Operating Engineers Local 12

Health & Welfare Fund

Summary Plan Description

2017

OPERATING ENGINEERS HEALTH AND WELFARE FUND
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OPERATING ENGINEERS HEALTH & WELFARE FUND

INTRODUCTION

We are pleased to provide you with this Summary Plan Description booklet that describes the comprehensive program of Health and Welfare Fund benefits available to you and your eligible dependents as of June 1, 2017.

We encourage you to review this booklet carefully so that you are aware of all of the benefits to which you are entitled as well as some important restrictions and responsibilities. Our goal is to present and explain your benefits in language that is easy to understand. However, sometimes we must use terms that are not used in everyday conversation for legal reasons. Terms and phrases that fall into this category are either explained in the context of their sections or are listed alphabetically in the Glossary at the end of this booklet.

This booklet provides a summary of the Fund rules as in effect as of June 1, 2017. If the facts and circumstances of a particular situation must be considered for a time before June 1, 2017, the provisions of the Fund in effect at the relevant date must be applied. Those provisions may be different from the current rules as explained in this booklet.

This booklet is only a summary of the Health and Welfare Fund rules. The complete rules of the Plan are contained in the Rules and Regulations Providing Health Care Benefits for Active Employees and the Rules and Regulations Providing Health Care Benefits for Retired Employees which are available upon request from the Fund Office. If there is any conflict between the information in this booklet and the Plan rules, the Plan rules will govern.

For your protection, only the Board of Trustees is authorized to interpret the rules of the Fund. Information you receive from the Union or employers or their representative should be regarded as unofficial. Official information about your rights under the Fund must be communicated to you, in writing, signed on behalf of the Board of Trustees. The Board has authorized the Fund Office to communicate with participants on its behalf. Please remember to keep the Fund Office informed of any change in your mailing address. This will ensure that you receive all communications.

The Health and Welfare Fund has been providing benefits for over 60 years. We are proud of the success of the Fund and believe it will continue to provide significant benefits to participants and their families for many years to come.

Sincerely,
BOARD OF TRUSTEES

TABLE OF CONTENTS

ELIGIBILITY

MEDICAL COVERAGE (All Active and Retired Participants, except Medicare Eligible Retirees)

MEDICAL COVERAGE (Medicare Eligible Retirees)

GENERAL PROVISIONS

ELIGIBILITY

ACTIVE ELIGIBILITY

Active Eligibility Requirements

Active Eligibility is based on your work for employers who have an agreement with Local 12 requiring contributions to the Health and Welfare Fund.

Quarterly Eligibility

For most Participants, eligibility is on a quarterly basis. If you have 200 or more hours reported on your behalf during a qualifying Work Quarter, you are eligible for the following Eligibility Quarter**. There is a one-month lag period between Qualifying Work Quarters and Eligibility Quarters.** The Qualifying Work Quarters and Eligibility Quarters are:

Qualifying Work Quarter *If you work 200 or more hours during:*	**Lag Month**	**Eligibility Quarter** *You will be eligible for coverage during:*
January, February, March	April	May, June, July
April, May, June	July	August, September, October
July, August, September	October	November, December, January
October, November, December	January	February, March, April

Eligibility can only be earned by hours reported in the appropriate quarter. No shifting of hours from one quarter to another is permitted.

Monthly Eligibility

For some Participants, eligibility is on a monthly basis. For each month you work (Work Month) for an employer who has a special agreement calling for monthly eligibility, you earn one Eligibility Month. **As with quarterly eligibility, the Work Month and Eligibility Month are separated by a one-month lag.** Examples of the Work and Eligibility Months for the first three work months of the year are:

Work Month *If you work during:*	**Lag Month**	**Eligibility Month** *You will be eligible for coverage during:*
January	February	March
February	March	April
March	April	May

For participants on monthly eligibility under the terms of a Principal Employee Program Participation Agreement (PEPPA), there are a few different rules from all others on monthly eligibility:

1. The eligibility for the participant and any eligible dependents will be terminated at the end of the month for which the full flat rate employer contribution and report form was not timely received.
2. Such terminated eligibility will not be reinstated until after (a) all delinquent payments and reports are properly filed, and (b) proper reports and payments are timely submitted for three consecutive months thereafter.
3. The Reserve Hours Account will not be available to participants whose eligibility has been terminated for delinquent employer contribution reports and payments.

Reserve Hours Account

The Reserve Hours Account provides extended eligibility if you do not have enough hours to earn eligibility. Hours in the Reserve Hours Account can be used to provide up to six months of eligibility depending on the number of hours in the Participant's Reserve Hours Account and the number of hours needed for eligibility.

For Participants with quarterly eligibility, all hours reported over 400 in a Work Quarter go into the Reserve Hours Account, up to a maximum of 500 hours. Should a Participant work less than 200 hours in a qualifying work quarter, hours will be withdrawn from the Participant's Reserve Hours Account as necessary to bring the Participant's hours up to 200.

For Participants with monthly eligibility, each month of reporting provides 15 hours into the Reserve Hours Account, up to a maximum of 500 hours. For each month of extended eligibility needed, 83 hours are withdrawn from the reserve. Please see page 4 for restrictions for those covered under a Principal Employee Program Participation Agreement (PEPPA).

Unused hours will remain in your Reserve Hours Account for four consecutive Eligibility Quarters for Participants with quarterly eligibility or for 12 consecutive calendar months for Participants with monthly eligibility. If no hours are reported during this period, the Reserve Hours Account is forfeited. However, any forfeited hours may be reinstated if the Board of Trustees receives satisfactory proof that the Active Employee was continuously on the Out-of-Work List of Local 12 in each Work Quarter (or work month for those on monthly eligibility) during which no contributions were reported on his behalf.

Collusion with an Employer. The Reserve Hours Account will be forfeited for any Employee who is in collusion with an employer to deliberately under-report the hours actually worked, or required to be reported to the Fund, or who works in a covered classification for an employer that does not contribute to the Fund. Upon discovery of either of these incidents, the Reserve Hours Account will be suspended, and the Employee will have 60 days to file a request for reconsideration.

Eligibility Card

Every Active Employee receives an eligibility card from the plan they are enrolled in. They will receive an eligibility card upon initial enrollment in the Plan and upon any change that pertains to their enrollment (benefit plan change, address change, new dependent, etc.).

Termination of Active Eligibility

Quarterly Eligibility. Your Active Eligibility will terminate on the last day of an Eligibility Quarter if you have fewer than 200 hours reported during the most recent Work Quarter plus the hours in your Reserve Hours Account combined.

Monthly Eligibility. If you are eligible on a monthly basis, your Active Eligibility will terminate on the last day of the second month after the month in which you were last reported. If you have sufficient hours in your Reserve Hours Account, your eligibility will continue until the reserve is exhausted. For example, a Participant whose last month of work is July (which would establish eligibility for September) will have his Active Eligibility terminated on September 30th unless sufficient hours are available in his Reserve Hours Account. Please see page 4 for restrictions for those covered under a Principal Employee Program Participation Agreement (PEPPA).

Eligibility Buy-Up

If an Active Member on hourly eligibility falls short of continuing eligibility for a given Eligibility Quarter by 50 or fewer hours, that member will have the option to buy-up the shortfall in hours at the same hourly contribution rate his or her employer would have paid ($15.20 in California and $15.30 in Nevada*). For example, if a member only worked 180 hours in a Qualifying Work Quarter in California, he or she would have the option to pay $304.00 (20 X $15.20*) to the Fund and continue their eligibility for the next quarter.
The Fund Office will automatically offer this option to every member, each quarter who falls short of continuing their eligibility by 50 or fewer hours.

*Based on the current employer contribution rates as of January, 2026.

Military Service. Whether you have quarterly or monthly eligibility, your Active Eligibility will terminate on the day you enter full-time military service unless such service was in response to a call to active duty in the Reserve Armed Forces of the United States. See Extended Eligibility for Military Service in the next section.

Extended Eligibility for Military Service

If you are a member of the Reserve Armed Forces of the United States and you are called to Active Military Duty, you must notify the Fund Office, in writing, within 60 days from the date of the call to duty. The written notice must include your name, Social Security Number, Operating Engineers Identification Number (OEID) or Local 12 Registration Number, the date you are required to report for duty and a copy of the military order. If the notice is made timely, the hours in your Reserve Hours Account shall remain available to provide eligibility when you are discharged from the service, provided you make yourself available and actively seek employment with a contributing employer within 90 days after discharge or recovery from disability that commenced while on active duty. Eligibility for your dependents will also continue until 90 days after your discharge from duty. Upon discharge from duty, you must contact the Fund Office and provide a copy of your discharge papers.

See also COBRA Continuation Coverage on page 9.

Extended Eligibility for Disability

If an Active Employee is prevented from maintaining eligibility because he is unable to perform his regular and customary duties due to an illness or injury, he and his qualified dependents may be entitled to an extension of eligibility. This extension is at no cost to the Employee and the Employee's Reserve Hours Account is not affected.

For Active Employees with quarterly eligibility, the extension is for a period of three consecutive Eligibility Quarters, provided the Employee remains disabled during this period and that the number of hours for which contributions were made on behalf of the Active Employee during the Work Quarter in which the Active Employee was disabled when added to the number of hours in the Active Employee's Hours Account totals at least 200 hours. The extension starts with the first Eligibility Quarter following the Work Quarter in which the Employee becomes disabled.

For Active Employees with monthly eligibility, the extension is for the month following the month in which he becomes disabled or, if greater, the number of months of eligibility in his Reserve Hours Account, provided the Employee remains disabled during this period.

Examples:

1. Mr. Smith has eligibility from February 1 through April 30 and becomes Totally Disabled on March 5. Because he was eligible at the time the disability occurred, he qualifies for a disability extension. Because his disability occurred during the Qualifying Work Quarter of January through March, the disability extension would be granted for the period of three Eligibility Quarters from May through January.

2. Mr. Jones' employer makes contributions on a monthly basis. He worked in February and March which provided Active Eligibility for April and May, and becomes Totally Disabled on April 5. Since he was eligible at the time the disability occurred, he qualifies for a disability extension for June. If he had hours in his Reserve Hours Account, he may be entitled to additional months of disability extension.

Extension of Medical Benefits Due to Disability

After the Extended Eligibility for Disability extension is exhausted, any eligible individual, Employee or Dependent, who lost eligibility due to Total Disability will be eligible for reimbursement of covered expenses **related to** the disabling injury or illness until the earliest of: 1) the date the Total Disability ends, 2) the end of the 12-consecutive month period from the date eligibility was lost, or 3) the date the Employee becomes covered as a Retired Employee.

If this extension applies to a Dependent child, stepchild, legally adopted child, or child placed with the Active Employee for adoption, benefits will be payable until the earlier of the date on which the Total Disability ends, or the 36-consecutive month period from the date eligibility was lost.

See also COBRA Continuation Coverage on page 9.

Benefits on account of pregnancy are limited to the benefit that would have been payable if eligibility had not been lost and will not be payable for any covered expenses incurred more than 90 days after the pregnancy terminates.

This extension is only for treatment of the disabling illness or injury. Any expenses for unrelated illness or injury or for other family members will not be covered. Work-incurred injuries or illnesses do not qualify for this extension.

RETIREE ELIGIBILITY

Retiree Eligibility Requirements

In order to qualify for Retiree Eligibility, a Participant must meet **ALL** of the following requirements:

1. Has sufficient hours of contributions at the master rate made to the Fund to satisfy the eligibility requirements for a Regular, Early or Disability Pension from the Pension Fund; and
2. Has not had a Separation from Employment unless, after the Separation from Employment has worked at least 6,000 hours in covered employment for which contributions were made to the Fund (or in certain circumstances 5,000 hours if the Participant becomes totally and permanently disabled.) A Separation from Employment means the Participant fails to work at least 500 hours for a signatory employer during a period of three consecutive Plan Years, or is employed as an Operating Engineer for a non-signatory employer who is doing Operating Engineer work but not making contributions to the Fund; and
3. Has at least 3,000 hours of contributions made to the Fund on his behalf as an Active Employee at the then-existing master rate; and
4. Has refrained, at all times after retirement, from any employment for a non-contributory employer if that employer performs Operating Engineer work; and
5. Has been eligible for Active Health and Welfare benefits for at least two of the eight consecutive Eligibility Quarters immediately preceding his pension effective date. However, if the Participant has worked 30,000 or more hours in contributory employment, he must have been eligible for at least three of the twenty consecutive quarters preceding his pension effective date. **This requirement is different for Pro-Rata or Reciprocal pensioners. Contact the Fund Office for details; and**
6. Makes the required monthly self-payment for coverage in a timely manner. The self-payment amounts are set by the Trustees and are subject to change from time to time. Self-payments may be deducted from the Retired Employee's pension check, paid by credit or debit card through the Fund's secure premium payment portal at www.oefi.org or by check mailed directly to the Fund Office. **Contact the Fund Office for details;** and
7. Is not engaged in any type of gainful employment and covered or eligible to be covered by group health insurance through that employment or continuation coverage under COBRA through that employment; and
8. Within five years prior to retirement, must have been eligible for at least three Eligibility Quarters under the Active Plan. At least 3,000 hours is required for minimum coverage (3,000 hours provides two years of coverage).

The length of Retiree Eligibility is based on employment for employers who made contributions to the Health and Welfare Fund on behalf of the Participant. A Participant is eligible for one year of Retiree Eligibility for each 1,500 hours on which contributions were made on his behalf to the Health and Welfare Fund.

Open Enrollment for Retiree Eligibility

During December each year, the Plan holds an open enrollment period for Retiree Eligibility. If you are eligible to enroll in the Plan and are not currently enrolled, you will automatically receive open enrollment information. **Coverage for Participants who elect to enroll during the open enrollment period will not begin until April 1, but the Participant must make the required premium payments for January through March. Any charges incurred between January 1 and March 31 will not be covered.**

Eligibility Card

Every eligible Retiree receives an eligibility card from the plan they are enrolled in. This card is issued when coverage under the Retiree program begins and upon any change that pertains to their enrollment (benefit plan change, address change, new dependent, etc.). There is no expiration date on the card because eligibility is determined on a monthly basis.

If you believe your eligibility record is incorrect, please inform the Fund Office as soon as possible to correct the information. If you do not receive an eligibility card, please contact the Fund Office.

Termination of Retiree Eligibility

Retiree Eligibility will be terminated on the earliest of the following dates:

1. The date your pension under the Operating Engineers Pension Trust is terminated, except if one of the following applies:

    - You have returned to active employment with contributing employers. In this case, your Retiree Eligibility will continue until Active Eligibility is earned through either the Quarterly or Monthly Eligibility System (see page 4). In the interim, you must continue to pay your Retiree Premium through the Retiree Plan.

    - Your Disability Pension is terminated. In this case, your Retiree Eligibility will continue for a maximum of five consecutive months or until you gain Active Eligibility, whichever occurs first. However, you must continue your premium payments under the Retiree Plan during this five-month period.

2. If fewer than 15,000 hours were contributed on your behalf to the Operating Engineers Health and Welfare Fund prior to the effective date of your pension award under the Operating Engineers Pension Trust, the last day of the month during which your Retiree Health and Welfare coverage has equaled one year for each full multiple of 1,500 hours of employment.

3. The last day of any month for which the required premium has not been received by the Fund Office.

4. The first day of the month in which you engage in gainful employment and are covered or eligible to be covered by any other group health insurance through that employment, including continuation coverage under COBRA, whether or not you elect that coverage.

5. The first day of the month following the month in which you fail to provide the documents requested by the Fund Office to determine your annual earned income.

6. The first day of any month in which you work **IN ANY CAPACITY ANYWHERE** for an employer not signatory to a Collective Bargaining Agreement requiring contributions to the Fund, if that employer does Operating Engineer work.

DEPENDENT ELIGIBILITY

The following family members of Active and Retired Participants are eligible for coverage:

- Legal spouse, including same-sex spouse. The Plan does not provide coverage for same-sex or opposite sex domestic partners.
- Children under 26 years of age who are the Participant's biological, step or adopted child. Additionally, a child placed with the Employee in anticipation of adoption for whom the Participant has a legal support obligation, or a child for whom a Qualified Medical Child Support Order requires the Participant to furnish medical coverage.
- Children under 26 years of age for whom an Active or Retired Participant has been appointed Legal Guardian or Conservator by court order.

IMPORTANT: **You must notify the Fund Office and enroll new dependents within 30 days of the marriage, birth, adoption, placement for adoption, or appointment of guardianship or conservatorship. You will be required to provide certain documents.**

Qualified Medical Child Support Orders (QMCSO)

A medical child support order is a court order that provides for medical child support or health benefit coverage with respect to a dependent child. In order to provide eligibility and pay benefits in accordance with a medical child support order, the Plan must determine that the order is a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the Plan's procedures for determining whether or not an order is a QMCSO from the Fund Office. The Fund Office can also provide you or your attorney, free of charge, with a model form order, which you or your attorney can use as a guide to draft a QMCSO. For a copy of this form please contact the Fund's Member Services Department at (866) 400-5200 or visit our website at www.oefi.org.

Termination of Dependent Eligibility

The eligibility of a dependent will terminate on the last day of the month in which they no longer qualify as a Dependent.

COBRA CONTINUATION COVERAGE

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides individuals the right to continue their health coverage by paying a monthly premium if they lose coverage under the Plan because of a "qualifying event." If COBRA is elected and premiums are paid in a timely manner, health coverage starts from the date coverage ends because of a qualifying event. The length of COBRA coverage is as follows:

Qualifying Event	Length of COBRA Coverage
Participant Loss of eligibility due to:	
• termination of employment for reasons other than gross misconduct	18 months
• reduction in hours	18 months
• voluntary resignation	18 months
Spouse Loss of eligibility due to:	
• termination of employee's employment for reasons other than gross misconduct	18 months
• death of employee	36 months
• divorce	36 months
Dependent Child Loss of eligibility due to:	
• termination of employee's employment for reasons other than gross misconduct	18 months
• death of employee	36 months
• divorce of parents	36 months
• attainment of age 26	36 months
• parent's eligibility for Medicare	36 months

Qualified Beneficiaries

Under COBRA, only "qualified beneficiaries" are entitled to continued coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the qualifying event.

While a Participant's COBRA coverage is in effect, the Participant may add a new spouse, a newborn child, an adopted child or a child placed with the Participant for adoption (for whom the Participant has financial responsibility). However, a new spouse, even though eligible as a dependent, does not become a qualified beneficiary and, therefore, does not have individual COBRA continuation rights. Adding a spouse or child to the coverage may increase the amount of your COBRA premium.

COBRA coverage is not available if the Participant or Dependent is covered by any other group insurance. COBRA coverage is also not available if the person has Medicare.

COBRA coverage is only available to a Retired Employee if he returns to work and regains Active Eligibility in the Plan or he does not otherwise qualify for Retiree coverage at retirement.

Extended Coverage for Disabled Qualified Beneficiaries

If your qualifying event entitles you to 18 months of COBRA coverage and you or a covered Dependent was disabled at the time of the qualifying event (or becomes disabled during the first 60 days of continuation coverage), you and any other covered Dependent may be eligible to continue your COBRA coverage at increased premium rates for up to an additional 11 months, for a total of up to 29 months.

To qualify for the additional months of coverage, the Social Security Administration must make a formal written determination that you or your Dependent is disabled and, therefore, is entitled to Social Security Disability income benefits before the 18-month period expires. You or your Dependent must notify the Fund Office of the Social Security determination within 60 days of the date you receive the determination and before the 18-month period expires. If the disability does not continue throughout the continuation period, you must notify the Fund Office of any later determination that you or your Dependent is no longer disabled.

Length of Coverage if you are enrolled in Medicare

If you are an Active Participant entitled to Medicare and you experience one of the qualifying events that entitles you to 18 months of COBRA coverage (reduction in your work hours, voluntary resignation or termination of employment), your eligible Dependents would be entitled to COBRA for a period of 18 months (29 months if the disability extension applies) from the date of the reduction in your work hours or resignation/termination of your employment or 36 months from the date you became entitled to Medicare, whichever is longer.

Second Qualifying Events

If your Dependents are in an 18-month COBRA coverage period because of a reduction in your work hours, your voluntary resignation or a termination of your employment and one of the following qualifying events occurs, the maximum COBRA period for your dependents will increase to 36 months:

- You get a divorce
- You become entitled to Medicare
- Your death
- Your child ceases to meet the Plan's definition of an eligible dependent (in this case only the child may be entitled to an additional 18 months of coverage)

This extension is only available to individuals who were covered Dependents at the time of the initial qualifying event and to children who are born to, or adopted by the Participant, during the initial 18-month period of coverage. The extension is not available to anyone who became the Participant's spouse following a qualifying event e.g. the termination of employment or reduction in hours.

