrative Office will send you the USERRA election form. You must return this form within the time prescribed on the form, together with the required initial payment, if any.

Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, in active duty training, or full-time National Guard duty, the Commissioned Corps of the Public Health Service, and any other category or persons designated by the President of the United States in time of war or emergency.

Contact the Department of Labor if you have any questions about the time limits for applying for and returning to work following your period of military service. If you have any questions about the coverage described above, please contact the Trust Fund Administrative Office at (800) 320-0106.

SPECIAL ENROLLMENT RIGHTS

There are no special enrollment (or late enrollee) requirements under HIPAA because participants and/or Dependents cannot decline coverage under this Plan, and new Dependents may be added at any time subject to proof of birth, marriage, etc.

One Employer contributions rate is paid by the participating Employer regardless of whether the Employee is single, married, or has dependents.

ELIGIBILITY RULES AND BENEFITS FOR RETIREES

Eligibility

Eligibility for Early Retiree Benefits
In order to be eligible for early Retiree benefits or the Senior Member Plan, you must be a retired Employee of an Employer or of the Union, provided you:

1. have ten years of service with a Contributing Employer or with Operating Engineers Local 501;

2. have been eligible for benefits in the Operating Engineers Local 501 Security Fund based on active service for which Employer contributions are due and received during at least 36 of the 48 months immediately preceding the effective date of your retirement (eligibility based on self-payment for COBRA continuation coverage or the Total Disability extension is not included);

3. are eligible for benefits with the Fund as an active Employee on the effective date of your retirement (this includes eligibility extensions given for Total Disability and eligibility under COBRA continuation coverage);

4. are drawing a pension from the Central Pension Fund based on at least 10 years of credited future service as certified by the Central Pension Fund with an Employer with Local 501; and

5. elect Retiree coverage under the Operating Engineers Local 501 Security Fund.

Retiree benefits are only available to you and your eligible legal Spouse or Registered Domestic Partner as of the date you retire; **no other eligible Dependent or Spouse acquired after your retirement date is covered under the Retiree Plan. Your eligible legal Spouse or Registered Domestic Partner may be covered under the Plan only if you are covered.**

Eligibility for Non-Medicare Disabled Early Retiree Subsidy, Effective January 1, 2017
If you are a non-Medicare eligible Retiree, you will be eligible for a subsidy if you meet the following criteria:

you are permanently and totally disabled. For purposes of the subsidy, a non-Medicare eligible Retiree shall be deemed permanently and totally disabled upon receipt of an award of disability benefits by the Social Security Administration in connection with that disability.

If you retired prior to January 1, 2017, and if at the time of retirement you met the above criteria, you will be eligible for the subsidy effective January 1, 2017. If you retire on or after January 1, 2017, you will be eligible for the subsidy on the effective date of your disability as determined by the Social Security Administration but no earlier than January 1, 2017. If there is a lag between when you applied for a Social Security disability award and when it was approved, you will be responsible for the full early retiree self-pay amount required until such time as a Social Security disability award is made. The subsidy will be applied retroactive to the SSA-determined disability effective date but no earlier than January 1, 2017. You will receive a credit for the excess amount paid that can be applied to future self-pay rates. In no event will refunds be made in these circumstances.

Choice of Coverage
Retiree Indemnity Medical Plan benefits are generally the same as those provided to active Employees and their Dependents. However, different enrollment rules are in place for the Retiree Dental Plans (see pages 88 to 90 of this booklet). Any deductibles, copayments, and/or coinsurance expenses accrued under the Indemnity Medical Plan as an active Employee during the calendar year in which the Participant becomes eligible for Retiree benefits will apply under the Retiree Plan.

Should you choose an HMO Medicare option, you may take advantage of additional benefits available under the Medicare Advantage programs, such as preventive medical, dental, and vision care.

Prescription drug benefits are offered through the OptumRx pharmacy program for those Retirees enrolled in the Indemnity Medical Plan. The Trust Fund also implemented a mail-order program allowing Participants to obtain a 90-day supply of maintenance medications.

Prescription drug benefits are also offered by the Kaiser HMO plan to Medicare eligibles. (Please refer to pages 59 to 65 for further information regarding the Prescription Drug Program).

Early Retirees (non-Medicare eligible Retirees) and their eligible Spouses will be eligible to participate in the following benefit programs: the Indemnity Medical Plan or Kaiser HMO Plan; the OptumRx prescription drug plan (for those Retirees who do not choose Kaiser); and the Indemnity Dental Plan or DHMO Plan (Delta).

Medicare-eligible Retirees and their eligible Spouses will be eligible to participate in the following benefit programs: the Indemnity Medical Plan or Kaiser Senior Advantage Plan; the OptumRx prescription drug plan (for those Retirees who do not choose Kaiser); and the Indemnity Dental Plan or DHMO Plan (Delta).

Please contact the Trust Fund Administrative Office for further information on Retiree benefits.

Self-Pay Coverage for Employees Retiring Prior to Age 65
If you are an eligible Retiree, age 65 or younger, you and your eligible Spouse will be able to participate in the early Retiree program on the basis of making monthly self-payments.

Coverage under this provision will continue until you reach age 65, the date you become eligible for Medicare, or the date you fail to make a monthly premium, whichever is earlier.

Self-Pay Coverage for Medicare Eligible Retirees
If you are an eligible Retiree, age 65 or older, or you are younger than 65 but Medicare eligible, you and your eligible Spouse will be eligible to participate in the Retiree program on the basis of making monthly self-payments. Coverage under this provision will continue from your 65th birthday (or your Medicare enrollment date) to the date you fail to make a monthly premium payment or otherwise lose coverage under the termination of coverage rules.

General Self-Payment Provisions
The following will also apply:

1. self-payments may be made by pension deduction;

2. self-payments must be made on a continuous monthly basis;

3. self-payments must be made directly to the Trust Funds Administrative Office no later than the 25th day of the month prior to the month of coverage; and

4. self-payments must be in the amount established by the Board of Trustees, which amount is subject to change from time to time.

Please call the Trust Fund Administrative Office for the early Retiree and Medicare-eligible Retiree programs self-payment rates, including the non-Medicare disabled early retiree subsidy.

Termination of Your Coverage
Your coverage will automatically terminate on the earliest of the following dates:

1. the date of your death;

2. with respect to Indemnity Medical Plan benefits, the date your coverage becomes effective under Kaiser (early Retiree or Senior Advantage Plan) if you choose Kaiser coverage;

3. the date the Plan or either Retiree program, as applicable, terminates;

4. the date you become eligible either as the primary insured or as a dependent under any other group insurance or benefit plan;

5. the date you elect to return to work under a Collective Bargaining Agreement and regain eligibility as an active Employee (when you cease to be an active Employee and lose active eligibility, coverage under the Retiree Plan will be reinstated effective with your loss of active eligibility; your monthly contribution rate when you again become covered under the Retiree Plan will be the Retiree rate in effect when your period of active eligibility ends);

6. the date any required monthly self-payment is not made in a timely manner;

7. the date you become a member of the Uniform Services of any country (USERRA does not apply to Retirees);

8. the date you start (or continue) performing work in the stationary engineering industry of which work is **NOT** pursuant to a recognized Collective Bargaining Agreement, provided both of the following apply:

    a. your employer is engaged in an industry in the organizing jurisdiction of the IUOE in which employees were employed and earned benefits; and

    b. you are working in a trade or craft for which you were employed at any time under the Plan, and in the geographic area covered by the Plan at the time your retirement began (trade or craft includes a related supervisory position); or

9. if the Employer from which you retired fails to make the required contributions to the Trust Fund on behalf of its active Employees, as a result of a decertification or a disclaimer of interest, your coverage will end on the first day of the month following the last month in which the contributions were submitted.

Termination of Spousal Coverage
Coverage for your Spouse will automatically terminate on the earliest of the following dates:

1. the date of your Spouse's death;

2. the date the Plan or either Retiree program, as applicable, terminates;

3. the date your Spouse becomes eligible under any other group insurance benefit plan;

4. the date on which your eligible Spouse ceases to qualify as an eligible Spouse (i.e., on the last day of that month);

5. the date you elect to return to work under a Collective Bargaining Agreement and regain eligibility as an active Employee (when you cease to be an active Employee and lose active eligibility, your eligible Spouse's coverage will be reinstated effective with your loss of active eligibility);

6. the date any required self-payment is not made in a timely manner;

7. the date coverage for Spouses of Retirees is terminated; or

8. the date your coverage ends, except if you die while covered under the Plan, the benefits for the eligible Spouse covered under the Plan on the date of your death will remain in force, to the same extent as if death had not occurred, if the applicable monthly self-payment is made, until the earlier of (1) the end of six months from the end of the calendar month in which the Retiree dies, or (2) the date of remarriage of the Retiree's surviving eligible Spouse; if your eligible Spouse is under age 65 at the time of your death, he/she will be eligible for the early Retiree program; if he/she is 65 or older, he/she will be eligible for the Medicare Retiree program; your eligible Spouse may continue coverage by making self-payments under COBRA continuation coverage (please refer to pages 17 to 22 for information on COBRA continuation coverage).

Retiree benefits (early or Medicare eligible) are not vested rights, benefits, or privileges under the Operating Engineers Local 501 Security Fund and are offered on a month-to-month basis only. The Participants and the Board of Trustees reserve the right to change or modify the Retiree eligibility rules, the benefit programs, or the self-payment rates in whole or in part, or terminate either or both of the Retiree programs in their entirety, at any time. This provision applies to claims in process and/or expenses already incurred.

MEDICARE ENROLLMENT

If you are actively employed (working a minimum of 72 hours for an Employer per month) or if you are the eligible Spouse of an active Employee and age 65 or over, you are entitled to the same benefits from the Plan as are provided to active Employees and their eligible Spouses under age 65.

Medicare will be secondary to this Plan as long as you are an active Employee. You may select Medicare as your primary coverage if you wish; however, no benefits will be provided under this Plan if you do.

You should apply for Medicare Part A (hospital coverage) three months before you reach age 65, even if you or your eligible Spouse is still employed. You should also apply for Medicare Part B when you reach age 65, even if you are still employed, since it may provide supplemental coverage. Although the Plan will not reimburse you for the amounts charged by Medicare, you should apply for Medicare Part B as soon as you reach age 65.

When you retire, Medicare will be primary. If you are enrolled in a medical HMO prepaid plan, you must assign your Medicare Part A and Part B benefits to the medical HMO prepaid plan. If you do not, or if you are not enrolled in both Part A and Part B of Medicare, you will be automatically placed in the Indemnity Medical Plan. Under the Indemnity Medical Plan, your benefits will be coordinated as if you were entitled to Medicare benefits. This also applies if you exhaust your benefits under Medicare.

If this Plan is secondary to Medicare after your retirement, then no further benefits (except for prescription drug benefits) shall be payable as of the date that the Retiree or eligible Spouse exhausts his/her Medicare benefits. If no benefits are payable by Medicare for a particular service received by the Retiree or eligible legal Spouse, then no medical benefits will be paid for such service by this Plan (except for prescription drug benefits).

END-STAGE RENAL DISEASE

Benefits for services and prescription drugs pertaining to the treatment of End Stage Renal Disease (ESRD) will be paid under the Indemnity Medical Plan, and Prescription Drug Program, or HMO Plan, as applicable, subject to the limitation stated below.

Medicare will cover ESRD services, no matter what your age, even if you are covered under this Plan. However, Medicare will be the secondary payor, and the Plan will be the primary payor, for the first 30 months following the date you would be entitled to Medicare because of kidney failure (see "Coordination of Benefits" later in this booklet for the meaning of "primary" and "secondary"). After the 30-month period ends, this Plan will pay benefits only as the secondary payor, **whether or not you have applied for Medicare.**

If you have ESRD, we urge you to apply for Medicare at the earliest opportunity. As the secondary payor during the first 30-month period, Medicare will pay for costs (including the annual deductible) that are not payable under the Plan.

CHOICE OF PLANS

The Trust Fund provides you and your Dependents with a choice of medical plans providing Hospital, medical (including mental health and substance use disorder), and surgical benefits. Your choices include the self-funded Indemnity Medical Plan or a Kaiser HMO plan.

The Trust Fund provides you and your eligible Dependents with prescription drug coverage. If you choose the Indemnity Medical Plan, you will receive prescription drug coverage through a self-funded plan administered by OptumRx. If you choose the Kaiser HMO plan, you will receive prescription drug coverage directly through Kaiser.

The Trust Fund provides you and your eligible Dependents with a choice of dental benefit programs. Your choices will include a self-funded Indemnity Dental Plan administered by Delta Dental and Delta Dental's prepaid DHMO plan. Early Retiree and Medicare Retirees Dental plan options are also through Delta Dental but have additional eligibility rules. Please refer to pages 81 to 90 of this Plan booklet.

The Trust Fund provides you and your eligible Dependents a vision service program through Vision Services Plan (VSP).

The Trust Fund provides you and your eligible Dependents with death and AD&D benefits.

If you choose a self-funded Indemnity Plan, you may go to any Doctor, Dentist, or Hospital, as applicable, but you will have lower out-of-pocket costs if you use a PPO/Network Doctor, Dentist, or Hospital, etc. Under the prepaid HMO plan(s), you must use the prepaid HMO's providers identified in the provider network information available from the carrier to have coverage. Only you can decide which of these plans will best serve the medical needs of you and your family. We suggest you thoroughly review the descriptions of the benefits under each plan.

Note: *If both you and your eligible Spouse are covered under the Trust Fund as Employees, and one of you selects the Kaiser HMO plan, and the other selects the Indemnity Medical Plan, each will be covered under the plan selected as an Employee and no benefits will be provided as a Dependent Spouse. Effective January 1, 2011, your Dependent child may be covered under either the Indemnity Medical Plan or Kaiser, as jointly elected by you and your Spouse. If you have more than one child, you and your Spouse may elect to have one or more child(ren) covered under the Indemnity Medical Plan and the remainder covered by Kaiser. You and your Spouse may change the coverage for any Dependent child in accordance with the Self-Directed Enrollment rules set forth below. If you and your Spouse cannot agree on an election, your Dependent child(ren) will be covered under the plan selected in accordance with the order of benefits determination in the Coordination of Benefits provisions on pages 97-98 of this Plan booklet.*

The foregoing applies only when you are covered under one medical plan, and your Spouse is covered under another medical plan. If at any time both of you are covered under the same medical plan, then all of your Dependent children will be covered under the same medical plan as well.

As used in this Note, "Spouse" includes a Registered Domestic Partner.

If both you and your eligible Spouse are covered under the Trust Fund as Employees and enrolled in the Indemnity Medical Plan, the Indemnity Medical Plan will coordinate benefits as if the Plan were both the primary and secondary plan. (Please refer to Coordination of Benefits on pages 97 to 98 of this Plan booklet for further information.)

ENROLLMENT CHANGES

Self-Directed Enrollment
You and your Dependents will remain covered by your chosen plan(s) as long as you remain eligible unless you fill out a new Plan Selection/Change Form and/or Enrollment/Change Form. You may change plans no more than once in a 12-month period. The 12-month period will commence on the effective date of the change.

For Example: If you are enrolled in one plan and wish to change to another plan that is offered, you may do so at any time as long as you made no other changes effective in the previous 12 months. You may then not change your plan again until at least 12 months later (e.g., if you make a change effective June 1, 2016, you may not make a change again until June 1, 2017).

To make a change, you must complete a Plan Selection/Change Form and/or Enrollment/Change Form and return it to the Trust Fund's Administrative Office. Your new choice will be effective on the first of the month immediately following the Trust Fund's Administrative Office's receipt of a new Plan Selection/Change Form and/or Enrollment/Change Form. The Form must be received by the Administrative Office by the 25th of the month preceding your desired effective date. You should verify with the Administrative Office before incurring any expenses to ensure your Plan Selection/Change Form and/or Enrollment/Change Form has been received, and the new coverage has been implemented.

Detailed information about the various plans will be sent to you upon request.

New hires, rehires, and transfers who have experienced a lapse in coverage can make a new selection within 90 days of being eligible. New hires and transfers who moved away from their plan service area can also make a new selection within 90 days of moving.

HEALTH REIMBURSEMENT ARRANGEMENT

A Health Reimbursement Arrangement or "HRA" is a consumer-directed health plan governed by Section 105 of the IRS Tax Code (IRC), which allows you to pay for qualified expenses on a tax-free basis ("Eligible Expenses"). These Eligible Expenses include copays, coinsurance, and other out-of-pocket costs for healthcare coverage.

I - ELIGIBILITY

Who is eligible for the HRA?
Beginning October 1, 2021, active Employees (and Dependents), including Employees (and Dependents) covered under the Total Disability extended coverage, who are eligible for health coverage under the Fund and enrolled in a medical plan option through the Fund in the month prior to start of the Plan Year (September 1st) are eligible for the HRA. Active Employees eligible for HRA coverage are:

1. Employees working in a position covered by a Collective Bargaining Agreement that provides for contributions to be made to the Trust Fund on your behalf and that has been approved by the Trustees;

2. an Employee of the Union;

3. an active Employee of an apprenticeship fund affiliated with Local 501 upon completion of a Participation Agreement and approved by the Trust Fund for participation in the Trust Fund;

4. active Employee(s) of a participating Employer working in a non-bargaining unit capacity, upon completion of a Participation Agreement, and approved by the Trust Fund for participation in the Trust Fund; or

5. an active Employee who is a Maintenance Attendant.

If you become eligible for coverage after September 1st, your lump-sum contribution to your HRA will be made at the beginning of the next Plan Year (October 1st), as long as you remain eligible on the following September 1st immediately preceding the start of the next Plan Year and contingent on whether there are sufficient assets to continue the HRA, as determined by the Board of Trustees. For example, if you are not eligible for coverage on September 1, 2021, but become eligible on September 2, 2021, you will receive HRA benefits beginning on October 1, 2022, as long as you are eligible on September 1, 2022, and contingent on whether the HRA benefit is continued, as determined by the Board of Trustees. This eligibility practice shall apply to each year thereafter.

II - BENEFITS

Eligible Expenses: All expenses described under IRC Sec 213(d) are eligible for reimbursement by the HRA and shall be referred to herein as "Eligible Expenses." Only expenses incurred by eligible active Employees or their eligible Dependents on or after the beginning of a Plan Year (October 1, 2021, and the October 1st of each Plan Year thereafter) qualify for reimbursement. These Eligible Expenses include certain copayments, coinsurance, prescription eyewear, hearing aids, etc. Ineligible expenses include cosmetic surgery, gym memberships, teeth whitening agents, and other non-medically related services or products.

Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage. This HRA does not coordinate benefits with other group or individual health coverage.

HRA Benefit: Your HRA benefit is the amount of contributions made to your HRA, less HRA benefits you have already used. Your HRA has been set up for bookkeeping purposes only - it is NOT a vested account and is subject to amendment or termination at any time and at the sole discretion of the Board of Trustees.

Your HRA will be funded in the amount of $500 per Plan Year effective October 1, 2022 and each year thereafter, effective October 1st. The Trustees will determine at the beginning of each Plan Year the amount to fund the HRA benefits. You must use the HRA Benefit received at the start of a Plan Year during that Plan Year, which is September 1st through October 31st. Any HRA Benefits not used by the end of the Plan Year (October 31st) are forfeited. If you have any remaining HRA Benefit at the end of the Plan Year, the amount does not roll over to the new Plan Year and is instead forfeited.

How Do I Use the Benefit Card, and Will I Need Receipts?
You will be provided with a prepaid benefit card when you receive your first HRA contribution, effective October 1st. No claims forms or mailed reimbursement checks will be needed if a benefit card is used, in most cases. Each time you incur an Eligible Expense on or after October 1, 2021, you may use the benefit card, and the amount of the purchase will be deducted from your HRA balance. HRA balances and account details can be viewed online, and questions can be directed to the Administrative Office.

The IRS requires the benefit card to be used only for Eligible Expenses. The card will only work at health care-related providers or stores. In certain situations, you may receive a letter asking you to furnish an itemized receipt to verify the Eligible Expense. When such a request is received, you must submit the receipts as soon as possible to avoid having your benefit card suspended until receipts are submitted and approved. You must keep the receipts of all Eligible Expenses incurred. Ineligible expenses or expenses that cannot be substantiated may cause your debit card to be suspended. In addition, you will be issued a 1099 for transactions involving ineligible expenses (considered taxable income).

You may check your account balance by visiting: https://www.ourbenefitoffice.com/Oelocal501/benefits/ or calling the phone number listed on the back of the benefit card.

When Will I Receive Payments From the Plan?
During the Plan Year, you may submit requests for reimbursement of Eligible Expenses you have incurred during that same Plan Year to the Administrative Office in lieu of using your benefit card. The Administrative Office will provide you with forms for submitting these requests for reimbursement.

In addition, you must submit proof of the Eligible Expenses you have incurred and that they have not been paid by any other health plan coverage. If the timely request qualifies as an Eligible Expense covered by the HRA, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the HRA are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

Overpayments and Fraud
If it is determined that you and/or your covered Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense wider the HRA that is later paid for by the corresponding medical plan or some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Fund reserves the right to offset future reimbursement equal to the overpayment or erroneous payment. The Fund reserves the right to recover the overpayment plus interest and cost, through whatever means are necessary, including without limitation, legal action, or by offsetting future benefit payments to you, your dependent, or you or your dependent's heirs assigns, or estates.

The Administrative Office and the Board of Trustees may audit the Plan to detect fraud or material misrepresentations of fact for health care operations and plan administration functions. Fraudulent claims are not protected health information because they do not relate to the health condition of an individual. Examples of fraudulent claims include claims for services not rendered or claims for services rendered by a provider that does not exist. In the event, fraudulent claims are discovered, the participant will be required to refund the payment to the HRA. In addition, if the Fund determines that you have submitted a fraudulent claim, the Fund may terminate, deny, suspend, or discontinue your coverage at any time and for any length of time under this HRA, even if you would otherwise be eligible. The Fund may also take any and all action permitted by state and federal law.

Forfeiture

Any unused HRA funds will be forfeited at the end of each Plan Year. In the event you lose coverage through the Fund, retire, or die, any unused HRA balance will be forfeited immediately after your active coverage has ended. You cannot cash out or roll over to another health plan your unused HRA balance upon termination of coverage. Any unused balance after the Plan Year ends will be forfeited, and your HRA will be replenished based on the annual contribution in effect for the next Plan Year cycle, as long as you remain eligible. Any unused HRA funds at the end of a Plan Year do not roll over to the next Plan Year. You must use the HRA funds and seek reimbursement during the same Plan Year. If you do not seek reimbursement during the same Plan Year in which you incurred an Eligible Expense, any unused HRA balance will be forfeited at the end of the Plan Year, which is October 31st.

INDEMNITY MEDICAL PLAN

The Indemnity Medical Plan provides you with an outstanding program of comprehensive Hospital and medical benefits (including mental health and substance use disorder benefits). The Indemnity Medical Plan includes a preferred provider network and a preauthorization services review feature provided through Anthem Blue Cross Managed Care Services for medical care and mental health and substance use disorders. All of these elements enable you and the Plan to control costs and maximize the benefits you receive from the Plan.

You will be reimbursed for Covered Expenses incurred for medical care or services received that are Medically Necessary and authorized by a Physician or Doctor, subject to the following provisions.

SUMMARY OF ACTIVE AND RETIREE INDEMNITY MEDICAL BENEFITS AND COVERED EXPENSES

	Network Provider	Non-Network Provider
Deductibles		
Calendar Year Deductible	$200 per person per calendar year $600 per family maximum per calendar year	$1,000 per person per calendar year No per family maximum
Note:	*The deductible does not apply to chiropractic spine x-rays, acupuncture care, or to Emergency services, office visits, or Preventive Services by Network Providers.*	
Out-of-Pocket Maximum		
Medical	$5,000 per person/ $10,000 per family, inclusive of deductibles and copayments, but exclusive of any preauthorization penalties	No out-of-pocket maximum
Prescription Drug	$1,600 per person/$3,200 per family for prescription drug expenses purchased through the Prescription Drug Program with OptumRx	
Calendar Year Maximum (while otherwise eligible) for Essential Health Benefits	None	
Lifetime Maximum Benefit (while otherwise eligible) for Essential Health Benefits	None	
Preauthorization Requirement	***Inpatient hospitalizations and durable medical equipment over $1,000 must be preauthorized, or benefits will be reduced by 50%, even if your out-of-pocket maximum has been reached.*** For preauthorization of inpatient medical and Mental Health/Substance Use Disorder services and durable medical equipment over $1,000, contact the Medical (and Mental Health/Substance Use Disorder) Services Review Organization, Anthem Blue Cross, at 800-274-7767 or visit the website at www.anthem.com/ca.	
Inpatient Hospital Admissions	90% (of contract rate) after annual deductible	$600 copayment per admission, then 50% (of UCR) after annual deductible
Outpatient Surgical Facility Services	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible; $1,000 maximum facility benefits per date of service
Skilled Nursing Facility/ Extended Care Facility	90% (of contract rate) after annual deductible; coverage is limited to 60 days per calendar year	$600 copayment per admission, then 50% (of UCR); coverage is limited to 60 days per calendar year
Note:	*Maximum benefit of 60 days per calendar year. If transferred directly from a Hospital, the Non-Network Hospital inpatient admission copayment is credited toward the Non-Network Skilled Nursing Facility inpatient admission copayment.*	

	Network Provider	Non-Network Provider
Hospice Care Services		
Inpatient Services	90% (of contract rate) after annual deductible	$600 copayment per admission, then 50% (of UCR) after annual deductible
Note:	If transferred directly from a Hospital, the Non-Network Hospital inpatient admission copayment is credited toward the Non-Network Hospice Care facility inpatient admission copayment.	
In-Home Hospice Services	$20 copayment, then 90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Inpatient Respite Services	90% (of contract rate) after annual deductible, up to a maximum benefit of $1,500 per calendar year	50% (of UCR) after annual deductible, up to a maximum benefit of $1,500 per calendar year
Outpatient Respite Services	$20 copayment, then 90% (of contract rate) after annual deductible, up to a maximum benefit of $1,000 per calendar year	50% (of UCR) after annual deductible, up to a maximum benefit of $1,000 per calendar year
Professional Services		
Office Visits	$20 copayment per visit; deductible not applicable	50% (of UCR) after annual deductible
Medical Specialist/Medical Consultant Office Visits	$40 copayment per visit; deductible not applicable	50% (of UCR) after annual deductible
House Calls	$25 copayment per visit; deductible not applicable	50% (of UCR) after annual deductible
Telehealth Office Visits (Primary)	$20 copayment per visit; deductible not applicable	50% (of UCR) after annual deductible
Telehealth Office Visits (Specialist)	$40 copayment per visit; deductible not applicable	50% (of UCR) after annual deductible
Inpatient and Outpatient Surgical Services (Professional Services Only)		
Attending Physician/Surgeon	$50 copayment per procedure, then 90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Assistant Surgeon	20% of the Covered Expenses of the Primary Surgeon after annual deductible	
Specialist	$50 copayment per procedure, then 90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Anesthesia Services	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Surgery Performed in Physician's Office		
Attending Physician/Surgeon	$20 copayment per procedure, then 90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Specialist	$40 copayment per procedure, then 90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Note:	*If there is a facility charge billed for surgery performed in a Physician's office, the service shall be treated as Outpatient Surgery.*	
Alternate Birth Center	In lieu of all other Hospital benefits; 90% (of UCR) after annual deductible, up to a maximum of $800	
Midwifery Benefit	In lieu of all other medical and surgical benefits; 90% (ofUCR) after annual deductible, up to a maximum of $550	
Emergency Room Services	$100 copayment per visit for facility, then 90% (of contract rate); deductible not applicable	90% (of UCR) after annual deductible
Note:	*For non-Emergency services received in an Emergency room, the maximum benefit is 50% of UCR for a Physician's initial office visit. Facility charges are NOT covered.*	
Urgent Care	$20 copayment per visit, then 90% (of contract rate) for a Physician's initial office visit after annual deductible	50% (of UCR) for a Physician's initial office visit after annual deductible

