Locals 302 and 612 International Union of Operating Engineers Construction Industry

Health and Security Fund

Summary Plan Description

January 2020

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com
Administered by
Welfare & Pension Administration Service, Inc.

August 27 , 2026

TO: All Active Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund
RE: Dollar Bank Deduction Changes

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Eligibility Provisions
The Trust is primarily funded with contributions required under collective bargaining agreements between the IUOE 302 and 612 and signatory employers in Washington and Alaska. When those collective bargaining rates change, monthly amounts required for continued eligibility in the health plan also change.

The following changes have been made to the eligibility provisions:
Initial Eligibility
The minimum contribution required to establish Initial Dollar Bank eligibility for Hourly employees **has changed to as follows**:

- $1,841.00 in Eastern Washington,
- $2,066.00 in Western Washington, and
- $2,424.00 in Alaska

(Contribution amount must be accumulated within a consecutive three-month period).

Continued Coverage
The monthly dollar bank deduction for coverage for Bargained Hourly employees whose employers remit contributions for ALL hours worked**, has changed to as follows**:

- $1,280.00 per month in Eastern Washington,
- $1,393.00 per month in Western Washington, and
- $1,618.00 per month in Alaska

The **monthly dollar bank deduction** for coverage **has changed to** as follows for Associate and Bargained Flat Rate employees beginning with **July 2026 work hours for September 2026 coverage:**

- $1,626.00 per month for Eastern Washington,
- $1,800.00 per month for Western Washington, and
- $2,137.00 per month for Alaska

Any participant covered by a collective bargaining agreement that has an hourly contribution which is not at least equivalent to the AGC Master Labor Agreement and/or whose employer remits contributions on less than all of participants' hours worked in a month, will be charged the higher Bargained Flat Rate deduction factor, for a month of coverage.

Dollar Bank Maximum

Effective with **June 2026 work hours for August 2026 coverage**, the maximum dollar amount that can accumulate in an Hourly employee's dollar bank is:

- $9,816 in Eastern Washington,
- $11,016 in Western Washington, and
- $12,928 in Alaska

If you have any questions regarding the change to eligibility provisions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212. You may also email us at eligibility@wpas-inc.com.

Board of Trustees
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
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August 19, 2025

TO: All Active Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund
RE: Dollar Bank Deduction Changes

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Eligibility Provisions
The Trust is primarily funded with contributions required under collective bargaining agreements between the IUOE 302 and 612 and signatory employers in Washington and Alaska. When those collective bargaining rates change, monthly amounts required for continued eligibility in the health plan also change.

The following changes have been made to the eligibility provisions:
Initial Eligibility
The minimum contribution required to establish Initial Dollar Bank eligibility for Hourly employees **will remain the same as the previous year, as follows:**

- $1,709.00 in Eastern Washington,
- $1,869.00 in Western Washington, and
- $2,276.00 in Alaska

(Contribution amount must be accumulated within a consecutive three-month period).

Continued Coverage
The monthly dollar bank deduction for coverage **will remain the same as the previous year** for Bargained Hourly employees whose employers remit contributions for ALL hours worked**, as follows**:

- $1,139.00 per month in Eastern Washington,
- $1,246.00 per month in Western Washington, and
- $1,517.00 per month in Alaska

The **monthly dollar bank deduction** for coverage **will change** as follows for Associate and Bargained Flat Rate employees beginning with **July 2025 work hours for September 2025 coverage:**

- from $1,420.00 to $1,472 per month for Eastern Washington,
- from $1,569.00 to $1,633.00 per month for Western Washington, and
- from $1,861.00 to $1,945.00 per month for Alaska

Any participant covered by a collective bargaining agreement that has an hourly contribution which is not at least equivalent to the AGC Master Labor Agreement and/or whose employer remits contributions on less than all of participants' hours worked in a month, will be charged the higher Bargained Flat Rate deduction factor, for a month of coverage.

Dollar Bank Maximum

Effective with **June 2025 work hours for August 2025 coverage**, the maximum dollar amount that can accumulate in an Hourly employee's dollar bank is:

- $9,112 in Eastern Washington,
- $9,968 in Western Washington, and
- $12,136 in Alaska

If you have any questions regarding the change to eligibility provisions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212. You may also email us at eligibility@wpas-inc.com.

Board of Trustees
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

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Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

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Administered by
Welfare & Pension Administration Service, Inc.

December 30, 2024

TO: **All Eligible Plan Participants**
Locals 302 and 612 IUOE Trust Funds

RE: **Dental Benefit Improvement**

This is a Summary of Material Modification describing a change to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

At their June 19, 2024 meeting, the Board of Trustees of the Local 302 and 612 IUOE Trust Funds (the "Trust") took action to update the dental fee schedule to 80% of UCR. The following lists the new schedule of benefits, effective January 1, 2025:

Scheduled Dental Benefits			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
	DIAGNOSTIC		
	Examinations		
0120	Periodic oral exam	$87	$100
0140	Limited oral exam	$146	$168
0150	Comprehensive oral exam	$154	$177
	Radiographs (X-Rays)		
0210	Intraoral–complete series (including bitewings)	$204	$255
0220	Single, first film	$41	$51
0230	Each additional film	$37	$46
0270	Bitewing–single film	$42	$50
0272	Bitewings–two films	$67	$80
0274	Bitewings–four films	$94	$113
0330	Panoramic film	$172	$204
	PREVENTIVE		
	Prophylaxis		
1110	Age 13 and over	$159	$171
1120	To age 13	$109	$118
	Fluoride Treatment: To age 18		
1208	Topical application of fluoride	$49	$55
	Fissure Sealants: Ages 6 to 18		
1351	Topical application of fissure sealant (per tooth)	$82	$96
	Space Maintainers: To age 19		
1510	Fixed–unilateral type	$581	$582
1516	Fixed–bilateral type	$477	$572
	MINOR RESTORATIONS		
2140	Amalgam–1 surface	$202	$274

Scheduled Dental Benefits			
ADA Code	Procedure	Washington & other areas	Alaska
2150	Amalgam–2 surfaces	$262	$290
2160	Amalgam–3 surfaces	$317	$350
2161	Amalgam–4 or more surfaces	$386	$426
2951	Pin retention–exclusive of amalgam	$44	$53
2330	Resin–1 surface anterior	$183	$220
2331	Resin–2 surfaces anterior	$234	$281
2332	Resin–3 surfaces anterior	$286	$343
2335	Resin–4 or more surfaces anterior	$338	$406
2391	Resin–1 surface posterior	$214	$258
2392	Resin–2 surfaces posterior	$281	$338
2393	Resin–3 surfaces posterior	$349	$419
2394	Resin–4 or more surfaces posterior	$427	$514
	MAJOR RESTORATIONS		
	Inlays and Onlays		
2510	Inlay, metallic–1 surface	$857	$1027
2520	Inlay, metallic–2 surfaces	$972	$1166
2530	Inlay, metallic–3 surfaces	$1,121	$1,343
2542	Onlay, metallic–2 surfaces	$1,099	$1,318
2543	Onlay, metallic–3 surfaces	$1,150	$1,378
2544	Onlay, metallic–4 or more surfaces	$1,196	$1,433
2642	Onlay, porcelain–2 surfaces	$1,102	$1,321
2643	Onlay, porcelain–3 surfaces	$1,189	$1,424
2644	Onlay, porcelain–4 or more surfaces	$1,261	$1,510
2910	Re-cement inlay	$73	$88
	Crowns		
2720	Resin with high noble	$805	$921
2721	Resin with predominantly base metal	$754	$864
2722	Resin with noble metal	$771	$883
2740	Porcelain/ceramic noble metal	$826	$946
2750	Porcelain fused to high noble metal	$815	$933
2751	Porcelain fused to predominantly base metal	$759	$869
2752	Porcelain fused to noble metal	$777	$890
2780	¾ cast high noble metal	$782	$895
2781	¾ cast base metal	$736	$843
2782	¾ cast noble metal	$760	$870
2783	¾ cast porcelain	$804	$920
2790	Full cast high noble metal	$786	$900
2791	Full cast predominantly base metal	$745	$853
2792	Full cast noble metal	$759	$869
2930	Stainless steel – primary tooth	$170	$204
2970	Temporary crown	$154	$185
2950	Crown buildup	$163	$196
2920	Re-cement crown	$74	$90
	Endodontics		
3110	Pulp cap–direct	$111	$138
3120	Pulp cap–indirect	$89	$110
3220	Vital pulpotomy	$227	$284
	Root Canal Therapy (includes treatment plan, clinical procedures, follow-up care; excludes final restoration)		
3310	Single-rooted	$980	$1048
3320	Bi-rooted	$1,201	$1,285