The maximum period of coverage under COBRA is 36 months regardless of how many qualifying events occur.

Active Participants are not entitled to COBRA coverage for more than 18 months (29 months in cases of disability). Even if you experience a reduction in your work hours followed by a resignation or termination of employment, the resignation or termination of employment is not treated as a second qualifying event and you may not extend your coverage.

Qualifying Event Notification Requirements

In order to be eligible for COBRA coverage, the Fund Office must be notified, in writing **within 60 days** of the qualifying event.

If the qualifying event is a divorce or a child losing dependent status, you or the dependent must notify the Fund Office **within 60 days** of the date of the qualifying event.

If the Fund Office is not notified, in writing, within this time frame, the individual losing eligibility as a dependent will forfeit his or her right to enroll in the COBRA continuation plan.

Electing COBRA Continuation Coverage

When the Fund Office receives notice of a qualifying event, it will send the qualifying beneficiary information about coverage options and COBRA election forms. Information sent to the Participant or Spouse will be deemed to have been sent to dependent children.

You and/or your covered Dependents must make your election **within 60 days** of the later of:

- The date of the qualifying event;
- The date you would have lost coverage because of a qualifying event; or
- The date you and/or your Dependents are sent the election form and COBRA information.

If you and/or any of your covered Dependents do not elect COBRA coverage within the 60-day period, your/their health coverage will end and the Plan will not pay claims for services incurred on and after the date coverage terminates.

Special COBRA Enrollment Rights

If during your COBRA coverage period, you acquire a new Dependent due to marriage, birth, adoption or placement for adoption of a child, you may enroll that Spouse or Dependent Child for coverage for the remainder of your COBRA period provided you notify the Fund Office and enroll the new Dependent within 30 days of the marriage, birth, adoption or placement for adoption.
Adding a new Dependent may cause an increase in the amount of the monthly COBRA premium.

Coverage

If you elect COBRA continuation coverage, you will be entitled to the same health coverage that is provided to other Participants and their family members in the Plan whose situation is similar to yours.

There are two different options and premiums under COBRA One option provides only medical and hospital benefits (COBRA Core Plan). The other option provides medical, hospital, prescription drug, dental and vision benefits (COBRA Full Plan). There is no coverage for life insurance under the COBRA Plans.

COBRA coverage is an extension of your benefits prior to loss of eligibility. Therefore, if you had already satisfied the applicable calendar year deductible and out-of-pocket maximums, new ones will not be taken.

If the coverage provided by the Plan to Active Participants is changed in any respect, those changes will apply at the same time and in the same manner for everyone covered under the COBRA Plan.

Paying for COBRA Continuation Coverage

You are responsible for the entire cost of COBRA coverage. The Fund Office will notify you of the COBRA premium amounts, which can change on a yearly basis. Payment rules are:

- Payments can be mailed to the Fund Office if made by check, cashier's check or money order.
- If you elect COBRA coverage, you must, within 45 days of your election date, submit your first payment to the Fund Office. This first payment must include payment for all calendar months from the expiration of coverage through the calendar month that ends prior to the date of the first payment.
- After the initial payment is made, payments must be made monthly to continue coverage. Failure to make a monthly payment within 30 days of the beginning of the coverage month will result in termination of coverage as of the end of the period for which the last payment has been made.

It is the responsibility of the qualified beneficiary to submit payments when due.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the earliest of:

1. The first of the month for which you or your Dependents do not pay the premium by the due date; or
2. The first of the month that begins 30 days after Social Security determines that the qualified beneficiary is no longer disabled if the coverage is under the 11-month extension for disabled individuals; or
3. The first of the month following the expiration of the maximum COBRA coverage period for which the individual qualifies; or
4. The date on which the Trustees reduce the amount of COBRA coverage available or no longer provide health coverage; or
5. The date on which the plan you have chosen is terminated, in which case, you may have the opportunity to change to another plan offered by the Fund; or
6. The date on which the person receiving coverage becomes covered by another group health plan (as an employee, spouse or dependent) that does not contain any exclusion or limitation for a pre-existing condition; or
7. The date on which the person receiving coverage becomes entitled to Medicare benefits after the date of election of COBRA; or
8. The date on which your employer withdraws from this Plan and establishes or joins another group health plan covering a significant number of its employees formerly covered by this Plan.

Conversion to Individual Coverage (Applicable only to HMO Participants)

Participants and eligible family members whose coverage through an HMO ends after exhaustion of COBRA and Cal-COBRA are allowed to purchase individual conversion coverage through their HMO without evidence of insurability. Individuals must apply for conversion coverage and pay the premium to the HMO within 31 days of the loss of their coverage.

To take advantage of this provision, you must remain in the HMO plan.

SELF-PAYMENT FOR SURVIVING SPOUSES AND OTHER DEPENDENTS

Active Employees

If the deceased individual was an Active Employee and eligible for Fund coverage at the time of death, coverage for the Spouse and other Dependents will continue until the Reserve Hours Account is exhausted, plus an additional two consecutive eligibility quarters or six months. The additional six months of coverage is provided at no charge.

After the six months of coverage has been exhausted, the surviving Spouse who has not remarried and who is not eligible for other group coverage (other than Medicare), and other Dependents without other group coverage, may participate in the Plan as long as the monthly premium required for coverage by the Trustees is paid. That premium is subject to change by the Trustees at any time. Complete details are provided upon the death of the Active Employee. When the Spouse reaches age 65, the spouse may continue to be covered by the Plan, but Medicare would be the primary carrier for payment of benefits.

Retired Employees

If the deceased individual was a Retired Employee and eligible for Fund coverage at the time of death, coverage for the Spouse and other eligible Dependents will continue until the end of the month in which the Employee died plus an additional six months. The additional six months of coverage is provided at no charge.

After the six months of coverage has been exhausted, the surviving Spouse who has not remarried and who is not eligible for other group coverage (other than Medicare) and other Dependents without other group coverage, may participate in the Retiree Plan as long as the monthly premium required by the Trustees is paid. That premium is subject to change at any time.

Eligibility under the Self-Payment program will terminate on the date the surviving spouse remarries or becomes entitled to any other group coverage, other than Medicare.

Open Enrollment for Retirees, Surviving Spouses and Dependents

During December of each year, the Fund holds an open enrollment period for retirees, surviving spouses and dependents. If you are eligible to enroll in the Plan but are not currently enrolled, you will automatically receive this open enrollment information. Health and Welfare coverage for retirees, surviving spouses and dependents who elect to enroll in the Plan during this open enrollment period will not begin until April, but they must pay the required premiums for January through March. Any charges incurred between January 1 and March 31 will not be covered.

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family Medical Leave Act provides that in some situations certain employers are required to grant leave to employees, and in such situations the employer is required to continue medical coverage for the employees. The FMLA specifically provides that more liberal provisions of state law are permitted and also provides that more liberal provisions contained within collective bargaining agreements are permitted.

It is not the role of the Trustees or the Health and Welfare Fund to determine whether or not an individual employee is entitled to leave with continuing medical benefits provided through employment under the FMLA, any state statute or the provisions of a collective bargaining agreement. Disputes about entitlement to leave with continuing medical benefits must be resolved by the employer, employee and, where applicable, the local union.

To the extent that Participants are entitled to leave with continuing medical benefits under the FMLA, state legislation or provisions contained within a collective bargaining agreement, the Fund will continue to provide medical coverage so long as required monthly contributions are received from the contributing employer. Rights under the FMLA do not affect rights under COBRA or rights to continuing medical care pursuant to the disability extension features contained within the Plan Rules and Regulations.

If you have completed 12 months and 1,250 hours of employment with a participating employer, you are entitled, by law, to up to 12 weeks each year of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child or parent who is seriously ill or for your own illness.

While you are officially on such family or medical leave, you will continue to accrue hours, and your employer will be required to pay contributions on such hours at the regular rate, for the period of leave authorized by such laws, thus maintaining your medical, dental and vision coverage during that period.

Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your medical, dental and vision coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Dependents who were covered by the Plan at the time you took your leave.

Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Dependents in the same way they apply to all other Participants and their Dependents. To find out more about your entitlement to family or medical leave as required by the FMLA and/or state law, and the terms in which you may be entitled to it, contact the Fund Office.

RESCISSION OF ELIGIBILITY

The Trustees may, with 30 days advance written notice, rescind the eligibility of any individual who engages in fraud or makes an intentional misrepresentation to gain eligibility. Rescission means a cancellation or discontinuation of eligibility that has a retroactive effect.

MEDICAL COVERAGE

For Active and Retired Participants, Excluding Medicare Retirees

Types of Medical Coverage Available

The Fund offers two types of medical coverage:

Preferred Provider Organization (PPO). The PPO is available to all Participants. This is a network of hospitals, doctors, physical therapists, chiropractors and hearing aid suppliers who offer services at a special contracted rate. The Plan's PPO is Anthem Blue Cross nationwide.

When you use hospitals and doctors in the PPO network, you will have lower deductibles and co-payments. You may use hospitals and doctors outside of the network, but your out-of-pocket costs will be higher. This non-network PPO benefit was formerly called the "Fee-for-Service Plan".

The PPO program requires no enrollment. If you are not enrolled in an HMO, you are automatically part of the PPO. You cannot use PPO providers if you are enrolled in an HMO. If you or your Dependents have primary coverage with another plan, you may choose PPO providers but the Plan will coordinate benefits as outlined on pages 64-65.

Health Maintenance Organization (HMO). Currently, the Plan offers three HMOs:

- Kaiser Permanente
- Anthem Blue Cross
- Health Plan of Nevada (limited to Nevada Participants)

The Kaiser and Anthem Blue Cross HMOs are available to Active Participants and non-Medicare Retirees. Health Plan of Nevada is available to all Active and Retired Participants. An HMO is an organization to whom the Fund pays a fee to provide medical coverage to you and your dependents. Except for small copayments and non-covered items, you make no direct payment for medical treatment. You must enroll to be covered under an HMO.

Deductibles

The following calendar year deductibles apply:

Type of Plan	Calendar Year Deductible
PPO – Network	$250 per person/$750 per family
PPO – Non-Network	$500 per person/$1,500 per family
HMO	None charged by the HMO. Claims submitted for services not covered by the HMO, but covered by the PPO plan, are subject to the PPO Non-Network Deductible

The deductibles under the PPO plan do not apply to:

- Outpatient hospital or ambulatory surgery center charges incurred in connection with a surgical procedure
- Emergency Ambulance Transport (ground and air)
- Home health agency charges
- Birthing Center charges
- Covered expenses for Eligible Individuals for whom Medicare is primary
- Preventative health services as required by applicable federal law and regulations

Deductible Waiver

In the event an individual eligible for benefits under the Plan had no covered medical expenses submitted to or paid by the Plan for a calendar year, the deductible for the immediately following calendar year will be waived. This deductible waiver is only available to individuals who were eligible for the entire calendar year immediately preceding the calendar year for which the deductible is being waived and will not apply to Medicare Primary Retirees or dependents of Retirees that are Medicare Primary.

Out-Of-Pocket Calendar Year Maximums

The maximum out-of-pocket amount you and your family pay for covered expenses each calendar year:

Type of Plan	Calendar Year Out-of-Pocket Maximum
PPO – Network	$3,000 per person/$6,000 per family
PPO – Non-Network	$6,000 per person/$12,000 per family
CVS Caremark – Rx Network	$3,600 per person/$7,200 per family
HMO	
Kaiser Permanente	$1,500 per person/$3,000 per family
Anthem Blue Cross	$1,500 per person/$3,000 for two family members/ $4,500 for three or more family members
Health Plan of Nevada	$6,000 per person/$12,000 per family

Case Management

Case Management is a process by which a coordinator works with the patient, the family and the attending physician to develop an appropriate treatment plan and to identify and suggest alternatives to traditional inpatient hospital care. The alternative treatment plan must be accepted by both the patient and the physician. Case Management can help with a wide variety of complex and potentially expensive health care problems including burns, spinal cord injuries, cancer, stroke, cardiovascular disease, AIDS, organ transplants, chronic infections or disease, and pain management.

This program is totally voluntary and assures that the patient is receiving the most appropriate treatment. Its purpose is to benefit the patient and is provided as part of the benefit plan so there is no additional cost to the patient.

Once your treatment has begun, the Case Management process can be initiated by your provider through Anthem's Utilization Management team by calling 800-274-7767.

Pain Management Programs

Pain Management programs are covered by the Fund when Medically Necessary. These types of services include, but are not limited to, comprehensive inpatient and outpatient pain management programs, implantable spinal pain management devices, and special pain control devices or medical equipment.

All types of pain management programs should be arranged and initiated by your provider with Anthem's Utilization Management team by calling 800-274-7767 prior to the beginning of service. You must submit a comlete description of the program or therapy, along with the estimate of the related costs and all medical records relating to the patient's disorder and reason for medial necessity.

Personal Injury Liability

If you or your covered dependents are injured by someone else (for example, in an automobile collision or a slip and fall accident) the Fund will pay benefits on medical claims arising from the injury only if you do BOTH of the following:

- Sign a lien or agreement in a form acceptable to the Fund Office in which you acknowledge and agree that the Fund has the right to all or a portion of damages you collect for your injuries to the extent of the benefit the Fund paid. The lien applies to all amounts you recover for your injuries, including amounts you collect from your own insurance (for example, uninsured motorist coverage on your automobile policy). The Trustees may reduce the amount of the lien if you have to pay an attorney to sue the person that injured you to collect damages for your injuries.
- Reimburse the Fund for the benefits it paid from any settlement or judgment you collect for those injuries. If you do not reimburse the Fund as required, future benefit payments will be withheld and applied to the amount you owe until the full amount is reimbursed.

You are required to file a claim with the third party insurance. If you fail to do so, you will be responsible to pay the bills you incurred as a result of the injury. The Fund will not pay these bills.

Worker's Compensation Policy

The Fund does not cover expenses in connection with work-related injuries or illnesses whether or not the Employee has Worker's Compensation Insurance through their employer or makes a claim for Worker's Compensation benefits. No benefits are payable from the Fund, even if the work-related injury occurred in the past and the case has already been closed.

Overpayments

If an overpayment occurs in connection with a claim for benefits, the Fund Office is required to recover the overpayment, *regardless of the reason for the overpayment*. The Trustees expect immediate payment. However, if that is not possible, a schedule of payments may be arranged with the Fund Office and, if that is not acceptable, the Fund Office is required to offset the payment of future claims against the overpaid amount until complete recovery is made.

If you have an existing overpayment with the Fund Office, you cannot enroll in an HMO until the overpayment has been recovered in full by the Fund.

Care in a Foreign Country

Medical claims incurred in foreign countries are covered by the Fund for treatment that is approved, legal and accepted practice in the United States. If you are planning to obtain non-emergency medical treatment in a foreign country, you should get pre-approval from the Fund Office, otherwise the claim may be denied.

The Plan covers only medical services and supplies reasonably necessary for the care and treatment of bodily injury or sickness. Whether such services or supplies are reasonably necessary is determined by the Trustees based on the opinions and decisions of recognized medical authorities and the U.S. Food and Drug Administration.

Following is a brief outline of the benefits available under the PPO Plan. Further details of the benefits covered, exclusions and limitations can be found in the pages that follow and in the Rules and Regulations of the Plan.

	PPO Network	PPO Non-Network
PROFESSIONAL SERVICES:		
Office Visits	Plan pays 90% of the Contract Rate after a $20 co-payment	Plan pays a maximum of $15 per visit
Hospital Visits	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Lab and X-Ray	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Therapy – Acupuncture, Chiropractic & Physical Therapy	Chiropractic – Plan pays 50% of the Contract Rate Acupuncture and Physical Therapy – Plan pays 90% of the Contract Rate after a $20 co-payment per visit Acupuncture and Chiropractic services have a combined limit of 26 visits per year	Plan pays a maximum of $15 per visit Acupuncture and Chiropractic services have a combined limit of 26 visits per year
Speech Therapy	Plan pays 90% of the Contract Rate after a $20 co-pay per visit	Plan pays 70% of Reasonable and Customary charges up to a maximum of $15
Routine Physicals	Plan pays 90% of the Contract Rate up to a maximum of $175 for one annual routine physical	Plan pays 70% of Reasonable and Customary charges up to a maximum of $150 for one annual routine physical
Surgeon	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Assistant Surgeon	Plan pays 90% of the Contract Rate for second surgeon, assistant surgeon, second assistant surgeon and physician assistant	Plan pays 70% of Reasonable and Customary charges for second surgeon, assistant surgeon, second assistant surgeon and physician assistant
Anesthetist	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Deductible	$250 per individual per calendar year; maximum $750 per family (Applicable to most services)	$500 per individual per calendar year; maximum $1,500 per family (Applicable to most services)
Annual Out-of-Pocket Maximum | Medical and Pediatric Dental & Vision	$3,000 per individual; $6,000 per family per calendar year	$6,000 per individual; $12,000 per family per calendar year
Annual Out-of-Pocket Maximum | Rx	$3,600 per individual; $7,200 per family per calendar year	Not Applicable

	PPO Network	PPO Non-Network
HOSPITAL SERVICES:		
Inpatient Care Semi-Private Room and Misc. Charges	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Outpatient Care		
Emergency Room Care – Non-Emergency	Plan pays 90% of the Contract Rate	Plan pays a maximum of $15 for Emergency Room Visit, 70% of Reasonable and Customary charges for Lab and X-Ray charges
Emergency Room Care – Emergency Related	Plan pays 90% of the Contract Rate	Plan pays 90% of Reasonable and Customary charges
Surgical Facility	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Inpatient Psychiatric Care	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Inpatient and Outpatient Alcohol and Substance Abuse Care	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges
Skilled Nursing Facility	Plan pays 90% of the Contract Rate with a 100-day maximum per confinement	Plan pays 80% of Reasonable and Customary charges with a 100-day maximum per confinement
OTHER SERVICES:		
Ambulance	Emergency Transport: Plan pays 80% of the Contract Rate (deductible waived) Non-Emergency Transport: Plan pays 80% of the Contract Rate (deductible applies) Transport Between In-Network Hospitals: Plan pays 100% of the Contract Rate. The deductible is waived	Emergency Transport: Plan pays 80% of Reasonable and Customary charges (deductible waived) Non-Emergency Transport: Plan pays 70% of Reasonable and Customary charges (deductible applies) Transport Between Out-of-Network Hospitals: Plan pays 70% of Reasonable and Customary charges. The deductible applies
Durable Medical Equipment	Plan pays 90% of the Contract Rate, not to exceed purchase price	Plan pays 70% of Reasonable and Customary charges, not to exceed purchase price
Prosthetic Appliances	Plan pays 90% of the Contract Rate	Plan pays 70% of Reasonable and Customary charges

MEDICAL BENEFITS

Following is a brief summary of medical benefits covered and some of the more significant restrictions and exclusions. All medical benefits are only covered to the extent they are deemed to be **Medically Necessary,** not in excess of **Reasonable and Customary Charges** and not **Experimental or Investigational** (see pages 82-84).

Alternative Therapy

Alternative Therapy includes:

- Acupuncture
- Biofeedback
- Chiropractic treatment

Acupuncture is covered only when performed by a medical doctor or state Certified Acupuncturist. The only exception applies to the State of Nevada where it is also covered when performed by a Doctor of Traditional Chinese Medicine.

Chiropractic treatment for Dependent Children under age 16 is not covered.

There is a combined limit of 26 visits per person per calendar year for Acupuncture and Chiropractic treatment.

Ambulance

If it is Medically Necessary, the Plan covers professional ambulance service to the nearest hospital for care and treatment of an injury or sickness. Air ambulance service is also covered when Medically Necessary to transport a patient to the closest treatment center. Transportation for the patient's convenience is not covered.

Durable Medical Equipment (DME)

The Plan covers the rental of a wheelchair, hospital-type bed or other durable medical equipment, used exclusively for the therapeutic treatment of injury or sickness.

If you require DME for a long period of time and the rental price is expected to exceed the purchase price, you should consider purchasing the equipment. A doctor's prescription and approval by the Board of Trustees is required.

Continuous Positive Airway Pressure (CPAP) Devices are covered with a diagnosis of obstructive sleep apnea (OSA) that has been documented by an attended, facility-based polysomnogram (sleep study) that meets one of the following criteria:

- The Apnea-Hypoapnea Index (AHI) is greater than or equal to 15 events per hour, or
- The Apnea-Hypoapnea Index (AHI) is from 5 to 14 events per hour with documented symptoms of either (a) excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or (b) hypertension, ischemic heart disease, or history of stroke.

Continued coverage of a CPAP device beyond three months of therapy will be handled by the Case Management Department who will contact the patient 61 days after the initial authorization to determine the patient's progress. Findings from that follow-up will dictate the continued approval of the CPAP for purchase and/or coordinating the return of the device to the DME company.