	Network Provider	Non-Network Provider
Ambulance Services		
Ground	$50 copayment per trip, then 100% (of contract rate) after annual deductible, up to a maximumbenefit of $5,000 per disability.	$50 copayment per trip, then 100% (of billed charges) after annual deductible, up to a maximum benefit of $5,000 per disability.
Air	$50 copayment per trip, then 100% (of contract rate) after annual deductible, up to a maximum benefit of $15,000 per disability.	50% (of UCR) after annual deductible, up to a maximum benefit of $15,000 per disability.
Home Health Care Services	$20 copayment per visit, then 90% (of contract rate) after annual deductible, up to a maximum benefit of 40 visits per calendar year	50% (of UCR) after annual deductible, up to a maximum benefit of 40 visits per calendar year
Note:	*The 40-visit limit does not apply for home health care authorized in lieu of hospitalization.*	
Short Term RehabilitativeServices		
Inpatient / Outpatient (Physical, Occupational, and Speech Therapy)	$20 copayment per therapy session, then 100% (of contract rate) after annual deductible, up to a combined inpatient and outpatient maximum benefit of 60 days of treatment. Upon day 61 patient is responsible for 100% of charges.	50% (of UCR) after annual deductible, up to a combined inpatient and outpatient maximum benefit of 60 days of treatment
Chiropractic Care	Maximum of 30 visits per calendar year at $40 per visit. One full spine x-ray covered up to $100 per year. Deductible not applicable.	
Acupuncture Care	Maximum of 20 visits per calendar year covered up to $80 per visit. Deductible not applicable.	
TMJ Treatment	50% (of contract rate or UCR) after annual deductible, up to a maximum benefit of $2,500 per calendar year and a maximum lifetime benefit of $4,000	
Hearing Aids	Maximum of $2,000 allowance per device per ear every thirty-six month period.	
Laboratory Services	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Routine Radiological and Non-Radiological Diagnostic Imaging	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Note:	*For CT Scans, MRI, etc., see "Other Diagnostic and Therapeutic Services."*	
Other Diagnostic and Therapeutic Services		
Chemotherapy	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Dialysis	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Therapeutic Radiology	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Allergy Testing and Serum Injections	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Hearing Evaluations	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Amniocentesis	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Complex Radiology (CT Scan, MRI, etc.)	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Medical Supplies	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible
Prosthetics and Orthotic Devices	90% (of contract rate) after annual deductible; limited to one device per lifetime	50% (of UCR) after annual deductible; limited to one device per lifetime
Durable Medical Equipment	90% (of contract rate) after annual deductible per device	50% (of UCR) after annual deductible per device
Preventive Care Preventive Services (as specifically provided for under "Covered Expenses" on page 52)	100% (of contract rate); deductible not applicable	50% (of UCR) after annual deductible
All Other Eligible Charges	90% (of contract rate) after annual deductible	50% (of UCR) after annual deductible

	Network Provider	Non-Network Provider
Prescription Drugs	Prescription Drugs are available through the Prescription Drug Program administered by OptumRx (see pages 59 to 65).	
Mental Health and Substance Use Disorders Benefits [1,2]		
Inpatient Admissions (Hospital, Residential Treatment Facility, or Substance Use Disorders Treatment Facility)	90% (of contract rate) after annual deductible	$600 copayment per admission, then 50% (of UCR) after annual deductible
Outpatient Services	$20 copayment per visit; deductible not applicable	50% (of UCR) after annual deductible
Emergency Room Services	See Emergency Room Services benefits described above	See Emergency Room Services benefits described above
Prescription Drug	See Prescription Drug benefits described under Prescription Drug Program pages 59 to 65; combined with medical benefits	See Prescription Drug benefits described under the Prescription Drug Program on 59 to 65; combined with medical benefits

1 Active Employees and their Dependents only

2 Any other categories not listed would be covered as indicated under the medical benefits.

NETWORK OF PROVIDERS AND MEDICAL (AND MENTAL HEALTH/SUBSTANCE USE DISORDER) SERVICES REVIEW

The Trustees have contracted with Anthem Blue Cross Managed Care Services to provide a network of preferred providers, medical care and treatment at contract rates, and a Medical (and Mental Health/Substance Use Disorder) Services Review Organization to provide medical (including Mental Health and Substance Use Disorder) services review and case management. The purpose of the program is to control health care costs and to ensure that services received are Medically Necessary and appropriate.

Medical (and Mental Health/Substance Use Disorder) Services Review
The Medical (and Mental Health/Substance Use Disorder) Services Review Organization provides prior authorization (also referred to as preauthorization), concurrent review, discharge planning, and case management when applicable. It does not determine Plan benefits or eligibility and approval by the Medical (and Mental Health/Substance Use Disorder) Services Review Organization does not guarantee eligibility or benefit coverage. If you have any questions regarding benefits or eligibility, please contact the Trust Fund Administrative Office.

When Must I Contact the Medical (and Mental Health/Substance Use Disorder) Services Review Organization?
Inpatient hospitalizations and durable medical equipment over $1,000 must be preauthorized, or benefits will be reduced by 50%, even if your out-of-pocket maximum has been reached. For preauthorization of inpatient medical and Mental Health/Substance Use Disorder services and durable medical equipment over $1,000, contact the Medical (and Mental Health/Substance Use Disorder) Services Review Organization, Anthem Blue Cross, at 800-274-7767 or visit the website at www.anthem.com/ca.

Exceptions: Emergencies, when the Plan is a secondary payer, and hospitalization for childbirth for up to 48 hours following a normal delivery or 96 hours following a cesarean section.

How Does Medical (and Mental Health/ Substance Use Disorder) Services Review Affect My Benefits?
If you do not obtain preauthorization from the Medical (and Mental Health/Substance Use Disorder) Services Review Organization when required in non-emergency situations, reimbursement for such services will be reduced by 50%. No benefits will be provided for any days of confinement or services or supplies determined to be not Medically Necessary by the Medical (and Mental Health/Substance Use Disorder) Services Review Organization. This penalty for failure to obtain preauthorization does not count toward your annual out-of-pocket maximum.

Authorization of Hospital Services
Anthem Blue Cross Managed Care Services will make a complete review of the reasons for the treatment. If there is any question concerning the proposed length of stay or whether the course of treatment is appropriate for your situation, Anthem Blue Cross will confer with medical (or Mental Health/Substance Use Disorder) professionals. You, your Physician, and the Hospital are notified whether the admission has been approved. If the treatment is not authorized, your Physician can contact Anthem Blue Cross Managed Care Services and request a second review.

Your Physician will be asked to submit additional medical evidence supporting the treatment plan. Anthem Blue Cross Managed Care Services will then make a final determination.

Non-Emergency Admissions
When you are advised that a Hospital admission may be necessary, inform your Physician that it must be approved by Anthem Blue Cross Managed Care Services prior to admission. You or your Physician must then contact Anthem Blue Cross Managed Care Services to obtain the necessary approval. If possible, Anthem Blue Cross Managed Care Services should be contacted at least five (5) days prior to the Hospital admission.

Emergency Admissions
In the case of an Emergency admission to a Hospital, prior approval is not necessary. However, Anthem Blue Cross Managed Care Services must be contacted within 24 hours after the admission in order to determine whether continued hospitalization is appropriate.

Continued Stay Review
All admissions, both Emergency and non-emergency, are subject to concurrent review. This process assures that only those patients with need remain hospitalized and that the treatment plan is customary for the diagnosis. At designated intervals, a review coordinator evaluates information pertinent to your case. If necessary, the coordinator will approve the additional days. Most cases do not require the involvement of the patient.

Second and Third Opinions
In some cases, when you notify Anthem Blue Cross Managed Care Services of a proposed treatment, they can request a second opinion to verify the treatment is necessary. Anthem Blue Cross Managed Care Services will provide you with a choice of Physicians qualified and authorized to perform the consultation. In the event that first and second opinions are in conflict, Anthem Blue Cross Managed Care Services may request a third opinion from a qualified Physician. You may make the final decision whether or not to have the treatment. You are not obligated to accept the second or third opinion. However, if Anthem Blue Cross Managed Care Services requires a second or third opinion and you do not obtain it, your benefits will be reduced by 50%. The cost of second and third opinion consultations by a Physician selected by Anthem Blue Cross Managed Care Services will be reimbursed in full by the Plan.

Case Management
Case management is used to determine that care is being provided in the best setting. In some instances, a patient's needs may be met as well or better by offering an alternative treatment to an acute care Hospital confinement. Such alternatives could include home, Skilled Nursing Facility, Extended Care Facility, Residential Treatment Facility/Substance Use Disorder Treatment Facility, Hospice, or Home Health Care. In those cases involving long-term disabling Illness or Injury or frequent re-admissions, Anthem Blue Cross Managed Care Services, working with the patient's Physician, assesses whether alternative care is suitable for the individual patient and that the health care services are carried out in manner that ensures continuity of care.

Call Anthem Blue Cross Managed Care Services at (800) 274-7767 for case management review.

Preferred Provider Network
The Plan contracts with the Anthem Blue Cross preferred provider network to provide a network of Hospitals and other facilities and Physicians. Using preferred providers or Network Providers means that you will pay less for covered services because:

- The Plan's benefit level is higher when you use Network Providers.
- Network Providers agree not to charge more than negotiated discounted rates.

You may choose any provider, even those who are not in the Network. However, when you use Non-Network Providers, the Plan reimburses Covered Expenses at a lower percentage, and the amount charged may be greater than charged by a Network Provider. Both of these situations mean that you will pay more out of your own pocket.

Participating Physician Network
Network Physicians have agreed to provide their medical or mental health and substance use disorders services to you at special reduced rates. You are not required to use a Network Physician, but both you and the Plan save money if you do. For most benefits, the Plan covers 90% of the contract rate (after any applicable deductible and/or copayment) when you use a Network Physician, or 50% of the Usual, Customary, and Reasonable (UCR) charge (after any applicable deductible and/or copayment) when you use a Non-Network Physician. You can also go to the Anthem Blue Cross website at www.anthem.com/ca for this information.

As an exception to the above, the reduction in benefits if you use a Non-Network Physician will not apply in an Emergency (i.e., for Emergency services provided in an Emergency department of a Hospital, which will be paid at 90% of UCR) or if there is not a Network Physician located within 35 miles of your home **OR** if you require treatment not provided by a Network Physician, provided the services are approved by Anthem Blue Cross Managed Care when appropriate. Those Participants who reside at least 35 miles outside the nearest Network Physician's facility will not incur a reduction in benefits. Preauthorization must still be obtained by Anthem Blue Cross Managed Care Services when appropriate. Your out-of-area benefits will mirror the Network benefits subject to UCR (Usual, Customary, and Reasonable) criteria.

Participating Hospital Network
Participating Hospitals in the Network charge special reduced rates, which, in turn, reduce your out-of-pocket expenses for approved hospitalizations and reduce the cost to the Trust Fund.

How Does the Hospital Network Affect My Benefits?
Your benefits will be affected as follows:

a. If you use a Network Hospital for a confinement approved by the Medical (and Mental Health/Substance Use Disorder) Services Review Organization, the Plan will provide a benefit of 90% of covered inpatient Hospital expenses after you pay any applicable copayment and the calendar year deductible.

b. If you do not use a Network Hospital, the Plan will cover 50% of the Usual, Customary, and Reasonable (UCR) charges after the $600 per admission copayment and the calendar year deductible. Your benefits will be reduced further by 50% if you do not obtain preauthorization of the Hospital admission.

c. Routine newborn care is a Covered Expense at Network Hospitals. Expenses for routine care at Non-Network Hospitals are not covered.

Penalties for failure to preauthorize and charges for Non-Network services do not count towards your out-of-pocket maximum.

How Do I Know if My Hospital is in the Network?
The list of Network Hospitals changes over time as providers are added or leave the Network. For a current list of Network Hospitals or to confirm that a certain facility is on the list, please call Anthem Blue Cross at (800) 274-7767. You can also go to www.anthem.com/ca for this information.

What Happens in an Emergency?
Emergencies requiring immediate care and treatment should be provided at the most convenient facility, regardless of whether it is a Network Hospital. In an Emergency, the Plan will not reduce your benefits for using a Non-Network Hospital. However, if continued hospitalization is necessary, the Plan may require you to move to a Network Hospital as soon as it is medically safe to transfer you. If you decline to be transferred to a Network Hospital, benefits will be reduced to 50% (of UCR) beginning on the date you could have been transferred.

What if There is no Network Hospital in My Area?
If there are no Network Hospitals within 35 miles of your home, the benefit reduction will not apply. Your out-of-area benefits will mirror the Network benefits subject to UCR. However, your out-of-pocket expenses may be less if you use a Network Hospital. Remember, the Medical (and Mental Health/Substance Use Disorder) Services Review Organization must be contacted for all Hospital admissions, not just those at a Network Hospital.

What if I Require Treatment Not Available at a Network Hospital?
In rare cases, there may be certain surgical procedures that require special facilities not available at a Network Hospital. In the event you require such a procedure, your benefit will not be reduced for using a non-Network Hospital. However, you must obtain prior approval from the Fund Administrative Office, and the Medical (and Mental Health/Substance Use Disorder) Services Review Organization must be contacted for preauthorization.

Outpatient Facility and Surgical Center Network
In addition to the Hospital Network, there is also a network of outpatient facilities for medical (and Mental Health/Substance Use Disorder) care and Surgical Centers, which includes outpatient departments of Hospitals. Expenses incurred in a participating facility in the outpatient Network are covered at 90% (of contract rate) after any applicable copayment or deductible. If services are received at a Non-Network facility, the Plan covers 50% of the Usual, Customary, and Reasonable (UCR) charges after the calendar year deductible is satisfied.

If you have services at a Non-Network Outpatient Surgical Facility, the maximum benefit payable for Non-Network charges is $1,000 per date of service.

Please contact the Fund Administrative Office or Anthem Blue Cross for a current listing of Network outpatient facilities. You can also go to www.anthem.com/ca for this information.

Health Care Provider Choices
The Plan does not require that you designate a primary care provider. You may choose to see any provider(s) that you wish.

Similarly, no preauthorization or referral is required if you are female and seek obstetrical or gynecological care provided by a Network Provider who specializes in obstetrics or gynecology (i.e., an OB-GYN).

INDEMNITY MEDICAL PLAN COVERAGE INFORMATION

The Indemnity Medical Plan has been structured to provide strong financial incentives for you and your Dependents to use Network Providers. A description of the Indemnity Medical Plan benefits is outlined below.

Deductibles and Copayments
The deductible is the initial amount of Covered Expenses you must pay each calendar year before the Plan will reimburse most Covered Expenses. The deductible does not apply to chiropractic spine x-rays; or to Emergency services, office visits, or Preventive Services provided by Network Providers. There are also copayments for certain services, including Non-Network Hospital or inpatient admissions, and office visits, Emergency, and Urgent Care Facility services, certain outpatient services, Home Health Care visits, certain rehabilitation services, in-home Hospice visits, etc.

If you or your Dependent are admitted to the Hospital more than once for the same course of treatment, only one inpatient admission copayment shall apply in a Non-Network facility. A course of treatment is all periods of illness arising from the same or related causes, including complications, without any intervening recovery or return to active full-time employment. A new copayment will apply if you recover or return to active full-time employment. For Dependents, a new copayment will apply if your Dependent recovers for a period of six months and resumes normal activities.

Your deductible is lower when you use the Plan's Network Providers.

Using Network Providers
The Plan requires a deductible of $200 per person per calendar year for Network Provider services. No more than three (3) family members' calendar year deductibles will be charged against your family's total Covered Expenses during any calendar year (i.e., $600 per family deductible). Covered Expenses that are applied toward satisfying the calendar year deductible during the last three months of the calendar year shall be applied toward satisfying the deductible in the following calendar year.

You will be required to make a copayment for many services you receive from Network Providers. The amount of the copayment is different depending on the type of service provided. The Summary of Benefits chart on pages 37 to 40 includes the copayments required for each type of service.

Using Non-Network Providers
The Plan requires a deductible of $1,000 per person per calendar year for Non-Network Provider services. There is no per family deductible. Covered Expenses that are applied toward satisfying the calendar year deductible during the last three months of the calendar year shall be applied toward satisfying the deductible in the following calendar year.

The Plan also requires a **$600 copayment per Hospital or inpatient admission** to Non-Network facilities.

If you have services at a Non-Network outpatient surgical facility, the maximum benefit payable for Non-Network charges is $1,000 per date of service.

Out-of-Pocket Maximum
The out-of-pocket maximum puts a limit on the amount you will pay out of your own pocket in one calendar year. There is an out-of-pocket maximum for Covered Expenses of $5,000 per person and $10,000 per family, including deductibles and copayments (but not including preauthorization penalties) if you use a Network Provider. There is an out-of-pocket maximum for covered prescription drug expenses of $1,600 per person and $3,200 per family if the prescription drugs are purchased through the Prescription Drug Program with OptumRx. After you have reached the out-of-pocket maximum, the Plan reimburses Covered Expenses at 100% of the contract rate (or for Non-Network services, for a covered person who lives out of area, or for Non-Network Emergency services, the Usual, Customary, and Reasonable (UCR) Charges) for the remainder of the calendar year. **There is no out-of-pocket maximum if you use a Non-Network Provider.**

Charges that you or your Dependent(s) might incur that are not Covered Expenses are not included in the out-of-pocket protection. Reductions in benefits applied for not obtaining authorization from the Medical (and Mental Health/Substance Use Disorder) Services Review Organization are also not included in the out-of-pocket maximum.

Calendar Year Maximum
There is no calendar year annual dollar maximum benefit for Essential Health Benefits provided under the Plan.

Certain annual (and lifetime) limits, such as limits on number of visits, dollar limits on non-Essential Health Benefits, and per-visit dollar limits, still apply. For example, there are per-visit dollar limits and annual visit limits on chiropractic care, annual visit limits for Skilled Nursing Facilities, annual dollar limits on Hospice-respite care, dollar limits for TMJ treatment, annual visit limits for Home Health Care services, and treatment limits for short-term rehabilitative services.

Lifetime Maximum Benefits
There are no dollar-amount lifetime maximum limits with respect to Essential Health Benefits provided under the Plan.

Certain lifetime limits may apply (see discussion above under “Calendar Year Maximum”).

Covered Expenses
The Plan’s reimbursement rate is applied to the contract rate for Network Providers or the Usual, Customary, and Reasonable (UCR) charges for Non-Network Providers, for Medically Necessary services and supplies performed or prescribed by a Doctor for treatment of a covered accidental Injury or Illness after any copayments and/or deductibles have been satisfied.

Remember, use of Network Providers and preauthorization by the Medical (and Mental Health/Substance Use Disorder) Services Review Organization is required to receive the highest level of benefits offered by the Plan. **Please also refer to the Summary of Active and Retiree Indemnity Medical Benefits and Covered Expenses chart on pages 37 to 40 for specific Network and Non-Network benefit amounts.**

Hospital Expenses
Room and Board and Miscellaneous Charges - The Plan covers room, board, and miscellaneous charges during a Hospital stay. This includes the semi-private room rate, and for an intensive care unit or coronary care unit, up to two and one-half times the Hospital’s most common charge for its standard semi-private room rate if such a room is Medically Necessary, miscellaneous charges, and supplies provided by the Hospital. Remember to call Anthem Blue Cross Managed Care Services at (800) 274-7767 to obtain preauthorization for Hospital admissions.

Residential Treatment Facility and Substance Use Disorder Treatment Facility
The Plan covers room, board, and general care during a stay. This includes the semi-private room rate. If the facility does not have semi-private rooms, that part of the facility’s daily charge in excess of the area’s prevailing rate for semi-private rooms will not be considered a Covered Expense.

Expenses for mental health and substance use disorder services and supplies required for treatment, including prescription drugs approved by the Federal Drug Administration, which are provided by the facility and used while admitted in the facility, are also considered Covered Expenses. Please remember to call Anthem Blue Cross Managed Care Services at (800) 274-7767 to obtain preauthorization for any inpatient admissions.

Emergency Services Charges
Covered Expenses for Emergency Services shall include charges for the facility and professional services in an Emergency Department of a Hospital.

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Ambulance Service
When Medically Necessary, professional ambulance service to and from the nearest appropriate Hospital is covered as shown in the Summary of Active and Retiree Indemnity Medical Benefits and Covered Expenses chart on pages 37 to 40, up to $5,000 for ground.

1. the patient is being admitted as a bed patient, and the service is recommended by the attending Physician;

2. the patient is being released as a bed patient, and such service is recommended by the attending Physician; or

3. the patient receives treatment for an Emergency Injury or Illness.

4. **Air Ambulance Services:** If you receive services from an air ambulance which is out-of-network, the most the provider may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these services. This does not apply to ground ambulance services.

Charges for professional ambulance service in the following circumstances shall not be covered:

1. going to the Hospital when the patient could be safely transported by means other than an ambulance, whether or not such other transportation is available; or

Surgical Expenses
The Plan provides benefits for inpatient and outpatient surgical services when Medically Necessary and which are generally recognized and accepted procedures for diagnostic or therapeutic purposes in the treatment of an Illness or Injury. You must call Anthem Blue Cross Managed Care Services at (800) 274-7767 before you schedule any inpatient surgery. If you do not obtain preauthorization when required, your benefits will be reduced by 50%.

Primary Surgeon - The Plan covers surgical procedures performed as a result of you or your Dependent's Injury or Illness, including surgery performed in the Physician's office. If a second or third surgical opinion is required by the Medical Services (and Mental Health/Substance Use Disorder) Review Organization, the cost of the additional opinion is covered at 100% of the Usual, Customary, and Reasonable (UCR) charge.

More than One Procedure - If two (2) or more Medically Necessary procedures are performed through the same incision during a single surgical session, the benefit provided will not exceed the largest amount reimbursable for any of the procedures. If two (2) or more Medically Necessary procedures are performed through different incisions during a single surgical session, the benefit provided will not exceed 100% of the amount reimbursable for the major procedure, 50% of the amount reimbursable for the second procedure, 25% of the amount reimbursable for the third procedure, 10% of the amount reimbursable for the fourth procedure, and 5% of the amount reimbursable for the fifth procedure.

Assistant Surgeon - Expenses for services performed by an assistant surgeon are reimbursable up to 20% of the Covered Expenses for the services of the primary surgeon. If services are performed by more than one assistant surgeon, the total benefit shall not exceed the amount for one assistant surgeon.

Anesthetist - The Plan reimburses Covered Expenses made by an anesthetist for the administration of anesthesia during surgery. Anesthesia services do **not** include acupuncture, hypnosis, or the administration of anesthesia by the primary surgeon or the assistant surgeon.

Outpatient Surgical Facility Services
If you or your Dependent undergo surgery in an outpatient department of a Hospital, a Surgical Center, a Doctor's office, or an approved Outpatient Surgical Facility, the Plan will cover charges incurred for necessary services and supplies provided by the facility, excluding charges for nursing care and Physician fees.

Physician Expenses
The Plan covers expenses for a Physician's services for conditions due to an Illness or Injury.

Hospital Visit - The Plan covers expenses for visits by a Physician during a period of Hospital confinement as a result of an Illness or Injury. No benefits shall be provided for a Physician's visit on the day he performs a surgical procedure or for post-operative care rendered by the Physician.

Office Visit/ House Call / Telehealth Visit - The Plan covers expenses for each office visit or house call made as a result of an Illness or Injury.

Specialist Consultant - The Plan covers expenses for a specialist or consultant treating the patient during a Hospital confinement or as an office visit.

Chiropractic Care
The Plan will reimburse a maximum of $40 per visit up to a maximum of thirty (30) visits per calendar year for chiropractic care. One full spine x-ray will be reimbursed per calendar year up to a maximum benefit of $100. HMO members are entitled to chiropractic care through the Indemnity Medical Plan.

Acupuncture Care
The Plan will reimburse a maximum of $80 per visit up to a maximum of twenty (20) visits per calendar year for acupuncture care. HMO members are entitled to acupuncture care through the Indemnity Medical Plan.

Temporomandibular Joint Treatment (TMJ)
The Plan covers the charges for professional services made by a Physician for TMJ when Medically Necessary at 50% of the contract rate or Usual, Customary, and Reasonable (UCR) charge, subject to a maximum benefit of $2,500 per calendar year and a maximum lifetime benefit of $4,000.

Hearing Aids
The Plan will reimburse a maximum of $2,000 per device per ear every thirty-six month period. HMO members are entitled to this hearing aid benefit through the Indemnity Medical Plan.

Skilled Nursing Facility Services
Benefits are provided if the stay in a Skilled Nursing Facility begins within seven days after a stay of at least five consecutive days in a Hospital. Covered Expenses include the Skilled Nursing Facility's most common charge for its standard semi-private room for up to a maximum of 60 days per calendar year. The stay in the Skilled Nursing Facility must be Medically Necessary and not substantially for custodial services. Inpatient admissions must be preauthorized, or benefits will be reduced by 50%. Remember to call Anthem Blue Cross Managed Care Services at (800) 274-7767 to obtain preauthorization for inpatient admissions.

If you or your Dependent are transferred directly from a Non-Network Hospital, the Non-Network inpatient admission copayment for the Hospital stay will be credited toward the inpatient admission copayment for the Skilled Nursing Facility.

Substance Use Disorder Facility/Residential Treatment Facility
The Plan covers room, board, and general care during a stay. This includes the semi-private room rate. If the facility does not have semi-private rooms, that part of the facility's daily charge in excess of the area's prevailing rate for semi-private rooms will not be considered a Covered Expense.

Expenses for Mental Health and Substance Use Disorder services and supplies required for treatment, including prescription drugs approved by the Federal Drug Administration, which are provided by the facility and used while admitted in the facility, are also considered Covered Expenses. Please remember to call Anthem Blue Cross Managed Care Services at (800) 274-7767 to obtain preauthorization for inpatient admissions.

Home Health Care
The Plan covers Home Health Care services for up to a maximum of forty (40) visits per calendar year. If Home Health Care services are authorized by the Anthem Blue Cross in lieu of hospitalization, the calendar year maximum of forty (40) visits shall not apply. Home Health Care services include intravenous (IV) therapy.

Hospice Services
The Plan covers the following Hospice services:

Hospice Services - If you or your Dependent are transferred directly from a Non-Network Hospital to a Non-Network Hospice facility, the Non-Network inpatient admission copayment for the Hospital stay will be applied toward the inpatient admission copayment for the Hospice facility. The Plan also covers nurses' charges for Hospice services provided in your home.

Respite Services - The Plan covers care for the Hospice patient, which provides a respite for caregivers from the stresses and responsibilities that result from the daily care of the patient. For inpatient Hospice respite services, the Plan reimburses a maximum of $1,500 per calendar year. For in-home Hospice respite services, the Plan reimburses a maximum of $1,000 per calendar year.

Organ Transplants
If you are in need of an organ transplant, you MUST call Anthem Blue Cross for a referral to a Center of Expertise. A Center of Expertise is a Hospital that has specialized facilities, Physicians, and other practitioners whose specialties include organ transplants. You MUST use a Center of Expertise facility, except when an alternative is approved by Anthem Blue Cross.

Network Provider benefits will apply to all care related to an organ transplant received at a Center of Expertise (unless an alternative is otherwise approved by Anthem Blue Cross). If you do not use a Center of Expertise, Non-Network Provider benefits will apply to all care related to the organ transplant.

Dental and Oral Surgical Services
The following services are covered under the Indemnity Medical Plan:

1. treatment for accidental Injuries to sound natural teeth, the jawbones, or surrounding tissues;

2. correction of a non-dental, physiological condition, which has resulted in a severe functional impairment; and

3. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

Benefits payable under the Plan will be reduced by any benefits payable under your dental plan if any.

Midwifery/Alternative Birthing Center
Midwifery Benefit - In lieu of all other medical and surgical benefits provided under the Plan as a result of any one pregnancy, midwifery expenses incurred by you or your eligible Dependent will be covered at 90% of Usual, Customary, and Reasonable (UCR) charges, up to a maximum benefit of $550. Services must be performed by a certified nurse-midwife or other service provider providing midwifery benefits within the scope of their license or certification, as applicable.