Scheduled Dental Benefits			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
3330	Tri-rooted	$1,490	$1,593
3410	Apicoectomy (as a separate surgical procedure)	$1,230	$1,430
	PERIODONTICS		
	Non-Surgical Services		
4910	Periodontal maintenance	$191	$208
4341	Periodontal scaling and planing (per quadrant)	$310	$338
	Surgical Services		
4210	Gingivectomy (per quad)	$934	$909
4241	Gingival flap procedure (per quad)	$685	$666
4260	Osseous surgery (per quad)	$1,1972	$,1918
4263	Bone replacement graft	$706	$686
	PROSTHODONTICS		
	Dentures (includes six months post-delivery care)		
5110	Complete upper or lower	$1,228	$1,297
5130	Immediate upper or lower	$1,339	$1,414
5211	Partial upper or lower, acrylic base (and conventional clasps/rests)	$1,037	$1,094
5213	Partial upper or lower, predominantly cast base with acrylic saddles (and conventional clasps/rests)	$1,357	$1,433
	Related Denture Services		
5410	Denture adjustment (complete or partial)	$67	$71
5520	Replace missing or broken teeth in complete denture–per tooth	$112	$119
5710	Rebase denture	$499	$527
5730	Reline denture–office	$282	$297
5750	Reline denture–lab	$376	$396
	Implant Services		
6010	Surgical placement of implant	$1,728	$2,073
6065	Implant supported porcelain/ceramic crown	$1,162	$1,227
6066	Implant supported porcelain fused to metal crown	$1,132	$1,195
6067	Implant supported metal crown	$1,098	$1,196
	Bridgework		
6210	Pontic–cast	$773	$952
6240	Pontic–porcelain	$763	$940
6250	Pontic–resin	$753	$928
6930	Re-cement bridge	$127	$164
	ORAL SURGERY		
	Extractions (includes local anesthesia, routine postoperative care)		
7140	Single tooth	$131	$162
7210	Erupted tooth–surgically removed	$209	$251
7220	Impacted tooth–soft tissue	$262	$314
7230	Impacted tooth–partially bony	$348	$418
7240	Impacted tooth–completely bony	$409	$491
7250	Root recovery–per tooth	$220	$264
	Related Oral Surgical Procedures		
7310	Alveoloplasty–per quadrant	$452	$542
7510	Incision, drainage of abscess intraoral	$486	$583
9222	Deep Sedation/General Anesthesia–First 15 Minutes	$195.50	$240.50
9223	Deep Sedation/General Anesthesia–Each Subsequent 15 Minute Increment	$147.50	$184

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212 and follow prompts for the Claims department.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

August 12, 2024

TO: **All Eligible Plan Participants**
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: **Benefit Change and Dollar Bank Deduction Charges**

This is a Summary of Material Modification describing a change to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Massage Therapy

The Plan currently provides coverage for massage therapy when part of a chiropractic or physical therapy treatment plan under the supervision of the provider prescribing the treatment plan and billed under the same clinic/tax ID number of the prescribing provider.

The Trustees have reviewed this limitation of coverage and effective January 1, 2024, the Plan will provide coverage for massage therapy which is performed as part of a chiropractic or physical therapy treatment plan prescribed by a medical provider or other licensed practitioner but will not require the therapy be provided within the same clinic/practice of the provider/practitioner issuing the treatment plan.

As with all services, coverage of massage therapy is subject to the Plan's requirements that such treatment is "Medically Necessary" as that term is defined in the Plan and is subject to eligibility, cost-sharing, deductibles and co-pays.

Dollar Bank Deductions

Eligibility Provisions
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The following changes have been made to the eligibility provisions:
Initial Eligibility
The minimum contribution required to establish Initial Dollar Bank eligibility for Hourly employees will change as follows with **June 2024 hours for August 2024 coverage**:

- $1,709.00 in Eastern Washington,
- from $1,724.00 to $1,869.00 in Western Washington, and
- from $2,115.00 to $2,276.00 in Alaska

(Contribution amount must be accumulated within a consecutive three-month period).

Continued Coverage
The monthly dollar bank deduction for coverage will change as follows for Bargained Hourly employees whose employers remit contributions for ALL hours worked, with **June 2024 hours for August 2024 coverage**:

- $1,139.00 per month in Eastern Washington,
- from $1,149.00 to $1,246.00 per month in Western Washington, and
- from $1,410.00 to $1,517.00 per month in Alaska

The monthly dollar bank deduction for coverage will change as follows for Associate and Bargained Flat Rate employees with **July 2024 hours for September 2024 coverage:**

- $1,420.00 per month for Eastern Washington,
- from $1,514.00 to $1,569.00 per month for Western Washington, and
- from $1,773.00 to $1,861.00 per month for Alaska

Any participant covered by a collective bargaining agreement that has an hourly contribution which is not at least equivalent to the AGC Master Labor Agreement and/or whose employer remits contributions on less than all of participants' hours worked in a month, will be charged the higher Bargained Flat Rate deduction factor, for a month of coverage.

Dollar Bank Maximum
Effective **June 2024 work hours for August 2024 coverage**, the maximum dollar amount that can accumulate in an Hourly employee's dollar bank is:

- $9,112 in Eastern Washington,
- $9,968 in Western Washington, and
- $12,136 in Alaska

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212 and follow prompts for appropriate department.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

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Administered by
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July 28, 2023

TO: **All Eligible Plan Participants**
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: **Benefit Changes**

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

COVID-19 At-Home Test Kits, In-Office Testing, and Vaccines

As you may be aware, the Biden Administration announced an end to the COVID-19 National Emergency and the related Public Health Emergency. Following this announcement, the Board of Trustees of the Locals 302 and 612 IUOE Construction Industry Health and Security Fund has adopted the following benefit plan provisions related to the diagnosis and treatment of COVID effective June 1, 2023.

- The Plan will continue to provide benefits for medically necessary FDA authorized, cleared or approved Over the Counter (OTC) COVID Antigen tests pursuant to the standard Plan provisions, subject to deductible, co-payments, in-network or out-of-network coinsurance.

- The Plan will continue to provide benefits for COVID vaccines as a preventative benefit (in-network paid at 100% without cost sharing, while cost sharing will apply to out-of-network).

- The Plan will continue to provide benefits for antiviral medication for the treatment of COVID (such as Paxlovid) under standard Plan provisions, subject to deductible, co-payments, in-network or out-of-network coinsurance.

- Other treatment of COVID and in office diagnostic testing remains covered under standard Plan provisions (subject to deductive, co-payments, in-network or out-of-network coinsurance).

Telehealth/Telemedicine

Prior to the pandemic, telehealth/telemedicine services outside of SwiftMD were excluded. Since March 1, 2020, the Plan has provided coverage for telehealth/telemedicine services. The Trustees have confirmed the Plan will continue to provide coverage for telehealth services under standard Plan provisions. This benefit will not change as a result of the end of the pandemic emergency declaration.

Hearing Care Expenses

Effective June 1, 2023, the Plan will cover hearing exams performed by licensed hearing care providers, and will not require the examiner be an audiologist. The Plan is modified as follows:

Hearing care expenses (for active and retired employees only) are limited to a maximum benefit payable of $1,000 per ear during any three-year period. Covered hearing care expenses include:

- Hearing exam, if that exam results in your purchase of a hearing aid device.
- Hearing aid devices prescribed by a legally qualified physician, a certified audiologist***, or a licensed hearing provider*** if the examining practitioner certifies in writing (within three consecutive calendar months immediately before the purchase of the device) that you are suffering a hearing loss and the device may serve to lessen that loss.
- Replacement of hearing aid devices, if you meet the above requirements and a three-year period has elapsed since you received your last hearing aid device.

No benefits are paid for batteries or other ancillary equipment not obtained when you purchase a hearing aid device. In addition, repairs, servicing or alteration of a hearing aid device is not covered.

The charges for a hearing aid device prescribed and ordered prior to termination of your eligibility and delivered within 30 days following your date of termination will be covered.

Cochlear implants are covered under a separate benefit (see page 33). Bone Anchored Hearing Aids (BAHAs) are not covered by the Plan.

Dental Personal Protective Equipment (PPE)

The Plan has discontinued coverage for dental personal protective equipment (PPE) upon the conclusion of the National Emergency on May 11, 2023.

Retail 90 Pharmacy

The OptumRx Retail 90 Pharmacy Network offers the convenience and flexibility for members to get 90-day supplies of maintenance medications. Plan Participants will now be able to obtain a 90-day supply of maintenance medications at a network retail pharmacy and pay a copay for each 30-day portion of the 90-day supply, effective June 1, 2023. This will allow for fewer trips to the pharmacy, save money and improve adherence. The OptumRx Retail 90 Pharmacy Network is a nationwide network with more than 57,000 pharmacies including Walgreens, CVS Pharmacy® and most other regional chains, mass merchants, grocers, and pharmacy services administration organizations (PSAOs).

Rx Coupon Card Variable Co-pay Program

The Trustees adopted a prescription coupon card program through Optum, effective June 1, 2023. This program will be at point of purchase at Optum® Specialty Pharmacy. Drug manufacturers offer coupons, also known as copay cards, to help consumers reduce their copay of costly specialty medications. If you are using a specialty medication, contact Optum® Specialty Pharmacy to check if your prescription has a coupon card program. As soon as you sign up for a manufacturer coupon and share the details with Optum® Specialty Pharmacy, the Variable Copay Program automatically adjusts the cost share for medication and applies the coupon value at the point of sale. This helps lower your cost share and both the participant and Plan will save.