Continuous Passive Motion (CPM) Machines are covered as DME to improve range of motion in any of the following circumstances:

1. During the postoperative rehabilitation period for Participants who have received a total knee arthroplasty or replacement as an adjunct to on-going physical therapy.
2. Participant who has had an anterior cruciate ligament repair until the Participant is participating in an active physical therapy program.
3. Participants undergoing surgical release of arthrofibrosis/adhesive capsulitis or manipulation under anesthesia of any joint: (knee, shoulder, and elbow the most common) until the Participant is participating in an active physical therapy program.

4. To promote cartilage growth and enhance cartilage healing during the non-weight bearing period following any of the following until the Participant begins the weight bearing phase of recovery:
    - Surgery for intra-articular cartilage fractures
    - Chondroplasties of focal cartilage defects
    - Surgical treatment of osteochondritis dissecans
    - After abrasion arthroplasty or micro-fracture procedure
    - Treatment of an intra-articular fracture of the knee (e.g., tibial plateau fracture repair)
    - Autologous chondrocyte transplantation
5. Participants who have undergone certain surgeries and may not benefit optimally from active physical therapy. This includes Participants with reflex sympathetic dystrophy, Dupuytren's contracture, extensive tendon fibrosis, or mental and behavioral disorders.
6. Participants who are unable to undergo active physical therapy.

When the CPM machine is used for surgical rehabilitation, the use of the device must commence within two days following surgery to meet Medical Necessity guidelines. Although the usual duration of CPM machines is 7 to 10 days, up to three weeks of CPM therapy may be considered Medically Necessary upon individual consideration. Use of the CPM machine beyond 21 days post-op is not supported by the medical literature and there is insufficient evidence to justify the use of these devices for longer periods of time or for other applications.

The Plan considers CPM machines experimental and investigational for all other purposes.

Examples of DME Expenses Not Covered

Benefits will not be payable for:

- Handrails
- Wheelchair batteries or any other batteries used with DME
- Over-the-bed tables
- Hot tubs, spas, Jacuzzi's, pools
- Air conditioners
- Special auto equipment, such as van lifts
- Exercise equipment (treadmill, rowing machine, etc.)
- Recliners
- Mattresses

Hearing Aid Benefit

All Participants and their Eligible Dependents are eligible for the hearing aid benefit. This includes those in the PPO Plan and those enrolled in an HMO.

The Plan will pay a maximum of $1,000 per ear for the purchase of a hearing aid or for repair and batteries after satisfaction of the deductible. Benefits for new hearing aids, repairs and batteries are covered once every three years.

Home Health Care/Registered Nurse

When skilled nursing or home health care is required in the home, you are urged to check with the Fund Office to determine if the services qualify for coverage.

Skilled nursing and home health care must be ordered by a medical doctor, and the duties to be performed by the nurse(s) must be described. Home health care must be provided by a licensed Home Health Agency. Situations that require housekeeping and meal preparation are not covered even if nursing has been prescribed by a doctor. Home health care and registered nurse visits will be combined. Contact Anthem's Utilization Management department by calling 800-274-7767 for assiststance in coordinating this type of care. Home health services are limited to 10 visits per calendar year for treatment within 90 days of a confinement of at least 3 days.

Immunizations and Flu Shots

Most immunizations are covered by the Plan. This includes immunizations for adults and Dependent children.

As approved by the FDA the following routine vaccinations are available with no co-payment at local CVS Caremark Network pharmacies:

- Seasonal Influenza
- Zoster (shingles)
- Tetanus, Diphtheria Toxoids, Pertussis
- Hepatitis A & B
- Measles, Mumps, Rubella, Varicella
- Pneumococcal (pneumonia)
- Human Papillomavirus
- Meningococcal
- COVID-19

Infertility/Fertility Treatment

Infertility or sterility is not in itself a bodily illness and, therefore, is not generally covered by the Plan. However, if the infertility is caused by an organic illness, the treatment of the underlying illness is covered.

The Plan will pay for the initial exam and diagnostic services necessary to determine infertility or sterility. However, the Plan will not pay for services performed to treat the infertility or sterility. Some of the non-covered services are:

- Artificial insemination
- Low tubal transfers
- In-Vitro Fertilization*
- Fertility Drugs
- Embryo Transplant
- Gamete Intrafellopian Transfer (GIFT)
- Reversal of elective sterilization unless medically necessary

*The Plan does not cover any charges related to In-Vitro Fertilization unless the direct cause of the sterility is testicular cancer, in which case the Plan will pay up to $6,000 per program or $3,000 per "cycle" with a limitation of two cycles of treatment.

Maternity Benefits

Maternity benefits are provided for the pregnancy of a Spouse, Dependent or Participant on the same basis as any other illness or disability. See page 30 for hospital benefits.

	PPO Network	PPO Non-Network
Physician	Plan pays 90% of the Contract Rate after satisfaction of the deductible toward Doctor's charges for "total O.B. Care." The Fund does not pre-pay medical benefits; payments are made after the birth of the child. Plan pays 90% of the Contract Rate after satisfaction of the deductible	Plan pays 70% of Reasonable and Customary charges after satisfaction of the deductible toward Doctor's charges for "Total O.B. Care." The Fund does pre-pay medical benefits; payments are made after the birth of the child. Plan pays 70% of Reasonable and Customary charges after satisfaction of the deductible
Midwife (Licensed)	Plan pays 90% of the Contract Rate after satisfaction of the deductible	Plan pays 70% of Reasonable and Customary charges after satisfaction of the deductible

	PPO Network	PPO Non-Network
Birthing Centers	Plan pays 90% of the Contract Rate. The deductible is waived	Plan pays 70% of Reasonable and Customary charges with a $1,200 maximum per delivery, including the baby's hospital charges. The deductible is waived
Voluntary Sterilization (Reversal of voluntary sterilization is not covered)	Plan pays 90% of the Contract Rate after satisfaction of the deductible	Plan pays 70% of Reasonable and Customary charges after satisfaction of the deductible

Care of Newborns: All hospital services and supplies necessary for the care of a newborn child during hospital confinement, including routine nursery care, will be paid in accordance with the Plan's hospital benefits. The Participant must be eligible at the time of service for these benefits to be provided.

Adoption: The Plan will provide medical and hospital benefits toward charges for the birth of a child who is in the process of being adopted by the Participant. The Plan will not cover the birth mother's charges.

Adoption proceedings usually take 6 to 12 months before the adoption becomes final. Therefore, the Plan will require copies of documents from the attorney handling the adoption or from the court showing that the adoption is in progress.

The child will be covered from the day he or she begins to live with the Participant.

If you are pregnant on the date eligibility terminates, benefits for hospital and obstetrical care will be payable as if eligibility had not terminated for a period of up to 90 days after the pregnancy terminates. However, charges for the dependent baby will not be covered.

Newborn's and Mother's Health Protection Act (NMHPA)

The Plan complies with a federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, this Plan does not require that a health care practitioner obtain authorization from the Plan (or its utilization review company) for prescribing a length of stay up to 48 hours (or 96 hours following a cesarean section).

Organ Transplants

An "Organ" is a somewhat independent part of the body that performs a special function or functions. The Plan will cover all expenses related to the transplantation of an organ, including patient screening, organ procurement and transportation of the organ, patient and/or donor, surgery for the patient and donor, follow-up care in the home or a hospital provided the procedure is medically necessary and not deemed experimental or investigational.

This transplant benefit is available only if the transplant recipient is eligible under the Plan at the time of surgery. Donor related expenses will only be covered if the donor has no other health insurance coverage for the transplant procedure.

The Plan will not cover expenses for transportation of surgeons or family members. If the individual is covered by Medicare, and the Plan provides secondary coverage for that individual, no benefits will be provided by the Plan unless the transplant center is approved by Medicare.

Immunosuppressant drugs are covered under the Plan's prescription drug benefit (see page 39).

The Plan does not consider a bone marrow transplant to be an organ transplant. Benefits may be available under the general benefit provisions of the Plan.

Participants enrolled in an HMO must utilize their HMO plan for these services.

IMPORTANT: *Due to the complexity and expense related to organ transplants, please contact either the Fund Office or Anthem Blue Cross Case Management Departments for coordination of services and a full explanation of coverage.*

Orthotics - Foot

Foot orthotics are external devices, other than casts, made especially for each individual person to support or correct a diseased or injured foot. Foot orthotics are covered only once every 12 months for adults and once in a period of 6 months for children under age 19. All foot orthotics must be custom-made and molded to the patient's foot. Custom-made foot orthotics are covered when prescribed by a physician and prepared by a qualified health professional. Casting is paid under surgery benefits.

Walking Boots

A walking boot is a type of medical shoe used to protect the foot and ankle after an injury or surgery. The boot can be used for broken bones, tendon injuries, severe sprains, or shin splints.
For walking boots that are prescribed by a doctor, the Plan will pay 90% of the Contract Rate for PPO network claims and 70% of Reasonable and Customary charges for non-network claims with a benefit maximum of $225 per claim, subject to deductible.

Physician Care

PPO Network: The Plan pays 90% of the Contract Rate after satisfaction of the deductible. You must pay a $20 co-payment plus 10% of the Contract Rate. You are also responsible for any services not covered by the Plan (see page 33). For consultations, you are responsible for any contract amount that exceeds the Plan's $150 consultation maximum.

Also, for this benefit, you must be referred by another physician or other appropriate medical professional for an opinion or advice regarding a specific medical condition. The request for consultation or referral must be documented in your medical record and the consulting physician must provide a written report to the referring physician. If these requirements are not met, the charges for the initial consultation will be paid at a maximum of $15 per consultation after satisfaction of the deductible.

An immediate consultation with a PPO Network physician is available with no deductible or co-payment through LiveHealth Online. See page 30 for details.

PPO Non-Network: The Plan pays a maximum of $15 per visit after satisfaction of the deductible.

For consultations with a specialist, the Plan will pay 70% of Reasonable and Customary charges up to a maximum of $150 after satisfaction of the deductible.

Preventive Health Services - PPO Network Providers Only

Federal law requires this Plan to cover certain preventive services received from PPO Network providers with no deductible, co-payments or coinsurance. The Plan will cover these services whether they are performed separately or in the course of an annual physical. However, to avoid cost sharing, the primary purpose of the office visit must be for preventive care. Many of these services are provided during a routine physical or well-child exam. See sections on these benefits on page 26 and 27.

	Covered Preventive Care Services
Newborns	• Gonorrhea preventive medication for eyes of all newborns • Screening all newborns for hearing loss, Sicle cell disease, Hypothyroidism, and Phenylketonuria (PKU)
Childhood/Adolescent Immunizations	• Diphtheria, Tetanus, Pertussis • Haemophilus influenza type B • Hepatitis A and B • Human Papillomavirus (HPV) • Inactive Poliovirus • Influenza (Flu) • Measles, Mumps, Rubella • Meningococcal • Pneumoccal (pneumonia) • Rotavirus • Varicella (chickenpox) • Tuberculin testing for children at higher risk for Tuberculosis • Vision screening when performed during the course of a routine pediatric visit
Childhood	• Autism screening for children at 18 and 24 months • Behavioral assessment for children of all ages • Blood pressure screening • Developmental screening for children throughout childhood • Dyslipidemia screening for children at higher risk of lipid disorder • Fluoride supplements for children without fluoride in their water • Height, weight and BMI measurements • Hematocrit or Hemoglobin screening • Iron supplements for children 6 to 12 months at risk for anemia • Lead screening for children at risk of exposure • Medical history for all children throughout development • Obesity screening and counseling • Oral health risk assessment for young children
Additional Screenings for Adolescents	• Alcohol and drug use assessment • Cervical dysplasia screening for sexually active individuals • Depression screening • HIV screening for adolescents at higher risk • Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
Adults	• Alcohol misuse screening and counseling • Aspirin use to prevent cardiovascular disease • Blood pressure screening • Cholesterol screening for adults age 45 or older, and younger adults at higher risk • Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy or colonoscopy for adults age 50 or older • Depression screening • Diabetes screening for type 2 diabetes for adults with high blood pressure • Diet counseling for adults at higher risk for chronic disease • HIV screening for sexually active adults • Obesity screening and counseling • Sexually transmitted infection (STI) screening • Syphilis screening for adults at higher risk • Tobacco use screening

Adult Immunizations	• Diphtheria, Tetanus, Pertussis • Hepatitis A and B • Zoster (Shingles) • Human Papillomavirus (HPV) • Influenza (Flu) • Measles, Mumps, Rubella • Meningococcal • Pneumoccal (pneumonia) • Varicella (chickenpox)
Additional Screenings	• Abdominal aortic aneurysm one-time screening for those age 65 to 75 who have smoked
Additional Services and Screenings for Adults	• BRCA counseling about genetic testing for those at higher risk • Breast cancer chemoprevention counseling for those at high risk for breast cancer • Breast cancer Mammography every one to two years for those age 40 or older • Cervical cancer pap test • Chlamydia infection screening for those at higher risk • Contraception – FDA-approved contraception methods, sterilization and contraceptive counseling • Domestic violence screening and counseling • Gonorrhea screening for those at higher risk • Human Papillomavirus (HPV) DNA testing every three years for those age 30 or older • Osteoporosis screening for those age 60 or older, depending on risk factors • Well-patient visits
Pregnancy	• Anemia screening for iron deficiency • Bacteriuria urinary tract infection screening • Breastfeeding support, supplies and counseling • Folic acid supplements for those with a medical need for them • Hepatitis B screening during the first prenatal visit • Prenatal visits • Rh incompatibility blood type screening • Gestational diabetes screening

Prosthetic Appliances

A prosthetic appliance is an artificial replacement for a missing body part, such as an artificial leg. If a natural limb or eye is lost while the patient was eligible under the Plan, the Plan will provide coverage for the artificial replacement of the lost limb or eye. A second artificial limb to replace an initial artificial limb may be covered if approved by Anthem's Utilization Management department. If a Dependent Child requires replacement of a prosthesis due to growth, each replacement will be a covered expense. Repairs and replacements of prosthetic appliances are subject to approval by the Fund Office.

Routine Physical Exam

The Plan will pay for physician charges incurred in connection with a routine physical exam once in any one year period as follows:

PPO Network: The Plan will pay 90% of the Contract Rate, up to a maximum of $175 after satisfaction of the deductible. See pages 26-27 for Covered Preventive Services.

PPO Non-Network: The Plan will pay 70% of Reasonable and Customary charges, up to a maximum of $150 after satisfaction of the deductible.

Benefits are not payable under the Routine Physical Exam benefit for:

- Diagnosis or treatment of any injury or illness
- Any examination of the teeth or gums
- Adoption or employment physicals or commercial driver's license (CDL) examinations

Speech Therapy

The Plan will pay for speech therapy only if the following conditions are met:

1. The treatment must be certified by a referring Physician as medically necessary.
2. The therapy must be given by, or under the direct supervision of, a certified or licensed Speech Pathologist.

PPO Network: The Plan pays 90% of the Contract Rate, subject to a $20 co-payment per visit, after satisfaction of the deductible.

PPO Non-Network: The Plan pays a maximum of $15 per visit after satisfaction of the deductible.

Substance Abuse/Chemical Dependency Treatment

Effective January 1, 2022 these benefits are provided through CBH (see pages 35-38).

The Plan will pay as follows:

	PPO Network Benefit	PPO Non-Network Benefit
Inpatient (hospital)	Actives: The Plan pays 90% of the Contract Rate Non-Medicare Retirees: The Plan pays 90% of the Contract Rate after satisfaction of the deductible	Actives: The Plan pays 70% of Reasonable and Customary charges Non-Medicare Retirees: The Plan pays 70% of Reasonable and Customary charges after satisfaction of the deductible
Outpatient Counseling	The Plan pays 90% of the Contract Rate after satisfaction of the deductible	The Plan pays a maximum of $15 per visit after satisfaction of the deductible
Day Treatment	The Plan pays 90% of the Contract Rate after satisfaction of the deductible	The Plan pays 70% of Reasonable and Customary charges after satisfaction of the deductible

Supplies

Supplies are items that are Medically Necessary for the therapeutic treatment of an illness or injury. Some examples of supplies that are not covered by the Plan are:

- Ace bandages
- Heating pads
- Alcohol swabs
- Back or neck pads, cushions or pillows
- Incontinence pads or diapers
- Sports braces or supports
- Nutritional supplements

Please contact the Fund Office for further information.

Cosmetic Surgery

The term "Cosmetic Surgery" means surgery that is performed merely for the purpose of improving the appearance of an individual. The Plan does not cover Cosmetic Surgery unless the surgery being done is to repair or alleviate disfigurement resulting from an accident or for the correction of a congenital defect in a Dependent Child or for breast reconstruction following cancer-related mastectomy.

Weight Control Programs

The Plan will cover most of the charges for weight control programs if the patient meets the following requirements:

1. The patient must have a Body Mass Index (BMI) greater than or equal to 30 and have serious medical conditions, *and*
2. The patient must have remained "morbidly obese" for five consecutive years as documented in the patient's medical records, *and*
3. The patient must have a serious medical complication of obesity such as uncontrolled diabetes, uncontrolled hypertension, Pickwickian Syndrome (or hypoventilation), a reduced rate and depth of breathing, or crippling degenerative joint disease requiring a need for replacement of the hip or knee.

The Plan does not cover nutritional supplements, special food, liquid or powdered food supplements or over-the-counter weight loss medications.

Well-Child Care

For Dependent Children younger than age 7, routine examinations are paid as follows:

PPO Network: The Plan will pay 90% of the Contract Rate subject to a $20 co-payment per visit after satisfaction of the deductible.

PPO Non-Network: The Plan will pay 70% of Reasonable and Customary charges to a maximum payment of $15 after satisfaction of the deductible.

For Dependent Children age 7 or older, the Plan will pay according to the Plan's Routine Physical Exam benefit (see page 28).

See pages 26-27 for Covered Preventive Services, page 23 for the immunization benefit, and pages 45-46 for routine eye exams.

LiveHealth Online

LiveHealth Online is a program available to non-Medicare PPO Plan enrollees that allows you to visit with a doctor online 24 hours a day, 7 days a week, and 365 days a year with no deductible or co-payment. It is available anywhere you have a computer or mobile device with Internet access. This means you have immediate access to an Anthem Blue Cross network, board-certified doctor via webcam, chat or voice, at no cost to you without having to wait for an appointment or going to an Urgent Care Center or Hospital Emergency Room. In most states, LiveHealth Online doctors can prescribe medications using local pharmacies.

This program is available in all states except Arkansas and Texas.

LiveHealth Online is convenient, easy to use and secure. Simply log onto **www.livehealthonline.com** and follow the registration instructions. You will need your OEID number. You can then choose a doctor and begin your consultation.

LiveHealth Online does **not** include:

- Reporting normal lab or other test results
- Office visit appointment requests or changes
- Billing, coverage or payment questions
- Requests for referrals to other physicians or healthcare practitioners
- Benefit precertification's
- Consultations between physicians
- Consultations provided by telephone, electronic mail, or FAX

Women's Health and Cancer Rights Act (WHCRA)

Under the Women's Health and Cancer Rights Act of 1998, all plans like this one that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which the surgery was performed and surgery and reconstruction of the other breast to provide a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymph node edemas. These services are elective and are chosen by the patient in consultation with the attending physician. They are subject to the Plan's usual provisions regarding deductibles, benefit maximums, coinsurance and co-payments.

HOSPITAL BENEFITS

The following describes the hospital benefits provided to participants in the PPO plan. If you are enrolled in an HMO and are not a Medicare Retiree, please refer to pages 51-54. If you are a Medicare Retiree, please refer to pages 59-63.

Eligibility and Benefit Verification: When verification of benefits and/or eligibility is needed, your physician or hospital must contact the Fund Office Member Services Department at (866) 400-5200. No other entity can verify benefits and/or eligibility.

Inpatient Benefits

When you or an eligible Dependent are a registered hospital bed patient, the Fund provides the benefits outlined below. Payment is limited to the most common semi-private room rate, subject to the following:

PPO Network Hospital:

The Fund will pay 90% of the Contract Rate after satisfaction of the deductible (Deductible applicable to Non-Medicare Retirees only).

If either you or your Dependent is hospitalized at the time eligibility terminates, the Plan will continue to provide hospital benefits only until you or your dependent are discharged.

When you obtain care from a PPO network hospital, you simply tell the admitting/billing clerk that you are an Operating Engineers Health & Welfare Fund Participant and have Anthem Blue Cross. The hospital will submit the claim directly to Anthem Blue Cross for you.

PPO Non-Network Hospital:

The Fund will pay 70% of Reasonable and Customary charges after satisfaction of the deductible (deductible applicable to Non-Medicare Retirees only) for the first 180 days of confinement.