If you or your eligible Dependent incurs any Covered Expenses for medical or surgical treatment with respect to such pregnancy, available benefits will be reduced by any amount provided for midwifery benefits.

Alternate Birthing Center - In lieu of all other Hospital benefits provided under the Plan, Hospital expenses incurred by you or your eligible Dependent in an Alternate Birthing Center of a Hospital will be covered at 90% of Usual, Customary, and Reasonable (UCR) charges, up to a maximum of $800.

If you or your eligible Dependent incurs any other Hospital expenses in conjunction with such pregnancy, available benefits will be reduced by any amount provided for the Alternate Birthing Center.

A free-standing Alternate Birthing Center is also covered under this benefit, provided there are Physicians on staff, and the Alternate Birthing Center has an agreement with a Hospital to provide Emergency care.

Short-Term Rehabilitative Services
Short-term rehabilitative services are covered up to a combined benefit for inpatient and outpatient services of 60 days. Short-term rehabilitation therapy includes Medically Necessary physical therapy, speech therapy, occupational therapy, and monitored cardiac rehabilitation on an inpatient or outpatient basis. Rehabilitation therapy is limited to acutely or recently acquired conditions that are subject to significant improvement through short-term therapy as determined by Anthem Blue Cross or the Medical (and Mental Health/Substance Use Disorder) Services Review Organization.

Laboratory Services
The Plan covers laboratory exams that are a result of an accidental Injury or Illness and is authorized by a Physician.

The following expenses are **not** covered:

1. any examination for routine check-up purposes not incident to or necessary to diagnose an Illness or accidental Injury (however, the Plan does provide Preventive Services benefits, as described on page 52);

2. examinations in connection with any dental work or procedure except as may be required on account of accidental Injury to natural teeth, unless such expenses are covered under the Dental Plan;

3. any examination for which you or your Dependent is entitled to benefits under any other provision of the Plan, or services rendered without charge, paid for or reimbursable by or through a national, state, provincial, county or municipal government or other political subdivision or any instrumentality or agency thereof, except to the extent that such services are reimbursable to the Veterans Administration for non-service connected conditions under 38 U.S.C. § 629; or

4. any premarital examination.

Routine Radiological and Non-Radiological Diagnostic Imaging
The Plan covers routine radiological and non-radiological diagnostic imaging. Covered Expenses include supplies and materials, general radiography, fluoroscopy, mammography, and abdominal ultrasound.

Other Diagnostic and Therapeutic Services
The Plan covers other diagnostic and therapeutic services as follows:

1. chemotherapy;

2. dialysis;

3. therapeutic radiology;

4. allergy testing and serum injections;

5. hearing evaluations;

6. amniocentesis – services provided must meet the American College of Obstetrics and Gynecology guidelines; and

7. other complex diagnostic and therapeutic services, including complex:

    - diagnostic imaging services including nuclear medicine, computerized axial tomography (CAT), cardiac ultrasonography, magnetic resonance imaging (MRI),and arthrography;

    - vascular diagnostic and therapeutic services including Holter monitoring, treadmill orstress testing, and impedance venous plethysmography;

    - neurological diagnostic services including electroencephalograms (EEG), electromyogram (EMG), and evoked potential;

    - psychological diagnostic testing; and

    - pulmonary diagnostic services, including pulmonary function testing and apnea monitoring.

Medical Supplies
The Plan covers the following medical supplies:

1. colostomy bags, catheters, dressings, syringes, and hypodermic needles and any other supplies authorized by Anthem Blue Cross Medical (and Mental Health/Substance Use Disorder) Services Review Organization or Case Management;

2. anesthesia and oxygen; and

3. blood and blood products.

Prosthetic and Orthotic Devices and Durable Medical Equipment
The Plan covers the following prosthetic and orthotic devices and durable medical equipment:

1. prosthetics and orthotics, including initial artificial limbs or eyes replacing natural ones; benefits are limited to one device per limb or eye; and

2. durable medical equipment - approved for therapeutic treatment, provided it is Medically Necessary, and the attending Physician submits a written statement to the Trust Fund Administrative Office indicating the approximate length of time the equipment will be needed and the medical reason for such equipment.

Durable medical equipment over $1,000 must be preauthorized, or benefits will be reduced by 50%. Remember to call Anthem Blue Cross Managed Care Services at (800) 274-7767 to obtain preauthorization for durable medical equipment.

Preventive Services
The Plan covers the following:

1. Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults (i.e., those immunizations that have been adopted for recommendation by the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention);

3. Preventive care and screening for infants, children, and adolescents, as provided for in the comprehensive guidelines by the Health Resources and Services Administration (HRSA); and

4. Preventive care and screening for women, as provided for by the HRSA that are not otherwise addressed by Task Force recommendations.

5. For more information please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Mental Health and Substance Use Disorder Services
The Plan covers inpatient and outpatient Mental Health and Substance Use Disorder services to the same extent as inpatient and outpatient medical benefits.

Inpatient Mental Health and Substance Use Disorder services must be preauthorized, or benefits will be reduced by 50%. Remember to call Anthem Blue Cross Managed Care Services at (800) 274-7767 to obtain preauthorization for inpatient Mental Health and Substance Use Disorder services.

Non-Network Provider Provision
If you are treated at a Network Provider hospital for emergency room services or for inpatient services but a Non-Network Provider performs certain medically necessary services, such as laboratory analyses, radiology imaging, anesthesia, or assistant surgeon services, and the choice to use a Non-Network Provider was outside your control, the Plan will reimburse the charges for such services as if a Network Provider had performed them.

Such Non-Network covered charges will be subject to the Network Provider Copayment, Out-of-Pocket Maximum, Deductible, and 90% of UCR thereafter.

EXCLUSIONS AND LIMITATIONS OF THE INDEMNITY MEDICAL PLAN

Benefits are not paid for the expenses incurred with any of the following (except as otherwise provided under *Preventive Services* benefits):

1. any injury or sickness for which treatment is not Medically Necessary or is not provided or authorized by a licensed Physician and/or Licensed Clinical Mental Health Professional as defined in *General Definitions;*

2. except as otherwise provided under *Dental and Oral Surgical Services*, dental splints, dental prostheses, or any treatment on or to the teeth, gums, or jaws, and other services customarily provided by a Dentist. Charges or services in connection with temporomandibular joint dysfunction are not covered unless determined to be Medically Necessary and not a dental procedure and are subject to the benefit limitation for such services listed in the Summary of Active and Retiree Indemnity Medical Benefits and Covered Expenses chart and in *Temporomandibular Joint Treatment (TMJ)*.

3. eye refractions or eyeglasses;

4. expense incurred for services and supplies: (a) for which no charge is made, (b) for which the Employee is not required to pay, or (c) which are paid for or reimbursable by or through a national, state, provincial, county, or municipal government or other political subdivision of any instrumentality or agency thereof, except to the extent that such services are reimbursable to the Veterans Administration for non-service connected conditions under 38 U.S.C. § 629;

5. any occupational injury or sickness for which there is or was a right to compensation under any Workers' Compensation or Occupational Disease Law or similar legislation;

6. any Injury or Illness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain;

7. any Hospital or medical services covered by the Medicare (Part A or Part B), except that any balance of monies payable by a Participant for Hospital or medical services received under Medicare will be subject to the Coordination of Benefits provisions of this Plan;

8. any Hospital or medical services in connection with an Injury or Illness resulting from insurrection or war (whether declared or undeclared), rebellion, armed invasion, acts of terrorism, or aggression, or any act incident thereto, participation in a riot, or participation in committing a crime or unlawful act or improper conduct, an intentional self-inflicting injury whether sane or insane or any services in connection with suicide or attempted suicide;

9. institutional care which, as determined by the Medical (and Mental Health/Substance Use Disorder) Services Review Organization, is for the primary purpose of controlling or changing the Participant's environment; or custodial care, including custodial home care;

10. anything other than a bodily Injury or sickness, such as routine physicals or check-ups or x-rays and laboratory tests not done solely for diagnostic purposes or which are unrelated to a diagnosis; however, the Plan does provide Preventive Services benefits that include routine pap smears and prostate exams, etc. (see *Preventive Services* on page 52 for information);

11. cosmetic surgery (or any expenses related to cosmetic surgery, which is defined as surgery to change the shape or structure of, or otherwise alter a portion of the body solely or primarily for the purpose of improving appearance and not as a result of disease or condition which, in accordance with accepted medical practice, requires surgical intervention to cure or alleviate pain or restore function; but please refer to page 105 regarding the Women's Cancer Rights Act;

The following procedures will **not** be considered cosmetic surgery:

- breast reconstructive surgery, including prosthetic devices, following a mastectomy that was covered under this Plan, provided the patient is covered under the Plan when reconstructive surgery is performed;
- reconstructive surgery, which is a result of accidental injury; and
- corrective surgery for newborns who are born with congenital defects and birth abnormalities.

12. any expense incurred in connection with reversal of an elective procedure, including but not limited to, reversal of a previous vasectomy or tubal ligation;

13. any expense incurred relative to a transsexual procedure (sex-change) or resulting from medical complications;

14. any expense incurred in connection with any experimental or investigational procedure (except that the Plan shall not deny participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; shall not deny or limit or impose additional conditions on the coverage of routine patient costsfor items or services furnished in connection with participation in the trial; and shall not discriminate against an individual on the basis of the individual's participation in a clinical trial, in accordance with the Patient Protection and Affordability Care Act of 2010, and any regulations issued thereunder);

15. milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electro sleep therapy, or electro narcosis;

16. expenses incurred for treatment of infertility or impotence, including artificial insemination, embryo transplants, in vitro fertilization, and low tubal transfers;

17. penile prosthesis;

18. charges made by a surgeon for visits on the same day he performs a surgical procedure or during the post-operative period;

19. charges made by a relative by blood or marriage of the Employee or Dependents or by any member of the patient's family;

20. non-human devices or artificial organs such as but not limited to, heart, lung, heart-lung, kidney, liver, and cochlear for transplant purposes shall not be covered; any services or supplies received by an organ transplant donor-related to the organ transplant and costs related to cadaver organ retrieval or maintenance of a donor for organ retrieval, except for those conditions as outlined under *Organ Transplants*;

21. vision examinations to determine refractive errors of vision and eyeglasses or contact lenses, except as otherwise provided under Vision Care Plan, as applicable; radial keratotomy, visual therapy, and orthoptics (see the Vision Care Plan for more information);

22. Hospital expenses incurred for dental treatment, unless for Medically Necessary treatment needed as a result of an accident (please refer to page 49 regarding *Dental and Oral Surgical Services*;

23. services rendered by any physician not meeting the definition above of a Doctor or Physician;

24. services rendered by any hospital not meeting the definition of a Hospital above;

25. surgical or invasive treatment or reversal thereof for reduction of weight regardless of associated medical or psychological conditions, including treatment of the complications resulting from surgical treatment of obesity, unless for morbid obesity; any weight loss programs, whether or not recommended, provided or prescribed by a Physician or other medical practitioner;

    Morbid obesity means:

    - a body mass index (your weight in kilograms divided by the square of your height in meters) of at least 35, with co-morbidity or co-existing medical conditions (e.g., hypertension, cardiopulmonary conditions, sleep apnea, or diabetes);

    - A body mass index of at least 40 without co-morbidity.

    In order to determine if the claimant qualifies for coverage, the following information must be obtained from the attending Physician:

    - the pathological source of the obesity and the tests performed that support the diagnosis;

    - other serious disabilities of the claimant complicated by the obesity;

    - the patient's pre-surgical weight and height; and

    - the details of the conservative treatment attempted prior to the decision to perform the surgery.

    If the claimant qualifies for coverage of the surgical benefit, then all other applicable Plan benefits will be payable; the Plan will not recognize any expenses incurred relative to any procedures performed to reverse such a surgical procedure;

26. personal comfort, hygiene, or convenience items such as a Hospital television, telephone, private room (except as Medically Necessary); housekeeping, homemaker, meal services as part of Home Health Care; modifications and alteration in a home or place of residence, including equipment to accommodate a physical handicap or disability;

27. third party physical examinations for employment, licensing, insurance, school, camp, sports, or adoption purposes; immunizations related to foreign travel; expenses for medical reports, including presentation and preparation; examination or treatment ordered by a court or in connection with legal proceedings if not otherwise covered;

28. abortions, unless the life of the mother (eligible Employee or Spouse) would be endangered if the fetus were carried to term or in the event of a miscarriage;

29. ecological or environmental medicine; use of chelation or chelation therapy, orthomolecular substances; use of substances of animal, vegetable, chemical, or mineral origin not specifically approved by the FDA as effective for such treatment; electro diagnosis; Hahnemannian dilution dental fillings; laetrile; or gerovital;

30. services for chronic, intractable pain by a pain control center or under a pain control program;

31. travel, whether or not recommended or prescribed by a Physician or other Medical Practitioner;

32. prescription and over-the-counter drugs, except as otherwise provided herein; drugs and medicines to the extent that they are administered for purposes other than those approved by the Federal Food and Drug Administration (FDA) regardless of whether obtained in the United States or elsewhere; drugs and medicines approved by the FDA for experimental or investigational use;

33. any services or supplies received in connection with a Participant acting as or utilizing the services of a surrogate mother;

34. any equipment or supplies that are primarily non-medical equipment or supplies;

35. special formulas, food supplements, or special diets;

36. any services, supplies, or accommodations provided without cost to the Participant or for which the Participant has no legal obligation to pay;

37. charges for family planning counseling, including genetic and sterility;

38. outpatient oxygen and its administration unless specifically approved by the Medical (and Mental Health/Substance Use Disorder) Services Review Organization;

39. sports medicine treatment plans, which are intended primarily to enhance athletic functions;

40. any service provided for educational training, except diabetic training;

41. outpatient injectables are excluded from the Indemnity Medical Plan; coverage is offered under the prescription drug program and will require prior authorization unless specified otherwise (please refer to pages 59 to 65 for further information);

42. health care services of any kind (including Emergency services and hospitalization) if those services are received outside of the United States;

43. treatment of congenital and/or organic disorders, including but not limited to Organic Brain Disease and Alzheimer's Disease;

44. treatment of mental retardation, other than the initial diagnosis;

45. court-ordered testing, counseling, and treatment;

46. case management and administrative supervision, when billed separately; this is considered an essential part of the billing for daily Hospital care by the attendingPhysician and should not be paid as a separate billing;

47. other administrative services such as expert testimony, medical records review and maintenance, preparation of reports regarding civil or legal matters (child custody issues), ability to stand trial, consultation with attorneys or other representatives of social control systems;

48. consultation with a counselor or professional for adjudication of marital, child support, and custody cases;

49. treatment for eating disorders, sexual addiction, and gambling programs based solely on the 12 Step Model;

50. health care services, treatment, or supplies which are primarily for rest, custodial, domiciliary, or custodial care; or

51. when the injury or illness of the covered Employee and/or eligible Dependent is caused by the act or omission of a third person unless an Acknowledgment of Lien and Subrogation is executed by the Employee and/or eligible Dependent (or his or her authorized representative) and returned to the Plan (please refer to Third Party Liability – Exclusion and Limitations, on pages 107 to 108).

SWIFTMD TELEMEDICINE SERVICES

Employees and their eligible Dependents of the Indemnity Medical Plan have access to a telemedicine program called SwiftMD as an alternative to avoid costly urgent care or emergency room visits. SwiftMD provides you with access to U.S. board-certified doctors who can treat many of your non-emergency medical issues by phone or videoconferencing 24/7, 365 days a year. The Plan covers SwiftMD visits in full, and such visits are not subject to the medical annual deductible.

SwiftMD physicians are emergency medicine and family practice doctors who specialize in dealing with a range of common medical conditions such as:

- Cold and flu symptoms;
- Allergies and rashes;
- Urinary tract infection;
- Joint and back pain;
- Respiratory infection;
- Sinus problems, and more.

Please note that SwiftMD is not intended for medical emergencies nor to replace your primary care doctor or specialist managing a chronic or serious condition. In addition, SwiftMD doctors do not prescribe controlled substances, psychiatric, and certain other medications.

To set up a phone or video call with a SwiftMD doctor, call (833) 794-3863 or log in at mySwiftMD.com.

TIME LIMITATION FOR A SECTION 502(A) LAWSUIT

A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination or, for eligible claims, the date of the notice of the final/external review decision. Please see the section of the booklet entitled "Claims and Appeal Procedures" on pages 114 to 123 for the detailed Claims and Appeals Procedures regarding Indemnity Medical Plan claims.

WAIVER OF CLASS, COLLECTIVE, AND REPRESENTATIVE ACTIONS

By participating in the Plan, to the fullest extent permitted by law, whether in court or otherwise, Participants waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy and Participants agree that any dispute, claim, or controversy may only be initiated or maintained and decided on an individual basis.

PRESCRIPTION DRUG PROGRAM FOR ACTIVE EMPLOYEES AND RETIREES UNDER THE INDEMNITY PLAN

SUMMARY OF PRESCRIPTION DRUG BENEFITS AND COVERED EXPENSES

<table>
<tr><th></th><th>Network Provider</th><th>Non-Network Provider</th></tr>
<tr><td>Prescription Drugs</td><td>Through OptumRx ONLY - You pay:</td><td rowspan="7">Not Covered</td></tr>
<tr><td>Walk-In Program</td><td><u>Formulary Generic</u>:
$10 copayment

<u>Formulary Brand</u>:
$35 copayment

<u>Non-Formulary Brand or Generic</u>: 60% of the cost of the drug for each prescription</td></tr>
<tr><td>Walk-In Supply Limit</td><td>30-day supply</td></tr>
<tr><td>Injectables/Other Specialty Drugs</td><td>20% of the cost per injectable with a $100 cap per injectable and subject to prior authorization. MUST be obtained through BriovaRx pharmacy. (Specialty drug Adynovate must be obtained through Diplomat).</td></tr>
<tr><td>Mail Order Program
Through Prescription Plan Only</td><td></td></tr>
<tr><td>Prescription Drugs</td><td>2½ times retail copayment for Generic and Formulary Brand Drugs; Non-Formulary Brand Drugs will be charged at 60% of each prescription</td></tr>
<tr><td>Mail Order Supply Limits</td><td>90-day supply</td></tr>
<tr><td colspan="3">Note: Preventive Service prescription drugs will be covered at $0 copayment for generics (or formulary/non-formulary brand drugs if generic/formulary brand drugs are medically inappropriate) to the extent recommended in the guidelines by the U.S. Preventive Care Task Force, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration, as applicable (see description under Preventive Service Prescription Drugs below).</td></tr>
</table>

Obtain your prescription drugs through the OptumRx network of pharmacies.

Through a service contract with OptumRx, the Trust Fund provides prescription drug benefits for covered prescriptions for all eligible Active Participants and Retirees covered by the Indemnity Plan.

Note: Active Employees covered by Kaiser should review their separate HMO plan documentation and information to determine the prescription drug coverage. Retirees covered by Kaiser should also review the separate HMO plan documentation and information for a description of their prescription drug coverage.

What is Covered?
Covered prescription drugs are drugs that can only be obtained by prescription (except insulin or as otherwise provided for herein) as required by state and federal law; have been approved by the Food and Drug Administration (FDA) for general marketing; are dispensed by a licensed pharmacist; and are prescribed for the Participant's use by a Physician. Covered drugs include outpatient injectables and other specialty drugs when preauthorized by BriovaRx (Adynovate must be preauthorized by Diplomat), Preventive Service prescription drugs, insulin, and insulin syringes.

Preventive Service Prescription Drugs
Preventive Service prescription drugs and supplies (including certain over-the-counter products, e.g., aspirin, prescribed by a health care provider) will be covered to the extent recommended as follows:

a. Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved;

b. Immunizations for routine use in children, adolescents, and adults (i.e., those immunizations that have been adopted for recommendation by the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention);

c. Preventive care and screening for infants, children, and adolescents as provided for in the comprehensive guidelines by the Health Resources and Services Administration (HRSA); and

d. Preventive care and screening for women, as provided for by the HRSA that are not otherwise addressed by Task Force recommendations.

Out-of-Pocket Maximum
The out-of-pocket maximum puts a limit on the amount you will pay out of your own pocket in one calendar year. There is an out-of-pocket maximum for covered prescription drug expenses of $1,600/person and $3,200/family if the prescription drugs are purchased through the Prescription Drug Program with OptumRx. After you have reached the out-of-pocket maximum, the Plan reimburses covered prescription drug expenses at 100% of the contract rate for the remainder of the calendar year. **Prescription drugs obtained at a non-Network pharmacy are not included in the annual out-of-pocket limits.**

Erectile Dysfunction
Medicare-eligible Retirees and/or their eligible Spouses are subject to a maximum of $300 per year in covered benefits for prescription erectile dysfunction drugs. Medicare-eligible Retirees and/or their eligible Spouses will have to pay the applicable copayment at the OptumRx-approved retail or mail-order pharmacy, and the Trust Fund will cover the remainder up to $300 per calendar year. Once Medicare-eligible Retirees and/or their eligible Spouses reach the maximum $300 benefit, they are responsible for the entire prescriptions cost for the remainder of the calendar year.

How Does the Program Work?
Provided your name is included in the list of eligible individuals for Prescription Drug Program coverage, when you obtain a covered prescription from a participating pharmacy, you will pay the applicable copayment. The participating pharmacy will bill the Trust Fund and will receive payment for the prescription directly from the Trust Fund.

You may either go to a participating pharmacy to fill your prescriptions (Walk-In Prescription Drug Program) or fill your prescription through the mail (Mail Order Prescription Drug Program). Through the Walk-In Program, you may receive up to a 30-day supply of your prescription. If the prescription is a maintenance drug, you may receive up to a 90-day supply of prescription drugs through the Mail Order Program.

What is a Generic Drug?
A generic drug generally refers to any drug that is sold under its designated chemical make-up rather than an advertised brand name.

While generic medicines may look different and have different names than brand-name medicines, they go through the same rigorous U.S. Food and Drug Administration (FDA) approval process and are required to provide the same results as brand-name medicines.

What is a Formulary?
A formulary is a list of preferred or recommended drugs that have been selected by doctors and pharmacists based upon the safety and effectiveness of those drugs. Formularies have been used for decades and are currently used by most hospitals, medical groups, and health maintenance organizations. The formulary for the Fund defines the drugs that will give you your medication at the lowest price. A drug that is not listed in the formulary will be referred to as a "non-formulary drug."

Walk-In Prescription Drug Program
You may go to any of the participating pharmacies to fill a prescription. You will be required to pay a $10 copayment for each generic formulary drug or a $35 copayment per formulary brand name prescription. If you want a generic or brand-name drug that is not on the formulary, you will pay 60% of the cost of the drug. You can call OptumRx at (800) 797-9791 for formulary information. You can also contact them online at www.optumrx.com.

A generic drug, if available, will automatically be substituted for a brand-name drug when you fill a prescription unless your Physician specifically indicates otherwise. Generic drugs are equal to brand-name drugs in chemical composition and active ingredients; however, generic drugs are identified by their chemical name because of patent laws. Generic drugs have the same effect and meet the same federal government standards as their brand-name equivalents, but they are less expensive.

When a prescription is written that allows for a refill (or refills), you may receive one (1) prescription only. Subsequent refills, if any, will be provided no sooner than five (5) days prior to the exhaustion of the previous prescription supply. For example, if your prescription is for a 30-day supply, a refill is allowed after 25 days have elapsed. Likewise, a 15-day supply would be refillable after ten (10) days have elapsed.

Mail Order Prescription Drug Program
OptumRx has a convenient mail-order program that allows you to order up to a 90-day supply of any covered prescription drug (not just maintenance medication) for direct delivery to your home. You may purchase up to a 90-day supply of maintenance or other drugs through the mail-order program only.

If you filled your prescription through the retail program and obtained two subsequent refills of the same prescription, the retail copayment for the third refill will increase to two times the 30-day supply copayment.

The copayment for up to a 90-day supply of medication is two and a half times the retail copayment for formulary generic or formulary brand prescription drugs. You will pay 60% coinsurance for non-formulary drugs.

Advantages of Using the Mail Order Program: You can save money and time. Order up to a 90-day supply of medication for a lower copayment than you would pay for a 90-day supply through the Walk-In Program. Your medications are conveniently delivered to your home via U.S. Mail or UPS. Since you can receive up to a 90-day supply, you will be spared the bother of frequent re-orders.

How to Use the Mail Order Program

1. Ask your Doctor to prescribe needed medications for up to a 90-day supply, plus refills.

2. Complete the Mail Order Form with your first order only. Be sure to answer all the questions for yourself and your Dependents. The Mail Order Form may be requested from OptumRx at (800) 711-4555 or online at www.optumrx.com.

3. Send the completed Mail Order Form and your original prescription(s) to OptumRx using the pre-addressed order envelope. Enclose your copayment with your prescription. You can contact OptumRx to get the cost of a brand-name drug and then enclose payment with your prescription. (OptumRx will mail you a re-order form, which will show the appropriate copayment for refilling your prescriptions.)

4. OptumRx will process your order within 14 days and send your medications to your home by U.S. Mail or UPS with instructions for future prescriptions and/or refills.

Injectables and Other Specialty Drugs
Specialty drugs are prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

Specialty drugs are subject to prior authorization under the Plan. Drugs subject to prior authorization require prescriber verification of specific clinical criteria to help manage the appropriate use of high-cost and/or highly utilized categories of drugs that are likely to be used for off-label indications or beyond recommended duration.

Outpatient injectable/specialty drugs require a 20% coinsurance per injectable/specialty drug with a $100 maximum. All injectables/specialty drugs require prior authorization and must be ordered through OptumRx. (Insulin is exempt from the prior authorization requirement.) Your Doctor should call OptumRx at (800) 711-4555 (and select Option 1). The injectable/specialty drug prescription will then be mailed to your home or to your Doctor. Consult with your Doctor for the administration of the injectable/specialty drug once it is received. Injectable/specialty drugs received on an inpatient basis are not subject to this requirement.

For more information about OptumRx Specialty Pharmacy, call (800) 711-4555. The Telephonic Device for the Hearing Impaired in (800) 498-5428. You may also visit www.optumrx.com.

Effective September 1, 2017, BriovaRx, the OptumRx Specialty Pharmacy, is the Plan's exclusive specialty pharmacy. Initially, a Patient Care Coordinator will reach out to you during the transition from the current specialty pharmacy to BriovaRx. After transitioning to BriovaRx, a Patient Care Coordinator will call you each month in order to coordinate your next medication delivery. You can enroll in BriovaRx by contacting OptumRx Specialty Pharmacy at 1-855-4BRIOVA (1-855-427-4682) or online at https://briovarx.com/newpatient. Please note that the prior authorization rules continue to apply. For specialty drug prior authorization, please call (800) 711-4555.

For more information about your Prescription Drug Program under the Indemnity Plan coverage and services, please contact OptumRx at (800) 797-9791.

Effective April 1, 2019, Diplomat is the Plan’s exclusive specialty pharmacy specifically for the specialty drug Adynovate to treat hemophilia. All other covered specialty drugs must be dispensed through the BriovaRx pharmacy. Please note that the prior authorization rules continue to apply.

Compound Medication Management Program
Compounding is a practice by which a licensed pharmacist or physician combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient. This may be done if the health needs of a patient cannot be met by an FDA-approved medication (due to allergies to certain standard drug ingredients or inability to utilize drugs in a particular form), or to add vitamins/supplements for cosmetic or other alternative purposes. However, compound drugs are not FDA-approved and this may lead to potential misuse. Ingredients used in compound drugs are not tested for efficacy or purity. Due to concerns about participant safety and drug efficacy, the following Compound Medication Management Program applies:

- Non-FDA approved bulk chemicals will be excluded from coverage as compound drug ingredients (contact OptumRx for the most recent list of such chemicals; this list is subject to change);

- Bulk chemicals for vitamins/supplements typically available over-the-counter will be excluded from benefit coverage as compound drug ingredients;

- Products for cosmetic uses will be excluded from coverage as compound drug ingredients; and

- Ingredients used in compounding topical formulations when the medication is not approved by the FDA for this route of administration will be excluded from coverage.