Rx Price Edge Program

The Trustees adopted a prescription coupon card program for generic prescriptions through Optum, effective September 1, 2023. This program will also be at point of purchase at a pharmacy. If your generic prescription can be obtained at a lower price using an alternative discount method (for example "GoodRx" or "Optum Perks") the prescription will automatically be priced at the lower amount and both the participant and Plan will save.

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212 and follow prompts for appropriate department.

Board of Trustees
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Construction Industry Health and Security Fund

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Administered by
Welfare & Pension Administration Service, Inc.

March 1, 2023

To: All Active and Non-Medicare Plan Participants
Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund

RE: Virtual Physical Therapy Benefit - Effective September 1, 2022

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Trustees have added a virtual treatment option for participants through Transcarent (formerly called "Bridgehealth"). Through Transcarent's SWORD program, participants may enroll for 12-months at a time to receive virtual access to physical therapists using sensor-based technology and real-time feedback for treatment of chronic joint pain and for post-surgery rehabilitation. This virtual care option is available to you <u>in addition to</u> the current physical therapy benefit under the Plan which has a maximum allowance of 20 visits per condition, per calendar year. There is no limitation on the number of conditions you can treat or the number of visits you can have in a year under this new virtual care option with this SWORD program.

Virtual Care through the SWORD Program:

Effective September 1, 2022, you can receive physical therapy, sensor-based technology services and real-time feedback in a virtual setting from the comfort of your home through the SWORD Physical Therapy benefit. There is no cost to you.

SWORD provides virtual physical therapy services for all major musculoskeletal issues, at any point in the journey: prevention, acute conditions, chronic pain, and post-surgical recovery.

You will be matched with a Doctor of Physical Therapy (DPT) who will create your personalized program and work with you every step of the way. A Digital Therapist tracks your progress and corrects your form in real time, so you get better, faster.

If you wish to enroll in the SWORD Program or have questions about this benefit, please contact Transcarent at (800) 680-1366.

Board of Trustees
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Welfare & Pension Administration Service, Inc.

July 15, 2022

TO: All Eligible Plan Participants
Locals 302 and 612 IUOE Construction Industry Health and Security Fund
RE: Dollar Bank Deduction Changes and Benefit Changes

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Eligibility Provisions
The Trust is primarily funded with contributions required under collective bargaining agreements between the IUOE 302 and 612 and signatory employers in Washington and Alaska. When those collective bargaining rates change, monthly amounts required for continued eligibility in the health plan also change.

The following changes have been made to the eligibility provisions:
Initial Eligibility
The minimum contribution required to establish Initial Dollar Bank eligibility for Hourly employees will change as follows with **June 2022 hours for August 2022 coverage**:

- from $1,616.00 to $1,724 in Washington, and
- from $1,991.00 to $2,115 in Alaska

(Contribution amount must be accumulated within a consecutive three-month period).

Continued Coverage
The monthly dollar bank deduction for coverage will change as follows for Bargained Hourly employees whose employers remit contributions for ALL hours worked, with **June 2022 hours for August 2022 coverage**:

- from $1,077.00 to $1,149.00 per month in Washington
- from $1,327.00 to $1,410.00 per month in Alaska

The monthly dollar bank deduction for coverage will change as follows for Associate and Bargained Flat Rate employees with **July 2022 hours for September 2022 coverage:**

- from $1,437.00 to $1,514.00 per month for Washington
- from $1,687.00 to $1,773.00 per month for Alaska

Any participant covered by a collective bargaining agreement that has an hourly contribution which is not at least equivalent to the AGC Master Labor Agreement and/or whose employer remits contributions on less than all of participants' hours worked in a month, will be charged the higher Bargained Flat Rate deduction factor, for a month of coverage.

Dollar Bank Maximum
Effective **June 2022 work hours for August 2022 coverage**, the maximum dollar amount that can accumulate in an Hourly employee's dollar bank is:

- $9,192 in Washington, and
- $11,280 in Alaska

If you have any questions regarding the change to eligibility provisions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Dental Personal Protective Equipment (PPE)
The Board of Trustees of the Locals 302 and 612 IUOE Construction Industry Health and Security Fund have acted to extend the dental PPE coverage until the expiration of the COVID-19 National Emergency. Appropriately billed charges by a licensed dental office for dental PPE will be covered up to $20 per visit.

Bone Anchored Hearing Aids Benefit
Effective **January 1, 2022**, the Trust will cover medically necessary Bone Anchored Hearing Aids (BAHA) when the patient is 5 years old or older and the following criteria is present:

- Any inner or outer ear conditions that prevent use of a conventional air-conductive hearing aid such as:
  - congenital or surgically induced malformations of the external ear canal or middle ear, or
  - chronic external otitis or otitis media, or
  - tumors of the external canal and/or tympanic cavity, or
  - dermatitis of the external canal
- Audiologic test results (hearing test) showing a level of hearing loss requiring BAHA

To obtain preauthorization of medical necessity, your provider or you should contact First Choice Health (FCH) at (800) 986-9156.

If you have questions regarding the changes to your benefits, please call the Administration Office Claims Department at (206) 441-7314 or (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

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Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124 Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

February 25, 2022

NOTICE REGARDING COVID TESTING

It's now almost two years since the Trust first communicated with you regarding the COVID-19 pandemic - waiving all costs associated with testing for COVID-19. Unfortunately, the pandemic continues and we are again reaching out regarding the importance of testing in mitigating the spread of the virus. Below we describe multiple methods for you to access At-Home Over the Counter (OTC) test kits at no cost.

At-Home OTC Test Kits available from the Federal Government - All Americans are now able to request free at-home COVID-19 tests from the federal government. Currently the limit is 4 OTC tests per household.

To request your free OTC Test Kits from the Federal Government, visit COVIDTests.gov, these tests are completely free to order, with tests expected to ship within 7 to 12 days. This website also includes a resource to locate any of the 20,000+ sites nationwide offering no cost antigen and PCR tests to everyone.

At-Home OTC Test Kits available from Washington State – Washington state has announced that it too will offer free tests for residents. The State advises 5 tests will be shipped to your home, free of cost within one to two weeks of placing the order. To request your free OTC Test Kits from Washington state, visit www.sayyescovidhometest.org.

At-Home OTC Test Kits Available from Medicare (Retirees) – The Centers for Medicare and Medicaid services (CMS) have advised starting in early spring, people with Medicare will be able to go to an eligible pharmacies and other entities that are participating in this initiative to receive over-the-counter COVID-19 tests for free through their Medicare part B coverage. More information about eligible pharmacies and other entities that are participating in this initiative will be available in the early spring.

At-Home OTC Test Kits covered by the Plan - The Plan is also complying with recent Federal government guidance requiring insurers, including the Trust's Plan, to cover 100% of the cost at-home OTC COVID-19 tests. This coverage is effective with tests purchased on or after January 15, 2022 through the end of the National Emergency Period, which was recently extended to April 16, 2022. The tests must have been authorized, cleared, or approved by the FDA and do not require a prescription or doctor's order.

Examples of FDA authorized, cleared, or approved OTC COVID-19 Antigen tests include, but are not limited to:

- BINAXNOW COVID-19 AG SELF TEST
- CARESTART COVID19 AG HOME TEST
- ELLUME COVID-19 HOME TEST
- FLOWFLEX COVID-19 AG HOME TEST
- IHEALTH COVID-19 AG RAPID TEST
- QUICKVUE AT-HOME COVID-19 TEST

The Plan will reimburse the cost of 8 tests every 30 days per covered individual in your household. Although tests may be sold in packages containing more than one test, *each test is counted separately*. Please note shipping and handling fees will *not* be reimbursed by the Plan.

The Plan will cover tests purchased for personal use only. Tests purchased for employment purposes and tests which have been (or will be) reimbursed by another source are **not** covered. Any OTC COVID-19 tests purchased and reimbursed by the Plan may not be resold.

At this time, to get reimbursement, you will need to submit a claim form and proof of purchase. To expedite your claim, we ask you to follow these steps:

1. Purchase the tests from any available retailer. OTC at-home tests are being sold at pharmacies as well as other retail outlets, as well as on-line. (if at all possible purchase tests separate from other items you may purchase so you have a clear receipt for the tests)
2. Take a photo or make a copy of the box the test is in, being sure to capture the UPC # and barcode
3. Either download from the Trust website at www.engineerstrust.com, or request from the Trust Office the required claim form
4. Complete the claim form and submit your claim (with receipt and photo):
    a. by email to claimstatus@wpas-inc.com; or
    b. by a paper claim via ground mail to:

    Operating Engineers Locals 302 and 612
    P.O. Box 34684
    Seattle, WA 98124-1684

Please take advantage of the free tests available to you from both the Federal and State governments and feel free to contact the Trust office at (877) 441-1212, option 1 if you have any questions.