Pre-Admission Testing

If either you or your eligible Dependent is going to be admitted as an in-patient for non-emergency care, you should have as many of the tests required for admission performed on an outpatient basis before the hospital stay begins. Charges for these tests will be paid at 100% of the Contract Rate (PPO Network provider) or 100% of Reasonable and Customary charges (PPO Non-Network provider) after the deductible. Diagnostic testing is not included in this benefit.

Outpatient Emergency Care

If you do not become a registered bed patient and incur hospital charges in the Outpatient Department of a hospital for care that normally cannot be performed in a doctor's office or laboratory, the Plan will provide the following coverage:

If the treatment is related to an emergency medical condition (such as emergency treatment of broken bones, a severe laceration, chest pain, poisoning, choking or convulsions):

PPO Network Hospital: The Plan will pay 90% of the Contract Rate after satisfaction of the PPO Network deductible.

Non-PPO Hospital: The Plan will pay 90% of Reasonable and Customary charges after satisfaction of the PPO Non-Network deductible.

If the treatment is NOT related to an emergency medical condition (such as a sore throat, cold, flu, headaches, aches or pains and dizziness):

PPO Network Hospital: The Plan will pay 90% of the Contract Rate, subject to a $20 co-payment per visit, after satisfaction of the deductible.

Non-PPO Hospital: The Plan will pay a maximum of $15 for the emergency room visit after satisfaction of the deductible and 70% of Reasonable and Customary charges for any necessary testing, after satisfaction of the deductible.

Outpatient Surgery Facility

Ambulatory surgery is surgery that is done without staying overnight in the hospital. Ambulatory surgery may be done in the outpatient department of a hospital or in a special facility known as an "Ambulatory Surgery Center". Ambulatory Surgery Centers in the Anthem Blue Cross network can be found at www.anthem.com or by calling the Fund Office.

Skilled Nursing Facility

Confinement in a Skilled Nursing Facility is covered, but benefits are limited to a maximum of 100 days of confinement beginning with the first day of admission, and provided:

1. You must be confined in an acute general hospital for at least 3 consecutive days and then transferred to a Skilled Nursing Facility within 30 days.
2. Your doctor must certify that you need daily skilled nursing or rehabilitation services.

Skilled Nursing Facilities in the Anthem Blue Cross network can be found at www.anthem.com or by calling the Fund Office.

Hospital Expenses not covered by the Plan

Hospital benefits are **NOT** payable for:

1. Confinement as a result of a work related injury or illness.

2. Cosmetic surgery, except operations necessary to repair or alleviate disfigurement due to an accident or treatment of a congenital defect in a Dependent Child or for breast reconstruction following mastectomy.

3. Confinement in a hospital owned or operated by the U.S. Government, or with respect to court-ordered care, or any care for which you are not required to pay. Confinements at Veterans Administration hospitals are covered only if the charges are for a non-service related illness or injury.

4. Confinements in connection with the fitting or wearing of dentures or treatment of the teeth or gums, except tumors and treatment of accidental injury to natural teeth and fractures due to an accident occurring while covered by the Plan.

5. Personal items such as telephone or television charges, guest trays, personal care items, slippers, etc.

6. Private rooms. Benefits would be paid according to the hospital's most common semi-private rate.

7. Charges for tests related to elective surgery made by a hospital which are required for admission as a registered bed patient which can be performed on an outpatient basis, unless your attending physician or surgeon requires that such tests must be done on an inpatient basis.

8. Charges incurred at a hospital during a hospitalization for non-emergency elective surgery which are incurred prior to the date of surgery, except that if the attending physician or surgeon requires that pre-admission testing must be done as an inpatient then such tests and the day(s) required for such test will be considered a covered expense.

9. Confinements that begin prior to the effective date of eligibility.

10. Confinements in connection with artificial insemination, in-vitro fertilization (IVF), Zygote intrafallopian organ transfer (ZIFT), gamete intrafallopian transfer (GIFT), intracytoplamic sperm injection (ICSI), and similar procedures, or the reversal of elective sterilizations including drugs used to treat infertility.

11. Hospice care.

12. Custodial care or housekeeping care. Nursing homes are sometimes referred to as Skilled Nursing Facilities but they are not the same. Nursing homes provide long term nursing care for persons who are unable to care for themselves due to disability, senility, and/or old age. This is considered to be "custodial" care.

Audit of Hospital Charges

When you are hospitalized, you are urged to review the itemized bill provided by the hospital. If the hospital has charged for something that was not provided, you should contact the Fund Office immediately. If the error is verified by the Plan's hospital auditor, you will receive 50% of the amount saved by the Plan up to a maximum of $1,000.

MEDICAL AND HOSPITAL BENEFIT EXCLUSIONS

Benefits are **NOT** provided for:

1. Expenses in connection with an injury or sickness that arises from or is sustained in the course of any occupation or employment.
2. Medical services which are provided by family members. For example, if your brother is a doctor or dentist and provides services to you, the claim will be denied.
3. Cosmetic surgery, except operations necessary to repair or alleviate disfigurement due to an accident and except for treatment of a congenital defect in a Dependent Child or except for breast reconstruction following mastectomy.
4. Supplies or services (a) for which no charge is made; or (b) for which the person is not required to pay; or (c) furnished by a hospital or facility operated by the U. S. Government or any authorized agency of the U.S. Government or furnished at the expense of such Government or agency with the exception of Veterans Administration hospitals where the charges are for a non-service related illness or injury; or (d) which are provided without cost by any municipality, county, or other political subdivision; or (e) for court-ordered hospital care.
5. Drugs, drug treatments and medical procedures not approved by the Food and Drug Administration (FDA) including, but not limited to, compounded medications, experimental drugs or drugs exceeding the FDA's recommended daily dosage.
6. Expenses from injuries incurred in accidents involving a third party to the extent recovery is made.
7. Non-prescription medications or medical supplies (over the counter items) unless otherwise covered under the prescription drug benefit.
8. Services or supplies where no charge is made by the provider.
9. Charges in excess of the Reasonable and Customary charge, where applicable.
10. Charges for chelation therapy except in cases of acute arsenic, gold, mercury or lead poisoning.
11. Personal items while in the hospital.
12. Routine eye care for which benefits are provided through the Vision Service Plan.
13. Educational materials and home care instructions other than for diabetic training and home healthcare services.
14. Fees for filling out forms or copying medical records or fees for special reports.
15. Laser eye surgery unless you meet the Plan's laser surgery requirements.
16. Charges for the following orthotic items:
    - Pre-made, non-custom foot orthotics
    - Spinal pelvic stabilizers
    - Arch supports or heel wedges
    - Shoes unless attached to a brace or if needed due to the diagnosis of severe foot disease.
17. Any bodily injury or sickness for which you are not under the care of a doctor.
18. Conditions caused by or arising out of an act of war, armed invasion or aggression.
19. Human Chorionic Gonadotropins (hCG) injections.
20. Claims received over one year from the date the service was rendered.

21. Expenses incurred for artificial insemination, in-vitro fertilization (IVF), Zygote intrafallopian organ transfer (ZIFT), gamete intrafallopian transfer (GIFT), intracytoplasmic sperm injection (ICSI), and similar procedures, or treatment of infertility, including drugs used to treat infertility.
22. Weight control programs or surgeries that do not meet the Plan's requirements.
23. Liposuction.
24. B-12 injections for most diagnoses.
25. Charges not related to an illness or injury.
26. Hair loss treatment.
27. Ambulance transportation for the patient's convenience.
28. Educational programs or vision therapy to correct learning disabilities such as dyslexia and similar problems.
29. Chiropractic treatment for Dependent Children under 16 years of age.
30. Doctors' additional charge for "Sunday/Holiday" and "after hour" visits.
31. Expenses for a full body scan or a virtual colonoscopy.
32. Chemical skin peeling or other non-medically necessary skin treatments.

MEMBER ASSISTANCE PROGRAM (MAP)

Provided by Carelon Behavioral Health (CBH)

The Member Assistance Program is available to all Active and Non-Medicare Primary Retired Participants enrolled in the Operating Engineers PPO Plan and their household members (not restricted only to eligible dependents). The MAP is a free, confidential, professional consultation and referral program. This program is designed to help you and your household members address and resolve personal problems that may be interfering with work or home life. There are no costs to you for these services and counseling is provided for up to eight (8) sessions per issue/incident per eligible person, per year.

The Health & Welfare Fund has contracted with CBH to provide these professional services for you 24 hours a day, 7 days a week, 365 days a year. Information, guidance, or assistance can be obtained by calling: (866) 250-1555. These no-cost counseling sessions are only available through CBH.

When you call the Member Assistance Program, a trained intake specialist will assist you with obtaining services. They will provide you with names and telephone numbers for providers best suited to meet your needs. You must call the provider to set up an appointment and then call CBH back to obtain an authorization. Up to eight (8) counseling sessions authorized by CBH are provided for each situation for which you seek assistance. These sessions may include:

- Short-term counseling by a qualified specialist
- Face-to-face, telephonic or web video assessments
- Crisis intervention
- Community resources and affiliations referrals
- Family mediation services

Confidentiality

Your concerns are your own private business. Any personal information you may share with a MAP counselor is strictly confidential, and all member assistance communications are in accordance with legal requirements for confidentiality.

What problems can the MAP help with?

Just about anything. The MAP program particularly focuses on the following problems:

- Marriage, family and relationship issues
- Stress and anxiety
- Depression
- Grief and loss
- Anger Management
- Domestic Violence
- Alcohol and drug dependency
- Other emotional health issues

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Provided by Carelon Behavioral Health (CBH)

All mental health and substance abuse care, both inpatient and outpatient, is covered through CBH. There is no prior authorization requirement. Mental Health and substance abuse care are covered the same as all other medical care; 90% coverage when a CBH Network provider is used and 70% for non-Network providers after satisfaction of the deductible (See page 15).

If you are Admitted to a Hospital in an Emergency

If you are admitted to a hospital or treatment center in an emergency, you or someone acting on your behalf should notify CBH at (866) 250-1555 as soon as possible to ensure maximum beneftis and coverage are available to you.

Mental Health Benefits

- Outpatient visits are covered at 90% of the contracted rate, after a $20 co-payment for CBH participating providers, subject to the annual in-network deductible of $250. If you use mental health providers who are not contracted with CBH, the Plan pays a maximum benefit of $15 after satisfaction of the $500 non-network calendar year deductible.
- Inpatient care is covered at an approved mental health facility. When you obtain services from an CBH contracted provider, you pay only 10% of the contract rate and the in-network calendar year deductible applies. If you are admitted to a facility that is not contracted with CBH you must pay 30% of the Reasonable and Customary Charge plus any amount that exceeds the Reasonable and Customary Charge, as determined by CBH. The non-network calendar year deductible also applies.

Substance Abuse Benefits

- Outpatient (including detoxification) visits are covered at 90% of the contracted rate, after a $20 co-payment for CBH participating providers, subject to the annual in-network deductible of $250. If you use providers who are not contracted with CBH, the Plan pays a maximum benefit of $15 after satisfaction of the $500 non-network calendar year deductible.
- Inpatient treatment (including detoxification and residential treatment) is covered at an approved substance abuse treatment facility. When you obtain services from an CBH contracted provider, you pay only 10% of the contract rate and the in-network calendar year deductible applies. If you are admitted to a facility that is not contracted with CBH, you must pay 30% of the Reasonable and Customary Charge plus any amount that exceeds the Reasonable and Customary Charge, as determined by CBH. The non-network calendar year deductible also applies.
- Alternate Levels of Care: (including partial hospitalization, day, and intensive outpatient treatment). Alternate levels of care are covered at an approved facility. When you obtain services from an CBH contracted provider, you pay 10% of the contract rate and the calendar year deductible applies. If you are admitted to a facility that is not contracted with CBH you must pay 30% of the Reasonable and Customary Charge plus any amount that exceeds the Reasonable and Customary Charge, as determined by CBH. The non-network calendar year deductible also applies.

Exclusions and Limitations

No benefits are payable for:

- Treatment of intellectual disability, developmental or learning disabilities other than the initial diagnosis;
- Court-ordered testing, counseling and treatment, including detention under Welfare and Institutional Code, Section 5150;
- Ancillary services such as psychological testing, neuropsychiatric testing, vocational rehabilitation, behavioral training, sleep therapy, speech therapy, employment counseling, training or educational therapy for learning disabilities or other education services;
- Services, treatment or supplies which are not Medically Necessary or Clinically Appropriate, such as those primarily for rest, custodial care, Domiciliary Care or convalescent care;
- Charges for smoking cessation or weight loss programs (however, there is coverage for smoking cessation treatments under the Comprehensive Medical Plan and prescription drug program);
- Services, treatment or supplies provided as a result of any Workers' Compensation law or similar legislation or obtained through or required by any governmental agency or program, whether federal, state or any subdivision thereof (exclusive of Medi-Cal); or
- Benefits, services, treatment or supplies that exceed the maximums allowed by the Fund.
- Out-patient laboratory services (however, there is coverage under the Comprehensive Medical Plan under the standard in-network and out-of network benefit structures)

Definitions

For purposes of this section:

- Domiciliary Care means inpatient institutional care provided not because it is Medically Necessary but because care in the home setting is not available, is unsuitable or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

- Clinically Appropriate means that the health care services, treatment or supplies meet all of the following conditions:
  - Are rendered for the purpose of diagnosis or treatment of a mental disorder or chemical dependency;
  - Are non-experimental treatments that can be reasonably expected to improve the patient's condition or level of functioning;
  - Are not mainly for the convenience of the patient or the patient's health care provider;
  - Are rendered in an environment in which services are performed at the least restrictive level of care providing effective treatment;
  - Are "appropriate," that is: (a) consistent with the symptoms and diagnosis; (b) the type, level, length and setting to provide safe and adequate care and treatment; and (c) in keeping with generally accepted standards for good medical practice within the organized medical community. Hospital care is provided when safe and adequate care cannot be received on an outpatient basis or in a less restrictive setting. Professional services must be by a licensed or certified professional acting within the permissible scope of his license and within the rules and regulations of any supervising professional organization.

Rights and Responsibilities

Dignity and Respect

You have the right to be treated with consideration, dignity and respect and the responsibility to respect the rights, property, and environment of all providers and other health care professionals, Employees and other patients. You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained. You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational, or religious background.

Member Accountability/Autonomy

As a partner in your own health care, you have the right to refuse treatment providing you accept responsibility and the consequences of such a decision and the right to refuse to participate in any medical research projects. You also have the responsibility to:

- Identify yourself as an CBH member when receiving services.
- Provide your current CBH contracted provider with previous treatment records, if requested, as well as provide accurate and complete medical information to CBH and any other health care professionals involved in the course of your treatment.
- Be on time for all appointments and notify your provider's office as far in advance as possible if you need to cancel or reschedule an appointment.
- You have the right at any and all times to contact CBH for assistance with issues regarding your behavioral health plan. It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

Filing a Claim

CBH and your care providers and facilities take care of claim forms when you receive services from CBH providers. Payment is made directly to the provider. If you received approved services from a provider who is not contracted with CBH, you will need to file your claims directly with CBH.

Appeals and Grievances

To submit an appeal or grievance, call Carelon Behavioral Health's Customer Service line at (866) 250-1555 or write to:

Carelon Behavioral Health
Attn: Appeals
PO Box 1850
Hicksville, NY 11802-1850

By calling the Customer Service number listed above or submitting a request in writing, you can also: (1) Request additional information and (2) Find out more about the appeal rights for your benefit plan. If you request an appeal, you or your representative may submit any additional information you would like Carelon Behavioral Health to consider their decision.

Carelon Behavioral Health will notify you, or your representative, of the information needed to decide the appeal. Please note that a request for appeal is not considered complete until all necessary information has been received, at a minimum, the name of the patient for whom a denial is being appealed or a valid member number for the patient, and the dates for which a denial is being appealed. Carelon Behavioral Health must receive your appeal request within 180 days from the date of your Explanation of Benefits notice. Appeal decisions are made within thirty (30) calendar days. You may also have the right to challenge this adverse benefit determination on review by bringing a civil action under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). This act governs health benefits that are obtained through some non-government employers.

PRESCRIPTION DRUG BENEFIT

The Plan's prescription drug benefit is administered by CVS Caremark. Participants and their Eligible Dependents are eligible for these benefits, except for those enrolled in an HMO (see page 54), Plan M and Medicare Retirees enrolled in a Medicare Advantage Plan (see pages 59-63).

In general, all medically or dentally necessary FDA approved drugs will be covered under the Plan. However, the Trustees will review all requests for newly approved drugs.

You may obtain your prescriptions through either a retail (walk-in) pharmacy or through mail order (home delivery). If you do not use a CVS Caremark Network pharmacy, you have only limited benefits which are reimbursed at a lower amount as outlined below.

Most of your prescriptions can be filled without prior authorization by the Fund Office at a retail pharmacy. However, some drugs are only covered for certain uses or in certain quantities. If you present a prescription to the pharmacy which requires prior authorization, your doctor may need to provide additional information before your prescription is covered. You can call the Fund Office at (866) 400-5200 to determine if your prescription requires prior authorization.

The Plan's benefits are as follows:

	Retail Co-payment	Mail Order Co-payment
Tier 1: Generic Drugs	$10 per 30-day supply **	$25 per 90-day supply
Tier 2: Preferred Brand Drugs*	$25 per 30-day supply **	$62.50 per 90-day supply
Tier 3: Non-Preferred Brand Drugs*	$40 per 30-day supply **	$100 per 90-day supply

*When a generic drug is available but the pharmacy dispenses the brand-name drug for any reason, you will pay the applicable co-payment **plus 50%** of the difference in cost between the brand and the generic.

**You can receive a 90-day supply of maintenance type medications directly from your CVS Caremark Network pharmacy at the lower, mail order co-pays.

Special Reimbursement Limits

- **Sleep Aids**. The maximum reimbursement for all prescription sleep aid medications is limited to $30 for a 30-day supply.
- **Ulcer Drugs (PPIs).** The maximum reimbursement for PPI medications is limited to $30 for a 30-day supply.

Immunization Service

As approved by the FDA the following routine vaccinations are available with no co-payment at local CVS Caremark Network pharmacies:

- Seasonal Influenza
- Zoster (shingles)
- Tetanus, Diphtheria Toxoids, Pertussis
- Hepatitis A & B
- Measles, Mumps, Rubella, Varicella
- Pneumococcal (pneumonia)
- Human Papillomavirus
- Meningococcal
- COVID-19

CVS Caremark Retail Benefit

To use the CVS Caremark retail pharmacy benefit, simply provide your CVS Caremark or OE Health & Welfare Fund ID card along with your prescription to any participating pharmacy. Major pharmacy chains are participating pharmacies as well as many of the independent pharmacies. You will only be charged the co-payment listed on the previous page. There are no claim forms to file.

If the pharmacist cannot determine your eligibility or has questions regarding your prescription, the pharmacist will call CVS Caremark or the Fund Office for authorization. If this occurs after business hours, you may have to return to the pharmacy for your prescription.

To locate a Network pharmacy near your home, workplace or while on vacation, call (833) 266-8149 or visit www.caremark.com.

The Retail Plan generally covers a 30-day supply of your prescription, provided your doctor prescribed that amount, with the following exceptions:

- You can receive up to a 90-day supply of maintenance type medications at a local CVS Caremark network pharmacy and at the lower Mail Order co-pays.
- You can receive more than a 30-day supply if you need several months of your prescription while you are on vacation. You must contact the Fund Office for pre-authorization at (866) 400-5200.

Maintenance-Type Medications

Participants and their covered dependents who take medications for chronic conditions, such as high blood pressure, high cholesterol or diabetes, can obtain 90-day supplies of medications resulting in lower co-pays and greater convenience.

Your physician will have to write a prescription for a 90-day supply and it can be filled in one of two ways:

CVS Caremark Network Pharmacy Maintenance Program

You can obtain up to a 90-day supply at any CVS Caremark network retail pharmacy nationwide.

CVS Caremark Mail Order Maintenance Medication Program

Mail order service is available nationwide and is generally used for participants who use maintenance-type drugs.

Mail Order Prescription

By using CVS Caremark's Mail Service Pharmacy, you can have prescriptions delivered to your home. To start filing your medications by mail, you can ask your doctor to send an electronic prescription to CVS Caremark Mail Service Pharmacy or have CVS Caremark contact your doctor and get the process started for you. You can expect to receive your prescriptions within 7 to 10 business days.

Up to a 90-day supply will be sent based on the amount your doctor prescribed. By law, CVS Caremark must fill your prescription for the exact quantity prescribed by your doctor, up to the 90-day limit. For example, if your prescription states:"30 days plus two refills," the pharmacy will only dispense a 30 day supply on your first order, not a 90 day supply. You can only get a 90 day supply on the first order if the prescription states you may have a 90 day supply initially.