If you are prescribed a compound ingredient that fits any of the criteria above, coverage of the compound medication will not be approved. You can still purchase the medication, but you will pay the full cost of the prescription. If you have a deductible or out-of-pocket maximum, non-covered charges will not count toward either. As you and your doctor make decisions about your prescription medications, we encourage you to discuss other covered options that may also treat your condition.

In addition, any compound drug that costs $150 or more will require prior authorization by OptumRx. You will be notified of this when you go to fill your prescription at the pharmacy. The pharmacist will initiate the prior authorization procedure by contacting OptumRx to request a prior authorization. OptumRx will either approve the drug or provide you with documentation as to why it was not approved. If you have any additional questions, please contact OptumRx at (800) 797-9791. If you are submitting a prescription drug through the OptumRx mail-order program, please contact OptumRx by calling (800) 711- 4555 or online at www.optumrx.com.

Time Limitation for a Section 502(a) Lawsuit
A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination or, for eligible claims, the date of the notice of the final/external review decision. Please see the section of the booklet entitled "Claims and Appeal Procedures" for the detailed Claims and Appeal Procedures regarding Prescription Drug Program claims on pages 123 to 133.

EXCLUSIONS UNDER THE PRESCRIPTION DRUG PROGRAM

The following drugs and supplies are not covered under the Prescription Drug Program (except as otherwise covered above, e.g., drugs and supplies covered under Preventive Service Prescription Drugs):

1. Drugs that are sold over the counter or that do not legally require a Physician's written prescription and prescription equivalents that are sold over the counter;

2. Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers' Compensation programs;

3. Devices of any type, even though a Physician has written a prescription;

4. Drugs prescribed for cosmetic purposes including, but not limited to:

    - Rogaine solutions;
    - External preparations of Minoxidil and any mixtures or compounds containing Minoxidil;
    - Weight reducing drugs; and
    - Retin-A in all forms, except when prescribed for Acne Vulgaris;

5. Outpatient injectable/specialty drugs not preauthorized by OptumRx;

6. Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of insulin;

7. Prescriptions related to any non-covered services;

8. Prescriptions dispensed in a Physician's office;

9. Methadone when used for drug dependency treatment;

10. Progesterone or progesterone compounds prescribed for the treatment of PMS or other non-approved indications;

11. Prescription vitamins;

12. Drugs administered to a Participant while institutionalized;

13. Any services, medication, or expenses related to smoking cessation; Physician recommendation does not establish eligibility for coverage;

14. Fertility drugs; all medications used for the treatment of infertility;

15. Lost, stolen, spilled, or broken prescriptions;

16. Experimental or Investigational drugs;

17. Prescriptions dispensed by a Hospital during confinement;

18. Any items prescribed for purposes other than the treatment or diagnosis of a specific Illness or Injury; or

19. Any services, medications, or expenses related to weight control or weight reduction, the fact that a physician may prescribe or recommend weight control because of the diagnosis of hypertension, heart disease, etc., does not establish eligibility for coverage.

20. Compound medications as described above under the Compound Medication Management Program.

21. Outpatient injectable/specialty drugs not obtainedthrough BriovaRx (the OptumRx specialty pharmacy).

22. Adynovate, unless dispensed through the Diplomat pharmacy.

23. When the injury or illness of the covered Employee and/or eligible Dependent is caused by the act or omission of a third person unless an Acknowledgment of Lien and Subrogation is executed by the Employee and/or eligible Dependent (or his or her authorized representative) and returned to the Plan (please refer to Third Party Liability – Exclusion and Limitations, on pages 107 to 108).

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Participants enrolled in the Indemnity Medical Plan, or Kaiser Plan are eligible for the Employee Assistance Program (EAP).

Under the EAP, you and your eligible Dependents can receive assistance program benefits designed to help you and your eligible Dependents deal with difficult situations that cause stress and can result in challenges to mental health and well-being. These benefits include up to three (3) sessions, at no cost, with counselors for issues including:

- Mental health and substance abuse;
- Emotional distress;
- Major life events;
- Family or personal issues; and
- Occupational stress.

Participants are not required to use the EAP before accessing comprehensive Mental Health, and Substance Use Disorder benefits through the Indemnity Medical Plan. Kaiser Plan participants can access comprehensive Mental Health, and Substance Use Disorder benefits through the Kaiser Plan.

HMO BENEFITS – KAISER PERMANENTE

This HMO provides benefits only to those Employees and their eligible Dependents who have properly chosen this particular coverage as described in the section of this booklet entitled "Choice of Medical Plans." **If there is any confusion or if you have any questions concerning your coverage election, please contact the Trust Fund Administrative Office at (800) 320-0106 before incurring any medical expenses.**

The information set forth in this section was provided by the HMO and is intended to comply with the Department of Labor summary plan description content regulations. Please see the applicable *Evidence of Coverage* for details regarding the extent of coverage offered and specific limitations and exclusions. Please note that the benefits summarized in this section are those as provided by the HMO when this booklet went to print; as such, the summary is subject to modification.

Kaiser – Benefit Summary for Active Employees
The services described below are covered only if all the following conditions are satisfied:

- You are an eligible active Employee;
- The services are medically necessary;
- The services are provided, prescribed, authorized, or directed by a plan Physician, and;
- You receive the services from plan providers inside the Kaiser Permanente service area, except where specifically noted to the contrary for authorized referrals, the visiting member program, emergency care, and out-of-area Urgent Care as described in the *Evidence of Coverage*. Note: Please refer to *Your Guidebook to Kaiser Permanente Services* for the types of covered services that are available from each plan facility because, at some facilities, only specific types of covered services are provided.

CATEGORY	COPAYMENT
Hospital Inpatient Care	
Room and board, including obstetrics	No charge
Physician, surgeon, and surgical services	No charge
Nursing care, anesthesia, x-rays, lab tests, and medications	No charge
Outpatient Care	
Primary care visits for internal medicine, family practice, pediatrics, and gynecology(includes routine and urgent care appointments)	$20 per visit
Specialty care visits (includes consultations, evaluations, and treatment provided by a personal plan physician who are not primary care physicians)	$40 per visit
Well-child preventive care visits (23 months or younger)	No charge
Scheduled prenatal care and first postpartum visits	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Outpatient surgery	$250 per procedure
Allergy injection visits	No charge
Immunizations (including the vaccine)	No charge

CATEGORY	COPAYMENT
X-rays and lab tests	No Charge
Physical, occupational, and speech therapy visits	$20 per visit
Health education:	
Most individual health education counseling	No charge
Covered health education programs	No charge
Emergency department visits	$100 per visit
Mental Health Services	
Inpatient psychiatric hospitalization	No charge
Outpatient evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit
Chemical Dependency Services	
Inpatient detoxification	No charge
Outpatient individual evaluation and treatment	$20 per visit
Outpatient group treatment	$5 per visit
Family Planning Services	
Office visits	No charge
Scheduled prenatal care exams	No charge
Infertility covered services	50% coinsurance
Additional Benefits	
Durable Medical Equipment (DME) in accord with formulary	20% coinsurance
External prosthetic and orthotic devices, ostomy and urological supplies	No charge
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Home health care (up to 100 visits per calendar year)	No charge
Hospice care	No charge
Ambulance services	No charge
Prescription Drug Coverage Covered outpatient items in accord with Kaiser drug formulary guidelines. Effective May 1, 2017, specialty drugs provided for Active Employees are subject to a 20% coinsurance (up to $100 per script).	
Most generic items at a plan pharmacy	$10 (30-day supply)
Most generic refills through mail-order service	$20 (100-day supply)
Most brand name items at a plan pharmacy	$30 (30-day supply)
Most brand name refills through mail-order service	$60 (100-day supply)

This chart does not fully describe the benefits. Please refer to the *Evidence of Coverage* to learn about what is covered under each benefit (including exclusions and limitations) and additional benefits that are not included in this summary. Note: Kaiser Permanente covers benefits in accord with applicable law (for example, diabetes supplies).

Kaiser – Benefit Summary for Retirees
The services described below are covered for those who are non-Medicare retirees and Medicare retirees under the aforementioned conditions and who satisfy the eligibility rules as described in the section of this booklet entitled “Eligibility Rules and Benefit for Retirees”:

Non-Medicare Retiree Benefits

CATEGORY	COPAYMENT
Hospital Inpatient Care	
Room and board, including obstetrics	No charge
Physician, surgeon, and surgical services	No charge
Nursing care, anesthesia, x-rays, lab tests, and medications	No charge
Outpatient Care	
Primary and specialty care consultations, evaluations, and treatment	$10 per visit
Well-child preventive care visits (23 months or younger)	No charge
Scheduled prenatal care and first postpartum visits	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Outpatient surgery	$10 per procedure
Allergy injection visits	No charge
Immunizations (including the vaccine)	No charge
X-rays and lab tests	No charge
Physical, occupational, and speech therapy visits	$10 per visit
Health education:	No charge
Most individual health education counseling	No charge
Covered health education programs	No charge
Emergency department visits	$50 per visit
Mental Health Services	
Inpatient psychiatric hospitalization	No charge
Outpatient evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Chemical Dependency Services	
Inpatient detoxification	No charge
Outpatient individual evaluation and treatment	$10 per visit
Outpatient group treatment	$5 per visit
Family Planning Services	
Office visits	No charge
Scheduled prenatal care exams	No charge
Infertility covered services	$10 per visit
Additional Benefits	
Durable Medical Equipment (DME) in accord with formulary	No charge
External prosthetic and orthotic devices, ostomy and urological supplies	No charge
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Home health care (up to 100 visits per calendar year)	No charge
Hospice care	No charge
Ambulance services	No charge
Prescription Drug Coverage Covered outpatient items in accord with Kaiser drug formulary guidelines. Effective May 1, 2017, specialty drugs provided for Non-Medicare Retirees are subject to a 20% coinsurance (up to $100 per script).	
Most generic items	$10 (100-day supply)
Most brand name items	$20 (100-day supply)

Medicare Retiree Benefits (Senior Advantage)

CATEGORY	COPAYMENT
Hospital Inpatient Care	
Room and board, including obstetrics	No charge
Physician, surgeon, and surgical services	No charge
Nursing care, anesthesia, x-rays, lab tests, and medications	No charge
Outpatient Care	
Primary and specialty care consultations, evaluations, and treatment	$10 per visit
Annual Wellness and Welcome to Medicare preventive visit	No charge
Eye exams for refraction	$10 per visit
Hearing exams	$10 per visit
Outpatient surgery	$10 per procedure
Allergy injection visits	No charge
Immunizations (including the vaccine)	No charge
X-rays and lab tests	No charge
Physical, occupational, and speech therapy visits	$10 per visit
Manual manipulation of the spine	$10 per visit
Emergency department visits	$50 per visit
Mental Health Services	
Inpatient psychiatric hospitalization	No charge
Outpatient evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Chemical Dependency Services	
Inpatient detoxification	No charge
Outpatient individual evaluation and treatment	$10 per visit
Outpatient group treatment	$5 per visit
Additional Benefits	
Durable Medical Equipment (DME) in accord with formulary	No charge
External prosthetic and orthotic devices, ostomy and urological supplies	No charge
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Home health care (up to 100 visits per calendar year)	No charge
Hospice care	No charge
Ambulance services	No charge
Eyewear purchased at plan medical or optical offices (every 24 months)	$150 allowance
Prescription Drug Coverage Covered outpatient items in accord with Kaiser drug formulary guidelines	
Most generic items	$10 (100-day supply)
Most brand name items	$20 (100-day supply)

The above charts do not fully describe benefits. Please refer to the *Evidence of Coverage* to learn about what is covered under each benefit (including exclusions and limitations) and additional benefits that are not included in this summary. Note: Kaiser Permanente covers benefits in accord with applicable law (for example, diabetes supplies).

Annual and Lifetime Maximums and Other Benefit Limits
Out-of-pocket maximums are $1,500 per member and $3,000 per family. The plan has no deductibles or out-of-pocket lifetime maximums. Some benefits have annual visit or day limitations (e.g., skilled nursing facility benefits).

Out-of-pocket maximums apply only to basic health services such as hospital care and physical, speech, and occupational therapies. Supplemental benefits such as Durable Medical Equipment (DME), prosthetics and orthotics (P&O), hearing aids, and vision do not apply to the out-of-pocket copayment maximums.

The *Evidence of Coverage* provides a complete description of exclusions and limitations.

Provisions Governing Use of Network Providers and Composition of Network
Kaiser Foundation Health Plan (KFHP) contracts with The Permanente Medical Group (TPMG) in the Southern California Permanente Medical Group (SCPMG) to exclusively provide comprehensive medical services to KFHP members.

On a very limited basis, TPMG and SCPMG contract locally with community physicians and health care professionals for expanded primary and specialty care services.

Conditions or Limits on Selection of Primary Care Providers and Specialists
Members may select from any of Kaiser Permanente's primary care physicians (PCPs) and can receive care at any Kaiser Permanente medical facility. At their discretion, members may also select a new physician at any time. Although not required, Kaiser Permanente encourages all members to establish a relationship with a personal physician.

Conditions or Limits Applicable to Emergency Care
For members' safety and health, Kaiser Permanente covers emergency care administered by plan providers and non-plan providers anywhere in the world. Emergency care is defined as Medically Necessary ambulance transportation and the evaluation of a member by appropriate medical personnel to determine if an emergency medical condition exists. If an emergency medical condition does exist, coverage also includes medically necessary care, treatment, and surgery required to clinically stabilize the member's emergency medical condition within the capabilities of the facility.

If a member thinks they have an emergency medical condition, they should call 911 or go to the nearest hospital. To better coordinate their emergency care, Kaiser Permanente recommends that members go to a plan hospital if it is reasonable to do so considering the condition or symptoms.

Urgent Care
An urgent care need is one that requires prompt medical attention but is not an emergency medical condition. If members think they may need urgent care, they need to call the appropriate appointment or advice telephone number at a plan facility.

When a member is temporarily outside of Kaiser Permanente's service area and has an urgent care need due to an unforeseen Illness or Injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- you are temporarily outside the Kaiser service area
- a reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed until return to a Kaiser Permanente service area.

Additional Coverage Limitations
Members need to request authorization for post-stabilization care before care is administered by a non-plan provider if it is reasonably possible to do so (otherwise, call as soon as reasonably possible).

Members or persons representing a member must call Kaiser Permanente at (800) 225-8883 (TTY users call 711) or the notification number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call Kaiser as soon as reasonably possible) After Kaiser has been notified, Kaiser will discuss your condition with the non-plan provider. If Kaiser decides that you require post-stabilization care and that this care would be covered if you received it from a plan provider, Kaiser will authorize your care from the non-plan provider or arrange to have a plan provider (or other designated provider) provide the care. If Kaiser decides to have a plan hospital, plan skilled nursing facility, or designated non-plan provider provide your care, Kaiser may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Kaiser Permanente understands that extraordinary circumstances can delay a member's ability to call a plan representative, for example, if the member is unconscious or a young child without a parent or guardian present, or you are unconscious. In these cases, the member must call Kaiser Permanente as soon as it is reasonably possible. Please keep in mind that anyone can call Kaiser for you. Kaiser does not cover any care you receive from non-plan providers after your emergency medical condition is stabilized unless Kaiser authorizes it, so if you don't call as soon as reasonably possible, you increase the risk that you will have to pay for this care.

Provisions Requiring Preauthorization or Utilization Review as a Condition to Obtaining a Benefit or Service Under the Plan
Unlike some managed care organizations or insurance companies where physician decisions or referrals are reviewed by health plan administrators or clerks, Permanente Medical Group physicians are solely responsible for making all medical decisions and do not require approval, pre-authorization, or review of medical decisions from Health Plan administrators.

Provider Listings
All members receive the *Evidence of Coverage (EOC),* which describes their health care benefits. The content of the EOC cannot be changed once it has been approved by the Department of Managed Health Care (DMHC). The EOC will not conflict with the Employee Retirement Income Security Act's (ERISA) disclosure requirements and will disclose information that is applicable to our plan.

The California section of the Kaiser Permanente website, http://www.kp.org, currently has an online provider directory that displays background information about each listed physician, including his or her specialty, location, education, residency, board certification, gender, date hired, and languages spoken (if the physician is conversant in more than one language). The directory also contains links to our California locations and services for maps and directions to our medical offices, hospitals, and pharmacies, along with department phone numbers and listings of the services offered at each Kaiser Permanente facility.

Throughout California, provider directories are given to all new members to aid them in their selection of a personal physician. In addition, each medical center maintains physician information that members can access to verify licensure, medical school graduation, residency and/or fellowship training, and board certification. Physician information can also be obtained by calling the Member Services Contact Center at (800) 464-4000.

Moreover, all members receive a copy of the Guidebook to Kaiser Permanente Services, which contains maps and directions to our medical offices, hospitals, and pharmacies, along with department phone numbers and listings of the services offered at each facility.

Coverage for Out-of-Network Services
Members are covered for unexpected Illness or Injury at a non-Kaiser Permanente facility under the terms of the Out-of-Plan Emergency Services benefit as outlined in the *Evidence of Coverage*. Covered Out-of-Plan emergency care is Medically Necessary health services and supplies received immediately from a non-plan provider due to a sudden, unforeseen Illness or Injury.

Members who receive emergency health care services at a non-plan hospital or facility outside of the Kaiser Permanente service area may submit a completed claim form or bills for review and payment to the Claims Administration Department.

Requests for Payment for Non-Plan Emergency or Out-of-Area Urgent Care
If you receive Emergency Care or Out-of-Area Urgent Care from a non-plan Provider as described in the "Emergency Services and Urgent Care" section of your *Evidence of Coverage*, you must file a claim if you want Kaiser Permanente to pay for the services. This is what you need to do:

- As soon as possible, get a claim form by calling the Member Service Contact Center toll free at (800) 464-4000 or (800) 390-3510 (TTY (800) 777-1370 or 711), 24 hours a day, seven days a week.

- If you have paid for the services, you must send the completed claim form for reimbursement. Please attach any bills from the non-plan provider and receipts.

- To request that a non-plan provider be paid for services, you must send the completed claim form and include any bills from the non-plan provider. If the non-plan provider states that they will submit the claim, you are still responsible for making sure that Kaiser Permanente receives everything needed to process the request for payment. If you later receive any bills from the non-plan provider, you should call the Member Service Contact Center toll free at (800) 464-4000 or (800) 390-3510 (TTY (800) 777-1370 or 711), 24 hours a day, seven days a week, to confirm that Kaiser Permanente has received everything needed.

- You must complete and return to Kaiser Permanente any information requested to process your claim, such as claim forms, consents for the release of medical records, assignments,and claims for any other benefits to which you may be entitled.

- The completed claim form must be mailed to the following address as soon as possible after receiving the care. Any additional information requested should also be mailed to this address:

  Kaiser Foundation Health Plan, Inc. Claims Department
  P.O. Box 7004
  Downey, CA 90242-7004

Kaiser Permanente will send you a written decision within 30 days after the claim is received from you. Kaiser may extend the time for making a decision for an additional 15 days if circumstances beyond their control delay their decision; they will notify you within 30 days after they receive your claim. If Kaiser Permanente needs more information, Kaiser Permanente will ask you for the information before the end of the initial 30-day decision period. Kaiser Permanente will send you a written decision within 15 days of receiving the additional information. However, if Kaiser Permanente does not receive the additional information within the timeframe specified in their letter, Kaiser will make a decision based on the information they have within 15 days after the end of that timeframe.

If your claim is denied, their letter will explain why it was denied and how you can appeal.

Requests for Services

Standard Decision
Plan providers make the decision about which services are right for you. If you have received a written denial of services from the medical group and you want to request that Kaiser Permanente cover the services, you can file a grievance as described in the "Dispute Resolution" section.

If you haven't received a written denial of services, you may make a request for services orally or in writing to your local Member Services Department. You will receive a written decision within 15 days unless you are notified that additional information is needed. The additional information must be received within 45 days of the request for information in order for it to be considered in the decision. You will receive a written decision within 15 days of receipt of the additional information. If you don't supply the additional information within 45 days of the request, you will receive a written decision no later than 75 days after the date you made your request to Member Services. If your request is denied in whole or in part, the written decision will fully explain why your request was denied and how you can file a grievance.

If you believe Kaiser Permanente should cover a medically necessary service that is not a covered benefit under your *Evidence of Coverage*, you may file a grievance as described in the "Dispute Resolution" section.

Expedited Decision
You or your physician may make an oral or written request that Kaiser Permanente expedite the decision about your request. Kaiser Permanente will inform you of the decision within 72 hours (orally) if Kaiser Permanente finds, or your Physician states, that waiting 15 days for the "Standard decision":

- Could seriously jeopardize your life, health, or ability to regain maximum function.
- Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services you are requesting.

If the request is for a continuation of an expiring course of treatment and you make the request at least 24 hours before the treatment expires, Kaiser Permanente will inform you of the decision within 24 hours.

You or your physician must request an expedited decision in one of the following ways, and you must specifically state that you want an "expedited decision":

- Call toll free (888) 987-7247 (TTY (800) 777-1370 or 711).
- Send your written request to Kaiser Foundation Health Plan, Inc., P.O. Box 23170, Oakland, CA 94623-0170, Attention: Expedited Review Unit.
- Fax your written request to (888) 987-2252.
- Deliver your request in-person to your local Member Services office at a plan facility.

If Kaiser Permanente denies your request for an expedited decision, you will be notified, and Kaiser Permanente will respond to your request for coverage as described under "Standard Decision." If Kaiser Permanente denies your request for coverage in whole or in part, a written decision will fully explain why it was denied and how you can file a grievance.

Grievances
Kaiser Permanente is permitted to providing you with quality care and with a timely response to your concerns if an issue arises. Member Service representatives are available to discuss your concerns at most plan facilities, or you can call the Member Service Contact Center toll-free at (800) 464-4000 (TTY (800) 777-1370 or 711) 24 hours a day, seven days a week.

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. Grievances may be submitted orally or in writing, and they must be submitted to:

- The following location for claims described under "Non-Plan Emergency or Out-of-Area Urgent Care" in the "Requests for Payment" section:

  Kaiser Permanente Special Services Unit
  P.O. Box 7004
  Downey, CA 90242-7004

- A Member Service representative for all other issues.

Kaiser Permanente will send you a confirming letter within five days of receipt of your grievance. Kaiser Permanente will send you a written decision within 30 days. If your grievance is denied in whole or in part, the written decision will fully explain why it was denied and additional dispute resolution options.

Expedited Grievance
You or your physician may make an oral or written request that Kaiser Permanente expedite a decision about your grievance. Kaiser Permanente will inform you of the decision within 72 hours (orally or in writing) if Kaiser Permanente finds, or your physician states, that waiting 30 days for a decision:

- Could seriously jeopardize your life, health, or ability to regain maximum function.

- Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment.

- A physician with knowledge of your medical condition determines that your grievance is urgent.

You or your physician must request an expedited decision in one of the following ways, and you must specifically state that you want an "expedited decision":

- Call toll-free (888) 987-7247.

- Send your written request to Kaiser Foundation Health Plan, Inc., P.O. Box 23170, Oakland, CA 94623-0170, Attention: Expedited Review Unit.

- Fax your written request to (888) 987-2252.

- Deliver your request in-person to your local Member Services office at a plan facility.

If Kaiser Permanente denies your request for an expedited decision, you will be notified, and Kaiser Permanente will respond to your grievance within 30 days. If your grievance is denied in whole or in part, the written decision will fully explain why it was denied and additional dispute resolution options.

Providing Supporting Documents for Your Request
It is helpful for you to include any information that clarifies or supports your position. You may want to include with your grievance supporting information, such as medical records or physician opinions, in support of your request. When appropriate, Kaiser Permanente will request medical records from plan providers on your behalf. If you have consulted with a non-plan provider and are unable to provide copies of relevant medical records, Kaiser Permanente will contact the provider to request a copy of your medical records. Kaiser Permanente will ask you to send or fax a written authorization to request your records. If Kaiser Permanente does not receive the information requested in a timely fashion, Kaiser Permanente will make a decision based on the information already received.

Who May File
The following persons may file a grievance:

- You may file for yourself.
- You can ask a friend, relative, or attorney to file a grievance for you by appointing him or her in writing as your authorized representative.
- A parent may file for his or her child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance.
- A court-appointed guardian may file for his or her ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance.

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility or by calling our Member Service Contact Center. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

DMHC Complaints
The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at (**800) 464-4000** (TTY users call (800) 777-1370 or 711) and use the plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(888) HMO-2219** and a TDD line (877) 688-9891) for the hearing and speech impaired. The department's internet website http://www.hmohelp.ca.gov http://www.hmohelp.ca.gov/ has complaint forms, IMR application forms, and instructions online.

Independent Medical Review (IMR)
If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against Kaiser Permanente.

You may qualify for IMR if all of the following are true:

One of these situations applies to you:

- You have a recommendation from a provider requesting medically necessary Services.
- You have received emergency services, emergency ambulance services, or urgent care from a provider who determined the services to be medically necessary.
- You have been seen by a Plan provider for the diagnosis or treatment of your medical condition.

- Your request for payment or services has been denied, modified, or delayed based in whole or in part on a decision that the services are not medically necessary.

- You have filed a grievance, and we have denied it, or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The Department of Managed Health Care may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function.

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the Department of Managed Health Care determines that your case is eligible for IMR, it will ask us to send your case to the Department of Managed Health Care's Independent Medical Review organization. The Department of Managed Health Care will promptly notify you of its decision after it receives the Independent Medical Review organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or Investigational Denials
If Kaiser denies a service because it is experimental or investigational, Kaiser will send you our written explanation within three days after giving you oral notice of their decision. Kaiser will explain why they denied the service and provide additional dispute resolution options. Also, Kaiser will provide information about your right to request an independent medical review if Kaiser has the following:

- The service you requested is for the treatment of a life-threatening or seriously debilitating condition, and that standard therapies have not been effective in improving this condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy Kaiser covers than the therapy being requested.

- If your treating physician is a plan physician, he or she recommended a treatment, drug, device, or procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan physician in certifying his or her recommendation.

- You (or your non-plan physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician’s certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. Kaiser does not cover the services of the non-plan provider.

Binding Arbitration
For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *Evidence of Coverage*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of Arbitration
Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

1. The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to the Evidence of Coverage or a Member Party’s relationship to Kaiser Foundation Health Plan, Inc., (Health Plan), including any claim for medical or hospital malpractice, (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services, irrespective of the legal theories upon which the claim is asserted.

2. The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties.

3. Governing law does not prevent the use of binding arbitration to resolve the claim.

Members enrolled under this Evidence of Coverage thus give up their right to a court or jury trial and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

1. Claims within the jurisdiction of the Small Claims Court.
2. Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members.
3. Claims that cannot be subject to binding arbitration under governing law.

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A member,
- A member's heir or personal representative
- Any person claiming that a duty to him or her arises from a member's relationship to one or more Kaiser Permanente Parties.

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- KP Cal, LLC
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group Physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any Employee or agent of any of the foregoing.

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above.

"Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure
Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Contact Center.

Initiating Arbitration
Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration
Health Plan, KFH, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc. Legal Department
393 East Walnut Street
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee
The claimants shall pay a single, non-refundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of claimants or respondents named in the demand for arbitration.

Any claimant who claims extreme hardship may request that the Independent Administrator waive the filing fee and the Neutral Arbitrator's fees and expenses. A claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling the Kaiser Permanente Member Service Contact Center toll-free at (800) 464-4000 (TTY (800) 777-1370 or 711), 24 hours a day, seven days a week.