For more information regarding OTC COVID-19 tests, you may be interested in checking out the Food and Drug Administration (FDA) website.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund

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Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

June 28, 2021

TO: All Plan Participants and Eligible Dependents
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: COVID-19 Vaccine

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

During the Public Health Emergency ("PHE") declared by the United States Department of Health and Human Services ("HHS"), the Plan will cover reasonable costs of the COVID-19 vaccine without cost sharing when provided by an in-network or out-of-network provider or pharmacy. Balance billing can occur when out-of-network providers charge more than Usual, Customary and Reasonable (UCR) costs.

When HHS declares the PHE has ended, the Plan will provide coverage for the COVID 19 vaccine as a Preventive Care benefit. Preventive Care benefits provided by an in-network Provider will be paid in full and will not be subject to the Calendar Year deductible or coinsurance. Preventive Care Services provided by an out-of-network Provider will be subject to the Plan deductible, coinsurance and Usual, Customary, and Reasonable (UCR) costs. Covered costs include the fee for vaccine administration by a health care provider or pharmacy.

If you have any questions, please contact the Trust Administration Office at (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

June 28, 2021

TO: **All Eligible Plan Participants**
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: **Changes to Dollar Bank Deduction for Monthly Coverage**

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Trust is primarily funded with contributions required under collective bargaining agreements between the IUOE 302 and 612 and signatory employers in Washington and Alaska. When those collective bargaining rates change, monthly amounts required for continued eligibility in the health plan also change.

The following changes have been made to the eligibility provisions:

Initial Eligibility

The minimum contribution required to establish Initial Dollar Bank eligibility for Hourly employees will change as follows with **June 2021 hours for August 2021 coverage**:

- from $1,509.00 to $1,616.00 in Washington, and
- from $1,852.00 to $1,991.00 in Alaska

(Contribution amount must be accumulated within a consecutive three-month period).

Continued Coverage

The monthly dollar bank deduction for coverage will change as follows for Bargained Hourly employees whose employers remit contributions for ALL hours worked, with **June 2021 hours for August 2021 coverage**:

- from $1,006.00 to $1,077.00 per month in Washington
- from $1,235.00 to $1,327.00 per month in Alaska

The monthly dollar bank deduction for coverage will change as follows for Associate and Bargained Flat Rate employees with **July 2021 hours for September 2021 coverage:**

- from $1,387.00 to $1,437.00 per month for Washington
- from $1,622.00 to $1,687.00 per month for Alaska

Any participant covered by a collective bargaining agreement that has an hourly contribution which is not at least equivalent to the AGC Master Labor Agreement and/or whose employer remits contributions on less than all of participants' hours worked in a month, will be charged the higher Bargained Flat Rate deduction factor, for a month of coverage.

Dollar Bank Maximum

Effective **June 2021 work hours for August 2021 coverage**, the maximum dollar amount that can accumulate in an Hourly employee's dollar bank is:

- $8,616.00 in Washington, and
- $10,616.00 in Alaska

If you have any questions, please contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 4.

Board of Trustees
Locals 302 and 612 of the International Union of Operating Engineers
Construction Industry Health and Security Fund

Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents, divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

March 1, 2021

TO: All Active Plan Participants and Eligible Dependents
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: Dental Benefit Changes

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Periodontics

The Plan provides a benefit for periodontal maintenance which limits coverage to one service in a consecutive four-month period. Effective October 1, 2020, the Scheduled Dental Benefit Limitations no longer requires this four-month period, and the benefit is revised as follows:

- **Periodontics:** Periodontal maintenance is covered for up to two services in a 12-month period. Periodontal scaling and root planing is covered for one service during any six consecutive month period.

The Scheduled Dental Benefits are described in detail beginning on page 52 of your 2020 Health and Security Plan booklet. Please note that this change does not apply to participants enrolled in the Willamette Dental option.

Dental Personal Protection Equipment

Effective **May 1, 2020 through June 1, 2021,** appropriately billed charges by a licensed dental office for dental personal protective equipment services will be covered up to $20 per visit.

If you have questions regarding dental benefits, please call the Administration Office Claims Department at (206) 441-7314 or (877) 441-1212, option 1.

Board of Trustees
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

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Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc

April 3, 2020

TO: All Participants and Eligible Dependents
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: Summary of Material Modification (SMM) - COVID-19

In its continuing effort to respond to the COVID-19 crisis, the Board of Trustees of the Locals 302 and 612 International Union of Operating Engineers Construction Industry Health and Security Fund (the "Trust") is implementing an additional coverage change effective **March 1, 2020**.

Many providers are converting scheduled appointments from an in-office visit to an over the phone or internet visit. Up until now, the Plan has had an exclusion for physician charges when the patient is not seen in person, other than with SwiftMD. Benefits under the Trust have been modified to limit this exclusion as follows until further notice:

The Trust will provide coverage for certain medical appointments which are not in-person and the exclusion at page 75 of your Health Plan Booklet will be limited to charges related to missed appointments and filling out forms:

- ~~Phone calls or~~ missed appointments or filling out forms. ~~Services where a patient is not physically seen by a physician or other covered provider except as provided under the Telemedicine benefit~~.

For a real-time interactive telephone or audio/video consultation (telehealth/telemedicine) visit to be covered, the Telehealth/telemedicine consultation must be diagnostic, and treatment focused via a live discussion or video exchange with ongoing participation by the patient and the provider throughout the visit. All services not related to COVID-19 testing are subject to applicable deductible and coinsurance unless otherwise stated in the Health Plan booklet.

The Trustees will continue to monitor as the COVID-19 health emergency develops. We recommend all participants and their families stay current on the recommendations of public health authorities with respect to best practices for keeping healthy. Below are several resources that are continually updated:

- US Center for Disease Control: https://www.cdc.gov/coronavirus
- Washington State Department of Health: https://www.doh.wa.gov/Emergencies/Coronavirus
- Alaska Department of Health and Social Services http://dhss.alaska.gov/dph/Epi/id/Pages/COVID-19/default.aspx

Important Note: the newest version of the Health Plan booklet is available online at https://www.engineerstrust.com and will be mailed to all participants in the near future.

As a reminder, a copy of the March 19, 2020 Summary of Material Modification mailing to all Participants is also posted on the Plan website. Please refer to that important notice regarding coverage for COVID-19 testing and SwiftMD telehealth services for Active and non-Medicare Retirees. There is no copay for the SwiftMD benefit – visits are available to you at no charge. All other telehealth services are subject to applicable deductible and coinsurance. Contact SwiftMD at SwiftMD.com or call 833-SWIFTMD (833-794-3863).

It is important to remember that the benefits provided to you by this Trust are self-funded. These benefits are not being provided by an insurance company. Benefits are paid directly from the contributions made by you and your employer. The Trustees continue to work hard to make sure this Plan provides the coverage you need in the most appropriate and cost-effective manner. If you have any questions, please contact the Trust Administration Office at 877 441-1212, option 1.

Sincerely,

The Board of Trustees

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 441-7314 or (877) 441-1212 • Fax (206) 505-9727 • Website: www.engineerstrust.com

Administered by
Welfare & Pension Administration Service, Inc

March 19, 2020

TO: All Participants and Eligible Dependents
Locals 302 and 612 IUOE Construction Industry Health and Security Fund

RE: Summary of Material Modification (SMM) - COVID-19

In light of the declaration of a world-wide pandemic arising from the outbreak of novel coronavirus (COVID-19) the Trustees are implementing this coverage change effective immediately. Benefits under the Locals 302 & 612 International Union of Operating Engineers Construction Industry Health Trust have been modified as follows until further notice:

1. The Plan will waive any medically necessary out-of-pocket costs associated with testing for COVID-19 for both PPO and non-PPO providers. This includes both the cost of the test as well as office visits or other provider charges related to the testing.

   NOTE: Treatment of COVID-19 is still subject to applicable cost sharing and PPO/non-PPO benefit levels depending on the provider's status.

2. The Plan will temporarily suspend any prior authorization requirement for treatment or testing of COVID-19.

3. The Plan will allow a one-time early refill on maintenance prescription drugs filled at retail or mail-order to avoid the need to leave home to refill a prescription if you are impacted by quarantine or illness. **(This early refill allowance will not apply to certain controlled substances).**

Telemedicine Benefit

If you are not feeling well, always contact a medical provider. Given the current strain on the healthcare system, public health officials have recommended that people consider telehealth services to get answers for their questions.. You have access to a doctor through **SwiftMD**, which allows you to connect with a Doctor 24/7 for remote care. **SwiftMD** doctors can provide consults for members who are suffering from symptoms of upper respiratory illness that occur with COVID-19 which include fever, cough, and shortness of breath. **There is no copayment for this benefit – a SwiftMD visit is available to you at no charge.**

SwiftMD doctors can provide supportive care to relieve symptoms, and answer questions about COVID-19 and help a member assess their risk factors, such as whether they have traveled to a high-risk area or been exposed to anyone who has traveled to a high-risk area or tested positive for COVID-19. Most cases are mild, and affected patients can isolate themselves at home to recover.