Mail Order Refills. You can order your refill(s) by internet or phone. The information included in your last order will show the date you can request a refill and the number of refills you have left.

1. **Internet:** This is the most convenient way to order refills and inquire about the status of your order any time of the day or night. You will need to register and log in to access service by going to www.caremark.com.
2. **Phone:** Call toll-free (833) 266-8149 24 hours a day, 7 days a week for the CVS Caremark refill phone service. Have your Social Security number or OEID number ready. For Participants who are hearing impaired, CVS Caremark supports TTY service to make ordering by telephone easy. To access this service, call TTY 711.

Transform Diabetes Care

Available with CVS Caremark, Transform Diabetes Care is a personalized program that can help make it easier to keep your diabetes and other conditions in check. Managing diabetes can be complex. Achieving and maintaining one's best health for this chronic condition, which causes higher than normal blood sugar levels, depends on a person's ability to monitor symptoms, manage complicated medication regimens, control blood glucose and practice healthy behaviors. This comprehensive program will be available at no cost to all eligible members, including Medicare eligible and non-Medicare eligible retirees and their dependents who are enrolled in the Fund's PPO Plan.

As a member of the program, you'll have access to:

- Two MinuteClinic® vouchers for in-person or virtual visits
- Access to the Health Optimizer™ app to help manage your condition
- Health resources, virtual care visits and more – all at no extra cost to you

Those who qualify for the Transform Diabetes Care program will receive a Welcome Letter in the mail which will include information about the program along with instructions on how to utilize the health tools which keep track of your progress and help reach your wellness goals.

This program is voluntary. You can opt out anytime by calling the Transform Diabetes Care team at (800) 348-5238.

For those who do not participate in the Transform Diabetes Care program, diabetic supplies will continue to be available through CVS Caremark's prescription drug program with the regular co-pays.

Over-the-Counter Birth Control

As approved by the FDA, over-the-counter birth control is available with $0 copay when filled at an CVS Caremark network pharmacy and prescribed by a physician. You will be responsible for the full cost of the drug medication if not purchased at a CVS Caremark network pharmacy and/or if it is not prescribed.

Non-Network Benefits

You have the option to go to any drug store of your choice to obtain your prescription on a limited basis. You may have to pay the entire cost of the prescription when you obtain it. You must then submit your claim for reimbursement, to the Fund Office, using a form available for printing at www.oefi.org or from the Fund Office.

The Plan will pay 80% of the Reasonable and Customary charge after satisfaction of the PPO Non- Network deductible. Reimbursement is limited to a maximum of 60 days for any one individual drug. Once you have obtained a 60-day supply, you must use a CVS Caremark Network pharmacy for additional refills. Continued purchases outside of a CVS Caremark Network pharmacy will be denied.

HMO Enrollees

If you are enrolled in an HMO, your prescription drugs must be obtained through your HMO.

Drug Expenses Not Covered

1. Drugs or medications not requiring a physician's or dentist's prescription. This would include any medication which can be purchased "over the counter."
2. "Over the counter" vitamins. If your doctor prescribes a vitamin which cannot be purchased over the counter, you may obtain the vitamin through the CVS Caremark Plan.
3. Bandages, heat lamps, splints, wrist supports, non-drug items (over the counter items).
4. Drugs or drug treatments not approved by the FDA, including those deemed experimental or investigational.
5. Retin-A, unless used in the treatment of acne or skin cancer.
6. Minoxidill, Rogaine, and any other hair growth treatment.
7. Drugs used in the treatment of infertility.
8. Homeopathic or holistic medications and herbal remedies. Homeopathic treatment is covered by the Plan only in the State of Nevada.
9. Unit dose drugs.
10. Nutritional dietary drugs.
11. Asthma and diabetic supplies for Medicare members except when a balance remains after the Medicare payment.
12. Miscellaneous over the counter medical supplies, including but not limited to such items as diapers, Band-Aids, and Ace bandages.
13. Liquid or powdered food supplements not requiring a prescription.
14. ED (erectile dysfunction) drugs such as Viagra and Levitra are limited to 8 pills per month if determined to be medically necessary. This means that the dysfunction must be caused by a physiological condition such as heart disease or prostate conditions, as certified in writing by the prescribing physician.
15. Compounded medications with the exception of compound liquid medications for eligible children age 5 and younger.

Appeals

If your claim for prescription drugs has been denied in whole or in part, you have the right to appeal. The following provides an overview of the CVS Caremark appeals process.

- Letters notifying the member or their representative of a prior authorization denial will include the appeals contact information.
- Once a member or a member's representative contacts CVS Caremark with a request to appeal, that individual is instructed on how to submit an appeal.
- You can submit an appeal online, via fax, or by telephone (for urgent appeals).
    - **Pre-Authorization Review** – CVS Caremark will make a decision on a prior authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim as soon as possible, but not later than 72 hours.
    - **Coverage Determination Review** – CVS Caremark will make a decision on a Coverage Determination within 15 days after it receives such a request. If the member is requesting the Coverage Determination of an Urgent Care Claim, a decision on such request will be made as soon as possible, but not later than 72 hours.
    - **Post-Service Review** – CVS Caremark will make a decision on a Post-Service Claim within 30 days after it receives such a request.
- Reviews of appeals are performed based on the Trust Fund's prescription benefit plan and approved prior authorization criteria. All appeals for prior authorization denials are reviewed by a registered pharmacist.
- A letter is sent to the member or their representative and/or the member's physician notifying them of the appeal decision and the next step in the appeals process, if another level is offered.

The review process includes the consideration of relevant and supporting documentation submitted by and for the claimant. Supporting documentation may include a letter written by the practitioner (physician) in support of the appeal, a copy of the denial letter sent by CVS Caremark a copy of the member's payment receipt, medical records, etc. All information received is handled in compliance with HIPAA regulations.

PrudentRx Solution for Specialty Medications

Operating Engineers Health and Welfare Fund has contracted with PrudentRx Solution to help provide a comprehensive and cost-effective prescription drug program for you and your family for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List* are included in the program and will be subject to a 30% co-insurance unless you are participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for your specialty medication.

IMPORTANT: You will have a $0 out-of-pocket responsibility for your specialty medications covered under the PrudentRx Solution if you are enrolled in an available manufacturer copay assistance program for those specialty medications.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible specialty medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with the privacy rules of HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a Welcome Letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication(s). All eligible members must call PrudentRx at (800) 578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call, PrudentRx will conduct outreach to help you with questions and enrollment. If you choose not to participate in the PrudentRx Solution, you must call (800) 578-4403 3 to opt-out of the program. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx. If you don't contact PrudentRx, they will proactively contact you to ensure you can take full advantage of the PrudentRx Solution.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your out-of-pocket maximum with the Plan, unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your deductible or out-of-pocket maximum (if any), unless otherwise required by law.

A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available from the Fund Office. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

If you have any questions regarding the PrudentRx Solution, please call (800) 578-4403.

*The PrudentRx Program Drug List may be updated periodically.

Rules for All Participants except Medicare Retirees Enrolled in a Medicare Advantage PPO or HMO Plan

The prescription drug coverage under the Operating Engineers Health and Welfare is as good as or better than the standard Medicare prescription drug coverage. **You do not have to enroll in a Medicare Part D plan.** You may enroll in a Medicare Part D plan in the future during the annual enrollment period and you will not be charged a late enrollment penalty if you follow Medicare's rules when you apply and if you apply timely according to those Medicare rules.

You can keep your current prescription drug coverage under the Plan and enroll in one of the Medicare Part D plans. The Active Plan coverage is primary to Medicare and the Retiree Plan coverage is secondary to Medicare. You will have to pay the Medicare Part D premium out of your own pocket. If you have Retiree Plan coverage, you are legally obligated to provide your Part D plan with information on the benefits you receive from this Plan.

Rules for Medicare Retirees Enrolled in a Medicare Advantage PPO or HMO Plan

Your prescription drug coverage is provided under the Medicare Advantage Plan in which you are enrolled.

Rules for Participants Enrolled in Plan M

Because your prescription drug coverage under Plan M is not, on average, as good as the standard Medicare Part D plans, you should consider whether to enroll in a Medicare Part D plan. Because your Plan M coverage is not creditable, if you do not enroll in a Part D plan before December 31st, you may have a late enrollment penalty on the premium you pay for that Medicare coverage.

You should consider enrolling in a Medicare Advantage Plan. You should compare information about your current prescription drug coverage and the drug coverage under Medicare Part D plans, such as monthly premiums, the covered and non-covered drugs, the deductible and co-payments or coinsurance, mail order service and retail pharmacy locations.

More Information about Medicare Part D

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook that you receive from Medicare. You can also get more information about Medicare Part D plans from the following places:

1. Visit www.medicare.gov.
2. Call your State Health Insurance Assistance Program (see your copy of "Medicare & You" for the telephone number).
3. Call Medicare at (800) 633-4227. TTY users should call (777) 486-2048.

For individuals with limited income and resources, extra help paying for a Medicare Part D plan is available. Information about this extra help is available from the Social Security Administration at www.socialsecurity.gov, or by phone at (800) 777-1213 (TTY 800-325-0778).

VISION CARE BENEFITS

The Fund contracts with Vision Service Plan (VSP) to offer vision benefits to all Participants and their Eligible Dependents except for those enrolled in the COBRA Core Plan, Plan M and Medicare Retirees enrolled in a Medicare Advantage Plan (see page 59).

How to Use the Benefit

1. Locate a VSP doctor by calling (800) 877-7195 to request a list of participating doctors or by visiting the VSP website at www.vsp.com.
2. Call the doctor of your choice and make an appointment. Identify yourself as a VSP member through Operating Engineers Health and Welfare Fund.
3. At your appointment, pay only the deductible for the covered services. VSP will pay the doctor directly for the balance of the charges.

Benefits Through VSP

Service	Deductible or Co-Pay	Limitations
Eye Examination	$15 deductible	Once every 12 months
Lenses and Frames	$25 deductible	Once every 24 months
Second Pair of Lenses and Frames	$65 co-pay	Once every 24 months for Employee only

Vision exams include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

Lenses will be ordered by the VSP doctor only if needed.

Extra Costs

The Plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following and your VSP doctor does not receive prior authorization, there will be an extra charge: oversize lenses, coated lenses, contact lenses, blended lenses, multi-focal plastic lenses, or a frame that is more than the Plan allowance. There is a 20% discount on the overage amount.

Contact lenses are covered when the VSP doctor secures prior approval for the conditions listed below. If the VSP doctor receives approval, the lenses are fully covered by VSP.

- Following cataract surgery
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
- Anisometropia
- Keratoconus

Using a doctor from the VSP list assures direct payment to the doctor and a guarantee of quality. If you use a non-VSP doctor, you must pay the doctor the full fee, obtain an itemized bill from your doctor and submit the bill to VSP, along with a VSP benefit form (available from VSP). You will be reimbursed by VSP in accordance with the reimbursement schedule below after satisfaction of the deductibles. There is no guarantee that the schedule will be sufficient to cover the cost of the services and supplies provided.

Service or Supply	Amount Payable
Vision Exam	$40
Single Lenses	Up to $40
Bifocal Lenses	Up to $60
Trifocal Lenses	Up to $80
Lenticular Lenses	Up to $125
Frames	Up to $45
Contact Lenses (necessary)	$250 in lieu of other Plan benefits
Contact Lenses (elective)	$150 in lieu of other Plan benefits

Eye Surgeries

Cataract Surgery. In addition to the normal surgical benefits, you may also be eligible for eye glasses at the time of surgery through VSP.

Laser Eye Surgery. The Plan will provide benefits for laser eye surgery only if the surgery on either eye or both eyes is medically necessary to correct severe progressive myopia involving refractive errors of negative 5 or greater. This benefit is subject to a lifetime maximum of $3,500. Covered laser surgeries include laser-assisted in situ keratomileusis (LASIK), laser epithelial keratomileusis (LASEK), and photoreactive keratectomy (PRK).

VSP offers discounts on laser eye surgeries that may not otherwise qualify for coverage. Contact VSP for details.

DENTAL BENEFITS

Eligibility

- Active and Retired Participants and Dependents who are eligible for the medical and hospital benefits.
- COBRA Participants who elect and pay for it.

30-Day Extended Eligibility

If you or your Dependents lose eligibility under the Operating Engineers Health & Welfare Plan, the Fund will continue to provide benefits for completing procedures which were actually in progress at the time eligibility terminated, but not beyond 30 days following the loss of eligibility.

For example, if your eligibility terminates before dental work for prosthetic procedures (including bridges and crowns) has been completed, benefits will be provided if the impressions were made while you were eligible and the prosthetic appliance, bridge or crown is installed or delivered within 30 days after eligibility terminates.

The 30-day extension does not apply if the only work completed when eligibility terminated was prophylaxis and X-Rays.

Dental Plan Options

The Plan offers the following five dental options:

PPO Plan: Eligible Participants are automatically covered by this Plan unless they elect one of the other options. Benefits are administered by the Fund. Participants may use any dentist they choose. However, benefits will be higher and out-of-pocket costs lower when a PPO network dentist is used. A list of PPO network dentists is available from the Fund Office or on the Plan's website at www.oefi.org.

United Concordia Preferred Plan (DPPO): All eligible Participants may elect this Plan which is administered by United Concordia. Participants must use one of the over 45,000 dentists and specialists in the nationwide United Concordia Advantage network. The list of network dentists is available by calling (800) 332-0366 or on United Concordia's website at www.unitedconcordia.com under "Concordia Preferred Network".

United Concordia Plus Plan (DHMO): This option is available ***only to California residents***. Eligible Participants must pre-select a dental office to provide all dental care. The list of over 1,200 DHMO offices is available by calling (800) 357-3304 or on United Concordia's website at www.unitedconcordia.com under "DHMO Concordia Plus."

Delta Dental PMI (DHMO) This option is administered by Delta Dental. Eligible Participants must pre-select a primary dental office to provide all dental care. The list of over 5,000 offices in California and Nevada is available from the Delta Dental website at www.deltadental.com under "Find a Dentist".

Western Dental (DHMO): This option is currently available ***only to California residents***. Eligible Participants must pre-select a dental office to provide all dental care. This list of over 3,400 DHMO offices is available by calling (800) 992-3366, or on Western Dental's website at www.mibbenefitplans.com/operating-engineers-union using Plan Type "8000C3".

Dental Benefits

	PPO Network	PPO Non-Network	United Concordia Preferred	United Concordia Plus	Delta Dental PMI	Operating Engineers Western Dental
Deductible	$25 per person per calendar year, $75 per family per calendar year	$25 per person per calendar year, $75 per family per calendar year	In Network: $25 per person per calendar year, $75 per family per calendar year Out of Network: $100 per person per calendar year, $300 per family per calendar year	No deductible	No deductible	No deductible
Coverage	The Plan pays 100% of the Contracted Amount	The Plan pays 100% of the non-contract fee schedule (approximately 50% of charges)	Th Plan pays 100% for network Dentists The Plan pays 50% for non-network Dentists	The Plan pays 100% of most covered services	The Plan pays 100% of most covered services	The Plan pays 100% of most covered services
Dental Maximum	Adult (19 years of age and older): $6,200 in any two consecutive calendar year period*	Adult (19 years of age and older): $6,200 in any two consecutive calendar year period*	$3,000 per person per year in network $1,000 per person, per year out of network	No maximum	No maximum	No maximum
Orthodontia **Must be provided by a Board eligible orthodontist**	The Plan pays 50% of charges up to lifetime maximum $3,000 lifetime maximum* Treatment cost limited to $6,000 Coverage available only to dependent children	The Plan pays 50% of charges up to lifetime maximum $3,000 lifetime maximum* No limitation on treatment cost Coverage available only to dependent children	The Plan pays 50% up to lifetime maximum $2,000 lifetime maximum Coverage available only to dependent children	Refer to the Plan Schedule of Benefits from Fund Office No calendar year maximum Coverage available to dependent children and adults	Refer to the Plan Schedule of Benefits from Fund Office No calendar year maximum Coverage available to dependent children and adults	Refer to the Plan Schedule of Benefits (available from the Fund Office) for specific coverage and copay amounts Coverage available to dependent children and adults

*Effective June 1, 2017

The following Limitations and Exclusions apply to the Fund's PPO Plan.

Limitations

The following are some of the PPO Plan's dental limitations:

1. Sealants are covered only for children under age 14.
2. Removable partials, fixed bridgework, porcelain, porcelain fused to metal and cast metal crowns are not covered for children under 16 years of age.
3. Prosthetic appliances (dentures, partials, fixed bridgework, crowns) are covered only once every two (2) years.
4. Prophylaxis (cleaning) is covered only once every six months.
5. Fluoride treatment is covered only for persons under age 19 and is limited to once every six months.
6. Replacement of amalgam, silicate or plastic fillings is limited to one replacement per year.
7. Post-operative X-Rays are required for all root canal therapy.
8. Root canal therapy is not covered if the canals are not filled to the apices of the teeth.
9. The fee allowed for a partial denture includes all teeth and clasps. Removable cast partial dentures for eligible individuals under age 16 must be approved by the Fund based on a written report from a dentist.
10. Fixed bridges are not covered for patients under age 16 (except in special cases approved by the Fund Office).
11. Replacement of a second or third molar is not generally covered unless as part of a bridge restoring other missing teeth.
12. Where a large number of teeth are missing in the same arch and moderate to advanced periodontal bone loss is evident radiographically, fixed prostheses are not a covered benefit, except in special circumstances approved by the Fund Office and by report.
13. Jackets, crowns, inlays, onlays, and fixed bridges are a covered benefit only once in any two (2) year period unless the need for replacement is approved in advance by the Fund Office.
14. Routine post-operative visits are considered part of, and included in, the fee for the total surgical procedure.

Exclusions

Expenses Not Covered

Dental benefits are **NOT** payable for:

1. Orthodontic treatment for adults unless approved in advance by the Fund's Dental Consultant.
2. Congenital malformations (covered under Medical Plan).
3. Services purely cosmetic in nature (such as bleaching or whitening).
4. Fees for instruction in personal oral hygiene, dietary planning or prevention.
5. Services provided by a "denturist" except in Idaho, Maine, Montana, Oregon and Washington.
6. Pulp caps.
7. Experimental procedures.
8. Procedures associated with overlays.
9. Charges for the completion of dental claim forms.
10. Replacement of lost or stolen dentures or partials.

Dental benefits are **NOT** payable for (cont):

11. Services provided by any person who is the spouse, parent, child, brother or sister of the eligible employee or Dependent.
12. Premedication and analgesia (nitrous oxide), except for documented handicapped or uncontrollable patients.
13. Orthodontics if provided by someone other than a Board eligible orthodontist.
14. Study models, except as part of orthodontic treatment where covered.
15. X-Rays that are unreadable or not diagnostically acceptable.
16. Hospitalization for dental treatment unless medical necessity is established.
17. Unilateral removable bridges.
18. Implants must be pre-authorized.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Kaiser, Anthem Blue Cross and Health Plan of Nevada

Eligible Employees living within certain areas may choose to enroll and be covered by an HMO instead of the PPO medical and hospital plan. The Kaiser and Anthem Blue Cross Plans are available only to Active Participants and non-Medicare Retired Participants. Health Plan of Nevada is available to all Active and Retired Participants residing in Nevada.

Employees may enroll upon becoming eligible and at the beginning of each calendar month. The following HMOs are offered by the Fund:

HMO	Eligible Employees	Conversion Information*	Contact for Questions
Kaiser Permanente Health Plan	Residents of areas where Kaiser facilities exist	Kaiser Membership Services (800) 464-4000	Kaiser Membership Services (800) 464-4000
Anthem Blue Cross	Residents of areas where Anthem Blue Cross facilities exist	Anthem Blue Cross (800) 522-0088	Anthem Blue Cross (800) 522-0088
Health Plan of Nevada	Residents of Nevada	HPN Membership Services Department (800) 777-1840	HPN Membership Services Department (800) 777-1840

*If coverage stops for you or any of your covered dependents because of loss of eligibility, you and/or your dependents may enroll in the HMO's conversion plan.

HMO Rules

1. If you want to be covered by one of these HMOs, you must complete the appropriate enrollment form and submit it to the Fund Office. For information and forms, contact the Fund Office.
2. If you have an existing overpayment with the Fund, you cannot enroll in an HMO. The Fund will have to recover the overpayment in full from you before your HMO enrollment can be accepted.
3. Continued enrollment in an HMO depends on continued eligibility in the Health and Welfare Plan. If you lose eligibility, you must re-enroll in the HMO when you regain eligibility. **Re-enrollment after loss of eligibility is not automatic.**

With the exception of the COBRA Core Plan, you and your family will continue to be covered under the Fund's Life Insurance (Active Employees only), vision care, Accidental Death & Dismemberment (Active Employees only), dental benefits and hearing aid programs regardless of which Health Plan option you choose.