Number of Arbitrators
The number of arbitrators may affect the claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the demand for arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two-party arbitrators and a neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the demand for arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two-party arbitrators, one jointly appointed by all claimants and one jointly appointed by all respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of Arbitrator Fees and Expenses
Kaiser Foundation Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (Rules of Procedure). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the claimants and one-half by the respondents.

If the parties select party arbitrators, claimants shall be responsible for paying the fees and expenses of their party arbitrator, and respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs
Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General Provisions

A claim shall be waived and forever barred if: (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, or (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the Neutral Arbitrator based on a showing of good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the Neutral Arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and non-arbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

DENTAL CARE PLANS

Who is Eligible?
You, your Spouse, and your Dependents become eligible for Dental benefits on the first day of the second calendar month following any calendar month in which you work or are paid for at least 72 hours for an employer, and the employer makes the required contributions. For example, if you work or are paid for 72 or more hours in January and the required hours and contributions are received in a timely manner in February, you will be eligible for dental coverage on March 1st.

Effective February 1, 2012, however, if you are part of a New Unit on the effective date of the Collective Bargaining Agreement covering such New Unit, then you will be eligible for benefits on the first day of the calendar month next following the month in which you have worked at least 72 hours in employment covered by the Collective Bargaining Agreement.

Dental Plan Choices
The Trust Fund provides you and your Dependents with a choice of dental plans providing comprehensive dental benefits. Your choices include the prepaid DHMO plan and self-funded Indemnity PPO plan, which are described below.

DENTAL DHMO PLAN

DeltaCare® USA
DeltaCare USA's Dental DHMO Plan is a choice for active Employees. DeltaCare USA'sDHMO Dental Plan provides care through private, well-established dental offices. All participating Dentists are in private practice.

When you enroll in DeltaCare USA, there are no claim forms involved because the Trust Fund pays DeltaCare USA directly for dental care. The DeltaCare USA Plan provides covered services either at no cost to you or at specified co-payment amounts for covered benefits.

Under the DeltaCare USA Plan, you must select a participating dental office and receive **all** dental care services from that office. Each member of your family may use a different dental office.

Orthodontic treatment under the DeltaCare USA DHMO has a range of copayments from $1,300 to $1,900 per Dependent child to age 19 and from $1,400 to $2,100 for adults and Dependent adult child ages 19 to 26 for 24 months of banding. There are additional charges of $250/$275 for retention and $270/$350 for pre and post-treatment records. Below is a benefitsummary under the DeltaCare® USA Plan:

The **Dental DHMO plan** provides orthodontic benefits to adults. Orthodontic care received through the DeltaCare USA DHMO has a range of copayments from $1,300 to $1,900 per Dependent child to age 19 and from $1,400 to $2,100 copayment for adults and Dependent adult child ages 19 to 26. There are additional charges of $250/$275 for retention and $270/$350 for pre and post-treatment records. Contact DeltaCare USA, Delta Dental's **DHMO Plan**, for details.

INDEMNITY PPO DENTAL PLAN

Delta Dental PPO Plan
Delta Dental PPO is another choice for active Employees. While covered under the PPO plan, you are free to choose any licensed dentist for treatment, but it is to your advantage to choose a Delta Dental Dentist. Although the levels (i.e., percentages) of Benefits are the same no matter what dentist you choose, your out-of-pocket expenses may differ depending upon whether you select a Delta Dental PPO Dentist. When receiving treatment from any other dentist, you will have potentially greater out-of-pocket expenses. To find a Delta Dental PPO Dentist, you can go to their website at www.deltadentalins.com. You can also call Delta Dental Customer Service at (800) 765-6003 to either talk to a customer service representative or to request a provider directory. When you choose a Delta Dental PPO Dentist for dental services, you will pay the network rate, and your out-of-pocket expenses will be lower.

Under the Dental PPO Plan, there is an annual deductible of $50 per person up to a maximum of three per family per calendar year ($150 maximum deductible per family). Preventive and diagnostic treatment is paid at 100% of the PPO contract rate, and the deductible does not apply. The Plan pays 90% of the contract rate for basic services and 65% of the contract rate for major treatment. The deductible does apply to both basic and major services.

The Dental Plan will pay the same percentage for all non-PPO services that is paid for PPO services, up to the Delta Dental PPO contract rate. You do not get the benefit of PPO network prices when you use a non-PPO Dentist, so your out-of-pocket expenses may be higher. The $50 deductible (maximum of three per family - $150 maximum deductible per family per year) will apply to both PPO and non-PPO services. PPO and non-PPO services will be a combined accumulation toward the dental calendar year maximum as well as the lifetime maximum for orthodontic services.

If you use **non-PPO services**, the annual deductible is also $50 per person up to a maximum of three per family per calendar year ($150 maximum deductible per family per year). Preventive and diagnostic treatment is paid at 100% of Covered Charges, up to the PPO contract rate, and the deductible does not apply. The Plan pays 90% of Covered Charges, up to the PPO contract rate for basic services, and 65% of Covered Charges, up to the PPO contract rate, for major treatment. The deductible applies to both basic and major services. The member will be responsible for the balance up to the Dentist's usual fee.

The annual maximum limit for all dental services is $2,000 per person per calendar year, PPO and non-PPO services combined. The $2,000 annual maximum does not apply to pediatric (ages 0 through 18) Diagnostic & Preventive, and Basic services. The Lifetime Maximum will continue to apply to Orthodontic benefits.

Prosthodontic Benefits under the Delta Dental PPO Plan are available only after 12 months of continuous coverage.

Orthodontic Treatment is covered under the Dental PPO plan at 60% of the PPO contract rate. Under the non-PPO plan, orthodontic treatment is covered at 60% of the Covered Charges, up to the PPO contract rate. Both PPO and non-PPO treatment have a combined lifetime maximum of $1,500 per Dependent under age 26. **Adult orthodontia is not covered under the Dental PPO plan.** Below is a benefit summary under the Delta Dental PPO Plan:

	DENTAL PPO PLAN	
	PPO Network	**Non-PPO Network**
DENTAL BENEFIT		
Annual Deductible	$50 per person 3 per family ($150 maximum) per calendar year	$50 per person 3 per family ($150 maximum) per calendar year
Preventive & Diagnostic Services	100% of PPO contract rate No deductible.	100% of Covered Charges, up to PPO contract rate No deductible.
Basic Services (Including endodontics (root canals), Periodontics (gum treatment), and oral surgery)	90% of PPO contract rate	90% of Covered Charges, up to PPO contract rate
Major Services *Prosthodontic Benefits are available only after 12 months of continuous coverage.*	60% of PPO contract rate	60% of Covered Charges, up to PPO contract rate
Annual Maximum (Diagnostic and preventative services do not apply to the Annual Maximum; including exams, cleaning and x-rays)	$2.000 per person per calendar year (this maximum does not apply to dental implants or pediatric, through age 18, or Preventive & Diagnostic and Basic services) $2,500 per person per calendar year for dental implants.	$2,000 per person per calendar year (this maximum does not apply to dental implants or pediatric, through age 18, or Preventive & Diagnostic and Basic services)
ORTHODONTICS		
Treatment for Children to age 26	60% of PPO contract rate	60% of Covered Charges, up to PPO contract rate
Lifetime Maximum	$1,500	$1,500

HOW TO USE YOUR DENTAL PLAN

Set up your first appointment with your Delta Dental Dentist. Tell him or her that you are covered by the Operating Engineers Local 501 Security Fund Dental plan. All claims under the Delta Dental PPO Plan must be submitted to Delta Dental of California at P.O. Box 997330, Sacramento, CA 95899-7330.

Delta Dental suggests that all treatments over $300 be submitted for a pre-treatment estimate. Discuss with your Dentist his or her charges for the work to be done so that you will know what you have to pay over and above what your dental plan will pay.

The following procedures are limited as follows:

Standard Limitations – Delta Dental PPO

1. Only the first two oral examinations, including any office visits for observation and specialist consultations, or a combination thereof, provided to a patient in a calendar year are covered while he or she is an enrollee under any Delta Dental program. See note on additional benefits during pregnancy.

2. A prophylaxis (cleaning) or single procedure that includes a prophylaxis is a benefit twice each calendar year under any Delta Dental plan. Routine prophylaxes are covered as a Diagnostic and Preventive Benefit, and periodontal prophylaxes are covered as a Basic Benefit. See note on additional benefits during pregnancy.

3. Complete intraoral series and panoramic films are each limited to once every five (5)years. A panoramic film taken in conjunction with a complete intraoral series is considered to be included in the complete series. Delta Dental limits the total reimbursable amount for a panoramic film submitted with supplemental films to the amount for a complete intraoral series.

4. Bitewing x-rays are provided on request by the dentist, but not more than twice in a calendar year for children to age 18, or once in any calendar year for adults ages 18 and over, while the patient is an enrollee under any Delta Dental plan.

5. Diagnostic casts are a benefit only when made in connection with subsequent orthodontic treatment covered under this plan.

6. Periodontal scaling and root planing is a benefit once for each quadrant each 24-month period. See note on additional benefits during pregnancy.

7. Fluoride treatment is a benefit twice each calendar year under any Delta Dental plan.

8. Sealant Benefits include the application of sealants only to permanent first molars through age eight (8) and second molars through age fifteen (15) if they are without caries (decay) or restorations on the occlusal surface. Sealant benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.

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

10. Crowns, inlays, onlays, or cast restorations are benefits on the same tooth only once every five (5) years while the patient is an enrollee under any Delta Dental plan unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

11. Prosthodontic appliances and implants that were provided under any Delta Dental plan will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing fixed bridge, partial denture or complete denture cannot be made satisfactory. Replacement of a prosthodontic appliance or implant-supported prosthesis not provided under a Delta Dental plan will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to one for each tooth during the enrollee's lifetime, whether provided under a Delta Dental or any other dental care plan.

12. Delta Dental will pay the applicable percentage of the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.)

13. If an enrollee selects a more expensive plan of treatment than is customarily provided or specialized techniques, an allowance will be made for the least expensive, professionally acceptable alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee, and the enrollee is responsible for the remainder of the dentist's fee. For example, a crown, where an amalgam filling would restore the tooth, or a precision denture, where a standard denture would suffice.

*Please note on additional benefits during pregnancy - When an enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the enrollee during the pregnancy. The additional services each calendar year, while the enrollee is covered under this Contract, include one additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the enrollee or her dentist when the claim is submitted.

Standard Exclusions – Delta Dental PPO

1. Services for injuries or conditions that are covered under Workers' Compensation or Employer's liability laws.

2. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county, or other political subdivision, except as provided in California Health and Safety Code Section 1373(a).

3. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, upper or lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.

5. Prosthodontic services or any single procedure started prior to the date the person became eligible for such services under this contract.

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

7. Experimental procedures.

8. All Hospital costs and any additional fees charged by the Dentist for Hospital treatment.

9. Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed dentist in connection with covered oral surgery and selected endodontic and periodontal surgical procedures.

10. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

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

12. Orthodontic services (treatment of the misalignment of teeth and /or jaws), unless covered by a rider to the contract.

13. Replacements of existing restorations for any purpose other than active tooth decay.

14. Occlusal guards and complete occlusal adjustment.

Limitations and exclusions may vary depending on the benefits selected and state regulation.

Orthodontic Care
Orthodontic Care means only treatment in connection with and the furnishing and installation of orthodontic appliances for the purposes of straightening teeth.

Covered Services

1. Treatment can be given by an Orthodontist of your choice if the Orthodontic Care is provided by or under the supervision of a member of the dental profession licensed to practice dentistry in the U.S. and whose practice is limited to Orthodontics. However, you will have less out-of-pocket expenses if you choose an Orthodontist from the network of providers for the **Delta PPO Dental Plan** administered through Delta Dental.

2. The Trust Fund will cover 60% of the contract rate for the total cost of Orthodontic Care as certified in a form acceptable to the Trust Fund Administrative Office, but not to exceed $1,500 in any individual case. The lifetime maximum of $1,500 per person applies to the charges that will be paid by this plan.

3. Once treatment (banding) has begun, the Trust Fund will pay benefits even if you (the Employee-parent) lose eligibility under the Dental Plan before the treatment program is completed.

Orthodontic Exclusions
In addition to Exclusions and Limitations stated, the following exclusions and limitations apply to Orthodontic Benefits:

1. The obligation of Delta Dental to make payments for an Orthodontic treatment plan begun prior to the Eligibility Date of the patient shall commence with the first payment due following the patient's Eligibility Date. The above-mentioned maximum amount payable will apply fully to this and subsequent payments;

2. The obligation of Delta Dental to make payments for Orthodontics shall terminate on the payment due next following the date the Dependent loses eligibility or the Employee loses eligibility, or upon the termination of treatment for any reason prior to completion of the case, or upon the termination of the Contract, whichever occurs first;

3. Delta Dental will not make any payment for repair or replacement of an Orthodontic appliance furnished, in whole or in part, under this plan;

4. X-rays and extraction procedures incident to Orthodontics are not covered by Orthodontic Benefits but may be covered under the provisions of the Delta Dental Contract; and

5. Delta Dental will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If the Enrollee selects specialized orthodontic appliances or procedures, an allowance will be made for the cost of the standard orthodontic treatment plan, and the patient is responsible for the remainder of the Dentist's fee.

6. Orthodontic coverage is limited to eligible Dependent children.

GENERAL INFORMATION ABOUT THE DENTAL BENEFIT

If the Fund Administrative Office does not receive your enrollment form for the dental plan you intend to select for you and your family, you will automatically be covered by the Indemnity Dental PPO Plan when you become eligible for benefits. You may change plans no more than once in a 12-month period (see *Self-Directed Enrollment Changes*).

The benefits of both Plans are made possible under a Collective Bargaining Agreement negotiated between the International Union of Operating Engineers, Local 501, AFL-CIO, and your employer. If you have any questions, you may call the Trust Fund Administrative Office for assistance. Information and answers given over the phone or orally in person are not binding upon the Trust Fund and cannot be relied on in any dispute concerning your benefits. This booklet has been prepared as a summary of your dental plan.

RETIREE DENTAL PLAN

General Information
The Trust Fund has entered into an arrangement with Delta Dental of California that will allow all eligible Retirees to receive coverage for dental benefits at reduced rates. You can enroll in either the PPO Plan (known as the "**Delta Dental PPO**") or the DHMO Plan (known as "**DeltaCare® USA**").

Under the Retiree Dental Plan, the Trust Fund itself does not pay any benefits directly. The Trust Fund collects your monthly premium payments (see below) and transmits them to Delta Dental. All dental benefits are provided by Delta.

When you retire, the Trust Fund Administrative office will furnish you with materials describing both the Delta Dental PPO Plan and the DHMO Plan for Retiree dental benefits. To find a participating dentist near you or to see if your current dentist participates in either the PPO Plan or the DHMO Plan, simply visit the Delta Dental website at www.deltadentalins.com. You can also call Delta at (800) 765-6003 (for the PPO Plan) or (800) 422-4234 (for the DHMO Plan).

Eligibility
To participate in the Retiree Dental Plan, you must be eligible for the Retiree Plan (Senior Member Plan) and actually be participating in that Plan. (See pages 26 to 29 for details.) An exception will be made if you are eligible for Retiree medical benefits from another source, such as CHAMPUS or your Spouse's group health plan. However, you must provide documentation of such other coverage to the Trust Fund Administrative Office. The Trust Fund Administrative Office will tell you what it needs.

If your coverage under the Retiree Plan (Senior Member Plan) terminates for any reason, your coverage under the Retiree Dental Plan will automatically terminate at the same time. Further, your coverage will end if you fail to pay the required monthly Retiree Dental Plan premiums.

If you do not enroll in the Retiree Dental Plan when it is first offered to you, you will not be eligible to enroll at any later time. Please carefully consider this when you decide whether to enroll.

All other eligibility provisions for the Retiree Plan (Senior Member Plan), including spousal eligibility, apply to the Retiree Dental Plan.

The Retiree Dental PPO Plan
Under the PPO Plan, you can receive services from any licensed dentist for treatment, but it is to your advantage to choose a participating Delta Dental PPO plan dentist. When receiving treatment from any other dentist, you will have potentially greater out-of-pocket expenses. Delta Dental pays the dentist under a fee schedule negotiated between Delta Dental and the dentist. Delta Dental pays only a portion of the fees. You must pay the balance directly to your dentist. The amount that Delta Dental pays, and your portion of the payments, are set forth in the materials furnished to you when you retire.

Please note that there are various limitations and exclusions on benefits and services that Delta Dental maintains under the PPO Plan. These limitations and exclusions will be described in the Delta Dental enrollment materials.

	DENTAL PPO PLAN	
	PPO Network	**Non-PPO Network**
DENTAL BENEFIT		
Annual Deductible	$50 per person 3 per family ($150 maximum) per calendar year	$50 per person 3 per family ($150 maximum) per calendar year
Preventive & Diagnostic Services	100% of PPO contract rate No deductible.	100% of Covered Charges, up to PPO contract rate No deductible.
Basic Services	80% of PPO contract rate	80% of Covered Charges, up to PPO contract rate
Major Services *(Including prosthodontic Benefits)*	50% of PPO contract rate	50% of Covered Charges, up to PPO contract rate
Annual Maximum	$1,500 per person per calendar year (this maximum does not apply to dental implants or pediatric, through age 18, Preventive & Diagnostic and Basic services) $2,500 per person per calendar year for dental implants.	$1,500 per person per calendar year (this maximum does not apply to dental implants or pediatric, through age 18, Preventive & Diagnostic and Basic services)
ORTHODONTICS		
Treatment for Children to age 26	60% of PPO contract rate	60% of Covered Charges, up to PPO contract rate
Lifetime Maximum	$1,000	$1,000

The Retiree Dental DHMO Plan
Under the DHMO Plan, you must select a DeltaCare USA contracted dentist. Delta Dental will pay your dentist a flat monthly fee. The dentist provides all services to you (and, if applicable, your Spouse) in exchange for this fee. However, there are copayments for certain services that you must pay to your dentist. These copayments are listed in Delta Dental's enrollment materials.

As with the PPO Plan, there are limitations and exclusions under the DHMO Plan. Details are provided by Delta Dental with this Summary Plan Description or with your enrollment materials.

Enrollment and Premium Payments
When you retire, you will be given the opportunity to enroll in the Retiree Dental Plan at the same time that you are given the opportunity to enroll in the Retiree Plan (Senior Member Plan). Remember that you must enroll in the Retiree Plan (Senior Member Plan) or be excused from such enrollment (see "Eligibility" above) in order to enroll in the Retiree Dental Plan. Also, remember that you and your Spouse will only be given the opportunity at the time of retirement. If you and your Spouse do not enroll at the time of retirement, you will not be given the opportunity to enroll at a later date.

When you enroll, you must select either the Retiree Dental PPO Plan or the Retiree Dental DHMO Plan. If your Spouse is eligible, he or she must be in the Plan that you select.

The enrollment materials will provide information on the current monthly premium payable for either Plan. Please note that these amounts are established by Delta Dental and may change from time to time.

You must send your monthly payment directly to the Trust Fund Administrative Office. You may combine it with your payment for the Retiree Plan (Senior Member Plan). The Trust Fund Administrative Office will forward your payment to Delta Dental.

If you fail to make your monthly payments timely, your participation in the Retiree Dental Plan will terminate, and you may not re-enroll.

Changing Plans
You can switch between the Delta Dental PPO Plan and the Delta Dental DHMO Plan, but only once every three (3) years. In other words, you must remain with the Plan initially selected for at least three (3) years. If you later switch to the other Plan, you must remain with that Plan for at least three (3) years. For further information or if you have any questions about eligibility or enrollment in Retiree Dental Plans, please contact the Trust Fund Administrative Office at (800) 320-0106. Questions about benefits under the Retiree Dental plans themselves should be directed to Delta Dental at the phone numbers listed in the General Information section above.

VISION CARE PLAN

The Trust Fund has contracted with Vision Service Plan (VSP) to provide an annual eye examination, lenses every twelve (12) months, and frames every twenty-four (24) months, if needed, for you, your Spouse, and your Dependents. The Vision Service Plan is designed to encourage you to maintain your vision through regular eye examinations and to help with vision care expenses for required glasses or contact lenses.

Who is Eligible?
You, your Spouse, and your Dependents become eligible for vision benefits on the first day of the second calendar month following any calendar month in which you work or are paid for at least 72 hours for an employer, and the employer makes the required contributions. For example, if you work or are paid for 72 or more hours in January and the required hours and contributions are received in a timely manner in February, you will be eligible for vision coverage on March 1st.

Retirees are not eligible for the Vision Care Plan.

What are the Benefits?

Eye Exams:	Once each 12 months (from your last date of service). A $10 copayment is required.
Spectacle Lenses:	Once each 12 months.
Frames:	Once each 24 months.

Contact lenses may be chosen instead of spectacle lenses and a frame. The Vision Care Plan will provide a fixed allowance for the contact lens evaluation exam, fitting costs, and materials. Any additional costs exceeding the allowance will be the responsibility of the patient.

If Medically Necessary contact lenses are prescribed, and the Panel Doctor receives prior approval, the lenses are covered in full for the following conditions:

- following cataract surgery;
- to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- certain conditions of Anisometropia; or
- certain conditions of Keratoconus.

How Do I Use This Plan?
Step One - In order to verify your eligibility and plan coverage, call Vision Service Plan at (800) 877-7195 or go to www.vsp.com to confirm you are registered as a member and to locate a Doctor.

Step Two - Select the Doctor of your choice from the list of Panel Doctors. Use Vision Service Plan's website or call the telephone number provided in Step One. When you call the Doctor to make an appointment, state that you are a Vision Service Plan member and provide the Doctor with your Member Identification number.

Step Three - When the eye examination has been completed, the Doctor will itemize any cosmetic options that are your responsibility in addition to the $10 copayment. Vision Service Plan pays the remaining charges to the Panel Doctor directly, according to their agreement with the Doctor.

What If I Don't Use a Panel Doctor? - You may obtain covered services or materials from any other licensed optometrist, ophthalmologist, or optician of your choice. You must pay the provider in full and submit an itemized receipt to the Vision Plan. The Vision Plan will reimburse you up to the amounts allowed based on the non-member provider schedule.

All claims must be filed **within six (6) months of the date services were completed.**

Reimbursement benefits are made directly to you and are not assignable to the Doctor.

Non-Member Provider Reimbursement Schedule
When you choose to go to a non-Panel Doctor, you are responsible for the Doctor's full charge, and then the Vision Plan will reimburse your expenses according to the following schedule.

There is no assurance that this schedule will be sufficient to pay for the eye examination or the materials. Reimbursements are not assignable to the Doctor.

Availability of services under this Reimbursement Schedule is subject to the same time limits and deductible as those described for Panel Doctor services. Services obtained from a non-Panel Doctor are in lieu of obtaining services from a Panel Doctor.

Professional Fees

Eye Examination, up to	$ 45.00
Materials	**Pair**
Single Vision Lenses, up to	$ 45.00
Bifocal Lenses, up to	$ 65.00
Trifocal Lenses, up to	$ 85.00
Lenticular Lenses, up to	$125.00
Frame, up to	$ 45.00
Progressive	$ 85.00
Contact Lenses[1]	
Necessary, up to	$210.00
Elective, up to	$105.00

The amounts shown are maximums. The actual reimbursement shall be the lesser of the maximum shown in the schedule, the amount charged or the amount usually charged by the provider to his or her private patients as determined by the vision plan.

Limitations - The Vision Plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, there will be an extra charge for which you are responsible:

- Blended lenses
- Contact lenses (except as noted elsewhere herein)
- Oversize lenses
- Progressive multifocal lenses
- Photochromic or tinted lenses other than Pink 1 or 2
- Coated or laminated lenses
- A frame that costs more than the plan allowance
- Certain limitations on low vision care
- Cosmetic lenses
- Optional cosmetic processes
- UV protected lenses

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[1] *Determination of "necessary" versus "elective" contact lenses under the non-member reimbursement schedule will be consistent with Panel Doctor services. The reimbursement allowance for necessary and elective contact lenses includes the contact lens evaluation fee, fitting costs and materials and is in lieu of all other material benefits, including spectacle lenses and frame.*

The above lens allowances are for two lenses; if only one lens is needed, the allowance will be one-half the pair allowance.

Exclusions - There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associate supplemental testing.
- Plano lenses (non-prescription).
- Two pair of glasses in lieu of bifocals.
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eye wear required by an employer as a condition of employment.
- Medical or surgical treatment of the eyes, except for laser eye surgery.

ProTec Safety Plan
Employees only are eligible for safety glasses through VSP called ProTec Safety Plan. The ProTec Safety Plan offers prescription and non-prescription lenses and frames certified as safe for a work environment by meeting necessary standards and test requirements.

What are the Benefits?

Exam and lenses:	Once each 12 months (from your last date of service). A $25 copayment is required.
Frames:	Once each 24 months.

Only safety glasses from VSP Panel Doctors are covered. To find a VSP Panel Doctor who specializes in ProTec protective eyewear, please call VSP at (800) 877-7195 or go to www.vsp.com.

Laser Eye Surgery
Employees and their Dependents are eligible for laser eye surgery limited to a $1,000 per eye per lifetime reimbursement. VSP offers special pricing with participating centers, which can help limit your out-of-pocket costs for LASIK, PRK, and custom LASIK procedures. To learn more about the discounted pricing available at VSP participating centers, please call VSP at (800) 877-7195 or go to www.vsp.com.

As a reminder, if you choose to go to a non-Panel Doctor or non-participating VSP center for laser eye surgery, you are responsible for the full charge, and then VSP will reimburse your expenses up to the maximum reimbursement.

DEATH BENEFITS

If you die from any cause while you are an Employee eligible for benefits under this Plan, your designated beneficiary will be entitled to $10,000 as a death benefit. **Participants covered under the Total Disability extension are not eligible for the death benefit. (Also see Exclusions below.)**

You may name or change your death benefit beneficiary anytime by completing a beneficiary designation form and submitting it to the Trust Fund Administrative Office. If you do not designate a beneficiary or if your beneficiary does not survive you, entitlement to the above amount will be established in the following order:

- Legal Spouse or Registered Domestic Partner
- Children (includes legally adopted children)
- Parents
- Brothers and Sisters
- Executor or Administrator

If two or more persons are entitled to benefits, they will share equally, unless specified otherwise.

ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT (AD&D) BENEFITS

If your death occurs as the result of an accident on or off your job while you are an Employee eligible for benefits under this Plan, the Plan will provide $10,000 in addition to the regular death benefit described above. **Participants covered under the Total Disability extension are not eligible for the AD&D benefit. (Also see Exclusions below.)**

If you suffer one of the following losses while eligible, you will be eligible for a $5,000 benefit:

Loss of:

- both hands or both feet;
- sight of both eyes; or
- any two or more of one foot, one hand, or sight of one eye.

If you suffer one of the following losses while eligible, you will be eligible for a $2,500 benefit:

Loss of:

- one hand;
- one foot;
- sight of one eye; or
- thumb and index finger of the same hand.

Loss of hand or foot means severance of the hand or foot at or above the wrist or ankle joint. Loss of sight means total and permanent blindness. Loss of thumb and index finger means severance at the joint closest to the wrist.

EXCLUSIONS – DEATH AND AD&D BENEFITS

No death benefits or accidental death, dismemberment, and loss of sight (AD&D) benefits will be provided for losses caused or contributed to by:

1. Any act due to war, rebellion, armed invasion, acts of terrorism, or aggression;

2. Participation in an insurrection or riot;

3. Committing or attempting to commit an assault or felony; or

4. Travel or flight in or descent from any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial route or chartered flight; or travel in any aircraft not holding a current and valid airworthiness certificate.

In addition, no accidental death, dismemberment, and loss of sight (AD&D) benefits will be provided for losses caused or contributed to by:

1. Bodily or mental infirmity (including the medical or surgical treatment of such a condition);

2. Disease or illness of any kind (including the medical or surgical treatment of such a condition); or

3. The taking of drugs or poison or asphyxiation from the inhaling of gas, when done on a voluntary basis. (This does not apply to drugs that are taken on the advice of a Physician.)