To schedule a consult log in at SwiftMD.com, or call 833-SWIFTMD (833-794-3863)

Included with this mailing is information from SwiftMD regarding COVID-19. If you have symptoms, we encourage you to use this option to seek medical advice at any time.

Future Developments

The Trustees will monitor as the COVID-19 health emergency develops. We recommend that all participants and their families stay current on the recommendations of public health authorities with respect to best practices for keeping healthy. Below are several resources that are continually updated:

- US Center for Disease Control: https://www.cdc.gov/coronavirus
- Washington State Department of Health: https://www.doh.wa.gov/Emergencies/Coronavirus
- Alaska Department of Health and Social Services http://dhss.alaska.gov/dph/Epi/id/Pages/COVID-19/default.aspx

The Health Plan booklet is available online at https://www.engineerstrust.com.

It is important to remember that the benefits provided to you by this Trust are self-funded. These benefits are not being provided by an insurance company. Benefits are paid directly from the contributions made by you and your employer. The Trustees continue to work hard to make sure this Plan provides the coverage you need in the most appropriate and cost-effective manner.

If you have any questions, please contact the Trust Administrative Office at 877 441-1212.

Sincerely,

The Board of Trustees

SWIFTMD
Talk to a doctor 24/7!

Coronavirus (COVID-19) FAQs

What is coronavirus (COVID-19)?

COVID-19 is a respiratory disease caused by a new coronavirus that was first detected in China and has been spreading across the globe. It is now affecting people in the United States.

What is the risk to me and my family?

Most cases are mild and for most of the American public, who are unlikely to be exposed to the virus at this time, the immediate health risk from COVID-19 is low. The elderly and people with pre-existing conditions are more vulnerable to severe illness, including illness resulting in death.

What are the symptoms?

The symptoms are fever, cough and shortness of breath, and usually appear 2-14 days after exposure. Occasionally the symptoms are more severe and may even require hospitalization.

How does COVID-19 spread?

The virus spreads from person-to-person through close contact, coughing and sneezing. People may also get COVID-19 by touching something that has the virus on it and then touching their own mouth, nose, or possibly their eyes. The virus is contagious and seems to be spreading easily.

How do I protect myself and my family members?

- Stay home when you are sick and avoid contact with those who show signs of illness.
- Cover coughs and sneezes with a tissue, then throw the tissue in the trash.
- Avoid touching your eyes, nose, and mouth.
- Wash your hands often with soap and water for at least 20 seconds and/or use an alcohol-based hand sanitizer.
- Clean and disinfect frequently touched objects and surfaces.
- Follow CDC's recommendations for using a facemask. Facemasks are not effective for healthy people trying to protect against COVID-19 but should be used by people who have symptoms to help prevent the spread of the disease to others.

What should I do if I think I may have COVID-19?

You should isolate yourself at home while you are sick, according to the Centers for Disease Control and Prevention (CDC). SwiftMD doctors can assess your symptoms, answer questions you may have about the disease, and provide supportive care for mild symptoms such as mild fever, cough or sore throat. For a definitive diagnosis, you will need to call your PCP's office to arrange for testing through your local health department, LabCorp or Quest Diagnostics. You should seek medical care in person if your symptoms worsen, such as high fever, weakness, lethargy or shortness of breath. Call ahead to let your healthcare provider know that you may have COVID-19 so they can take steps to prevent others from getting exposed or affected.

How is COVID-19 Treated?

There is no specific antiviral treatment recommended for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms. For severe cases, treatment should include care to support vital organ functions.

Get the most up-to-date information from the CDC.

To All Operating Engineers:

This booklet describes the benefits available to you and your family from your Health and Security Fund as of January 1, 2020. We encourage you to review this booklet carefully; it will help you understand what services are and are not covered and special steps you need to take to receive the highest level of coverage.

How you use your benefits can help make our health care dollar stretch further. Three things that you can do to help keep your health care costs reasonable are:

- **Use Preferred Provider Organization (PPO) Providers**. You and the Plan save money when you use PPO providers (hospitals, doctors, labs, etc.). These providers have agreed to provide eligible participants with efficient, cost effective services and supplies at a discounted rate.
- For prescription drugs, **use a network pharmacy**, and you won't have to fill out a claim form.
- **Use SwiftMD** to consult with a doctor, via phone or video conference, instead of using urgent care or an emergency room. There is no cost to you for this consultation.

Also, don't forget to notify the Administration Office whenever you have a change in family status or address (including a change in address for a dependent child). Dependents must be enrolled before benefits are payable.

If you have any questions about your eligibility or benefits, please call the Administration Office at (877) 441-1212 or (206) 441-7314.

Sincerely,

Board of Trustees

Union Trustees	**Employer Trustees**
Daren Konopaski	Andrew Ledbetter
Jason Alward	Corey Christensen
Sean Jeffries	Mike Lee
Curt Koegen	Mike Miller
Todd Mickelson	Mike Tucci

This booklet constitutes the Plan for the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund. It provides information about the benefits and how they work and is written as clearly and accurately as possible.

The Trustees will frequently review these benefits. The Board of Trustees has sole discretion to add, modify or eliminate provisions of the Plan (in whole or part) at any time for any group of employees or participants. The Trustees also have the right to terminate the Plan. If any changes occur, you will be notified and you will receive revised information.

The Board of Trustees has delegated to its third-party administrator and other designated entities the authority to provide certain administrative services to the Plan and provide information relating to the amount of benefits, eligibility and other Plan provisions. The Plan's third-party administrator or any other entity used by the Fund may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. The Plan's third-party administrator does not have the authority to change the provisions of the Plan. Administration of the Plan by the Plan's third-party administrator is subject to review by the Board of Trustees. No individual trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan.

In carrying out their respective responsibilities under the Plan, the Board of Trustees has sole discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits. Any interpretation or determination made under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was an abuse of discretion.

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Website

Locals 302 and 612 of the International Union of Operating Engineers Trust Funds have established a website to provide you with immediate access to your plan information. The site located at **www.engineerstrust.com** includes the following Trust Fund related material:

- Plan Booklets
  - Health and Welfare
  - Retirement
  - Updates to plan documents
- Website Links
  - Premera Blue Cross
  - OptumRx (actives and non-Medicare retirees/spouses)
  - VSP (vision service plan)
  - Other useful sites
- Forms
  - Health and Welfare Enrollment
  - Medical, dental, vision, weekly disability claims
  - Retirement
- HIPAA Privacy Notice and Information
- Local Union Contact Information and Website Links

This site will also provide a link to "My Personal Benefit" information, which may be viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security number. A PIN will be assigned and mailed to you upon your written request. To request a PIN, please complete a PIN REQUEST FORM which can be printed from the website. Please note that a PIN will be assigned. For security purposes you *may not* choose your own PIN. "My Personal Benefits" information includes the following data:

- Personal Information – Name, address, gender, birth date, marital status, etc.
- Health Eligibility – eligibility in the current and past eleven months
- Retirement – years of service, total hours and benefit amount
- Hours/Contributions – A statement showing recent employers reporting hours and contributions to the Fund on your behalf.
- Dependent Enrollment Information – names of enrolled dependents
- Beneficiary Designation
- Medical/Dental Claims Summary

Employees will only have access to their own paid claims history and that of dependents under the age of 13. Spouses and dependent children age 13 and over must request their own PIN. To request a dependent PIN, go to the Fund website (**www.engineerstrust.com**) and download a Dependent Only PIN form.

If you have any questions about the contents of the website or access to "My Personal Benefits" information, please contact the Administration Office at (877) 441-1212.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund (the "Trust") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex. The Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, gender identity, or sex.

Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the claims manager, PO Box 34203, Seattle, WA 98124-1203, (877) 441-1212, extension 3500, Fax (206) 441-9110.

You may 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
1-800-368-1019, 800-537-7697 (TDD)

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

Spanish - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-441-1212.

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-441-1212。

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-441-1212.

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-441-1212 번으로 전화해 주십시오.

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-441-1212.

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-441-1212.

Ukrainian - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-441-1212.

Mon-Khmer, Cambodian - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-441-1212.

Japanese - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-441-1212 まで、お電話にてご連絡ください。

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-441-1212.

Cushite - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-441-1212.

Arabic - ملحوظة: إذا كنت تتحدث اللغة، اذكر فإن تتوافر اللغوية المساعدة خدمات بالمجان لك. برقم اتصل-1-877-441-1212

Panjabi - ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-877-441-1212 'ਤੇ ਕਾਲ ਕਰੋ।

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-441-1212.

Laotian - ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-441-1212.

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-441-1212.

Samoan - MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-877-441-1212.

Ilocano - PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-877-441-1212

Thai - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-441-1212

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-441-1212.

Summary of Benefits - Actives

The following chart provides a brief summary of benefits for active employees as of the date of this booklet. For a complete description of the benefits listed below, refer to the appropriate section of this booklet. Please be aware that benefits and plan design may change from time to time, and you should read this booklet and any Summaries of Material Modifications which are issued, when reviewing for benefits.