FOLLOWING IS A BRIEF DESCRIPTION OF THE BENEFITS AVAILABLE UNDER THE HMO PLANS. PLEASE REFER TO EACH PLAN'S BROCHURE FOR A COMPLETE BENEFIT DESCRIPTION AS WELL AS THEIR PLAN EXCLUSIONS AND LIMITATIONS. A COPY OF THIS MATERIAL IS AVAILABLE FROM THE FUND OFFICE OR THE HMO DIRECTLY.

OPERATING ENGINEERS HEALTH & WELFARE FUND
HMO BENEFIT SUMMARY

	Kaiser Plan	Anthem Blue Cross Plan	Health Plan of Nevada
Deductible	None	None	None
Calendar Year Maximum	None	None	None
Annual Out-of-Pocket Maximum	$1,500 per person $3,000 for two or more family members	$1,500 per person $3,000 for two family members $4,500 for three or more family members	$6,000 per person $12,000 per family
PROFESSIONAL SERVICES:			
Office Visits	$25 co-pay per visit	$25 co-pay per visit	$5 co-pay per visit
Hospital Visits	$250 co-pay per admission	$250 co-pay per admission	Inpatient - $300 co-pay per admission Outpatient-$200 co-pay per surgery
Lab and X-Ray	$10 co-pay per service	No Charge	$5 co-pay per service (lab) $10 per service (x-ray)
Alternative Therapy– Acupuncture, Biofeedback, Chiropractic, Physical Therapy (PT)	$25 co-pay per visit (see Kaiser's Summary of Benefits for details)	$25 co-pay per visit	$5 co-pay per visit for PT and chiropractic (see HP of Nevada's Summary of Benefits for details)
Speech Therapy	$25 co-pay per visit		$5 co-pay per visit
Routine Physicals	$25 co-pay per visit	$25 co-pay per visit	$5 co-pay per visit
Surgeon	No charge	No charge	$100 per surgery (hospital) $50 per surgery (surgical facility)
Assistant Surgeon	No charge	No charge	No charge
Anesthetis	No charge	$35 co-pay per occurrence	$100 co-pay per surgery
Urgent Care Services	$25 co-pay per visit	$35 co-pay per visit	$20 co-pay per visit

	Kaiser Plan	Anthem Blue Cross Plan	Health Plan of Nevada
HOSPITAL SERVICES:			
Inpatient Care Semi-private Room and Misc. Charges	$250 co-pay per admission	$250 co-pay per admission	$300 co-pay per admission
Outpatient Care Emergency Room Care Surgical Facility	$100 co-pay per visit; waived if admitted $250 co-pay per occurrence	$100 co-pay per visit; waived if admitted $250 co-pay per occurrence	$150 co-pay per visit; waived if admitted $50 co-pay per surgery
Inpatient Psychiatric Care	$250 co-pay per admission	$250 co-pay per admission	$300 co-pay per admission
Inpatient Alcohol and Substance Abuse Care	$250 co-pay per admission for detoxification $100 co-pay per admission for transitional residential recovery services Maximum of 60 days per calendar year, not to exceed 120 days in any 5-year period	$250 co-pay per admission for detoxification only	$300 co-pay per admission
Skilled Nursing Facility	Maximum of 100 days per benefit period (2/1-1/31)	$250 co-pay per admission Maximum of 100 days per calendar year	$300 co-pay per admission; waived if admitted from an acute care facility Maximum of 100 days per calendar year
OTHER SERVICES:			
Ambulance	$50 co-pay per trip	$50 co-pay per trip	$150 co-pay per trip
Hearing Aids	Not covered	Not covered	$0 co-pay
Durable Medical Equipment	No charge, including diabetic testing supplies	No charge	$0 co-pay subject to maximum

	Kaiser Plan	Anthem Blue Cross Plan	Health Plan of Nevada
Prosthetic Appliances	No charge	No charge	$750 co-pay per device; subject to maximum benefit
PRESCRIPTION DRUGS:			
Contract Prescription Card **Walk-in (30 day supply)**	For generic drugs at Kaiser pharmacies, you pay $10 for up to a 31 day supply, $20 for a 100 day supply For brand name drugs at plan pharmacies, you pay $25 for up to a 31 day supply, $50 for a 100 day supply	At contract pharmacies you pay $10 for a generic drug on the Anthem Blue Cross recommended drug list (RDL). For a RDL brand name drug you pay $30. For a drug not listed on the RDL you pay 50% of the drug cost	At contract pharmacies you pay $7 for a Tier I drug For a Tier II drug with NO generic equivalent you pay $30 For a Tier III drug you pay $50 per prescription
Mail Order (90 day supply)	For generic drugs you pay $10 for up to a 30 day supply or $20 for a 31 to 100 day supply	You pay twice the applicable co-pay as outlined above	You pay 2.5 times the applicable co-pay as outlined above
VISION CARE:			
Eye Examination	$25 co-pay per visit	$25 co-pay per visit	Through **Vision Service Plan (VSP)**
Eye Lenses/Frames	Through **Vision Service Plan (VSP)** $25 co-pay Lenses covered once every 24 months Frames covered once every 24 months For the Member Only: Extra pair of glasses or lenses every 24 months for a $65 co-pay	Through **Vision Service Plan (VSP)** $25 co-pay Lenses covered once every 24 months Frames covered once every 24 months For the Member Only: Extra pair of glasses or lenses every 24 months for a $65 co-pay	Through **Vision Service Plan (VSP)** $25 co-pay Lenses covered once every 24 months Frames covered once every 24 months For the Member Only: Extra pair of glasses or lenses every 24 months for a $65 co-pay

OPTIONAL LIMITED COVERAGE RETIREE PLAN *(PLAN L)*

The Fund offers a lower-cost plan for Retired Participants. Plan L enables Retired Participants to obtain medical and hospital coverage elsewhere at the Participant's cost. For example, Participants may already be covered by Medicare or their spouse's employment-related health coverage. Under Plan L, all of the Participant's medical and hospital care must be obtained through Medicare or the other plan. The Fund will not provide secondary coverage. The Fund will only cover prescription drugs, dental, vision, hearing aids and death benefits.

LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS AND WEEKLY DISABILITY BENEFITS FOR ACTIVE EMPLOYEES

The following benefits are for Active Employees only. There are no life insurance or Accidental Death and Dismemberment benefits for Retirees. See Retiree Death Benefit section on page 57.

There is no life insurance coverage under the COBRA continuation plan.

LIFE INSURANCE

Death of Active Employee

Upon the death of an Active Employee, an $8,000 group life insurance benefit will be paid to the Employee's beneficiary.

The beneficiary may be any person or persons you name and may be changed at any time. The beneficiary must be designated, in writing, on the form provided by the Fund Office. If no beneficiary is designated or if the designated beneficiary dies before the Employee, the beneficiary will be the surviving person or persons in the order listed below:

- Spouse
- Children
- Parents
- Brothers and sisters
- Executor or administrator

If two or more persons are entitled to receive benefits they will share equally unless the Employee designates otherwise.

Death of Covered Dependent

If a covered dependent dies while eligible in the Plan or within 31 days following termination of such eligibility, the Fund will provide the following benefits to the Active Employee:

Spouse	$2,500
Children: 14 days but less than 6 months of age while an eligible Dependent	$100
6 months but less than 26 years of age while an eligible Dependent	$1,000

Accidental Death and Dismemberment Benefits for Active Employees

If you incur any of the following losses through accidental means on or off the job, the following benefits will be paid. The loss must occur within 90 days after the accident. Payment will be made regardless of any other benefits you may receive.

Loss of Life	$8,000 paid to your beneficiary
Loss of: • Both hands • Both feet • Sight of both eyes • One hand and one foot • One hand and sight of one eye • One foot and sight of one eye	$8,000 paid to you
Loss of: • One hand • One foot • Sight of one eye	$4,000 paid to you

If you suffer more than one loss in an accident, payment will be made only for the one loss for which the largest amount is payable.

Your beneficiary may be any person or persons you name and may be changed at any time. The beneficiary must be designated, in writing, on the form provided by the Fund Office. If no beneficiary is designated or if the designated beneficiary dies before the Employee, the beneficiary will be the surviving person or persons in the order listed below:

- Spouse
- Children
- Parents
- Brothers and sisters
- Executor or administrator

If two or more persons are entitled to receive benefits they will share equally unless the Employee designates otherwise.

Exclusions

No benefit will be paid for any accidental death or dismemberment loss caused from:

- Disease
- Drugs, chemicals, poisons or inhalation of gases
- Injury that is sustained in the course of any medical or dental diagnosis or treatment
- Injury that is sustained while you are in any aircraft unless you are a paying passenger on a regularly scheduled flight
- Injury that is intentionally self-inflicted while sane or self-inflicted while insane
- Injury that results from your commission of a crime
- Any act of war or any release of nuclear energy

Weekly Disability Benefit (Nevada Only)

Disabled participants who live in California receive a disability benefit directly from the State. Nevada does not have a State Disability program, so the Fund receives an additional contribution on behalf of Southern Nevada employees. This additional contribution funds a Weekly Disability program for eligible participants who worked for Southern Nevada employers.

Benefits

$70 per day or $490 per week; up to a maximum benefit of 52 weeks.

There is a 7-day waiting period for disability due to illness (payments begin on the eighth day). There is no waiting period for injury.

Benefits are reduced by any federal disability benefits.

Total Disability Definition

Total disability means that the eligible individual is unable, due to illness, injury or pregnancy, to perform the substantial and material duties of the occupation he or she was engaged in when the disability occurred and that the disabled individual is not engaged in any gainful occupation.

Exclusions

No weekly disability benefit will be paid for any period during which the Active Employee is not under the care of a physician or other medical practitioner.

No weekly disability benefit will be paid for a disability that is caused by or related to any injury or sickness that:

- Is intentionally self-inflicted while sane or that is self-inflicted while insane
- Results from any act of war
- Results from your commission of a crime
- Results from the release of nuclear energy
- Results from or arises out of any past or present employment or occupation for compensation or profit

Filing a Claim

Nevada Weekly Disability claim forms are available from the Las Vegas or Pasadena Fund Offices or the Las Vegas District Office of I.U.O.E., Local 12, or from the Fund's website at www.oefi.org. You and your doctor must complete the form and return it to the Pasadena Fund Office.

RETIREE DEATH BENEFIT

Death of Retired Employee

If a Retired Employee dies while eligible or within 31 days following termination of eligibility, the Fund will pay a death benefit of $2,500.

This benefit will be paid to the legal spouse of the Retired Employee, or if there is no surviving spouse (or the spouse cannot be located within 2 years of the Employee's death), to the Retiree's designated beneficiary.

Death of Retired Employee's Spouse

If the spouse of a Retired Employee dies while the Retired Employee is eligible or within 31 days of the termination of his eligibility, the Fund will pay a death benefit of $2,500.

This benefit will be paid to the Retired Employee or, if the Retired Employee is not alive at the time of payment, then to the Retired Employee's designated beneficiary.

Beneficiary Rules

The beneficiary may be any person or persons you name and may be changed at any time. You must name your beneficiary, in writing, on the form provided by the Fund Office. For a copy of this form please contact the Fund's Member Services department at (866) 400-5200 or visit our website at www.oefi.org.

If no beneficiary has been designated, or the designated beneficiary dies before payment is made, or the designated beneficiary cannot be located within two years of the Retired Employee's death, the Trustees may, at their sole discretion, apply any or all of the death benefit to the payment of burial expenses. Any amount not applied to burial expenses will be paid to the surviving person or persons in the order listed below:

- Children
- Parents
- Brothers and sisters
- Executors or administrators

If no such beneficiaries are identified or qualify for benefits within three years of the Employee's death, the death benefit will be retained by the Fund.

If two or more persons are entitled to receive benefits they will share equally unless the Employee designates otherwise.

MEDICAL BENEFITS FOR MEDICARE RETIREES

The Medical Coverage outlined in this section applies to Medicare Retirees. Premium rates for each option outlined in this section are subject to change from time to time. The Fund Office can provide information on premium rates.

The Fund offers four full health plans and two supplemental plans as follows:

Full Plans:

1. Operating Engineers PPO Plan. This Plan is the same plan offered to Active and non-Medicare Retirees. The full details of this plan are outlined on pages 19 through 43.
2. UnitedHealthcare Group Medicare Advantage PPO. This plan allows you to use any provider that accepts Medicare. This means there is no in and out of network differences. All benefits are the same no matter what provider you use.
3. Kaiser Permanente Senior Advantage Plan. This plan requires that you use Kaiser providers. This Plan is only available to Participants in Kaiser services areas in California.
4. Health Plan of Nevada HMO. This plan requires that you use providers in the HMO. This Plan is only available to Participants who reside in Nevada. The full details of this plan are outlined on pages 51 through 54.

Both Medicare Advantage plans, UnitedHealthcare Group Medicare Advantage PPO and Kaiser Permanente Senior Advantage Plan, include coverage for medical, hospital, prescription drug and vision benefits. They include all of the benefits of Medicare as well as some additional benefits and lower out-of-pocket expenses than traditional Medicare. All of your benefits are provided by the plan you choose, so there is no need for coordinating benefits between Medicare and your Operating Engineers coverage. **You must be enrolled in Medicare Parts A and B and pay your Part B premium.**

Dental benefits are provided by the Fund as outlined on pages 47-50.

Retiree Death Benefits provided by the Fund as outlined on page 57.

Coverage for Dependents

Operating Engineers PPO Plan. If you elect this Plan, your dependents will automatically be covered by this Plan.

UnitedHealthcare Group Medicare Advantage PPO. If you elect this Plan, your dependents age 65 or older will automatically be covered by this Plan. Your dependents under age 65 will be covered by the Operating Engineers self-funded PPO as outlined beginning on page 19.

Kaiser Senior Advantage Plan. If you elect this Plan, your dependents must also be enrolled in a Kaiser Plan.

Health Plan of Nevada HMO. If you elect this Plan, your dependents must also be enrolled in a Health Plan of Nevada Plan.

	Kaiser Senior Advantage HMO Plan	UnitedHealthcare Medicare Advantage PPO Plan The following benefits are effective July 1, 2017	Operating Engineers PPO Plan
Deductible	None	None	None
Annual Out-of-Pocket Maximum	$1,500 per individual/ $3,000 per family	None	$6,000 per individual/ $12,000 per family per calendar year
PROFESSIONAL SERVICES			
Office Visit	$5 co-pay per visit	No charge	Plan pays the difference between Medicare's allowance and their paid amount, limited to a maximum payment of $15 per office/therapy/urgent care visit. Member pays balance remaining after Fund Payment
Therapy (Physical, Occupational and Speech)	$5 co-pay per visit	No charge	
Chiropractic	$5 co-pay per visit for manual manipulation of spine	No charge for manual manipulation of spine No charge for up to 26 visits per year for routine chiropractic care	
Urgent Care	$5 co-pay per visit	No charge	
Routine Physical	No charge – 1 per calendar year	No charge for Medicare covered services	No charge Plan pays difference between Medicare's allowance and their paid amount
Outpatient Surgery	$5 co-pay per visit	No charge	No charge Plan pays difference between Medicare's allowance and their paid amount
INPATIENT HOSPITAL	No charge	No charge	No charge Plan pays the Medicare Inpatient Deductible

	Kaiser Senior Advantage HMO Plan	UnitedHealthcare Medicare Advantage PPO Plan The following benefits are effective July 1, 2017	Operating Engineers PPO Plan
OTHER SERVICES			
Ambulance	No charge	No charge	No charge Plan pays difference between Medicare's allowance and their paid amount
Emergency Care	$20 co-pay per episode	No charge	No charge Plan pays difference between Medicare's allowance and their paid amount
Lab and X-ray	No charge	No charge	No charge Plan pays difference between Medicare's allowance and their paid amount
Durable Medical Equipment	No charge, including diabetic testing supplies	No charge	No charge Plan pays difference between Medicare's allowance and their paid amount
Skilled Nursing Facility	No charge up to 100 days	No charge up to 100 days	No charge up to 100 days
Hearing Benefits	$5 co-pay per exam	No charge for 1 routine hearing exam every 12 months Plan pays up to $1,000 for one hearing aid per ear every 3 years	Plan pays $1,000 for one hearing aid per ear every 3 years
MENTAL HEALTH	No charge for inpatient $5 co-pay per visit for individual outpatient evaluation and treatment $2 co-pay per visit for group outpatient treatment	No charge subject to 190 day inpatient stay lifetime maximum No charge for outpatient treatment	Plan pays the difference between Medicare's allowance and their paid amount, limited to a maximum payment of $15 for office/therapy visits. Member pays balance remaining after Fund Payment

	Kaiser Senior Advantage HMO Plan	UnitedHealthcare Medicare Advantage PPO Plan The following benefits are effective July 1, 2017	Operating Engineers PPO Plan
CHEMICAL DEPENDENCY	No charge for inpatient detoxification $5 co-pay per visit for outpatient evaluation and treatment	No charge	No charge Plan pays difference between Medicare's allowance and their paid amount
PRESCRIPTION DRUGS	$5 per prescription (walk in or mail order up to a 100-day supply)	Walk-in pharmacy (30-day supply): $5 - generic drug $15 - preferred brand drug $30 - non-preferred brand drug Mail Order (90-day supply): $10 - generic drug $30 - preferred brand drug $80 - non-preferred brand drug	Walk-in pharmacy (30-day supply): $10 - generic drug $25 - preferred brand drug $40 - non-preferred brand drug Mail Order (90-day supply): $25 - generic drug $62.50 - preferred brand drug $100 - non-preferred brand drug
VISION BENEFITS			
Routine eye exams	$5 co-pay	No charge - 1 exam every 12 months	$15 co-pay - 1 exam every 12 months
Eyewear	Up to $150 allowance every two years	Up to $130 eyewear allowance every two years Up to $175 contact lens allowance in lieu of eyewear every two years	$25 co-pay - lenses and frames or contacts once every 24 months

Additional Benefits under UnitedHealthcare Medicare Advantage PPO

Nurseline: You may call the *Nurseline* 24 hours a day, 7 days a week to speak to a registered nurse about your medical concerns and questions. There is no charge for this service. The *Nurseline* phone number is on your UnitedHealthcare identification card.

Fitness Program: The *SilverSneakers* fitness program provides free membership at network fitness centers. If you live more than 15 miles from a network fitness center, you are entitled to the *SilverSneakers* Steps at Home program which provides general fitness, strength, walking or yoga in your home at no charge.

Routine Foot Care: The Plan provides up to 6 visits per year for routine foot care. You pay $30 for each visit.

Pharmacy Saver: Hundreds of prescription drugs can be obtained with co-pays as little as $1.50 when obtained from many of the national and regional pharmacy chains.

Supplemental Plans:

Plan M. Plan M allows a Participant to enroll in any Medicare HMO of his choice in the area where he lives. In this case, all medical, hospital and prescription drugs must be obtained from the Medicare HMO. The Fund will then provide benefits only for:

- Hearing aids
- Chiropractic care
- Dental care
- Death Benefits

Participants in Plan M pay a lower monthly premium to the Fund for their coverage. The premiums are set by the Trustees and may be adjusted from time to time. The Participant must pay the Medicare HMO premium, if any, directly to the HMO.

Participants cannot enroll in a Medicare HMO if:

- They reside outside the service area of the HMO; or
- They have End-Stage Renal Disease (ESRD); or
- They do not have Part B Medicare; or
- They are currently receiving Medicare Hospice benefits.

Participants who want to elect Plan M must complete an Authorization Form and return it to the Fund Office, along with written confirmation from the Medicare HMO of the effective date of coverage with the HMO. The monthly premium for Fund coverage will be adjusted on the first day of the month following receipt of the Authorization Form and written HMO confirmation.

Plan L. This limited coverage plan enables Participants to obtain medical and hospital coverage elsewhere at the Participant's cost. For example, Participants may already be covered by Medicare or their spouse's employment-related health coverage. All of the Participant's medical and hospital care must be obtained through Medicare or the other plan. The Fund will not provide secondary coverage. The Fund will cover prescription drugs, dental, vision, hearing aids and death benefits.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is the method of dividing responsibility for payment among group health plans that cover an individual so that the total of all covered expenses will be paid.

Primary Plan

The primary plan is the plan that pays first on the claim. If a balance is still due after the primary plan's payment, the secondary plan will consider the claim. In determining which of the plans is primary or secondary, this Plan will apply the following rules. The first rule that applies to the situation will be used.