COORDINATION OF BENEFITS

You, your Spouse, and your Dependents may be entitled to benefits under this Plan as well as benefits under another plan. In such cases, this Plan will coordinate its benefits with those provided by:

a. any group coverage arranged through any employer, trust, union, or Employee benefit association;

b. any government or tax-supported benefit program; or

c. Medicare or Medicaid (Medi-Cal).

With coordination of benefits, the benefits payable by this Trust Fund will not exceed the benefit that would have been paid had this Trust Fund been the primary payer and will not exceed 100% of the billed charges when combined with the benefits payable by the other plan(s).

One of the two or more plans involved is the primary plan, while the others are secondary plans. The primary plan pays benefits first without regard to the other plans involved.

If two eligible Employees are lawfully married, they shall be deemed both Employees and Spouses hereunder, and the Plan will coordinate benefits for them, as well as for their Dependent children as if the Plan were both the primary plan and the secondary plan.

After payment of benefits as the primary plan, this Plan shall provide benefits as the secondary plan in accordance with the following:

1. for Network Providers, the Plan will reimburse the deductibles, co-payments, and the co-insurance amount up to the contract rate for services covered by the Plan; or

2. for Non-Network Providers, the Plan will reimburse only the deductibles and copayments. The Plan will not cover the coinsurance amount for Non-Network Providers.

Notwithstanding the foregoing, when this Plan is both the primary plan and the secondary plan, there shall be no increase in any applicable limitations for benefits set forth in the Plan.

If this Plan is designated as secondary and another plan as primary, then benefits will be determined as follows:

1. this Plan shall pay the difference between the amount payable by the primary plan and the total Covered Expenses under the primary plan, not to exceed the amount that this Plan would have paid for the Covered Expenses under this Plan if it had been the primary plan;

2. if the benefit is not a Covered Expense under the primary plan, this Plan shall pay as if it had been the primary plan; and

3. if the primary plan's benefit is provided through a Health Maintenance Organization (HMO) or other prepaid arrangement, benefits under this Plan will reimburse up to this Plan's benefit only co-payments, surcharges, or other charges that the Participant is legally obligated to pay out of pocket to the provider for services rendered.

If one plan has no coordination of benefits provision, it is automatically primary.

Determination of Primary and Secondary Plans
In order to determine which plan will be primary and which will be secondary, the following rules will apply:

Employees, Their Spouses, and Dependents
The plan that covers the person as an Employee will be primary and pay benefits first. The plan that covers the person as a Spouse or Dependent will be secondary and will pay benefits last.

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

COBRA Beneficiaries I Self-Payment
The plan that covers the person as an Employee or Dependent will be primary and pay benefits first. The plan that covers the person as a COBRA Beneficiary, or covers the person through self-payment, will be secondary and will pay benefits last.

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

Dependent Children of Parents Separated or Divorced
The following order shall apply:

- the plan of the parent with custody pays first;
- the plan of the Spouse of the parent with custody (the stepparent) pays next; and
- the plan of the parent without custody pays last.

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

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

Medicare
This Plan is primary to Medicare under the following circumstances:

- an active Employee (even those over age 65);
- an active Employee's Spouse (even those over age 65);
- the first 18 months of treatment for end-stage renal disease received by any covered person; and
- an active Employee's Spouse or Dependent who is eligible for Medicare due to disability and a disabled Employee who is eligible for Medicare, but who has coverage under the Plan as a result of current employment (for example, during a trial work period).

Preferred Provider Organization
Where this Plan is coordinating benefits with another health plan which has entered into a preferred provider arrangement with a medical or hospital provider, in no event will this Plan's Covered Expenses under this coordination of benefits provision for benefits provided under another plan's preferred provider agreement exceed the lesser of UCR charges or the discounted rates charged to the other health plan under the preferred provider agreement.

Health Maintenance Organization
Where this Plan is coordinating benefits with a Health Maintenance Organization, this Plan will coordinate only on copayments, surcharges, or other charges that the patient is legally obligated to pay out of pocket to the provider for services given to the patient.

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA

This Plan will use and disclose protected health information (PHI) in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (the HITECH Act), and the regulations promulgated thereunder.

PHI is defined as individually identifiable health information that is maintained or transmitted in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, health plan (including this Plan), employer, or health care clearinghouse; and related to the past, present, or future physical or mental health or condition of you or your eligible Dependents; the provision of health care to you or your eligible Dependents; or the past, present, or future payment for the provision of health care to you or your eligible dependents. When held by this Plan, it also means information that identifies you or your eligible Dependents directly or indirectly, in that one has a reasonable belief that you or your eligible Dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage or whether you are an active Employee, retiree, or Medicare enrollee.

PHI excludes individually identifiable health information in certain education records, in records of post-secondary education students made by a doctor or other professional in connection with treatment to the student, in employment records held by a Covered Entity in its role as an employer, and regarding a person who has been deceased for more than 50 years.

THE FOLLOWING USES AND DISCLOSURES OF PHI, AND CORRESPONDING RIGHTS AND DUTIES, APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS

Permitted Uses and Disclosures of PHI
Except with respect to the prohibited uses and disclosures described below, this Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment, and health care operations, subject to the minimum necessary standard discussed below. Treatment includes but is not limited to the provision, coordination, or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefits (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualification of health care professionals, underwriting, premium rating, and other insurance contracts. It also includes legal services, consulting services, and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

Required Uses and Disclosures of PHI
This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, and in response to your request for an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of the U.S. Department of Health and Human Services (HHS) and its Office of Civil Rights (OCR) or other authorized government organizations to investigate or determine this Plan’s compliance with the Privacy Rule.

Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Use or Disclosure
This Plan will disclose PHI to family members, other relatives, or close personal friends if the information is directly relevant to the family's or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected, or if you are deceased and the disclosure is not inconsistent with any prior expressed preference known to this Plan.

Allowed Uses and Disclosures of PHI for which Authorization or Opportunity to Object is Not Required
This Plan will use or disclose PHI without your authorization or opportunity to object when required by law or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors, and organ procurement organizations, judicial and administrative agencies, military and national security agencies, workers' compensation programs, correctional facilities, and when necessary to prevent or lessen a serious and imminent threat to health and safety. These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Administrative Office.

Prohibited Uses and Disclosures of PHI
This Plan will not use or disclosure PHI that is genetic information for underwriting purposes, including determining eligibility or benefits under this Plan, for computing any contribution amounts under this Plan, or for other activities related to the enrollment and/or continued eligibility under this Plan. In addition, this Plan will not sell PHI or receive remuneration in exchange for the use or disclosure of PHI unless authorization is obtained, as described below.

Uses and Disclosure of PHI that Require Your Written Authorization
This Plan must obtain your written authorization for any use or disclosure of your PHI not specifically required or permitted by law or described in this Notice. This Plan does not anticipate using or disclosing your PHI in a manner that would require your authorization. However, should authorization be required, this Plan will provide you with an authorization form. You have the right to revoke your authorization at any time. All revocations will be honored by this Plan. If you do provide written authorization, it will allow PHI to be used and disclosed by both this Plan and its Business Associates.

Your written authorization will be obtained before this Plan will use or disclose psychotherapy notes about you from your psychotherapist, if applicable. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. This Plan may use and disclose such notes without your written authorization when needed by this Plan to defend against litigation filed by you. Written authorization will also be obtained if PHI is used or disclosed for marketing purposes or is sold.

Your Individual Rights

HIPAA and the Privacy Rule afford you're the following rights:

1. You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment, or health care operations or to restrict uses and disclosures to family members, relatives, friends, or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request with one exception. This Plan is required to comply with a restriction request if you request restricted disclosure of PHI to this Plan for payment or health care operations purposes (not for treatment purposes) and the PHI at issues related solely to a health care item or service for which you (or persona other than this Plan, on your behalf) have paid the health care provider in full. In any other circumstances, if this Plan agrees, it is bound by the restriction except with otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

2. You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such requests if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a form requesting to receive communications of PHI by alternative means or at alternative locations.

3. You (or your personal representative) have the right to request access to you PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about your maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication, and care or medical management record systems maintained by or for this Plan; or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a form requesting access to PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days, whether the requested information is maintained onsite or offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If access is granted, this Plan will provide access to the PHI in the form request by you, if readily producible in such form or format; or, if not, in a readable hard copy form or other form agreed to by this Plan and you. As described further below, if the PHI is maintained electronically, and if you request an electronic copy, this Plan will provide access in the electronic form and format requested by you if it is readily producible; or, if not, in a readable electronic form and format agreed to by this Plan and you. This Plan may charge a reasonable fee for the costs of the paper copy or electronic media, as applicable. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or HHS or its OCR.

4. You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a form to request an amendment to the PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may deny your request to amend for any of the following reasons: (i) the request for amendment is not in writing; (ii) the request for amendment does not provide any reason(s) for the requested amendment; (iii) the PHI or record that is the subject of the request was not created by this Plan unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment; (iv) the PHI or record that is the subject of the request is not part of a Designated Record Set; (v) the PHI or record that is the subject of the request is accurate or complete, or (vi) the PHI or record would not be available to you for inspection or copying as discussed above under the Access to PHI section. If the request is denied in whole or part, this Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

5. You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for a six-year period starting from the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment, or health care operations or disclosures made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures: (i) incident to a use or disclosure otherwise permitted or required by law; (ii) made pursuant to your authorization; (iii) to individuals permitted by law; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement officials; and (vi) of a limited data set. You will be required to complete a form requesting an accounting of PHI disclosures by this Plan. This Plan will provide an accounting of disclosures by this Plan. This Plan will provide an accounting of disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days

is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

6. You have the right to request access to any Electronic Health Records (EHRs) used or maintained by this Plan, and this Plan will provide access to your EHRs in the electronic form and format requested by you if it is readily producible; or, if not, in a readable electronic form and format agreed to by this Plan and you. EHRs are electronic records of health-related information on an individual that are created, gathered, managed, and consulted by authorized health care clinicians and staff. In addition, you have the right to request that this Plan provide your EHRs to another request is clear, conspicuous, and specific. This Plan is entitled to charge you a reasonable fee for any labor costs or supplies (e.g., portable electronic media) incurred in providing the electronic information. You will be required to complete a form requesting access to any EHRs or to have your EHRs provided to another entity or individual.

Access by Personal Representative to PHI
This Plan will treat your personal representative as you with respect to uses and disclosures of PHI and all the rights afforded you by the Privacy Rule under certain circumstances, but only to the extent, such PHI is relevant to their representation. For example, a personal representative with a limited health care power of attorney regarding a specific treatment, such as use of artificial life support, is your representative only with respect to PHI that related to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable, or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect of a minor child's health care information.

This Plan's Duties
In accordance with the Privacy Rule, only certain Employees may be given access to your PHI. The Administrative Office has designated this group of Employees to include Claims Adjustors, Claims File Clerks, Mail Clerks, Eligibility Certifiers, Supervisors, and Managers. The Employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices (Notice) upon request. Also, the Notice must be distributed by this Plan to new Employees and Dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures; or will post the Notice on its website by the effective date of the material change with a copy of the revised Notice in its next annual mailing.

This Plan will limit, to the extent practicable, the PHI subject to use and disclosure to de-identified information, which excludes certain information that could be used to identify you. However, to the extent this Plan deems it necessary, it may use, disclose or request more than de-identified information so long as it does not disclose, use, or request more than the minimum amount of your PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures pursuant to your authorization; disclosures made to HHS or its OCR for enforcement purposes; uses or disclosures that are required by law; or uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

Notification of Breach of Unsecured PHI

This Plan is required to notify you following a Breach of Unsecured PHI. No later than 60 days from the discovery of any Breach of unsecured PHI, this Plan will provide you with notice of such Breach. Unsecured PHI includes PHI in electronic form that is not encrypted and PHI in paper form that has not been destroyed. A Breach of Unsecured PHI is an impermissible acquisition, access, use, or disclosure that compromises the security or privacy of such information unless this Plan (or Business Associate of this Plan, as applicable) can demonstrate that there is a low probability that the PHI has been comprised based on a risk assessment of at least the following factors: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated. However, an impermissible acquisition, access, use, or disclosure of PHI will not be considered a Breach if it is within one of the following three exceptions: (i) an unintentional acquisition, access, use, or disclosure of PHI by a workforce member or person acting under the authority of this Plan or one of its Business Associates if made in good faith and within the scope of authority so long as the information is not further acquired, accessed, used, or disclosed by any person; (ii) an inadvertent disclosure by an individual who is authorized to access PHI at this Plan or a Business Associate to another person who is also authorized to access PHI at this Plan or the Business Associate if the information is not further used or disclosed without authorization; or (iii) a disclosure of PHI for which this Plan or its Business Associate has a good faith belief that the unauthorized individual to whom the disclosure was made would not reasonably be able to retain it.

In the event of a Breach of Unsecured PHI, this Plan's written notification to you will include the following information: the date of the breach; the date of discovery of the breach; the type of PHI involved; the steps you should take to protect yourself from potential harm from the Breach; and explanation of what steps this Plan is taking to investigate the Breach, mitigate harm to you and to protect against further breaches; and contact procedures for you to obtain additional information. If this Plan lacks current contact information for you, it will provide substitute notice, which will be by email, telephone, or may be by other means, including posting notice on this Plan's website or conspicuous notice in major print or broadcast media in the geographic area where you are likely to reside. In circumstances in which the Breach of Unsecured PHI is reasonably believed by this Plan to have affected more than 500 individuals in a particular state or jurisdiction, this Plan will provide additional notice to prominent media outlets within the state or jurisdiction no later than 60 days after discovery of the Breach. Finally, this Plan will report any Breach of Unsecured PHI to HHS as required by HHS.

Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you, and there is no reasonable basis to believe the information can be used to identify you. For example, health information is de-identified if certain identifiers are removed, including but not limited to your name, geographic identifiers (e.g., address, etc.), all elements of dates relating to you (e.g., your birth date), Social Security Number, telephone number, medical record number, etc.

This Plan may disclose summary health information to this Board of Trustees or a Business Associate. Summary health information is information that may be individually identifiable information, and that summarizes your claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

Although this Plan is allowed to use and disclose your PHI for marketing purposes with your written authorization, this Plan will not use and/or disclose PHI for purposes of marketing.

Marketing is defined as making a communication about a product or service that encourages recipients of the communication to purchase or use the product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase.

However, marketing does not include the following communications made, unless direct or indirect payment is received from or on behalf of a third party whose product or service is being described: (i) to provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual (payment may be received if it is reasonably related to the cost of making the communication); (ii) for the treatment of an individual by a health care provider, including case management or care coordinating for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual; (iii) to describe a health-related product or service (or payment for such product or service) that is provided by, or included in the plan of benefits of the entity making the communication, including communications about participating in a health care provider network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan enrollee that add value to, but are not a part of, a plan of benefits; or (iv) for case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions.

This Plan does not anticipate making any fundraising communications; however, to the extent, this Plan provides you with any written fundraising communication that is a healthcare operation as defined under the Privacy Rule, it shall provide in a clear and conspicuous manner that you are entitled to elect not to receive any further such communication and such election shall be treated as a revocation of authorization.

The Board of Trustees' Duties

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by this Plan's documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administrative Office.

Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment, or accounting of PHI), you may contact the Privacy Officer at the following address: BeneSys, Inc., P.O. Box 990, West Covina, CA 91793. **A complaint may also be filed with HHS in writing, either electronically via the OCR Complaint Portal, or on paper by faxing, emailing, or mailing it to the applicable OCR regional office. For more information on filing a complaint with HHS, please visit www.hhs.gov/ocr/privacy/hipaa/complaints/ or call (800) 368-1019 to request a copy of a complaint form.**

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if a good cause is shown. This Plan will not retaliate against you for filing a complaint.

CERTAIN LEGISLATION AFFECTING YOUR HEALTHCARE

Family and Medical Leave Act of 1993
If your Employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you, your Spouse, and your eligible Dependents will continue to be covered under this Plan, provided you were covered under the Plan when the leave began, and your employer continues to make the required contribution. Coverage will be continued while you are absent from work on an FMLA leave as if there were no interruption of active employment and as if you were continuing to work the number of hours required for coverage. Coverage will continue until the earlier of the expiration of the FMLA leave, the date your employer fails to make a contribution on your behalf or the date on which you give notice to your Employer that you do not intend to return to work at the end of the leave.

It is not the role of the Plan to determine whether or not an Employee is entitled to FMLA leave. Any disputes regarding entitlement to FMLA leave with continuing Plan benefit coverage must be resolved with your Employer.

Coverage of Former Medicaid or State Children's Health Insurance Program Participants
The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provides enrollment rights for eligible individuals. The Plan is amended effective April 1, 2009, to provide the following special enrollment rights for individuals who are eligible for coverage under the Plan but are not enrolled for coverage:

1. an Employee or eligible Dependent who is covered under Medicaid or the State Children's Health Insurance Program (SCHIP) and loses coverage under Medicaid or SCHIP because the Employee or Dependent is no longer eligible for such coverage may request coverage under the Plan with sixty (60) days of the loss of Medicaid or SCHIP coverage. Like other special enrollment rights under the Plan, qualified individuals may enroll in the Plan outsideof the regular open enrollment period; and

2. an Employee or eligible Dependent who becomes eligible for a premium assistance subsidy in the Plan under Medicaid or SCHIP may request coverage under the Plan within sixty (60)days after such eligibility is determined. State-specific notices will be provided to Employees regarding the state-provided subsidy after they have been issued by the Department of Labor and Division of Health and Human Services.

Newborns' and Mothers' Health Protection Act of 1996
Under federal law, group health plans and health insurance issuers generally may not restrict benefits for a 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother (or the newborn's authorized representative), from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the plan or insurance issuer may not, under federal law, require that a health care provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, if applicable).

Women's Health and Cancer Rights Act of 1998
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1. all stages of reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same annual deductibles and coinsurance applicable to other medical and surgical benefits provided under the Fund. If you would like more information about these benefits, contact the Trust Fund Administrative Office.

Qualified Medical Child Support Order

A Qualified Medical Child support Order (QMCSO) issued by a court or a state agency requires the Plan to provide health coverage to the child(ren) of a Plan Participant. The Plan has adopted Qualified Medical Child Support Order Procedures to determine whether a particular order qualifies as a QMCSO. Plan Participants and Beneficiaries can obtain, without charge, a copy of these procedures form the Trust Fund Administrative Office.

GENERAL INFORMATION

a. Right to Interpret the Plan

If any person shall have a dispute as to eligibility, type, amount, or duration of benefits, the dispute shall be resolved by the Board of Trustees in their absolute discretion under and pursuant to the Plan, and this procedure, its interpretation of the Plan and its decision of the dispute shall be final and binding upon all parties to the dispute.

b. Physical Examination

The Plan at its own expense shall have the right and opportunity to have an independent Doctor examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim.

c. Recovery of Overpayments

If for any reason the Fund pays any amount not required under the Plan, or in excess of what is required under the Plan, to any Employee or to any eligible Dependent, the Fund may, but shall not be required to, recover such overpayment, or any portion thereof, through an offset against future benefits owing to such individual or to any family member of such individual. This shall not be deemed a waiver or limitation on the Fund's right to recover overpayments by any other method.

d. Submission of False Information

If an Employee, Dependent, or other beneficiary submits false information either in enrolling in the Plan or in claiming benefits, this action could constitute fraud and could result in termination of employment, disciplinary action, and termination of benefits.

e. Amendment and Termination

The Board of Trustees shall, in their sole discretion and without notice to eligible Participants or Employers, but on a non-discriminatory basis, reserve the right to:

1. Terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects claims in process and/or expenses already incurred; and

2. Alter or postpone the method of payment of any benefit; and

3. Amend any provisions of these rules and regulations.

Upon termination of the Plan, the Trustees will wind up the affairs of the Trust Fund, and any remaining funds will be used to continue payment of benefits to Plan Participants under the Plan.

f. Third-Party Liability – Exclusions and Limitations

Benefits are not paid for any expenses when an injury or illness of the Employee and/or Dependent ("Employee/Dependent") is caused by a third party. However, the Plan may assist the Employee/Dependent whose illness or injury is caused by a third party, by advancing the benefits pursuant to the Plan, on the condition that the Employee/Dependent and their attorney sign an Acknowledgment of Lien and Subrogation Agreement. Employee/Dependent shall immediately notify the Plan of an injury or illness caused by a third party.

If Employee/Dependent receives a Recovery in connection with such third party or if Employee/Dependent is injured and receives Workers' Compensation or insurance benefits, the Plan shall be entitled to a first right to recover the amount of benefits paid under the Plan for services provided for such injury or illness up to the extent of any Recovery by the Employee/Dependent. Under the Plan and Acknowledgement of Lien and Subrogation Agreement, Employee/Dependent agrees to repay the Plan in full, before all others, from any Recovery received and shall direct their attorney to reimburse the Plan first, before all others. "Recovery" means the total amount received of any kind from any source. This means any amounts the Employee/Dependent receives from (a) the third party, the third party's insurer, or someone acting for or on behalf of the third party, whether by judgement, settlement or otherwise; (b) any insurance policy, including the Employee/Dependent's uninsured or underinsured motorist coverage; and/or (c) any other source. The reimbursement to the Plan will not be subject to the common fund doctrine, the make-whole doctrine, and any reduction based on comparative fault, nor will the characterization of the Employee/Dependent's damages impair or hinder the Plan's right to reimbursement. Reimbursement shall be made without deduction for the Employee/Dependent's attorney's fees.

The Plan shall have a lien against any Recovery by the Employee/Dependent for any of the aforesaid benefits and may in its own name intervene in any administrative or judicial proceeding as a party thereto for the purpose of ensuring enforcement of its lien rights, but shall not be obligated to do so. The Employee/Dependent shall be deemed to hold the Recovery, up to the amount of the Plan's lien, in trust for the benefit of the Plan, whether or not the same is segregated or is commingled with the Employee/Dependent's other assets and property. Payment of the Plan's lien shall be made promptly after the Employee/Dependent receives the recovery.

In addition, the Plan shall be subrogated to the rights of the Employee/Dependent. This means that the Plan may (but shall not be required to) initiate its own action against the responsible third party or parties to recover its lien, whether or not the Employee/Dependent has initiated any action and whether or not the Employee/Dependent consents. In the event the Plan brings any legal action or proceeding to enforce any lien created hereunder or to collect amounts due to the Plan pursuant to this Section, the Plan shall be entitled to recover all costs incurred in connection therewith, including reasonable attorney's fees.

The Plan's lien shall exist and shall be fully enforceable whether or not such Acknowledgement of Lien and Subrogation has been executed and whether or not such Acknowledgment of Lien and Subrogation has been lost destroyed, or modified in any manner. The Plan may withhold the processing of benefits pending the return of a signed Acknowledgement of Lien and Subrogation. The Plan is entitled to deny benefits if the Employee/Dependent and/or his/her attorney fail to sign the Acknowledgement of Lien and Subrogation.

The Plan may also require the filing of periodic reports regarding the status of such claims as a condition of continued eligibility for benefits hereunder. Failure to furnish such reports or otherwise cooperate with the Plan may result in automatic termination of eligibility for benefits.

If the Employee/Dependent fails to execute an Acknowledgement of Lien and Subrogation or other document required by the Plan, or if the Employee/Dependent (or such Employee/Dependent's attorney or representative) fails to provide such information as may be requested from time to time by the Plan or its representative, or if the Employee/Dependent (or such Employee/Dependent's attorney or representative) attempts to evade or avoid the Plan's lien, the Plan may offset all or any portion of the lien against any other benefits which may be owing at any time to or on behalf of the Employee/Dependent or any eligible family member.

g. Disclaimer

The benefits provided by the Trust Fund under the Indemnity Plan are not insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payment over and above the amounts in the Trust Fund collected and available for such payment.

BASIC PLAN INFORMATION

a. Name of the Plan

The name of the Plan is the Operating Engineers Local 501 Security Fund.

b. Name, Address, and Telephone Number of the Board of Trustees

Board of Trustees of the Operating Engineers Local 501 Security Fund
c/o BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

c. Plan Identification Number

The taxpayer identification number assigned to the Plan by the Internal Revenue Service is 95-6049026. The plan number is 501.

d. Type of Plan

The Plan is a group health plan as defined by ERISA Section 733. The Plan provides group benefits, including hospital, medical, surgical, prescription drug, dental, vision, and death, and accidental death and dismemberment benefits through a multiemployer trust fund.

e. Type of Administration

The Plan is administered by the Board of Trustees utilizing the services of a third-party contract administrator, BeneSys, Inc.

f. Name, Address, and Telephone Number of the Plan Administrator

BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793
(800) 320-0106

g. Name and Address of Agent for Service of Legal Process

Operating Engineers Local 501 Security Fund
c/o BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793

Service of legal process may be made upon a Plan Trustee or the Plan Administrator.

h. Board of Trustees

The names and addresses of the current Plan Trustees are:

Employer Trustees

Will Webster
ABM Onsite Services
1150 South Olive Street, Floor 19
Los Angeles, CA 90015

Tom Crosser
Cushman & Wakefield
1155 Camino Del Mar, #147
Del Mar, CA 92014

Brian Pagac
Brookfield Office Properties
601 South Figueroa Street, Suite 2200
Los Angeles, CA 90017

Reginald Denson
George S. Hall, Inc.
515 S. Flower Street, 18th Floor
Los Angeles, CA 90071

Union Trustees

Edward Curly
Operating Engineers Local 501
2405 W. Third Street
Los Angeles, CA 90057

Denise Vukojevich
Operating Engineers Local 501
400 West Washington Blvd., Oak Hall F212
Los Angeles, CA 90015

Thomas O'Mahar
Operating Engineers Local 501
301 Deauville Street
Las Vegas, NV 89106

Michael Narez
Operating Engineers Local 501
2405 W. Third Street
Los Angeles, CA 90057

Alternate Union Trustee

Diego Back
Operating Engineers Local 501
2405 W. Third Street
Los Angeles, CA 90057

i. Description of Collective Bargaining Agreements

The Plan is maintained pursuant to one or more Collective Bargaining Agreements. Copies of the Collective Bargaining Agreement(s) may be obtained by Participants and beneficiaries upon written request to the Trust Fund Administrative Office, identified above, and are available for examination as required by law. Contributions to the Trust Fund provide medical coverage under the Plan and are made by individual Employers as required by the terms of the various Collective Bargaining Agreements.

j. Participation, Eligibility, and Benefits

Indemnity Medical Plan

- Participation and eligibility rules for active Employees: see pages 12 to 16.
- Participation and eligibility rules for Retirees: see pages 26 to 29.
- Benefits: see pages 37 to 40.
- Cost-sharing: see pages 37 to 40.
- General limitations and exclusions: see pages 53 to 56.
- Preventive Services: see page 52.
- Coverage of drugs: see pages 59 to 65.
- Medical tests, devices, and procedures: see pages 37 to 40.
- Anthem Blue Cross PPO Network: see pages 41 to 44.
- Non-Network provider reimbursement: see pages 37 to 40.
- Emergency care benefits: see pages 38 and 47.
- Preauthorization and utilization review: see pages 41 to 42.

Kaiser Permanente HMO Plan

- Participation and eligibility rules for active Employees: see pages 12 to 16.
- Participation and eligibility rules for Retirees: see pages 26 to 29.
- Benefits: see pages 67 to 80 for a summary of the Kaiser Permanente HMO plan benefits.

The description will include all cost-sharing provisions, general limitations and exclusions, preventive services covered, coverage of drugs, medical tests, devices, and procedures, out-of-network provider reimbursement provisions (if any), emergency care benefits, and preauthorization and utilization review requirements (if any).

Dental Care Plans

- Participation and eligibility rules for active Employees: see page 81.
- Participation and eligibility rules for Retirees: see page 88.
- Benefits: see pages 81 to 90.

Vision Care Plan

- Participation and eligibility rules for active Employees: see page 91.
- Benefits: see pages 91 to 93.

Death and AD&D Benefits

- Participation and eligibility rules for active Employees: see pages 94 to 95.
- Benefits: see pages 94 to 96.