For a description of Retiree Benefits, see page 64.

Medical Benefits	
Annual Deductible (7/1 – 6/30)	$300 per person $600 per family
Coinsurance (7/1 – 6/30)	**PPO Providers** – Plan pays 80% of the PPO Allowed Amount for most covered expenses until the out-of-pocket maximum is reached (see below), then the Plan pays 100% of most covered expenses for the rest of the coinsurance period **Non-PPO Providers** – Plan pays 70% of the Usual, Customary and Reasonable (UCR) Amount for most covered expenses (these expenses do not apply to the out-of-pocket maximum)
Out-of-Pocket Maximum (7/1 – 6/30)	$2,300 per person (including deductible) $4,600 per family (including deductible) Refer to page 25 for expenses that do not apply to the out-of-pocket maximum

Prescription Drug Program		
Retail Pharmacy Card (34 day supply maximum)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic	$10 copay	$10 copay
Preferred brand	$25 copay	$25 copay
Non-preferred brand	$40 copay	$40 copay
Mail Order (90 day supply maximum)		
Generic	$20 copay	
Preferred brand	$40 copay	
Non-preferred brand	$60 copay	
Out-of-Pocket Maximum (7/1 – 6/30)	$4,300 per person $8,600 per family Refer to page 47 for expenses that do not apply to the out-of-pocket maximum	

Dental Benefits – Schedule of Allowances* (see page 51)	
Calendar Year Maximum	$2,500 in Washington and all other areas outside of Alaska; $3,000 in Alaska
Orthodontic Lifetime Maximum	$2,500 in Washington and all other areas outside of Alaska; $3,000 in Alaska
***** If you are enrolled in the Willamette Dental plan, the dental benefits described in this booklet do not apply (see page 57)	

Vision Benefits	Schedule (see page 58)

Weekly Disability Benefit (for active employees only)	$300 per week Maximum of 39 weeks
Life Insurance Benefit (for active employees only)	$50,000
Accidental Death And Dismemberment (AD&D) Benefit (for active employees only)	$50,000 Principal Amount

All claims, with all supporting documentation regarding the service, must be submitted within one year following the date expenses were incurred. Incomplete claims will not be considered until all required information has been provided. Claims submitted or completed more than one year from the date of service will not be considered for payment and are excluded from coverage.

IN ORDER TO AVOID DELAY IN PROCESSING YOUR CLAIM, A COMPLETED ENROLLMENT FORM AND ALL REQUIRED DOCUMENTATION MUST BE ON FILE AT THE ADMINISTRATION OFFICE.

Eligibility Provisions

This Plan is funded by contributions made by employers, as specified in the collective bargaining agreements with Locals 302, 612, or Stationary Engineers Local 286 or in the associate agreements with the Fund.

It is your responsibility to check with your employer or the Administration Office to make certain that Health and Welfare contributions are being made for you by your employer.

Your eligibility depends on the employer contributions made on your behalf to the Fund pursuant to the terms of a collective bargaining agreement or associate agreement:

- If you are a bargaining unit employee and your employer contributes on a cents-per-hour basis at a rate that is at least equivalent to the AGC Master Labor Agreement, you will be considered an Hourly dollar bank employee and your eligibility is determined under a dollar bank system. (See the following section for eligibility information related to dollar bank employees.)
- If you are a bargaining unit employee and your employer contributes on a cents-per-hour basis, however at a rate that is below the AGC Master Labor Agreement, you will be considered a Monthly Flat Rate dollar bank employee and your eligibility is determined under a dollar bank system. (See the following section for eligibility information related to dollar bank employees.)
- If you are a bargaining unit employee (other than a Stationary Engineer), you work a minimum of 100 hours per month and your employer contributes on a flat-amount-per-month basis, you will be considered a Monthly Flat Rate dollar bank employee and your eligibility is determined under a dollar bank system. (See the following section for eligibility information related to dollar bank employees.)
- If you are a Stationary Engineer covered by a collective bargaining agreement requiring contributions to the Fund, or you are a non-bargaining unit associate employee covered by an associate agreement between your employer and the Fund, your eligibility is determined by payment of a flat-amount-per-month contribution on a month-to-month basis. (See page 14 for eligibility information related to month-to-month employees.)

Retired employees' eligibility and benefits are described beginning on page 64.

Dollar Bank Eligibility

Eligibility for bargaining unit hourly and flat rate employees (other than Stationary Engineers) is determined on the basis of a dollar bank system. Your dollar bank is an account containing employer contributions, which are made on your behalf pursuant to the terms of the collective bargaining agreement while you are covered under that agreement. Dollars are paid one month following the month you actually worked.

Contributions for hours you worked under the National Pipeline Agreement which were paid to the Pipe Line Employers Health and Welfare Fund will be credited to your dollar bank if:

- The contributions were transferred to the Plan within 120 days of receipt by the Pipe Line Employers Health and Welfare Fund;
- You were previously covered in this Plan; and
- The transfer is made pursuant to the National Pipeline Agreement.

Contributions for hours you worked under a "money follows the man" reciprocity agreement will be credited to your dollar bank when the contributions and report of hours are received from the sending Trust.

Initial Eligibility/When Coverage Begins

You are eligible on the first day of the second month following accumulation in your dollar bank of the minimum contribution required to establish initial eligibility, as set by the Board of Trustees from time to time. The minimum contribution amount must be reported and paid to the Fund within a consecutive three month period.

Here's how it works:

Calendar Months				
1	**2**	**3**	**4**	**5**
If you accumulate the required amount in your dollar bank in 3 consecutive calendar months			LAG	You are eligible the first day of this calendar month

If you earn the required amount in your dollar bank in *one* calendar month, you are eligible on the first day of the second following calendar month. Here's how it works:

Calendar Months		
1	**2**	**3**
If you accumulate the required amount in your dollar bank in 1 calendar month	LAG	You are eligible the first day of this calendar month

This lag month is necessary for the processing of reported hours by the Administration Office.

You have up to twelve months to accumulate the contributions over a three consecutive month period that are required to establish initial eligibility. If by the end of the twelve months for which the Plan has received contributions on your behalf, you have not yet accumulated sufficient contributions to achieve initial eligibility, the contributions received in the first month will be forfeited. Thereafter, the oldest month of contributions will be forfeited at the end of each twelve-month period in which you do not accumulate sufficient contributions to achieve initial eligibility.

From time-to-time the Trustees may provide subsidies to the initial and continuing eligibility qualification rules. Contact the Administration Office, or check on the Fund's website, for the current dollar bank amount required for initial eligibility.

Continuing Coverage

After becoming initially eligible, you must continue to accumulate sufficient contributions in your dollar bank to purchase a month of coverage at the current dollar bank deduction.

Contributions received in excess of the amount needed to purchase a month of coverage are added to your dollar bank and apply toward future coverage during months of little or no employment.

The maximum contributions you can accumulate at any one time is set by the Board of Trustees. As of the date of this booklet, the maximum you can accumulate in your dollar bank is eight months of coverage, after deduction for the current month's coverage.

From time-to-time the Trustees may provide subsidies to the initial and continuing eligibility qualification rules. Contact the Administration Office, or check on the Fund's website, for the current dollar bank amount required for continuing eligibility.

Acceleration of Initial Eligibility

Initial dollar bank eligibility may be accelerated if each of the following requirements are met:

- Your employer begins contributing to the Fund for the first time under a full compliance collective bargaining agreement on or after March 1, 2004, and signs a written agreement with the Fund to provide accelerated eligibility for all employees who qualify, or:
- If you are part of a new employee group which was employed by an employer that was not signatory to a full compliance agreement, and the new employee group is acquired on or after April 1, 2011 by an employer signatory to a full compliance agreement covering the new employee group and the employer

signs a written agreement to provide accelerated eligibility. An employee is considered part of a "new employee group" if the contributing employer: acquires substantial assets (such as a plant or division or substantially all of the assets of a trade or business) of the prior employer; or acquires all of the stock of the prior employer; or otherwise enters into a business transaction wherein the employer acquires the employees of the former employer and the former employer terminates employment of the new employee group.

AND

- You must be employed by the employer that is signatory to the full compliance agreement and covered by that agreement on the date accelerated eligibility becomes effective. If you become employed by the employer after the effective date of accelerated eligibility, or you are not covered by the collective bargaining agreement, you will not qualify for accelerated eligibility.
- The collective bargaining agreement must provide for payment of contributions on your behalf to the Fund on a cents-per-hour basis or a monthly flat rate basis. If contributions are paid on a flat rate basis, and your employer does not advance the cost of accelerated eligibility, the flat rate must be set at a rate to recover the cost of accelerated eligibility within 12 months of the first day of coverage.
- You were covered under the employer's (or prior employer's) group health insurance plan on the date immediately preceding the effective date of accelerated eligibility.