1. The plan covering the person as an employee is primary to the plan covering the person as a dependent.
2. When both plans cover a child as a dependent, the plan of the parent whose birthday (using month and day of birth) falls earlier in the year pays first. If both parents have the same birthday, the plan that has covered the child for the longer period of time is primary. This is called the "birthday rule." See special rules below for children of divorced parents.
3. The plan covering the person as an active employee (or that employee's dependent) is primary to the plan covering the person as a retired employee.
4. The plan covering the person for the longest continuous period is primary to the plan covering the person for a shorter continuous period.

Children of Divorced Parents

With a QMCSO:

If one of the parents is required by a Qualified Medical Child Support Order ("QMCSO") to provide health care coverage for the child, the plan of the parent who is responsible for coverage as ordered by the court is primary. The plan of the other parent is secondary.

Without a QMCSO:

- The plan of the parent with custody is primary, the plan of the step-parent (if any) with custody is secondary, and the plan of the parent without custody is third.
- If the parents were awarded joint custody, the "birthday rule" outlined above applies.

Coordination of Benefits under COBRA Continuation Coverage

If an individual is covered by this Plan or another plan under a COBRA provision, the following coordination of benefit rules apply:

- The plan covering the person as other than a qualified beneficiary under COBRA (or a dependent of a qualified beneficiary) pays primary to the plan covering the person as a qualified beneficiary.
- When both plans cover the person as a qualified beneficiary under COBRA (or a dependent of a qualified beneficiary), the plan which has covered the person for the longer period of time is primary to the plan covering the person for the shorter period of time.

Coordination of Benefits with Medicare – Active Employees and Spouses

When you or your spouse continues to work after age 65:

Medicare has special rules that apply to Medicare beneficiaries who are older than 65 and who have group health coverage through their own employment or the employment of a spouse. In such situations, Medicare will give you and your spouse the option to accept or reject coverage with the Fund.

If you accept coverage through this Fund, the Fund will provide benefits as the primary plan and Medicare will be the secondary payer.

If you reject coverage through this Fund, Medicare will be the only health insurance payer. The Fund will provide NO benefits.

When you have Medicare because of kidney disease:

If you are entitled to Medicare solely because of end stage renal disease (ESRD), the Fund is required to provide benefits as the primary plan for 30 months during which time Medicare will be the secondary payer. When the 30-month period is over, Medicare will provide benefits as the primary plan and the Fund will be secondary.

When you are covered by the widow/widower self-payment plan and turn 65:

When a widow/widower reaches age 65, he or she will be covered by the Fund's Retiree Plan and Medicare will become the primary plan.

Coordination of Benefits With Medicare – Retired Employees and Spouses

When you or your dependent spouse reaches age 65, you or your spouse are eligible for Medicare benefits. At that time, if you enroll in a Medicare Advantage Plan, that plan will become your primary and only plan. No additional benefits are provided by the Fund. If you are enrolled in the Operating Engineers PPO Plan, Medicare will become your primary plan and the Operating Engineers PPO Plan will become secondary. The maximum allowance on any claim involving Medicare will be the amount approved by the Medicare Advantage Plan.

Medicare Enrollment

You must enroll in Medicare in advance of age 65 to avoid a reduction in coverage.

Medicare enrollment is NOT automatic unless you have filed an application and establish eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application during the three-month period prior to your 65th birthday in order for Medicare benefits to begin during the month you reach age 65. Call or write the nearest Social Security Office at least 90 days before your 65th birthday and ask for an application. You can also apply online at www.ssa.gov/medicare.

If you fail to enroll in Medicare during this period, you will have to wait until the beginning of the next calendar year to enroll and you will have to pay an additional 10% on your Medicare Part B premium.

Medicare Claims

In most cases, Medicare will forward this information directly to the Fund on your behalf. In the event Medicare doesn't forward the information on your behalf, you or your provider must submit the Medicare Explanation of Benefits (MEOB) along with the complete itemized bill to Anthem Blue Cross or payment cannot be made. The Fund cannot provide benefits on your claims without a MEOB. This is the notice Medicare will send to you which shows what services were covered, what charges were approved, how much was credited to your deductible and the amount Medicare paid for each service.

You or your provider should mail the itemized bill and the MEOB to:

Anthem Blue Cross
P O Box 60007
Los Angeles, CA 90060-0007

Questions About Medicare

If you have any questions or need information regarding Medicare in general, Medicare Health Plans, etc., please contact Medicare directly at (800) MEDICARE or (800) 633-4227 or go to www.cms.gov.

FILING A CLAIM FOR BENEFITS

Hospital and Medical Benefits

All PPO Network and PPO Non-Network claims should be sent to Anthem Blue Cross at the address indicated on your Anthem Blue Cross ID card.

All PPO Network and PPO Non-Network benefit payments will be issued by Anthem Blue Cross. Explanation of Benefits (EOB) will be issued by the Fund Office.

The Fund will accept hospital and medical expense claims for up to 12 months after the date of service subject to contract restrictions between Anthem Blue Cross and providers.

If you receive treatment outside of the United States, submit a detailed, translated bill to the Fund Office. The bill should include the date services were provided, a description of each service, the charge for each service and the reason treatment was provided (diagnosis). Be sure to also include the type of currency that was used when you paid for these services.

If you have any questions about your claim, call the Fund Office at (866) 400-5200.

Prescription Drug Benefit

If you use a non-participating retail pharmacy for your prescription drugs, you need to file a Prescription Drug Claim Form as provided by the Fund Office. You must pay the full price for the prescription item and submit the claim form to the Fund Office for reimbursement. Reimbursement is limited to a maximum of 60 days for any one individual drug.

To file a claim for prescription drug benefits, follow these steps:

1. Request an itemized bill from the pharmacy showing the following information for each prescription:
    - Prescription number
    - Date of sale
    - Name of the physician who issued the prescription
    - Patient's name
    - Cost of the prescription
    - National Drug Code (NDC) number for the drug
2. Complete the prescription drug claim form. Make sure you include the Participant's name and Social Security or OEID number, the patient's name, address, date of birth and relationship to the Participant, your billing address and the policy number and insurance company name for any other group coverage the patient has. For a copy of this form please contact the Fund's Member Services Department at (866) 400-5200 or visit our website at www.oefi.org.
3. Attach the itemized bill to the claim form and submit it to the Fund Office.

Dental Benefits

Claim forms for dental benefits may be obtained from the Fund Office, or on the Plan's website at www.oefi.org. All completed claims should be sent to the Fund Office for processing. All PPO Plan benefit checks, including your Explanation of Benefits (EOB), will be issued by the Fund Office.

When you use PPO, United Concordia, Delta Dental or Western Dental participating dentists, the dentist will file the claim for you.

To file a claim for a PPO Plan non-participating dentist, just request an itemized statement and forward it to the Fund Office.

Vision Benefits

If you use a VSP provider, you do not need to file a claim form. You will pay the amount due from you at the end of the visit, and your provider will take care of billing VSP for the balance.

If you use a non-VSP provider, you will need to request an itemized bill and send it to:

Vision Service Plan
Attention: Claims Services
P.O. Box 385018,
Birmingham, AL 35238-5018

Be sure to include the Participant's name, mailing address and Social Security Number, the patient's name, relationship to the Participant and date of birth.

Hearing Aid Benefit

To file a claim form for hearing aid benefits, submit an itemized bill to the Fund Office showing the cost of the hearing aid device and the ear in which the hearing aid was placed.

Life Insurance and Accidental Death and Dismemberment Benefits

Life Insurance and Accidental Death and Dismemberment claim forms are available from the Fund Office or on the Plan's website at www.oefi.org. In the event of death, provide a copy of the death certificate and, if appropriate, written evidence of the accidental nature of the death, to the Fund Office. In the event of dismemberment, notify the Fund Office and a claim form will be sent to you.

For further details, contact the Death Benefits Department at (866) 400-5200.

Weekly Disability Benefit (Southern Nevada Only)

Disability claim forms are available from the Las Vegas Fund Office, the Pasadena Fund Office, on the Plan's website at www.oefi.org or from the Las Vegas District Office of the I.U.O.E., Local 12. You and your physician must complete the form and return it to the Pasadena Fund Office for processing.

HMO and Medicare Advantage Plan Claims

For services rendered by providers in the HMO Plans (Kaiser, Anthem Blue Cross or Health Plan of Nevada), or by providers in the Medicare Advantage Plans (Kaiser Senior Advantage Plan or UnitedHealthcare Advantage plan) the requirements for filing a claim are different than those outlined above. You should contact the contracting provider if you require information on submitting a claim for reimbursement.

Mental Health, Substance Abuse and MAP Benefits

If you use a Carelon Behavioral Health Participating Provider, claims will be filed with CBH directly by your provider and payment will be made directly to the provider. If you use a provider that is not an CBH Participating Provider, you or your provider will need to send the claim to:

Carelon Behavioral Health
PO Box 1850
Hicksville, NY 11802-1850

Be sure to include the Participant's name, mailing address, and Social Security Number along with the patient's name, relationship to the Participant, and date of birth.

CLAIM REVIEW AND APPEALS PROCEDURE

The following information does not apply to these programs:

- CVS Caremark prescription drug program, see page 42
- Anthem Blue Cross HMO program, contact the plan directly for guidance
- Kaiser Permanente HMO program, contact the plan directly for guidance
- Health Plan of Nevada HMO program, contact the plan directly for guidance
- United Healthcare Group Medicare Advantage PPO program, contact the plan directly for guidance
- Carelon Behavioral Health (CBH) Mental Health, Substance Abuse and Member Assistance Program, see pages 37-38
- United Concordia Preferred Dental PPO program, contact the plan directly for guidance
- United Concordia Plus Dental HMO program, contact the plan directly for guidance
- Delta Dental PMI Dental HMO program, contact the plan directly for guidance
- Western Dental HMO program, contact the plan directly for guidance

If you are enrolled in one of the above plans, please refer to their materials for information on their claim review and appeals procedures.

Types of Claims

- **Urgent Claim** means a claim for medical care or treatment that requires review sooner than other claims to avoid the possibility of:
  - Serious jeopardy to your life or health or your ability to regain maximum function; or
  - Severe pain that could not be adequately managed without the care or treatment that is the subject of the claim if this is the opinion of a physician who knows your medical condition.

  Note: Claims that do not require prior approval before incurring services or treatment are not Urgent Claims. Also, the Urgent Claim procedures do not apply to Emergency Care. If you experience a medical emergency you should go directly to the nearest hospital emergency room. The term "Emergency" means the sudden onset of a condition requiring immediate treatment including, but not limited to, heart attack, poisoning, loss of consciousness or convulsions. The charges for these services will be submitted as Post-Service Claims and are subject to the Plan's limitations and exclusions.

- **Pre-Service Claim** means any claim for benefits for which the Plan requires you to obtain approval before obtaining medical care.

  Note: Except as required under the Dental Plan or the Prescription Drug Plan, the Plan does not require prior approval of benefits.

- **Post-Service Claim** means any claim for payment of treatment, services or supplies that have already been provided to you.

- **Concurrent Claim** means any claim that is reconsidered after an initial approval was made and which results in a reduced or terminated benefit.

  Note: Currently, the Plan does not require reconsideration of treatment that was pre-authorized. Therefore, the Plan will not treat any claim as a Concurrent Claim.

- **Disability Claim** means any claim that requires a finding of disability as a condition of eligibility. For example, claims for Weekly Disability Benefits for Participants in Southern Nevada are treated as Disability Claims.

Authorized Representative

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself. Another Dependent or a friend may also complete the claim form for you if you are unable to complete the form yourself and you have previously designated the individual to act on your behalf. A form to designate an authorized representative may be obtained from the Fund Office or on the Plan's website at www.oefi.org.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Claim without you having to complete the special authorization form.

Initial Claim Determination

The guidelines below are time frames within which a claim must be **decided** for approval or denial. These are **not** the periods within which claim payments that have been granted must actually be paid or services that have been approved must actually be rendered. The payment of a claim or the provision of a service following Plan approval is done so in a timeframe appropriate with applicable law.

Claims Procedures	Pre-Service Health Claims	Urgent Care Health Claims	Post-Service Health Claims	Disability Claims
How long does the Plan have to make a determination when you file a claim?	15 days	72 hours	30 days	45 days
Are there any extensions available?	Yes, one 15-day Extension	No	Yes, one 15-day Extension	Yes, two 30-day Extensions. You will be notified of the first extension within 45 days. You will be notified of the second extension within the first 30-day extension
What happens if the Plan needs additional information?	The Plan will tell you what information is needed within 15 days of receipt of the claim. You have 45 days to respond	The Plan will tell you what information is needed within 24 hours of receipt of the claim. You have 48 hours to respond	The Plan will tell you what information is needed within 30 days of receipt of the claim. you have 45 days to respond	The Plan will tell you what information is needed within the time periods outlined above. You have 45 days to respond
If additional information is requested, when must the Plan make its determination?	The time for making the determination is suspended for 45 days or until the requested information is received, whichever occurs first	Within 48 hours of the earlier of the time you respond, or the end of the 48-hour response period	The time for making the determination is suspended (tolled) for 45 days or until the requested information is received, whichever occurs first	The time for making the determination is suspended (tolled) for 45 days or until the requested information is received, whichever occurs first

Claim Appeals Procedures

If your claim is denied, in whole or in part, you may request a review of an initial benefit determination. Your request must be made in writing (except for Urgent Claims which may be made verbally), must state the reason for disputing the denial and must be accompanied by any pertinent documents not already furnished including date of service, facility name, patient's name, and participant's Social Security, Local 12 Registration or OEID number. The request for review must be filed with the Fund Office with 180 days after you receive the notice of denial.

The Plan has two levels of appeal, an internal review performed by the Board of Trustees and an external review performed by an independent review organization (IRO).

Internal Review

	Pre-Service	Urgent Care	Post-Service	Disability
How much time do I have to appeal?	180 days	180 days	180 days	180 days
How may I make my appeal?	In writing	In writing or verbally	In writing	In writing
How long does the Plan have to make a decision on my appeal?	30 days	72 hours	60 days	45 days with one 45-day extension

You will be notified of the decision of the Board of Trustees in writing. The decision of the Board of Trustees is final and binding on all parties, subject only to external review or judicial review as provided by federal law.

Standard External Review

You have the right to request an external review of your claim if the request is filed within 4 months of the date of receipt of an initial denial or final internal adverse benefit determination.

The Board of Trustees will complete a preliminary review of your request within 5 days of receipt of the request for an external review. The preliminary review will determine that the claimant was eligible at the time the service was provided, the prior denial does not relate to the claimant's failure to meet the Plan's eligibility requirements, the petitioner has exhausted the internal appeal process, and the claimant has provided all information necessary to process the external review.

You will be notified, in writing, within one business day after the Board of Trustees has completed its preliminary external review.

Assignment to an IRO (Independent Review Organization)

If all requirements for an external review have been satisfied, the claim will be referred to an independent review organization (IRO) to conduct the external review. The IRO will notify you when they receive the external review request. The notice will include a statement that you may submit additional information for the IRO to consider. The information should be submitted within 10 business days of receiving the notice. The IRO may accept and consider additional information submitted after the 10-day period but is not required to do so.

The Plan will provide the IRO any documents and information used in denying the claim or denying the internal review within five business days after the external review is assigned to the IRO. If the Plan fails to do so, the IRO may terminate the external review and make a decision to reverse the denial. Within one business day after making such decision, the IRO must notify you and the Plan.

Upon receipt of any information submitted by you in connection with the external review, the IRO will forward it to the Plan within one business day. Upon receipt of the information, the Plan may reconsider its claim denial or internal review denial. The Plan will provide written notice to you and the IRO if it reverses its previous decision within one business day of such reversal. The IRO will then terminate the external review.

External Review Decision

The IRO will review all information and documents timely received and use experts where appropriate to make coverage determinations under the Plan. The IRO is not bound by any decisions or conclusions reached during the initial benefit denial or internal appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, when making its decision:

- The claimant's medical records.
- The attending health care professional's recommendation.
- Reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating provider.
- The applicable provisions of the Plan Rules and Regulations.
- Appropriate medical practice guidelines, including evidence-based standards.
- Any applicable clinical review criteria developed and used by the Plan unless such criteria are inconsistent with the Plan Rules and Regulations or applicable law.
- The opinion of the IRO's clinical reviewer.

The IRO will provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the external review request. This notice will include:

- An explanation of the primary reason for the IRO's decision including the rationale for its decision and any evidence-based standards that were relied on in making its decision.
- References to the evidence or documentation considered in making its decision, including specific coverage provisions and evidence-based standards considered in reaching its decision.
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law.
- A statement that judicial review may be available.
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under federal law.

If the IRO reverses the previous adverse benefit determination, the Plan will immediately provide coverage or payment for the claim.

Expedited External Review

The Plan will allow a claimant to make a request for an expedited external review at the time the claimant receives:

- An adverse benefit determination if such determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination if the claimant has a medical condition for which the timeframe for completion of a Standard External Review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the requirements and will send a notice to the claimant of its determination. If the request meets the requirements for an expedited external review, the Plan will assign an IRO and provide all necessary documents and information electronically or by telephone or by facsimile or other expeditious method.

The IRO will provide a notice of the final expedited external review decision as expeditiously as the claimant's medical condition or circumstances require, but no more than 72 hours after the IRO receives the request. If such notice is not in writing, the IRO will provide written confirmation of its decision within 48 hours after providing the notice.

PRIVACY STATEMENT

The Health Insurance Portability and Accountability Act (HIPAA) requires the Operating Engineers Health and Welfare Fund to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund's Privacy Notice which was given to you when you first became eligible and is available from the Fund Office. This statement does not represent the Fund's Privacy Notice.

This Fund and the Fund Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health care operations and as required by a governmental agency. In particular, the Fund will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Fund Sponsor.

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

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosers of the information and, under certain circumstances, amend the information. You have the right to request reasonable restrictions on disclosure of information about you. You also have the right to file a complaint with the Fund or with the Secretary of Health and Human Services if you believe your rights have been violated.

The Fund maintains a Privacy Notice that provides a complete description of your rights under HIPAA's privacy rules. For a copy of that Notice or if you have questions about the privacy of your health information or if you wish to file a complaint about a privacy issue, please contact the Fund Office and ask for the Privacy Official. The Privacy Notice is also available on the Plan's website at www.oefi.org.

STATEMENT OF ERISA RIGHTS

As a Participant in the Operating Engineers Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's Office (the Fund Office) and at other specific locations, such as work sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series). The Administrator may make a reasonable charge for the copies.

Receive a summary of the Fund's annual financial report. The Fund is required by law to furnish each Participant with a copy of this summary annual report.

Continued Group Health Plan Coverage

Continued health care coverage for you, your 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 the documents governing the plan on the rules governing your COBRA continuation coverage right.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done. You must receive a written explanation of the reason for the denial. You have the right to have the Plan (the Board of Trustees) review and reconsider your claim within certain time schedules, and a right to obtain copies of documents relating to the decision without charge.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for health benefits which is denied or ignored, in whole or in part, you may request a standard external review of the decision by an independent review organization (IRO) following the exhaustion of the Plan's appeal process. External Review may also be available if your health coverage has been retroactively terminated unless the decision to terminate coverage was made because you did not meet the Plan's eligibility rule.

You must request a standard external review within four (4) months of receipt of a notice of an adverse appeal determination made by the Board of Trustees. You also have the right to file suit in state or federal court for benefits which you claim and which were denied or ignored. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

The Trustees' written decision on an appeal and the IRO decision on an external review, if applicable, will be deemed to have been provided on the fifth business day following the postmark date, if mailed, or the date of delivery, if personally delivered or delivered by facsimile. A copy of this Statement of ERISA Rights, which shall constitute written notice of any applicable limitations period, shall be provided to the applicant along with the written notification of the Trustees' decision on appeal.

If the Plan fiduciaries are misusing the Fund'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 frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Pension and Welfare Benefits Administration (866) 444-3272.

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Operating Engineers Health and Welfare Fund ("Fund") complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Fund provides the following:

1. Free aids and services to people with disabilities to communicate effectively with us, such as:
    a. Qualified sign language interpreters;
    b. Written information in other formats (large print, audio, accessible electronic formats, other formats);
2. Free language services to people whose primary language is not English, such as:
    a. Qualified interpreters;
    b. Information written in other languages.

If you need these services, please contact the Fund's Language Assistance Line at (626) 356-3555.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance Officer, who is located at 100 Corson St., Ste. 100, Pasadena, CA 91103, telephone number (626) 356-1092, (866) 400-5200, TTY (626) 356-3582, Fax (626) 356-1065 and Email at complianceofficer@oefi.org.