This "Participation, Eligibility, and Benefits" section is also subject to the Plan's policies and procedures, etc. A listing of the Anthem Blue Cross PPO Network Providers or the Kaiser Permanente HMO network providers are available free of charge upon request to BeneSys, Inc. or Kaiser Permanente, as applicable. You can also access the Anthem BlueCross Network Provider listing at www.anthem.com/ca.

Participants and beneficiaries may also request a copy of the Plan's Qualified Medical Child Support Order (QMCSO) written procedures.

k. Circumstances Which May Result in Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction, or Recovery of Benefits

An Employee or beneficiary who is eligible for benefits may become ineligible as a result of the following circumstances:

1. The Employee's failure to work the required hours to maintain eligibility (or failure to make a COBRA or USERRA payment, where authorized). Employees must work 72 hours or be directly paid for at least 72 hours or more per month by a participating Employer with payments made to the Fund. See the eligibility rules set forth on pages 12 to 16 of this booklet.

2. The failure of your Employer to report the hours and remit correct contributions on your behalf to the Fund.

3. The failure of your Employer to enter into a signed written Collective Bargaining Agreement, or renewal thereof, with the Union.

4. In the case of beneficiaries who are Dependents of an eligible Employee, they may become ineligible if (a) they are no longer Dependents or (b) they have attained the disqualifying age. See Dependent eligibility rules set forth on pages 12 to 16 of this booklet.

5. You or your eligible Dependents do not elect COBRA continuation coverage upon a qualifying event, or if you or your Dependents elect COBRA continuation coverage, and the required payments are not made timely or the COBRA extension period expires. See pages 17 to 22 of this booklet.

6. If you or you eligible Dependents are paid benefits in error, and the Plan is not reimbursed, the Plan may offset future claims payments by the amount that was not repaid.

7. If you or your Dependent is injured by a third party and a claim or lawsuit is being pursued against a third party. See also the Third Party Liability section on pages 107 to 108 of this booklet.

An Employee or beneficiary who is eligible may be denied benefits as a result of any of the following circumstances:

1. The failure of the Employee or beneficiary to file a claim for benefits within 90 days following the date of loss, or within one year of the date he or she incurred the expense for which benefits are payable if it was not reasonably possible to file within the 90-day filing period.

2. The failure of the Employee or beneficiary to file a complete and truthful benefit application.

3. If the Employee or beneficiary has other group insurance coverage, benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two plans.

4. If the loss for which the claim is being made is subject to an exclusion or limitation ofthe benefit plan/insurance policy or health plan agreement.

5. If you or your Dependents are paid benefits in error, and the Plan is not reimbursed, the Plan may offset future claims payments by the amount that was not repaid.

6. If you or your Dependent is injured by a third party and a claim or lawsuit is being pursued against a third party. In the event a claim or lawsuit is being pursued against a third party (including a workers' compensation claim, lawsuit, etc.), and the Fund is unaware of the claim, lawsuit, etc. and consequently pays claims in error, and you and/or your Dependent recover money from a third party (including through workers' compensation/employer insurance, etc.), then you and/or your Dependent must refund the Fund 100% of the claims paid, which may be up to the total amount recovered from the third party (or through workers' compensation/employment insurance, etc.), and there will be no offset for attorney's fees under any legal theory whatsoever, including, but not limited to, the make-whole doctrine and common fund doctrine. See also the Third Party Liability section on pages 107 to 108 of this booklet.

The information provided is intended as a summary of the circumstances that would result in a denial of eligibility or benefits. It is not intended to be an exhaustive list of all such circumstances. Please refer to the remainder of this booklet for additional circumstances.

l. COBRA Rights

You and your eligible Dependents' COBRA rights are summarized on pages 17 to 22 of this booklet.

m. Compliance with ERISA and the Internal Revenue Code

The Trustees believe that the Plan fully complies with the Employee Retirement Income Security Act of 1974, as amended, the Internal Revenue Code, as amended, and any other applicable federal law. Any omissions or oversights will be resolved in accordance with the statute or other applicable law(s).

n. Plan Amendments or Plan Termination

The Trustees reserve the right to interpret and apply the provisions of the benefit plan(s) created and administered by them and to, in turn, amend the benefit plan(s), in whole or in part, in their discretion. The Trustees may also, in their discretion, terminate the benefit plan(s), in whole or in part, at any time if such action(s) is deemed necessary by the Trustees. In any event, the benefit plan(s) shall be automatically terminated upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Fund, provided that for purposes of this provision, a collective bargaining agreement or special agreement shall not be deemed to have expired in a strike or lockout situation, unless said strike or lockout continues for more than six (6) months. You and your eligible Dependents will be provided with a Summary of Material Modifications (SMM) no later than 60 days after the adoption date of the modification or change. Any modification or change in the Summary of Benefits and Coverage (SBC) will be provided at least 60 days in advance of the adoption date of the modification or change. If the benefit plan(s) is terminated, the Participants will be notified as soon as reasonably possible.

o. Source of Contributions

Contributions are made primarily by the participating Employers under the terms of various Collective Bargaining Agreements. Generally, the Collective Bargaining Agreements provide that the Employer will contribute a specified rate per Employee per month.

Employee self-payments are also allowed (including COBRA or USERRA payments, other self-payments as authorized, and early and Medicare-eligible Retiree self-payments) under certain circumstances. Provisions for these payments are described on pages 17 to 29.

p. Plan Year

The Plan Year is October 1 through September 30.

q. Entities Used for Accumulation of Assets, Employer Contributions, and Payment of Benefits

All Employer contributions are received, collected, and deposited by a designated bank or trust company. The funds are then used to pay premiums to the insurance carriers and providers of services, pay benefits directly when applicable, pay the expenses of administration, and to provide reserves. COBRA, USERRA, and other self-payments are received by Plan Administrator and deposited with a designated bank or trust company.

r. Insurers and Providers of Service to the Plan

BeneSys, Inc. provides third-party administration to the Plan and administers the payment of medical claims through the Indemnity Medical Plan. The Indemnity Medical Plan is self-funded and reinsured through a stop-loss carrier. Some benefits under the Plan are provided through a Health Maintenance Organization (HMO) or fully insured plans.

Premiums are paid to the HMO or the provider of the fully insured benefit for the applicable coverage on behalf of you and your eligible Dependents if you elected coverage under those plan(s). Any claims disputes involving the HMO or a fully insured plan must be handled directly with the HMO. The carriers and providers of service to the Plan for the benefits described in the booklet are:

Anthem Blue Cross Managed Care Services
21555 Oxnard Street
Woodland Hills, CA 91365
(Indemnity Medical Plan – self-insured plan – Network access to Hospitals and Physicians)

OptumRx
2300 Main Street
Irvine, CA 92614
(Prescription Drug Program – self-insured plan – administration services only)

Kaiser Permanente
1 Kaiser Plaza
Oakland, CA 94612
(Medical HMO plan – fully-insured plan)

Mental Health Network (MHN)
32 Hampden Street
Springfield, MA 01103
(EAP Services)

Vision Service Plan (VSP)
101 California Street, Suite 975
San Francisco, CA 94111
(Vision Care Plan – self-insured plan – administration services only)

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
(Dental Care Plans – fully insured and self-insured plans)

Telemedicine Management, Inc., d/b/a SwiftMD
801 Springdale Drive
Exton, PA 19341
(Telemedicine services)

s. Benefit Claim and Appeal Procedures

The Claims and Appeals Procedures for the Indemnity Medical Plan and Prescription Drug Program are set forth below. The Claims and Appeals Procedures for Death Benefits and Accidental Death, Dismemberment, and Loss of Sight (AD&D) Benefits will be handled in the same manner as the Indemnity Medical Plan Claims and Appeals Procedures, as applicable. For procedures relating to HMO Benefits – Kaiser Permanente, the Dental Care Plan, the Retiree Dental Plan, or the Vision Care Plan, please refer to the applicable sections(s) of the booklet or the plan documents provided by the applicable entity.

CLAIMS AND APPEALS PROCEDURES FOR THE INDEMNITY MEDICAL PLAN

The benefits provided to you and your eligible Dependents under the Indemnity Medical Plan will only be available if you (i.e., the Claimant) comply with the procedures set forth below.

ADMINISTRATIVE REVIEW

PRE-SERVICE CLAIMS

A pre-service claim for medical care is a claim that the Plan requires approval of in advance of obtaining medical care. The Plan requires preauthorization for the following services:

1. Hospitalizations; except for:
    a. Emergencies;
    b. When the Fund is a secondary payor; or
    c. Hospitalization for childbirth for up to 48 hours following a normal delivery or 96 hours following a caesarean section.
2. Durable medical equipment (DME) over $1,000.

Anthem Blue Cross will determine for the Plan whether a service is medically necessary and other medical judgments based on the appropriateness for treating the illness or injury, the health care setting, the level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational.

There are two types of pre-service claims for medical care through Anthem Blue Cross: urgent and non-urgent.

Urgent Care Claims
An urgent care claim is one that must be resolved more quickly than within the time periods for non-urgent care claims because if it is not so resolved, it could: (a) seriously jeopardize your life or health or your ability to regain maximum function or (b) would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a claim for urgent care is to be determined by Anthem Blue Cross, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Additionally, a claim will be considered an urgent care claim if a Physician will knowledge of your medical condition states that it is a claim involving urgent care.

Benefit Claim Procedures for Pre-Service Urgent Care Claims
Urgent care claims may be made orally or in writing by you, your Physician, or other authorized representative. Urgent care medical care claims requiring preauthorization must be made to Anthem Blue Cross by calling (800) 274-7767 or by writing to 2155 Oxnard Street, Woodland Hills, CA 91367.

All claims must identify your name; the specific medical condition or symptom; and the specific treatment, service, or product for which approval is sought. Anthem Blue Cross will notify you of its decision within 72 hours of receipt of the claim. You and Anthem may agree to an extension of this time period, but Anthem Blue Cross may not unilaterally extend same. Notification may be oral unless written notification is requested by you or your authorized representative. Any oral notification by Anthem Blue Cross will be followed up in writing within three days by U.S. mail, facsimile transmission, or other electronic means.

Incomplete Claims
If you or your authorized representative fail to follow the above-described procedures or do not provide sufficient information to describe a claim, Anthem Blue Cross will notify you within 24 hours of the failure and inform you of the information necessary to file a complete claim. You will have a reasonable amount of time (at least 48 hours) to supply the additional information. When your complete claim is filed with Anthem Blue Cross, you will be notified of the determination, whether adverse or not, as soon as possible, but no later than 48 hours after the earlier of their receipt of the specified information or the end of the period afforded you to provide the additional information. You and Anthem Blue Cross may agree to further extension of these time periods.

Non-Urgent Care Claims
A non-urgent care claim for medical care is a claim that is not an urgent care claim.

Benefit Claim Procedure for Pre-Service Non-Urgent Care Claims
Non-urgent care claims will be handled in a similar manner as urgent care claims, except that after filing a non-urgent care claim, Anthem Blue Cross will notify you in writing of the decision no later than 15 days from the date the claim is filed. This period may be extended for an additional 15 days if, prior to the expiration of the initial 15-day period, you are notified of the circumstances requiring the extension of time and the date by which Anthem Blue Cross expects to render a decision. You and Anthem Blue Cross may agree to further extension of these time periods.

Incomplete Claims
If you or your authorized representative fail to follow the above-described procedures or do not provide sufficient information to decide a claim, Anthem Blue Cross will notify you as soon as possible but no later than the end of the initial 15-day period. You will have 45 days from the receipt of the notice within which to provide the information. You and Anthem Blue Cross may agree to further extension of these time periods. The time period for deciding such a claim shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

CONCURRENT CARE CLAIMS
A concurrent care claim is a claim for continued treatment that has been provided over a period of time or number of treatments, which was previously approved through the initial preauthorization process or for a decision made regarding a request(s) by you to extend a course of treatment beyond what was approved. The Plan will not reduce or terminate treatment previously approved as medically necessary. The Plan also does not condition the receipt of continuing medical care and, as such, there are generally no concurrent care claims (urgent or non-urgent).

Although continuing medical care is not conditioned upon pre-approval, the Plan will not pay for charges incurred for services and supplies that are not medical necessary. In this regard, members are encouraged but not required to obtain a continuing care authorization through Anthem Blue Cross. Notwithstanding, if you voluntarily seek a concurrent care authorization, and Anthem Blue Cross determines that the continuing services or supplies are not medically necessary, you may request an internal appeal and/or a standard/expedited external review of the determination through Anthem Blue Cross. Please see procedures under Pre-Service Claims above for instructions on contacting Anthem Blue Cross. However, since the Plan does not require pre-approval for concurrent care claims, the Department of Labor (DOL) benefit claims procedure regulations, including any time-free restrictions within which to make concurrent care claim determinations, do not apply.

BENEFIT COVERAGE DETERMINATIONS
The Plan does not require pre-approval for benefit coverage before medical care is received for either urgent or non-urgent claims. Therefore, the Department of Labor (DOL) benefit claim procedure regulations, including any time-frame restrictions within which to make benefit coverage determinations, do not apply. However, this does not mean the Plan will pay for the medical expenses incurred when the billing is actually received. There are cost-sharing arrangements and other limitations and exclusions under the Plan that must be taken into consideration.

Notwithstanding, for convenience purposes only, if you and/or your medical provider has any questions regarding a benefit coverage issue, you may request, in writing, a Plan determination for benefit coverage (e.g., whether a certain benefit is covered under the terms of the Plan) by sending your request to the Fund's Administrative Office at Operating Engineers Local 501 Security Fund, c/o BeneSys, Inc., P.O. Box 990, West Covina, CA 91793. The Administrative Office will respond within a reasonable time period. No such request will be viewed as a "claim for benefits" as defined in the DOL claims procedures regulations. Please note with regard to benefit coverage decisions; the Plan cannot tell you or the medical provider the specific amount payable under the Plan until it receives the appropriate medical claim form and reviews the actual request for payment.

POST-SERVICE CLAIMS
A post-service claim is a claim for a benefit under the Plan that is not a pre-service claim or a concurrent care claim (e.g., treatment has been rendered or a service performed, and you are requesting payment for the treatment or services under the Plan). Post-service claims include requests for actual payment by the Plan of any pre-service claim or concurrent care claim. If you file a post-service claim, the Administrative Office will notify you of its decision within 30 days of receipt of the claim. The Plan is allowed one 15-day maximum extension if the claim decision cannot be made for reasons beyond the control of the Plan and the Administrative Office notifies you prior to the expiration of the initial 30-day period, explains the circumstances for the extension, and identifies the date it expects to render a decision. You are the Administrative Office may agree to further extensions of these time periods.

Benefit Claim Procedures for Post-Service Claims
A post-service claim for medical care must be filed with the Administrative Office in accordance with the following procedures before any benefits can be paid:

If you or your eligible Dependent received medical treatment, you must obtain a claim form from your union or the Administrative Office. After obtaining the form, fill out the top portion of the form using the proper sections as provided for Employee's claims or for Dependent's claims and sign the form. Then submit the form to your medical provider for completion of the required sections (or for attachment of an itemized billing) and provide the form along with an itemized billing to the Administrative Office at Operating Engineers Local 501 Security Fund, c/o BeneSys, Inc., P.O. Box 990, West Covina, CA 91793.

For post-service claims assistance, write the Administrative Office or call (800) 320-0106.

Post-service claims must be submitted no more than 90 days after services are rendered. If filing your claim is delayed through no fault of yours, the Plan may consider the claim if it is submitted within one year after the date of service. No benefits will be payable if a post-service claim is submitted more than one year from the date of service.

Incomplete Claims

If you fail to follow the above procedures or do not provide sufficient information to decide a claim, the Administrative Office will notify you within 30 days of the failure and inform you what is required to file a complete claim. You will have at least 45 days from receipt of the notice within which to provide the specified information. You and the Administrative Office may agree to further extensions of this time period. The time period for deciding a post-service claim shall be tolled from the date on which notification of the extension is sent to you until the date you respond to the request for additional information.

NOTICE OF CLAIMS DENIAL/NOTICE OF ADVERSE BENEFIT DETERMINATION

If any claim is denied in whole or in part on the basis of eligibility; that the benefits will not be paid under the Plan because they are not medically necessary or not covered; or if your coverage is rescinded, you will be provided with a notice of claims denial/notice of adverse benefit determination, which will contain:

1. Date(s) of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, and a reference to the specific Plan provision(s) which the denial is based;

5. A statement that you are entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim for benefits;

6. A description of the Plan's standard used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol, or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or

    b. if the denial was based on medical necessity or experimental treatment or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request;

7. A description of any additional material or information necessary for you to perfect theclaim and an explanation of why such material or information is necessary;

8. An explanation of the Internal Appeal Procedures and time limits applicable to such procedures, including a statement of your right to file a civil action under Section 502(a)or ERISA following the exhaustion of the Internal Appeal Procedures (see below);

9. A statement that the diagnosis and treatment codes, and their corresponding meanings, will be provided free of charge to you upon request;

10. In the case of a pre-service or concurrent urgent care claim, a description of the expedited internal appeal/external review process available for such a claim throughAnthem Blue Cross;

11. The contact information for the applicable office of the Department of Labor, Employee Benefit Security Administration, to assist you with questions you may haveabout your rights, the adverse benefit determination notice, or for other assistance; and

12. A statement about the availability of language services on notices sent to addresses in applicable counties.

INTERNAL APPEAL PROCEDURES

These internal appeal procedures shall be the exclusive procedures available to an Employee or beneficiary who is dissatisfied with an eligibility determination, benefit award, or who is otherwise adversely affected by any action of Anthem Blue Cross or the Administrative Office. These procedures must be exhausted before you (i.e., the Claimant) may file a lawsuit under Section 502(a) of ERISA.

You may request an appeal within 180 days of receipt of an administrative claims denial/notice of adverse benefit determination. Anthem Blue Cross or the Administrative Office, as applicable, shall provide you with access to and copies of documents, records, and other information free of charge that are relevant to the claim, including any new or additional evidence considered in connection with the claim, or any new or additional rationale upon which the final adverse benefit sufficiently in advance of the appeal so you can respond prior to that date. You will have the opportunity to submit written comments, documents, records, or any other information in support of the appeal. If the new or additional evidence is received so late that it would be impossible to provide it to the Claimant in time for the Claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the Claimant has a reasonable opportunity to respond.

PRE-SERVICE CLAIMS

You may file a request for an appeal of any Anthem Blue Cross pre-service preauthorization decision for medical care. There are two types of pre-service appeals: urgent and non-urgent. Pre-service claim denials are subject to one level of mandatory appeal to Anthem Blue Cross.

Appeal Procedures for Pre-Service Urgent Care Claims

You may file a request for an expedited urgent care appeal to Anthem Blue Cross, either orally to (800) 274-7767 or in writing to 2155 Oxnard Street, Woodland Hills, CA 91367. Information transmitted between Anthem Blue Cross and you shall be by telephone, facsimile transmission, or other expeditious means. You will be notified of the appeal decision, whether adverse or not, as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for an appeal. If the notification is made orally, a written decision will also be provided within three days.

You and Anthem Blue Cross may agree to further extensions of these time periods.

Appeal Procedures for Pre-Service Non-Urgent Care Claims
You may file a request for a non-urgent care appeal to Anthem Blue Cross in writing to 2155 Oxnard Street, Woodland Hills, CA 91367. You will be notified of the appeal decision, whether adverse or not, no later than 30 days after receipt of the written appeal.

CONCURRENT CARE CLAIMS AND BENEFIT COVERAGE DETERMINATIONS
There are no appeals of concurrent care claims or benefit coverage determinations since the Plan does not require pre-approval of concurrent care or benefit coverage. However, if you requested a concurrent care decision or a benefit coverage determination as described above, you may appeal an adverse concurrent care claim or benefit coverage determination. Notwithstanding, such a request is not covered by the DOL regulations, including any time frame restrictions within which an appeal must take place.

Appeals from concurrent care decisions by Anthem Blue Cross must be submitted in writing or made by telephone at the address or numbers contained in the Appeal Procedures for Pre-Service Urgent Care Claims or Appeal Procedures for Pre-Service Non-Urgent Care Claims, as applicable (see page 119).

Appeals from benefit coverage determinations made by the Administrative Office must be submitted in writing to P.O. Box 990, West Covina, CA 91793.

POST-SERVICE CLAIMS

Appeal Procedures for Post-Service Claims
You may file a request for an appeal of any post-service claim denial by the Administrative Office. Claims denied are subject to mandatory appeal procedures as follows:

The appeal will be heard by written submission no later than the Board of Trustees' quarterly meeting that immediately follows the receipt of a request for appeal except if the request for an appeal is filed within 30 days of the date of the meeting. In such a case, an appeal decision will be made no later than the date of the second meeting following the Plan's receipt of your request.

If there are special circumstances, the appeal will be heard and decided no later than the third meeting date following the Plan's receipt of the request for an appeal. If such an extension is required, you will be provided with notice in advance of the extension that will describe the special circumstances and identify the date the appeal will be heard and decided.

You will be notified of all post-service appeal decisions no later than five days after the decision is made. You and the Board of Trustees may agree to further extension of these time periods.

If the Board of Trustees requests, an in-person hearing will be held in which you and/or your authorized representative will be asked to attend and present information and documentation in support of the appeal. Such a hearing will be scheduled only if the Board of Trustees cannot decide an appeal from the written submission. The hearing will occur within the time frames identified above and is an example of a special circumstance.

Incomplete Claims
If you fail to follow the above-referenced procedures or do not provide sufficient information to decide an appeal, the Plan will notify you prior to the appeal date. You will have 45 days from receipt of the notification within which to provide the additional information. You and the Plan may agree to further extensions of this time period. All-time periods for deciding an appeal mentioned above shall be tolled from the date on which the notification of an extension(s) is sent to you until the date on which you respond to the request for additional material.

NOTICE OF INTERNAL APPEAL DECISION

NOTICE OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

All appeal decisions, whether adverse or not, will be provided to you in writing or by electronic notification. If the appeal is denied, in whole or in part, the notification will contain the following information.

1. Date(s) of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, and a reference to the specific plan provision(s) on which the denial is based;

5. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

6. A description of the Plan's standard used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol, or other similar criterion was relied uponin the denial, then the internal rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or

    b. if the denial was based on medical necessity or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge toyou upon request; and

    c. a discussion of the decision denying the claim;

7. An explanation of the External Review Processes and a statement of your right to bring an action under Section 502(a) of ERISA;

8. A statement that the diagnosis and treatment codes will be provided free of charge to you upon request;

9. The contact information for the applicable office of the Department of Labor, Employee Benefits Security Administration, for questions about your rights, the final adverse benefit determination notice, or for other assistance; and

10. A statement about the availability of language services on notices sent to addresses in applicable counties.

INTERNAL APPEAL STANDARDS

Anthem Blue Cross's or the Board of Trustees' review of your request for appeal will be a de novo review. It will take into account all information submitted by you without regard to whether such information was submitted or considered during the administrative review phase.

Anthem Blue Cross or the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine if the decision under appeal was based in whole or in part on a medical judgment. The health care professional will be independent from any person who was involved in the initial administrative review phase.

Anthem Blue Cross or the Board of Trustees will provide for the identification of any medical or vocational experts whose advice was obtained in connection with the claim under appeal.

Any entity reviewing Anthem Blue Cross's or the Board of Trustees' decision under an external review may not consider evidence or facts that were not presented during the internal appeal. Anthem Blue Cross or the Board of Trustees, as applicable, have the sole power and discretion to construe any and all terms of the Plan, and any such construction shall be binding on all persons concerned to the fullest extent of the law.

All claims and appeals are adjudicated in a manner designed to ensure the independence an impartiality of the persons involved in making the decisions.

If the Plan fails to strictly adhere to the requirements of the Internal Appeal Procedures, except with respect to certain de minimis, non-prejudicial, good-faith errors, as may be permitted, you are deemed to have exhausted the Internal Appeal Procedures and may initiate an external review, if applicable, and/or pursue any available remedies under Section 502(a) of ERISA. If the Plan asserts the de minimis exception, you may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the Internal Appeal Procedures to be deemed exhausted.

EXTERNAL REVIEW PROCESS

STANDARD EXTERNAL REVIEW PROCESS

If your claim (pre-service, concurrent care, or post-service) is denied by Anthem Blue Cross or the Board of Trustees, as applicable, under the Internal Appeal Procedures, you may request an independent external review of certain claims (see below) by an independent Review Organization (IRO) that is accredited by URAC or by a similarly nationally-recognized accrediting organization. Your request for review must be made within four months after the date of receipt of a notice of the internal appeal decision/notice of final internal adverse benefit determination (or the notice of adverse benefit determination, if applicable). Anthem Blue Cross or the Administrative Office, as applicable, will determine, within five business days, whether the claim is eligible for external review. Claims that are eligible for external review involve medical judgment(s) (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, a determination regarding whether you are entitled to a reasonable alternative standard for a reward under a wellness program (if applicable), or a determination regarding compliance with nonquantitative treatment limitations under Internal Revenue Code Section 9812, and the regulations thereunder, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer; and any decision to rescind coverage.

You will be notified within one day after Anthem Blue Cross or the Administrative Office, as applicable, completes its preliminary review whether the claim is eligible for external review or, if not eligible, with the reason(s) for ineligibility and/or information/documentation needed to make the request complete and the contact information for the Employee Benefits Security Administration. If the claim is appropriate for external review, Anthem Blue Cross or the Administrative Office, as applicable, will refer the claim to an IRO. Anthem Blue Cross or the Board of Trustees through the Administrative Office, as applicable, will contract with three IROs and will rotate assignments randomly among them. You may request copies of information relevant to your claim (free of charge) by contacting Anthem Blue Cross at (800) 274-7767 or the Administrative Office at (800) 320-0106, as applicable. Once the external review is initiated, you will receive instructions on how to provide additional information to the IRO.

The IRO will conduct a de novo review of the claim. Notice of the final/external review decision will be provided within 45 days after the IRO receives the request for the external review. The IRO's decision is binding on Anthem Blue Cross or the Board of Trustees, as applicable, and you, except to the extent that other remedies may be available under Section 502(a) of ERISA or applicable state law.

EXPEDITED EXTERNAL REVIEW PROCESS
If your claim (pre-service or concurrent care) is denied by Anthem Blue Cross, you may make a request for an expedited external review with Anthem Blue Cross at the time you receive:

(a) an adverse benefit determination, if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited urgent care appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or you have filed a request for an expedited internal appeal, or

(b) a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a Standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns medical care used during the course of your receiving emergency services when you have not been discharged from a facility.

Immediately upon receipt of the request for any expedited external review, Anthem Blue Cross must determine whether the request meets the reviewability requirements set forth under the Standard/External Review Process (see above). Anthem Blue cross must immediately send a notice that meets the requirements set forth under the Standard/External Review Processes (see above) to you of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, Anthem Blue Cross will assign an IRO pursuant to the requirements set forth in the Standard Review Process (see above). Anthem Blue Cross must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone, facsimile, or any other available expeditious method. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Internal Benefit Claims and Appeal Process.

The IRO must provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event, more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and Anthem Blue Cross.

MISCELLANEOUS BENEFIT CLAIM AND APPEAL PROCEDURES

The claim and appeal rights described herein cannot be assigned to any medical provider or other person or entity. Therefore, all benefit claims, appeals, external reviews, and Section 502(a) actions shall be made by you. You may authorize a representative, such as a medical provider with knowledge of your condition, to participate in the benefit claim process or to act on your behalf. However, the authorization must be made by you in writing or by electronic means to Anthem Blue Cross or the Administrative Office, as applicable (orally to Anthem Blue Cross if it is an urgent care claim (unless you are unable to do so because of medical exigencies)) and cannot be made via assignment by you to a medical provider or by a medical provider to a collection agency, etc.