Accelerated eligibility becomes effective coincident with the termination of the employer's (or prior employer's) group insurance plan. The employer may elect to provide either one month or two months of accelerated eligibility for employees, with all employees receiving the same period of accelerated eligibility. If your employment terminates, accelerated eligibility terminates at the end of the month in which employment terminates. After expiration of accelerated eligibility, eligibility will continue only if you satisfy the dollar bank eligibility rules or apply for self-payment (COBRA) coverage pursuant to the provisions beginning on page 16.

To offset the cost of accelerated eligibility, once you establish dollar bank eligibility, the monthly dollar bank charge, plus an additional amount that is the lesser of the balance in the dollar bank (after deduction of the monthly dollar bank charge) or 25% of the monthly dollar bank charge, will be deducted from your dollar bank for each month of coverage. The additional amount will continue to be assessed until the total of the additional amounts equals the dollar value of the number of months of accelerated eligibility that you were provided.

The dollar bank will be used first to provide a month of current eligibility before assessing the additional amount. If the balance in the dollar bank is not sufficient to provide a month of current eligibility, then an additional amount will not be assessed for that month. However, any dollar bank balance that would otherwise be forfeited, because coverage is lost and not reinstated within a 14-month period, will be credited toward the amount due to offset the cost of the accelerated eligibility. If the cost of accelerated eligibility is not recovered before your dollar bank is forfeited, and you later reestablish eligibility, the Plan shall resume debiting your dollar bank for the additional amount remaining due.

If contributions are paid on a flat rate basis, and the employer advances the cost of accelerated eligibility, them there will not be a monthly charge to your dollar bank.

Work for a Non-Contributing Employer – Eligibility Freeze and Forfeiture

If you are eligible for benefits your coverage will be frozen if you commence work:

- In the industry, which means work for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and
- In a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or as an employee.

While your coverage is frozen, no benefits or claims are payable with respect to any expenses incurred by you or your dependents during the "freeze" period. This freeze period will be effective the first day of the

month following notification by the Administration Office to your address of record. If you continue to work for a non-contributing employer, after receipt of notice, you will permanently forfeit one (1) month of coverage from your dollar bank for each month in which you continue such employment or until your dollar bank has less than a month of eligibility at the current dollar bank deduction rate.

To reinstate frozen eligibility, you must return to work for a contributing employer and earn sufficient employer contributions to maintain continuing eligibility. If you do not reinstate dollar bank eligibility before your dollar bank decreases below the amount needed for a month of eligibility at the current dollar bank deduction rate, you will be required to satisfy the initial eligibility rules to again be covered.

The forfeiture provisions do not apply if you are temporarily employed under a written agreement with any of the Operating Engineers local unions participating in the Plan. Nor do the forfeiture provisions affect your or your dependent's COBRA rights.

When Coverage Ends for Dollar Bank Employees

Your coverage ends:

- On the last day of the month prior to any month your dollar bank account has less than a month of eligibility at the current dollar bank deduction rate.
- On the last day of the month after you enter the Armed Services of the United States, except for periods of Reservist Training, unless you elect to run-out your dollar bank coverage. If not, your dollar bank will be frozen until you qualify for reemployment rights. For more information, see Military Service on page 20.
- Upon termination of the Plan.
- On the last day of the month in which you fail to make any required self-pay contributions.

Reinstatement of Eligibility

If your coverage ends because your dollar bank has less than the current dollar bank deduction rate, the balance in your dollar bank account, if any, is carried for 14 months.

If during the twelve months beginning on the first day of the month in which you first lose coverage, you work and sufficient dollars are added to your account, your eligibility will be reinstated on the first day of the second month after the account has the minimum required for a month of eligibility, i.e., eligibility must be effective no later than the first day of the fourteenth month after you lost eligibility.

If eligibility is not reinstated by the first day of the fourteenth month following the date coverage ends, you are required to satisfy the initial eligibility rules to again be covered under the Plan. In addition, beginning the first day of the fourteenth consecutive month in which you do not reinstate eligibility, the oldest month of contributions in your account will be forfeited. Thereafter, on the first day of each consecutive month in which your account does not have sufficient contributions to reestablish eligibility, you will forfeit the oldest month of contributions in your account.

If you become an associate employee (described next), the balance in your dollar bank is retained and can be used when you no longer are eligible as an associate employee.

If coverage was terminated as the result of uniformed (military) service subject to USERRA, your coverage will be reinstated when the balance of your dollar bank is enough to cover the current dollar bank deduction rate or you make the necessary self-payment. See Reinstatement of Eligibility Following Military Service on page 22.

Month-To-Month Eligibility

To be eligible for benefits from this Plan, you must be a Stationary Engineer working under a collective bargaining agreement requiring contributions to the Plan, or a non-bargaining employee covered by an associate agreement between your employer and the Fund. Contributions are made by your employer on your behalf in a fixed amount per month. You will be eligible on the first day of the second calendar month following the calendar month you worked (e.g., work during March provides coverage for May). Your coverage is month-by-month; for each month the required contribution is made on your behalf, you earn a month of coverage.

When Coverage Ends for Stationary Engineers and Associate Employees

Your coverage ends:

- On the last day of the second calendar month following the month for which you last worked and your employer made the required contribution on your behalf.
- On the last day of the month after you enter the Armed Services of the United States, except for periods of Reservist Training, unless you elect to run-out your accrued eligibility. For more information, see Military Service on page 20.
- On the last day of the month in which the associate agreement is terminated.
- Upon termination of the Plan.
- On the last day of the month in which you fail to make any required self-pay contributions.

Dependents

Your eligible dependents are covered whenever you are covered, or on the date they become an eligible dependent, if later, provided you have completed an enrollment form and have submitted the proper dependent documentation.

Eligible dependents are your:

- Spouse (including your legally separated spouse).
- Your following children who are under age 26:
  - Natural children
  - Legally adopted children or children placed with you for adoption
  - Stepchildren
  - Foster children
- The following unmarried children who are under age 19 (or under age 24 if attending an accredited college, university or comparable educational institution as a full-course student), are dependent on you for their support and are not listed in the bullet above:
  - Children who depend on you by virtue of a court order
  - Children for whom you have legal custody

  For students you must continue to provide proof of enrollment. Coverage is not automatic each quarter/semester. To be covered during the summer, your dependent must be qualified as a full-time student the preceding spring quarter/semester and registered for the following fall quarter/semester.
- Benefits are continued beyond the limiting age for your unmarried child who is chiefly dependent on you for support and is incapable of earning their own living due to a developmental, physical or mental disability which began before reaching the limiting age. The child must be covered under this Plan when they reach the limiting age. Coverage will continue for the child as long as the incapacity continues and the child does not marry or become gainfully employed, if you remain eligible. Coverage

is not automatic; you must submit proof of the incapacity to the Administration Office within 31 days after the date the child reaches the limiting age. Periodic updates may be required.

If you have any changes in family status (e.g., marriage, birth of child, marriage of any of your children, death of any of your dependents or divorce) you must notify the Administration Office. If the change in family status is due to marriage, you must provide a copy of the marriage certificate. If the change in family status is due to divorce, you must provide a copy of the divorce decree, including parenting plan if applicable as soon as possible after entry with the Court. If benefits are paid by the Fund for an ineligible ex-spouse, the Fund will recover those overpaid amounts from the employee/participant. Also, benefits may only be extended under COBRA due to a divorce if the Administration Office receives notice of the divorce within 60 days from the last day of the month in which the divorce is final.

Qualified Medical Child Support Order

Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders (QMCSO) and enrolls an employee's natural dependent children, adopted dependent children and dependent children placed with the employee in anticipation of adoption as directed by the order. A QMCSO is any judgment, decree or order (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:

- Provides child support or health benefit coverage to a dependent child, or
- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the employee does not enroll the dependent child, then the non-employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- The name and last known mailing address of the employee,
- The name and mailing address of each dependent child covered by the order or the name and mailing address of the State official issuing the order,
- A description of the type of coverage to be provided by the Plan to each such dependent child,
- The period of coverage to which the order applies, and
- The name of each plan to which the order applies.

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

Payment of benefits by the Plan under a QMCSO to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian if so required by the QMCSO.

No eligible dependent child covered by a QMCSO will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

If a proposed or final order is received, the Administration Office will notify the employee and each child named in the order. The order will then be reviewed to determine if it meets the definition of a Qualified Medical Child Support Order. A properly completed National Medical Support Notice issued by a State agency shall be deemed to be a QMCSO. Within a reasonable time, the employee and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party or parties filing the order will be given an opportunity to correct the order. If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire QMCSO and any required self-payments pursuant to an order will be subject to all provisions applicable to dependent coverage under the Plan.

When Dependents' Coverage Ends

Your dependents' coverage ends:

- On the date your coverage ends.
- On the last day of the month for which the dependent no longer meets the definition of an eligible dependent as described in this section.
- On the last day of the month after the dependent enters the Armed Services of the United States, except for periods of Reservist Training.

If your dependents' coverage ends, your dependents may be eligible to continue coverage as described in the next section.

Continuing Your Coverage by Self-Payments (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), "qualified beneficiaries" may extend health benefits (medical, prescription drug, dental, vision) on a self-pay basis under certain circumstances called "qualifying events."