You may file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Compliance Officer is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 868-1019, or (800) 537-7679 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

FACTS ABOUT YOUR PLAN

Name and Type of Administration of the Plan. The Plan is known as the Operating Engineers Health and Welfare Fund. It is a collectively bargained, jointly-trusteed, labor-management trust.

Type of Plan. The Plan is an employee welfare benefit plan maintained for the purpose of providing health benefits for participants in the Plan.

Plan Identification Numbers. The Employer Identification Number (EIN) issued by the Internal Revenue Service is 95-6034886. The Plan Number is 003.

Agent for Service of Legal Process. The name and address of the agent designated for the service of legal process is:

Michael B. De Chellis
Operating Engineers Funds, Inc.
100 Corson Street, Suite 100
Pasadena, CA 91103 (626) 356-1000

Legal process may also be served on a Plan Trustee.

Plan Administrator. The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with ERISA.

The Board of Trustees has designated the following administrative organization to perform the routine administrative functions and day-to-day business of the Plan:

Operating Engineers Funds, Inc.
100 Corson Street, Suite 100
Pasadena, CA 91103 (626) 356-1000

Board of Trustees. The Board of Trustees consists of an equal number of employer and union representatives selected by the employers and union in accordance with the provisions of the Trust Agreement. If you wish to contact the Board of Trustees, you should use the following address and phone number:

Operating Engineers Health and Welfare Fund
100 Corson Street, Suite 100
Pasadena, CA 91103 (626) 356-1000

Names, Titles and Addresses of the Trustees. As of January 2026 the Trustees of the Fund are:

Union Trustees	Employer Trustees
David K. Sikorski	Jaimie Angus
David Garbarino	Michael Crawford
Ken Hunt	Stanley Howard
Shawn Kinsey	Patrick Velasquez
Perry Hawkins	George Butorovich
Robert Ninteman	Dave Greco
Joe Rangel, Jr.	Eddie Speccro

Collective Bargaining Agreements. The Plan was established, and is maintained, through collective bargaining agreements between the International Union of Operating Engineers, Local Union No 12, and participating employers. Contributions to this Plan are made on behalf of each Participant in accordance with these collective bargaining agreements.

The Fund Office will provide you, upon written request, a copy of any of the collective bargaining agreements. The collective bargaining agreements are also available for examination at the Fund Office.

Source of Contributions. The benefits described in this booklet are provided through employer contributions to this Plan. The amount of employer contributions is determined by the provisions of the collective bargaining agreements which require contributions to this Plan at a fixed rate per hour worked. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreement.

Trust Fund. The assets and reserves of the Plan are held in trust by the Board of Trustees.

Plan Amendment and Termination. The benefits provided under the Plan are not permanent. The Board of Trustees reserves the right, in its sole discretion at any time and from time to time to:

- Terminate or amend the amount or condition of any benefits even though such termination or amendment affects claims which you may already have incurred.
- Change or postpone the method of payment of any benefit.
- Amend or cancel any other provision of the Plan.

The Trustees do not promise to continue the benefits and coverages in full or in part in the future, and rights to future benefits and coverages are not vested. This means they can be taken away. In particular, retirement or the completion of the requirements to receive a pension benefit under the Operating Engineers Pension Plan does not give any Participant or former Participant any vested right to continued benefits or coverages under the Operating Engineers Health and Welfare Fund.

The Board of Trustees is authorized and empowered to:

- Decide the meaning of any doubtful or ambiguous provision of the Rules and Regulations of the Plan.
- Decide on a Participant's entitlement to or application for benefits under the Rules and Regulations of the Plan.
- Sign agreements, write and carry out reasonable Rules and Regulations, and do all things necessary in the establishment, maintenance and administration of the Plan.

If the Plan terminates, any and all money and assets remaining in the Fund, after payment of expenses, will be used to continue the benefits provided by the Plan, until such money and assets have been used up.

Funding. Benefits of the Plan are provided under service agreements or insurance contracts or directly from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the trust agreement, and are held in trust for the purpose of providing benefits to covered Participants and defraying reasonable operating costs.

- PPO hospital, PPO medical, prescription drug, hearing aid, dental, vision, life and accidental death and dismemberment and weekly disability income benefits are paid directly from Fund assets.
- Prepaid medical and prescription drug benefits are provided through Kaiser, Anthem Blue Cross, Health Plan of Nevada and United HealthCare.
- Prepaid dental benefits are provided through United Concordia, Delta Dental, MetLife, and Western Dental.

Organizations through which benefits are provided.

The carriers listed below provide fully insured benefits under the Plan.

Prepaid Dental Benefits

Delta Dental
12898 Towne Center Drive
Cerritos, CA 90703

MetLife Dental
505 N. Euclid St., Suite 200
Anaheim, CA 92803

United Concordia Dental Plan of California
PO Box 10194
Van Nuys, CA 91420

Western Dental
101 Park Lane Blvd., Ste 301
Sugar Land TX, 77178

Prepaid Medical and Prescription Drug Benefits

Anthem Blue Cross
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Plan of Nevada
PO Box 15645
Las Vegas, NV 89114

Kaiser Permanente
393 E. Walnut St.
Pasadena, CA 91188

UnitedHealthcare
9900 Bren Road East
Minnetonka, MN 55434

The Plan is fully self-insured for the benefits obtained through the companies listed below. These companies administer at least a portion of the benefits for the Plan, but do not insure or otherwise guarantee any of the benefits of the Plan.

Company	Benefits
Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060-0007	Provides access to its network of hospital and medical providers, performs healthcare management services, provider credentialing and claims screening
CVS Caremark PO Box 52136 Phoenix, AZ 85072-2136	Administers the prescription drug benefit.
Vision Service Plan of America 100 Howe Ave. Sacramento, CA 95825	Administers the vision benefit and provides access to its network of vision providers.
Carelon Behavioral Health PO Box 1850 Hicksville, NY 11802-1850	Administers the Member Assistance Program, mental health and substance abuse benefits.

Individual conversion policies are provided by Kaiser Permanente, Anthem Blue Cross and Health Plan of Nevada (hospital, medical and prescription drug coverage).

All benefit types provided by the Plan are set forth in this summary plan description. The complete terms of the Vision Care Benefits are set forth in the Agreements with Vision Service Plan. The complete terms of the prepaid benefits are set forth in the Kaiser Permanente Group Hospital and Medical Service Agreement, the Anthem Blue Cross Group Hospital and Professional Service Agreement, the Health Plan of Nevada Service Agreement, the Delta Dental Plans Service Agreement, the MetLife Dental Services Agreement, the United Concordia Service Agreement and the Western Dental Benefit Plans Service Agreement. The complete terms of the self-funded benefits are set forth in the Rules and Regulations which are available to any participant at any time.

Fiscal Plan Year. The fiscal records of the Plan are kept separately for each fiscal Plan Year. The fiscal Plan Year begins on July 1 and ends on June 30.

The Plan's Requirements with Respect to Eligibility for Participation and Benefits. The eligibility requirements are specified on pages 4 through 9 of this booklet.

1. **Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits.** Loss of eligibility is described throughout this booklet. For additional information please contact the Fund's Member Services department at (866) 400-5200.

Procedures to Follow for Filing a Claim. The procedure to be followed in filing a claim for benefits is outlined on pages 66 through 67 of this booklet.

Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims by the Fund Office or the Board of Trustees.

Review Procedure. If your claim is denied, in whole or in part, you will receive a written explanation giving detailed reasons for the denial, specific reference to the Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and any explanation of why such information or material is necessary, as well as an explanation of the Plan's claim appeals procedure. A description of the appeals procedure appears on pages 67 through 71 of this booklet.

GENERAL INFORMATION

Plan Identification Numbers

The Plan uses the Social Security Number (SSN) of the Participant, the Operating Engineers Identification Number (OEID) or the Operating Engineers Union Local 12 Register Number as an identification number for all transactions. All claims and correspondence that you send to the Fund Office should include one of these identification numbers. A missing identification number can significantly delay payment of your claims.

Plan Rules and Regulations

This booklet contains a summary of the most important provisions of the Plan rules. The actual Rules and Regulations of the Plan govern every aspect of the Plan. That is the legal document which is the basis for all eligibility and benefit provisions. You may obtain a copy of the current Rules and Regulations by contacting the Fund Office.

Change of Address

It is important to keep the Fund Office advised of your current physical and mailing address. All mailings from the Fund Office will be made to the last known mailing address.

All address changes must be in writing signed by the eligible Participant. Telephone changes cannot be accepted. For a copy of this form please contact the Fund's Member Services department at (866) 400-5200 or visit our website at www.oefi.org.

Life Events

The Plan requires certain documentation on various occasions known as "Life Events" as outlined in the following chart.

Life Event	Documentation Required by the Plan
Marriage	**Certified copy** of the recorded marriage certificate
Divorce	Copy of the recorded final divorce decree
Birth	**Certified copy** of the recorded birth certificate
Adoption	Copy of the adoption papers issued by the court
Guardianship	Copy of the guardianship papers issued by the court
Physically and/or Mentally Disabled Dependent	A completed Total Disability Application (available from the Fund Office or on the Plan's website at www.oefi.org) and a copy of the attending physician's history and physical report
Death	**Certified copy** of the death certificate

Useful Telephone Numbers

Fund Office Telephone Numbers

Member Services	(866) 400-5200	**Vacation - Holiday**	(800) 877-4444
Administration, Human Resources and I.T. Departments	(626) 356-1000	**Las Vegas Fund Office**	(702) 949-1219
Language Assist Line	(626) 356-3555	**TTY Line**	(626) 356-3582

To avoid the expense of a long distance call to FAX something to the Fund Office you may call the appropriate local District Office of I.U.O.E., Local 12 listed below and ask them to FAX your material to the Fund Office.

Pasadena	(626) 792-2519
Lancaster	(661) 942-1175
Ventura	(805) 643-8740
Arroyo Grande	(805) 489-1533
Bakersfield	(661) 325-9491
San Diego	(858) 427-8788
Palm Desert	(760) 779-0299
Redlands	(909) 307-8700
Las Vegas	(702) 598-1212
Anaheim	(714) 827-4591

Spanish - ATENCIÓN : Si necesita ayuda en otro idioma, los servicios están disponibles para usted de forma gratuita, Llamada (626) 356-3555.
Chinese - 注意：如果你用另一种语言需要帮助，服务，为您提供免费的。呼叫 (626) 356-3555.

The Fund complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

GLOSSARY OF TERMS

Active Employee, Active Participant or Participant. Any person who, by reason of their employment, meets the eligibility requirements for participation in the Plan.

Allowed Amount or Allowed Charges. The amount established by the Plan as the amount payable for benefits covered by the Plan.

Ambulatory Surgical Center. A freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Assignment of Benefits. An authorization to the Plan to pay the Physician, hospital or other provider of service directly for the benefits received. The Plan accepts an assignment of benefits for all services except the following:

- Prescription drugs
- Vision benefits if benefits are received from a Physician other than a Vision Service Plan provider.
- Certain health care providers as designated by the Trustees. At your request, the Fund Office will provide a complete list of providers to whom you cannot assign benefits. You should check with the Fund Office to see if the plan allows benefit assignment to the Hospital, Doctor or other provider treating you.

Birthing Center. A facility equipped and operated solely as a setting for prenatal care, delivery and immediate postpartum care for patients with low risk pregnancies.

A Birthing Center may be free-standing, Hospital-based or Hospital associated. It must be licensed under the direction of an MD or DO specializing in obstetrics and gynecology. It shall provide skilled nursing services under the direction of an RN or certified nurse midwife in the delivery and recovery rooms and have a written agreement with an area Hospital for immediate transfer in case of emergency.

Case Management. A program in which a coordinator works with the patient, his or her Physician, his or her family, and the Plan to decide on an appropriate treatment plan. Case Management is generally used in cases of catastrophic or chronic sickness or injury.

Certified Nurse-Midwife. A registered nurse who has gained the special knowledge and skills of midwifery in an educational program accredited by the American College of Nurse-Midwives and who is licensed in the State of California by the Board of Registered Nursing as a Nurse Midwife.

Contract Rate. The amount a PPO Network provider has agreed to accept as the total charge. PPO Network providers cannot bill you for covered charges in excess of the Contract Rate.

Coordination of Benefits. The method of dividing responsibility for payment among the health plans that cover an Eligible Individual so that the total of all reasonable expenses for covered services will be paid.

Co-payment or Coinsurance. Any amount you are responsible to pay after the Fund has provided benefits. This is your portion of the cost of care and is also called your “out-of-pocket” expense.

Cosmetic Surgery. Surgery which is performed merely for the purpose of improving the appearance of the individual.

Deductible. The amount of covered expenses you must pay before the Plan begins to pay. Deductibles may be higher when you use non-network providers.

Dentist. A Dentist licensed to practice dentistry in the state or county in which he or she renders treatment and is not the spouse, child, brother, sister or parent of the Participant or the Participant’s Dependent.

Denturist. A dental technician who is licensed to make and fit dentures without the supervision of a Dentist. A Denturist is not responsible for making any type of diagnosis or carrying out any other treatment (e.g., removing teeth). Denturists are not licensed to practice in every state.

Dependent. Individuals who meet the Plan's requirement to be covered by the Plan as a result of their relationship to the Participant. See pages 9-12.

DHMO – Dental Health Maintenance Organization. An organization which contracts with the Plan to provide complete, pre paid-dental coverage for Plan participants and their Dependents. The Plan has contracts with United Concordia and Delta Dental.

Doctor or Physician. A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Certified Nurse Practitioner, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.) Physiotherapist, Psychiatrist, Psychologist (PhD), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license. A Physician cannot be the employee or the employee's Dependent or any person who is the Spouse, parent, child, brother or sister of the employee or the employee's Dependents.

Elective Surgery. A surgery which is not a matter of life or death – a surgery which can be performed at any time. It does not include any surgery which must be performed immediately in order to protect the health and life of a person.

Eligible Individual. Participants and each of their eligible Dependents.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of 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:

- Placing the health of the individual in serious jeopardy; or
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Experimental.

- Any treatment which is not recognized by the American Medical Association and the California Medical Association as having medical significance or therapeutic value to the patient; and
- Any course of treatment making use of devices or drugs not yet approved by the U.S. Food and Drug Administration; and
- Drugs approved by the U.S. Food and Drug Administration used in a course of treatment which is not generally accepted medical practice or which is not covered by Medicare.

Health Maintenance Organization (HMO). An organization which contracts with the Plan to provide complete pre-paid medical coverage for Plan Participants. The Plan has contracts with Kaiser, Anthem Blue Cross and Health Plan of Nevada HMOs.

Home Health Agency. An organization or agency which meets the requirements for participation as a "Home Health Agency" under Medicare.

Hospital. Only an institution which meets the following requirements:

- Maintains a permanent full-time facility for bed care of five or more resident patients; and
- Has a Physician in regular attendance; and
- Continuously provides 24-hour-a-day nursing service by Registered Nurses; and
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, Skilled Nursing Facility, a place for the aged or a place for drug addicts, and is operating lawfully in the jurisdiction where it is located; or
- Is recognized by the Board of Trustees by name, on a specific basis, and is primarily operated in providing Physician-related inpatient medical treatment of alcoholism, chemical dependency or mental health services.

Investigational. Procedures or treatments that have progressed to limited use on humans, but which are not widely accepted as proven effective procedures with the organized medical community.

Itemized Bill. A bill from a provider of service which has a breakdown for each specific service rendered and an individual price for each service. The itemized bill is provided for each individual patient. The Plan will accept itemized billing as long as all of the information indicated above is provided as well as the Participant's name, the patient's name, the Participant's Social Security Number or Operating Engineers Identification Number (OEID), the diagnosis, place of service and the provider's name, address, National Provider Identifier (NPI) and Federal Tax ID Number.

Medically Necessary. Medically Necessary procedures, supplies, equipment or services are those considered to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your physician or another provider;
6. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition;
7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.
8. Is not conducted for research purposes, unless as part of a covered clinical trial;
9. It is the most appropriate supply or level of care needed to provide safe and adequate care. Also, the site of the service must be the most appropriate due to the inherent clinical condition of the patient or to the nature of the services provided.

Medicare Advantage Plan. A health plan offered by private insurers approved by Medicare. Medicare pays these companies to cover all of your Medicare benefits (Part A; Hospital benefits, Part B; professional services, and Part D; prescription drug benefits). Often times, these health plans offer services and benefits beyond traditional Medicare.

Morbidly Obese. A physical condition in which the Eligible Individual has a Body Mass Index (BMI) greater than, or equal to, 30 and has serious medical conditions.

Operating Engineer Identification Number (OEID). A randomly generated number used to identify the Active or Retired Participant and his/her Dependents as reflected on the Participant's Anthem Blue Cross or Fund issued ID card.

Orthodontist. A Dentist with additional specialist training in correcting defects in the teeth and is board eligible to practice orthodontia in his/her state.

PPO Plan Dentist. Any Dentist contracted with the Plan, or one of the Plan's contracted dental PPO insurers to provide dental services and supplies at a fixed rate.

Plan. The Rules and Regulations of the Operating Engineers Health and Welfare Fund for Active Employees and the Rules and Regulations of the Operating Engineers Health and Welfare Fund for Retired Employees.

Preferred Provider Organization (PPO). An organization consisting of a network of providers which has contracted with the Plan to provide benefits at certain prices. Services from PPO network providers give you the best value for your health dollar. The Plan uses Anthem Blue Cross as the medical PPO nationwide.

Qualified Medical Child Support Order (QMCSO). An order by a court resulting from a divorce which designates one parent to pay for a child's health coverage and which meets all of the federal legal requirements for this type of order.

Reasonable Charge/Reasonable and Customary Charge. For covered services performed by a provider participating in the PPO Network, the maximum Reasonable and Customary Charge will be the Contract Rate that the provider has agreed to accept as reimbursement for the provided covered services from the PPO Network. For covered services performed by a provider not participating in the PPO Network, the maximum Reasonable and Customary Charge will be based on the applicable PPO Network non-participating provider rate or fee schedule, an amount negotiated by the PPO Network or a third party vendor which has been agreed to by the non-participating provider, an amount derived from the total charges billed by the non-participating provider, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS").

Reasonable and Customary Charge amounts, including those resulting from a negotiated agreement between the provider and the PPO Network or authorized third party vendor, will be subject to coverage, terms and benefit amounts as any Allowed Amount or Allowed Charge.

IMPORTANT NOTE: Because the PPO Network (Anthem Blue Cross) may change its determination of what is a Reasonable and Customary Charge for any particular treatment or service at any time, you should check with both the provider of service and Anthem before you consent to receive treatment or service from a Non-PPO Network Provider. Ask both the provider of service and Anthem what the maximum allowed amount is for the treatment or service you are requesting. Neither Anthem nor the Fund will give notice of these changed calculations; so it is very important that you inquire about them. You should do this even if you have had the same treatment or procedure in the past, because Anthem may have changed the maximum allowed amount since your last treatment. A change in what Anthem considers to be Reasonable and Customary Charge and what will be the maximum allowed amount for a treatment or service could mean a change in hundreds or even thousands of dollars in your out-of-pocket cost.

Registered Nurse. A registered graduate nurse who does not ordinarily reside in the Participant's home and is not the spouse, parent, brother or sister of the Participant or the Participant's Dependent.

Retiree/Retired Participant/Retired Employee. Any person who, by reason of their retirement, meets the eligibility requirements for participation in the Plan. A Medicare Retiree is a Retiree who is either under or over age 65 and eligible for Medicare.

Schedule of Dental Procedures. The description of dental procedures and the maximum amounts payable as set forth by the Board of Trustees as amended from time to time.

Skilled Nursing Facility. An institution which is primarily engaged in providing inpatients with (1) skilled nursing care and related services for patients who require medical or nursing care, or (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons which meets all of the following requirements:

- Is regularly engaged in providing skilled nursing care to sick and injured persons under 24-hour-a-day supervision of a Physician and surgeon (MD) or graduate Registered Nurse (RN); and
- Has available at all times the services of a Physician and surgeon (MD) who is a staff member of a general hospital; and
- Has on duty 24 hours a day a graduate Registered Nurse (RN), Licensed Vocational Nurse (LVN), or skilled practical nurse, and has a graduate Registered Nurse (RN) on duty at least eight hours per day; and
- Is not, other than incidentally, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution; and
- Complies with all licensing and other legal requirements, and is recognized as a "Skilled Nursing Facility" by the secretary of Health and Human Services of the United States in accordance with the Social Security Amendments Act of 1965.

Spouse. A legal Spouse, including same-sex Spouse. Same-sex or opposite sex domestic partners do not qualify as a Spouse.

Total Disability. With respect to an Active Participant, prevention by reason of bodily injury or sickness from engaging in any occupation for wages or profit, and with respect to a Dependent, prevention by reason of bodily injury or sickness, from engaging in normal activities.

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