The Benefit Claim and Appeal Procedures contained in this booklet are in compliance with ERISA Section 503, and the Department of Labor Regulations set forth at 29 CFR 2560-503.1 and the Internal Claims and Appeals and External Review Process implemented under Section 2719 of the Patient Protection and Affordable Care Act and the regulations and guidance promulgated thereunder, and as such are intended to be reasonable and offer a full and fair review process. Any omission or oversights will be interpreted in accordance with the applicable law and its corresponding regulations.

TIME LIMITATION FOR A SECTION 502(A) LAWSUIT
A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination or, for eligible claims, the date of the notice of the final/external review decision.

WAIVER OF CLASS, COLLECTIVE, AND REPRESENTATIVE ACTIONS
By participating in the Plan, to the fullest extent permitted by law, whether in court or otherwise, Participants waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy and Participants agree that any dispute, claim, or controversy may only be initiated or maintained and decided on an individual basis.

CLAIMS AND APPEAL PROCEDURES FOR THE PRESCRIPTION DRUG PROGRAM UNDER THE INDEMNITY PLAN

The benefits provided to you and your eligible Dependents under the Indemnity Plan Prescription Drug Program will only be available if you comply with the following procedures. The HMO plans may have additional or different claim and appeal procedures that must be followed. Please see the appropriate HMO section(s) in this booklet or the plan documents provided by the applicable entity for those procedures.

ADMINISTRATIVE REVIEW

PRE-SERVICE OR CONCURRENT CARE NON-INJECTABLE/SPECIALTY DRUG CLAIMS OR CLAIMS FOR BENEFIT COVERAGEDETERMINATIONS

The Indemnity Plan Prescription Drug Program does not require pre-approval of non-injectable/specialty drugs or claims for benefit coverage before Prescription Drugs are purchased for either urgent or non-urgent pre-service or concurrent care claims with the exception of injectable/specialty drugs. See below for the special benefit claims and appeal procedures for these types of drugs only. Therefore, the Department of Labor (DOL) Benefit Claims and Appeal Procedures regulations, including any time-frame restrictions within which to make these decisions or determinations, do not apply. However, this does not mean the Plan will pay for the Prescription Drug expenses incurred when the claim is actually received. There are cost-sharing arrangements and other limitations and exclusions under the Plan that must be taken into consideration.

Notwithstanding, for convenience purposes only, if you and/or your provider have any questions regarding a Prescription Drug claim before you purchase it, you may request, in writing, a pre-service claim or concurrent claim non-injectable/specialty drug decision by sending your request to:

For Prescription Drugs, except injectable/specialty drug Adynovate:

OptumRx, Inc.
2300 Main Street
Irvine, CA 92614; or

For injectable/specialty drug Adynovate:

Diplomat Specialty Infusion Group of Diplomat Pharmacy, Inc.
Attn: Reimbursement Department
7177 E. Kemper Road
Cincinnati, OH 45249

You may request a Plan determination for benefit coverage by sending your request to the Administrative Office at:

Operating Engineers Local 501 Security Fund
c/o BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793

OptumRx, Diplomat Pharmacy, Inc., or the Administrative Office, as applicable, will respond within a reasonable time period. However, no such request will be viewed as a "claim for benefits" as defined in the DOL Benefit Claims and Appeal Procedures regulations. Please note that with regard to benefit coverage determinations, the Plan cannot tell you or the provider the specific amount payable under the Plan until the drug is purchased or, in the rare instance, when you file a claim form for reimbursement after you have paid for a Prescription Drug.

PRE-SERVICE CLAIMS FOR INJECTABLE/SPECIALTY DRUGS
A pre-service claim for a Prescription Drug is a claim that the Plan requires approval of in advance of purchasing the Prescription Drug. The Plan requires preauthorization for Prescription Drugs in only one area: injectable/specialty drugs.

With the exception of the injectable/specialty drug Adynovate to treat hemophilia, OptumRx, the Fund's current pharmacy benefit manager, will determine for the Plan whether your injectable/specialty drug claim is medically necessary, appropriate for treating the underlying illness or injury, effective as a covered drug, or experimental or investigational in nature. Diplomat Pharmacy, Inc. will make all determinations for the Plan for the injectable/specialty drug Adynovate.

There are two types of pre-service injectable/specialty drug claims: urgent and non-urgent.

Urgent Care Claims for Injectable/Specialty Drugs
An urgent care claim for injectable/specialty drugs is one that must be resolved more quickly than within the time periods for non-urgent care claims jeopardize your life or health or your ability to regain maximum function or (b) would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a claim for urgent care is to be determined by OptumRx or Diplomat Pharmacy, Inc. for Adynovate only applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Additionally, a claim will be considered an urgent care claim if a Physician with knowledge of your medical condition states that it is a claim involving urgent care.

Benefit Claim Procedures for Pre-Service Urgent Care Injectable/Specialty Drug Claims
Pre-Service urgent care injectable/specialty drug claims may be made orally or in writing by you, your Physician, or other authorized representative. These claims must be made toOptumRx at 800-797-9791 if made orally. Claims for the injectable/specialty drug Adynovate must be made to Diplomat Pharmacy, Inc. at 866-422-4679 if made orally.

Written requests should be addressed to OptumRx at:

OptumRx, Inc.
2300 Main Street
Irvine, CA 92614

A Written request for Adynovate only should be addressed to Diplomat Pharmacy, Inc. at:

Diplomat Specialty Infusion Group of Diplomat Pharmacy, Inc.
Attn: Reimbursement Department
7177 E. Kemper Road
Cincinnati, OH 45249

All claims must identify your name, the specific medical condition or symptom, and the specific treatment, service, or product for which approval is sought. OptumRx or DiplomatPharmacy, Inc. (for Adynovate only) will notify you of its decision within 72 hours of receipt of the claim. You and OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only)may agree to an extension of this time period, but OptumRx and Diplomat Pharmacy, Inc. (for Adynovate only) may not unilaterally extend same. Notification may be oral unless written notification is requested by you or your authorized representative. Any oral notification by OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) will be followed up in writing within three days by U.S. mail, facsimile transmission, or other electronic means.

Incomplete Claims
If you or your authorized representative fails to follow the above described procedures ordoes not provide sufficient information to decide an injectable/specialty drug claim, OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) will notify you within 24 hours of the failure and inform you of the information necessary to file a complete claim. You will have a reasonable amount of time (at least 48 hours) to supply the additional information. When your complete claim is filed with OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only), you will be notified of the determination, whether adverse or not, as soon as possible, but no later than 48 hours after the earlier of their receipt of the specified information or the end of the period afforded you to provide the additional information. You and OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) may agree to further extensions of these time periods.

Non-Urgent Care Claims for Injectable/Specialty Drugs
A non-urgent claim for injectable/specialty drugs is a claim that is not an urgent careclaim.

Benefit Claim Procedures for Claims Pre-Service Non-Urgent Care Injectable/Specialty Drug Claims
With the exception of the injectable/specialty drug Adynovate, pre-service non-urgent care injectable/specialty drug claims may be made in writing by you, your Physician, or other authorized representative. These claims must be addressed to OptumRx at:

OptumRx, Inc.
2300 Main Street
Irvine, CA 92614

Pre-service non-urgent care claims for the injectable/specialty drug Adynovate may be made in writing by you, your Physician, or other authorized representative. These claimsmust be addressed to Diplomat Pharmacy, Inc. at:

Diplomat Specialty Infusion Group of Diplomat Pharmacy, Inc.
Attn: Reimbursement Department
7177 E. Kemper Road
Cincinnati, OH 45249

Non-urgent care claims will be handled in a similar manner as urgent care claims except that after filing a non-urgent care claim, OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) will notify you in writing of the decision no later than 15 days from the date the claim is filed. This period may be extended for an additional 15 days if prior to the expiration of the initial 15-day period you are notified of the circumstances requiring the extension of time and the date by which OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) expects to render a decision. You and OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) may agree to further extensions of these time periods.

Incomplete Claims
If you or your authorized representative fails to follow the above-described procedures or do not provide sufficient information to decide an injectable/specialty drug claim,

OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) will notify you as soon as possible but no later than the end of the initial 15-day period of what is required to file a complete claim. You will have at least 45 days from the receipt of the notice within which to provide the information. You and OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) may agree to further extensions of this time period. The time period for deciding such a claim shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

CONCURRENT CARE CLAIMS FOR INJECTABLE/SPECIALTY DRUGS
A concurrent care claim for Specialty Drugs is a claim for continued use of the injectable/specialty drug that has been provided over a period of time or number of treatments, which was previously approved, and you have been informed of a decision to reduce or terminate this ongoing course of treatment, or for a decision made regarding a request(s) by you to extend a course of treatment beyond what has been approved.

Benefit Claim Procedures for Concurrent Care Claims
You will be notified by OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) of any reduction or termination of a previously approved injectable/specialty drug prior to the date of the reduction or termination, allowing you sufficient time to appeal and obtain a determination on the appeal before the decision is to take effect.

If an urgent care concurrent claim is involved, any request by you to extend the course of treatment beyond the period of time or number of treatments previously approved will be decided by OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) as soon as reasonably possible. In any case, you will be notified of their determination within 24 hours of receipt of the request.

Incomplete Claims
Incomplete claims for concurrent care will be handled the same as incomplete pre-service urgent care or non-urgent care claims, as applicable. (See pages 126 to 127.)

POST-SERVICE CLAIMS
A post-service claim is a claim for a benefit under the Indemnity Plan Prescription Drug Program that is not a pre-service or concurrent care claim for an injectable/specialty drug (e.g., the Prescription Drug (injectable/specialty drug or otherwise) has been purchased, and you are requesting payment for the Prescription Drug under the Plan). Post-service claims include requests for actual payment by the Plan of any pre-service or concurrent injectable/specialty drug claims. The Administrative Office will notify you of its decision within 30 days of receipt of the claim. The Administrative Office is allowed one 1-days maximum extension if the claim decision cannot be made for reasons beyond the control of the Administrative Office and the Administrative Office notifies you prior to the expiration of the initial 30-day period, explains the circumstances for the extension, and identifies the date it expects to render a decision. You and the Administrative Office may also agree to further extensions of these time periods.

Benefit Claim Procedures for Post-Service Claims
A post-service claim must be filed with the Administrative Office in accordance with the following procedures before any benefits can be paid:

If you or your eligible Dependent received Prescription Drugs, you must obtain a claim form from your union or the Administrative Office. After obtaining the form, fill out the top portion of the form using the proper sections as provided for Employee's claims or for Dependent's claims and sign the form. Then submit the form along with an itemized billing to the Administrative Office at Operating Engineers Local 501 Security Fund, c/o BeneSys, Inc., P.O. Box 990, West Covina, CA 91793.

For post-service claims assistance, write the Administrative Office or call 800-320-0106.

Post-service claims must be submitted no more than 90 days after the date of purchase. No benefits will be payable if a post-service claim is submitted more than one year from the date of purchase.

If filing your claim is delayed through no fault of yours, the Plan may consider the claim if it is submitted within one year after the date of service.

Incomplete Claims
If you fail to follow the above procedures or do not provide sufficient information to decide a claim, the Administrative Office will notify you within 30 days of the failure and inform you of what is required to file a complete claim. You will have at least 45 days from receipt of the notice within which to provide the specific information. You and the Administrative Office may agree to further extensions of this time period. The time period for deciding a post-service claim shall be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

NOTICE OF CLAIMS DENIAL/NOTICE OF ADVERSE BENEFIT DETERMINATION
If any claim (pre-service, concurrent care, or post-service) is denied in whole or in part on the basis of eligibility or that the benefits will not be paid under the Plan because they were not pre-approved, not necessary, not covered, etc.; or if your coverage is rescinded; you will be provided with a notice of denial/adverse benefit determination, which will contain:

1. Date(s) of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, if applicable, and a reference to the specific Plan provision(s) which the denial is based;

5. A statement that you are entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim for benefits;

6. A description of the OptumRx's, or Diplomat Pharmacy, Inc.'s (for Adynovate only) or the Plan's standard, as applicable, used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol, or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or

b. if the denial was based on medical necessity or experimental treatment or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request;

7. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

8. An explanation of the Internal Appeal Procedures and time limits applicable to such procedures, including a statement of your right to file a civil action under Section 502(a) of ERISA following the exhaustion of the Internal Appeal Procedures (see below);

9. In the case of a pre-service or concurrent urgent care injectable/specialty drug claim, a description of the expedited internal appeal review process available for such a claim;

10. A statement that the diagnosis and treatment codes, and their corresponding meanings, will be provided, if applicable, free of charge to you upon request;

11. The contact information for the applicable office of the Department of Labor, Employee Benefit Security Administration, to assist you with questions you may have about your rights, the adverse benefit determination notice, or for other assistance; and

12. A statement about the availability of language services on notices sent to addresses in applicable counties.

INTERNAL APPEAL PROCEDURES

These appeal procedures shall be the exclusive procedures available to an Employee or beneficiary who is dissatisfied with an eligibility determination, benefit award, or who is otherwise adversely affected by any action of OptumRx, Diplomat Pharmacy, Inc. (for Adynovate only), or the Administrative Office, as applicable. These procedures must be exhausted before you (i.e., the Claimant) may file suit under Section 502(a) of ERISA. You may request an appeal within 180 days of the receipt of an administrative denial/adverse benefit determination notice. You shall be provided access to and copies of documents, records, and other information, free of charge, that are relevant to the claim, including any new or additional evidence considered by OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees, as applicable, in connection with the claim, or any new or additional rationale upon which the final adverse benefit determination will be based, as soon as possible and sufficiently in advance of your appeal date so you can respond prior to that date. You will have the opportunity to submit written comments, documents, records, or any other information in support of the appeal. If the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time that you have a reasonable opportunity to respond.

PRE-SERVICE CLAIMS FOR INJECTABLE/SPECIALTY DRUGS

You may file a request for an appeal of any OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only), pre-service claim decision on injectable/specialty drugs. There are two types of pre-service appeals: urgent and non-urgent. Pre-service claim denials are subject to one level of mandatory appeal to OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only).

Appeal Procedures for Pre-Service Urgent Care Claims

You may file a request for an expedited urgent care appeal to OptumRx either orally at 800-797-9791 or in writing by you, your Physician, or authorized representative to OptumRx at:

OptumRx, Inc.
2300 Main Street
Irvine, CA 92614

You may file a request for an expedited urgent care appeal to Diplomat Pharmacy, Inc. (for Adynovate only) either orally or at 866-442-4679 or in writing by you, your Physician, or authorized representative to Diplomat Pharmacy, Inc. at:

Diplomat Specialty Infusion Group of Diplomat Pharmacy, Inc.
Attn: Reimbursement Department
7177 E. Kemper Road
Cincinnati, OH 45249

Information transmitted between OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) and you shall be by telephone, facsimile transmission, or other expeditious means. You will be notified of the appeal decision, whether adverse or not, as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for an appeal. If the notification is made orally, a written decision will also be provided within three days. You and OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) may agree to further extensions of these time periods.

Appeal Procedures for Pre-Service Non-Urgent Care Claims
You may file a request for a non-urgent care appeal in writing to OptumRx at:

OptumRx, Inc.
2300 Main Street
Irvine, CA 92614

You may file a request for a non-urgent care appeal in writing to Diplomat Pharmacy,Inc. (for Adynovate only) at:

Diplomat Specialty Infusion Group of Diplomat Pharmacy, Inc.
Attn: Reimbursement Department
7177 E. Kemper
Road Cincinnati, OH 45249

You will be notified of the appeal decision, whether adverse or not, no later than 30 days after receipt of the written appeal.

CONCURRENT CARE CLAIMS FOR INJECTABLE/SPECIALTY DRUGS
You may file a request for an appeal of any OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) concurrent care claim decision on injectable/specialty drugs. Concurrent care claims denials are subject to one level of mandatory appeal to OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only).

Appeal Procedures for Concurrent Care Claims
If the appeal involves a concurrent care urgent or non-urgent care claim, please use the appeal procedure for pre-service claims on page 129.

PRE-SERVICE OR CONCURRENT CARE

NON-SPECIALTY DRUG OR CLAIMS FOR BENEFIT COVERAGE
There are no appeals of pre-service or concurrent care non-specialty drug decisions or benefit coverage determinations since the Plan does not require pre-approval of non-specialty drug claims of benefit coverage. However, if you requested a non-specialty drug pre-service, concurrent care, or a benefit coverage decision as described above, you may appeal an adverse pre-service, concurrent care, or benefit coverage determination. Notwithstanding, such a request is not covered by the DOL regulations, including any time frame restrictions within which an appeal must take place, or an appeal decision is made.

Appeals from non-specialty drug decisions made by OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) must be submitted in writing or made by telephone at the address or number contained in the Appeal Procedures for Pre-Service Urgent or Non- Urgent Care Claims of the Appeal Procedures for Concurrent Care Claims, as applicable (see page 119). Appeals from benefit coverage determinations made by the Administrative Office must be submitted in writing to the Operating Engineers Local 501 Security Fund, c/o BeneSys, Inc., P.O. Box 990, West Covina, CA 91793.

POST-SERVICE CLAIMS
You may file a request for an appeal of any post-service claim denial. Post-service claim denials are subject to one level of mandatory appeal.

Appeal Procedures for Post-Service Claims
You may file a request for a post-service claim appeal in writing to the Administrative Office at:

Operating Engineers Local 501 Security Fund
c/o BeneSys, Inc.
P.O. Box 990
West Covina, CA 91793

The appeal will be heard in written submission no later than the Board of Trustees' quarterly meeting that immediately follows the receipt of a request for appeal except if the request for an appeal is filed within 30 days of the date of the meeting. In such a case, an appeal decision will be made no later than the date of the second meeting following the Plan's receipt of your request.

If there are special circumstances, the appeal will be heard and decided no later than the third meeting date following the Plan's receipt of the request for an appeal. If such an extension is required, you will be provided with notice in advance of the extension that will describe the special circumstances and identify the date the appeal will be heard and decided.

You will be notified of all post-service claim appeal decisions no later than five days after the decision is made. You and the Board of Trustees may agree to further extension of these time periods.

If the Board of Trustees request, an in-person hearing will be held in which you and/or your authorized representative will be asked to attend and present information and documentation in support of the appeal. Such a hearing will be scheduled only if the Board of Trustees cannot decide an appeal from the written submission. Any such hearing will occur within the time frames identified above and is an example of a special circumstance.

Incomplete Claims
If you fail to follow the above-referenced procedures or do not provide sufficient information to decide an appeal, OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only), or the Administrative Office, as applicable, will notify you prior to the appeal date. You will have 45 days from receipt of the notification within which to provide the additional information. You and OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only), or the Administrative Office, as applicable, may agree to further extensions of this time period. All-time periods for deciding an appeal mentioned above shall be tolled from the date on which the notification of any extension(s) is sent to you until the date on which you respond to the request for additional material.

NOTICE OF INTERNAL APPEAL DECISION/NOTICE OF FINAL ADVERSE BENEFIT DETERMINATION

All appeal decisions (pre-service, concurrent care, or post-service claims), whether adverse or not, will be provided to you in writing or by electronic notification. If the appeal is denied in whole or in part, the notification will contain the following information:

1. Date(s) of service(s);

2. Health care provider(s);

3. Claim amount(s), if applicable;

4. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, and a reference to the specific plan provision(s) on which the denial is based;

5. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

6. A description of OptumRx's, or Diplomat Pharmacy, Inc.'s (for Adynovate only), or the Plan's standard, as applicable, used in denying the claim, if any, including a statement that:

    a. if an internal rule, guideline, protocol, or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or

    b. if the denial was based on medical necessity or experimental treatment or similar exclusion or limit, then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request; and

    c. a discussion of the decision denying the claim;

7. An explanation of the External Appeal Processes and a statement of your right to bringan action under Section 502(a) of ERISA;

8. A statement that the diagnosis and treatment codes will be provided, if applicable, freeof charge to you upon request;

9. The contact information for the applicable office of the Department of Labor, Employee Benefits Security Administration, for questions about your rights, the finaladverse benefit determination notice, or for other assistance; and

10. A statement about the availability of language services on notices sent to addresses in applicable counties.

INTERNAL APPEAL STANDARDS

OptumRx's, or Diplomat Pharmacy, Inc.'s (for Adynovate only), or the Board of Trustees' review, as applicable, of your request for appeal, will be a de novo review. It will take into account all information submitted by you without regard to whether such information was submitted or considered during the administrative review process.

OptumRx, or Diplomat Pharmacy, Inc.'s (for Adynovate only), or the Board of Trustees, as applicable, will consult with a health care professional who has appropriate training and experience in the field of medicine if the decision under appeal was based in whole or in part on a medical judgment. The health care professional will be independent from any person who was involved in the initial administrative review phase.

OptumRx, or Diplomat Pharmacy, Inc.'s (for Adynovate only), or the Board of Trustees, as applicable, will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees, as applicable, in connection with the claim under appeal.

Any entity reviewing OptumRx's, or Diplomat Pharmacy, Inc.'s (for Adynovate only), or the Board of Trustees' decision, as applicable, may not consider evidence of facts that were not presented to OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees on appeal. OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees, as applicable, have the sole power and discretion to construe any and all terms of the Plan, and any such construction shall be binding on all persons concerned to the fullest extent of the law.

All claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

If OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees, as applicable, fails to strictly adhere to the requirements of the Internal Appeal Procedures, except with respect to certain de minimis, non-prejudicial, good-faith errors, as may be permitted, the Claimant is deemed to have exhausted the Internal Appeal Procedures and may initiate an external review and/or pursue any available remedies under Section 502(a) of ERISA. If OptumRx or the Board of Trustees, as applicable, asserts the de minimis exception, you may request a written explanation of the violation from OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees, as applicable, must provide such explanation within 10 days, including a specific description of their basis, if any, for asserting that the violation should not cause the Internal Appeal Procedures to be deemed exhausted.

EXTERNAL REVIEW PROCESS

STANDARD EXTERNAL REVIEW PROCESS

If your Prescription Drug claim (pre-service, concurrent, or post-service) is denied by OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees, as applicable, under the Internal Appeal Procedures, you may request an independent, external review of certain claims (see below) by an Independent Review Organization (IRO) that is accredited by the URAC or by a similar nationally-recognized accrediting organization to conduct external reviews. Your request for review must be made within four months after the date of receipt of a notice of the internal appeal decision/notice of final internal adverse benefit determination (or the notice of adverse benefit determination, if applicable).

OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Administrative Office, as applicable, will determine, within five business days, whether the claim is eligible for external review. Prescription Drug claims that are eligible for external review involve medical judgment(s) (including, but not limited to, those based on medical necessity, appropriateness, or effectiveness of a covered Prescription Drug benefit, a determination that a covered Prescription Drug is experimental or investigational, or a determination regarding compliance with nonquantitative treatment limitations under Internal Revenue Code Section 9812, and the regulations thereunder, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer; and any decision to rescind coverage.

You will be notified within one day after OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Administrative Office, as applicable, completes its preliminary review whether the claim is eligible for external review or, if not eligible, with the reasons for ineligibility and/or information/documentation needed to make the request complete and the contact information for the Employee Benefits Security Administration. If the claim is appropriate for external review, OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Administrative Office, as applicable, will refer the claim to an IRO. OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), or the Board of Trustees, through the Administrative Office, as applicable, will contract with three IROs and will rotate assignments randomly among them. You may request copies of information relevant to your claim (free of charge) by contacting OptumRx at (800) 797-9791 or Diplomat Pharmacy, Inc. (for Adynovate only) at 866-442-4679, or the Administrative Office at (800) 320-0106, as applicable. Once the external review is initiated, you will also receive instructions on how to provide additional information to the IRO.

The IRO will conduct a de novo review of the claim. Notice of the final external review decision will be provided within 45 days after the IRO receives the request for the external review. The IRO's decision is binding on the Plan and you, except to the extent that other remedies may be available under Section 502(a) of ERISA or applicable state law.

EXPEDITED EXTERNAL REVIEW PROCESS

If your claim (pre-service or concurrent care injectable/specialty drug claim) is denied by OptumRx, or Diplomat Pharmacy, Inc. (for Adynovate only), you may make a request for an expedited external review with OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) at the time you receive: (a) an adverse benefit determination, if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited urgent care appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or you have filed a request for an expedited internal appeal, or (b) a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a Standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an injectable/specialty drug used during the course of you receiving emergency services, when you have not been discharged from a facility.

Immediately upon receipt of the request for an expedited external review, OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) must determine whether the request meets the reviewability requirements set forth under the Standard External Review Procedures (see above). OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) must immediately send a notice that meets the requirements set forth under the Standard External Review Procedures (see above) to you of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) will assign an IRO pursuant to the requirements set forth in the Standard External Review Procedures (see above). OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only) must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the internal benefit claims and appeal process.

The IRO must provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event, more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only).

MISCELLANEOUS BENEFIT CLAIM AND APPEAL PROCEDURES

The claim and appeal rights described herein cannot be assigned to any medical provider or other person or entity. Therefore, all benefit claims, appeals, and Section 502(a) actions shall be made by you. You may authorize a representative to participate in the benefit claim process or to act on your behalf; however, the authorization must be made by you in writing or by electronic means to OptumRx or Diplomat Pharmacy, Inc. (for Adynovate only), or the Administrative Office, as applicable.

The Benefit Claim and Appeal Procedures contained in this booklet are intended to be in compliance with ERISA Section 503, the Department of Labor Regulations 29 CFR 2560-503.1, and the Internal Claims and Appeals and External Review Processes implemented under Section 2719 of the Public Health Service Act, as enacted by the Patient Protection and Affordable Care Act and the regulations and guidance promulgated thereunder, and as such are intended to be reasonable and offer members a full and fair review process. Any omission or oversights will be interpreted in accordance with the applicable law and its corresponding regulations(s).

TIME LIMITATION FOR A SECTION 502(A) LAWSUIT

A lawsuit under Section 502(a) of ERISA must be filed within one year of the later of the date of the notice of the internal appeal decision/notice of final internal adverse benefit determination or, for eligible claims, the date of the notice of the final/external review decision.

WAIVER OF CLASS, COLLECTIVE, AND REPRESENTATIVE ACTIONS

By participating in the Plan, to the fullest extent permitted by law, whether in court or otherwise, Participants waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy and Participants agree that any dispute, claim, or controversy may only be initiated or maintained and decided on an individual basis.

t. Statement of ERISA Rights

As a Participant in the Operating Engineers Local 501 Security Fund, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Trust Fund Administrative Office and at other specified locations, such as worksites and union halls, all Plan documents, including prepaid group service plan contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Trust Fund with the U.S. Department of Labor.

- Obtain copies upon written request of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, a copy of the latest annual report (Form 5500 Series), and an updated Summary Plan. The Administrative Office may impose a reasonable charge for the copies.

- Receive a summary of the Trust Fund's annual financial report. The 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, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and Plan Document booklet on the rules governing your COBRA continuation coverage rights.

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

Enforce Your Rights
If your claim for a benefit is denied, 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. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in state or federal court subject to the exhaustion of the Plan's Benefit Claim and Appeal Procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Administrator. In addition, if you disagree with the Plan Administrator'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 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, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration or through the website at www.dol.gov/ebsa.

u. Newborns' and Mothers' Health Protection Act
Under federal law, group health plans and health insurance issuers 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother (or the newborn's authorized representative), from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurance issuers may not, under federal law, require that a health care provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, if applicable).

The foregoing is a Summary Plan Description and Plan Document required by federal law. Of necessity, this booklet describes in general terms the benefits provided through the Fund. It is not to be considered a contract of insurance.

All questions with respect to Plan participation, eligibility for benefits, the nature and amount of benefits, or with respect to any matter of Fund or Plan administration should be referred to the Administrative Office of the Fund.

No representations made to a Participant, Physician, Hospital, or other medical provider concerning eligibility, entitlement to benefits, or amount of benefits payable is binding on the Fund unless the representation is in writing and made by the Board of Trustees or the Administrative Office.

The only parties authorized to answer any questions concerning the Fund and Plan are the Board of Trustees and the Administrative Office. No participating Employer, employer association, or labor organization, nor any individual employed thereby, has any such authority.