Qualified Beneficiaries

A qualified beneficiary means:

- Any individual who, on the day before a qualifying event, is covered under the Plan, either as an employee, or as a dependent of an employee or retiree.
- A child who is born to, adopted by, or placed for adoption with an employee (as opposed to another family member) during COBRA, provided the child is enrolled by submitting an enrollment form and a copy of the birth certificate or adoption papers to the Administration Office within 30 days of birth, adoption, or placement for adoption, and the appropriate self-payments are made. The child will have the same COBRA rights as a dependent who was covered by the Plan before the qualifying event that resulted in the loss of coverage.

Other dependents who are newly acquired during a period of COBRA may be enrolled in COBRA by submitting an enrollment form along with the appropriate certificates to the Administration Office within 30 days of becoming a dependent. However, such dependents will not be considered qualified beneficiaries.

Only qualified beneficiaries may extend COBRA when there is a second qualifying event.

An individual ceases to be a qualified beneficiary if COBRA is not timely elected, or when the Plan's obligation to provide COBRA otherwise ends.

18-Month Qualifying Events

You and your dependents may elect COBRA for a maximum of 18 months following the date coverage would otherwise end due to one of the following qualifying events:

- Your termination of employment; or
- Your layoff or reduction in hours of employment.

If Social Security determines that a qualified beneficiary is totally disabled either before the 18-month qualifying event or within the first 60 days of COBRA, the disabled individual and all qualified beneficiaries may extend COBRA an additional 11 months beyond the original 18 months, to a maximum of 29 months. In order to qualify for this extension, the qualified beneficiary must notify the Administration Office in writing before expiration of the initial 18 months of COBRA. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Administration Office in writing within 30 days of the determination. For an individual who has extended COBRA beyond the initial 18 months, COBRA will end on the earlier of 29 months from the qualifying event, or the month

that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

36-Month Qualifying Events

A dependent may elect COBRA for a maximum of 36 months following the date coverage would otherwise end due to one of the following qualifying events:

- Death of the employee;
- Divorce between the employee and spouse; or
- The dependent child ceases to meet the Plan's definition of "dependent."

In the event of the death of an employee, an eligible surviving spouse and dependent children may be eligible to continue coverage beyond the initial 36 months. See the Continuation Coverage for Surviving Spouses and Dependent Children section on page 22 for more details.

Second Qualifying Event

An 18-month period of COBRA may be extended an additional 18 months, for a total of 36 months, for the affected qualified beneficiary (spouse or child), if one of the 36-month period qualifying events occurs during the first 18 months of COBRA. In no event will COBRA extend beyond 36 months from the date coverage was first lost due to the initial qualifying event. This extension applies only if the qualified beneficiary notifies the Administration Office in writing within 60 days of the second qualifying event. The notice must identify the qualifying event that occurred. In the absence of such notice, COBRA will terminate.

Medicare Entitlement

If you have an 18-month qualifying event after becoming entitled to Medicare, your dependents may continue COBRA until the later of:

- 18 months from the date coverage would normally end due to the termination of employment or reduction in hours; or
- 36 months from the date you become entitled to Medicare.

Notice Requirements

The Plan offers COBRA only after it has been notified of a qualifying event. A qualified beneficiary is responsible for notifying the Administration Office of a qualifying event that is a divorce or child losing dependent status. **The qualified beneficiary must provide this notice to the Administration Office in writing within 60 days of the later of the date of the qualifying event; or the date coverage would be terminated as a result of the qualifying event; or the date this booklet or other notice is provided describing the procedure for electing COBRA.** The notice must identify the individual who has experienced a qualifying event, the employee's name, and the qualifying event which occurred. If the Administration Office is not notified during the 60-day period, the qualified beneficiary will lose the right to elect COBRA.

If a child is born to, adopted by, or placed for adoption with you during a period of COBRA, you must notify the Administration Office in writing within 30 days of the birth, adoption or placement for adoption, and provide a copy of the child's birth certificate or adoption papers. If the Administration Office is not notified in a timely manner, the child will lose the right to receive COBRA.

In order to qualify for a Social Security disability extension, the qualified beneficiary must notify the Administration Office in writing before expiration of the initial 18 months of COBRA. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Administration Office in writing within 30 days of the determination.

A qualified beneficiary who first becomes covered under any other group health plan after the date of the election of COBRA, must notify the Administration Office in writing of the other coverage.

The Administration Office will notify qualified beneficiaries of loss of coverage due to termination of employment, reduction in work hours, or the employee's death. However, you are encouraged to inform the Administration Office of any qualifying event to best ensure prompt handling of your COBRA rights.

Election of COBRA

When the Administration Office is notified of a qualifying event, an election form is mailed to the qualified beneficiaries. The election form must be completed and returned to the Administration Office within 60 days of the later of the termination of coverage, or the date the application was sent. If the election form is not sent to the Administration Office by this date, the qualified beneficiaries will lose the right to elect COBRA.

Each qualified beneficiary has an independent right to elect COBRA. An employee or spouse may elect COBRA on behalf of other qualified beneficiaries in the family. A parent or legal guardian may elect COBRA on behalf of a minor child.

Type of Benefits

The following benefit options are available under COBRA, provided the qualified beneficiary was eligible and properly enrolled for such benefits immediately prior to the qualifying event:

- Medical and prescription drug; or
- Medical, prescription drug, dental, and vision.

Life insurance, accidental death and dismemberment benefits, and weekly disability benefits are not available under COBRA.

Cost and Payment

There is a cost for COBRA. Information regarding the cost will be sent with the election forms. The first payment is due 45 days from the date the timely election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Thereafter, payments must be made monthly to continue COBRA. All payments must be sent to the Administration Office.

COBRA eligibility will not commence, nor will claims be processed for expenses incurred following the date coverage would have otherwise terminated, until the appropriate COBRA payments have been made. COBRA terminates if a monthly payment is made later than 30 days from the beginning of the month to be covered. If the initial payment, or any subsequent payment is not made in a timely fashion, COBRA terminates.

Notices

Notices and self-payments that are required for COBRA must be sent in writing to the Administration Office at the following address:

Locals 302 and 612 of the IUOE Construction Industry
Health and Security Fund
P.O. Box 34203
Seattle, WA 98124-1203

If you have any questions about continuation coverage, call the Administration Office.

For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor at **www.dol.gov/ebsa**, or call their toll-free number at (866) 444-3272.

Termination of COBRA

COBRA ends on the first of the dates indicated below:

- The last day of the month the maximum coverage period for the qualifying event has ended (18, 29, or 36 months).
- The last date for which the self-payment was paid, or when the qualified beneficiary does not make the next payment in full when due. Payments must be made within 30 days of the due date.
- The date the qualified beneficiary first becomes, after the date of election of COBRA, covered under any other group health plan which does not contain any exclusion or limitation that actually applies to any pre-existing condition of the qualified beneficiary.
- The date the qualified beneficiary becomes entitled to Medicare after the date of election of COBRA.
- The last day of the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled as determined by Social Security. This applies only to the 19th through 29th month of disability extended COBRA.
- The date the Fund no longer provides group health coverage.

COBRA is provided subject to eligibility. The Plan reserves the right to terminate COBRA retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Relationship Between COBRA, Medicare and Other Coverage

If you qualify for both COBRA and retiree medical, you and your dependents may elect COBRA in lieu of retiree medical. Following termination of COBRA, you and your dependents may apply for retiree medical. However, if COBRA is declined in favor of retiree medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

If you have Fund coverage based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Fund will only pay secondary and coordinate with Medicare. If you are eligible to enroll in Medicare Part A and Part B but do not enroll, the Plan's benefits will be paid as if you are enrolled and you will have greater out-of-pocket expenses.

If you have Medicare coverage based on end stage renal disease and have Fund coverage (based on COBRA or otherwise), the Fund will pay primary during the 30-month coordination period provided for by statute.

Health Insurance Marketplace

Instead of enrolling in COBRA, there may be other more affordable coverage options available through the Health Insurance Marketplace. Employees and dependents who enroll in coverage through the Marketplace may qualify for lower monthly premiums and lower out-of-pocket costs than under COBRA.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Losing your job-based coverage is a special enrollment event in the Marketplace. To qualify for special enrollment in a Marketplace plan, you must select a plan within 60 days before or 60 days after losing your job-based coverage. In addition, during an open enrollment period, anyone can enroll in Marketplace coverage.

Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace. If you or your dependents elect COBRA instead of a Marketplace plan, you will

have another opportunity to request special enrollment in a Marketplace plan if you have a new special enrollment event, such as marriage, the birth of a child, or if you exhaust COBRA. If you or your dependent elects COBRA you can also switch to the Marketplace during the Marketplace open enrollment. However, if COBRA is terminated early without an event that gives rise to a special enrollment, then Marketplace coverage is not available until the next Marketplace open enrollment period. Once COBRA is exhausted and expires, special enrollment is available through the Marketplace even if the open enrollment ended.

If the Marketplace Plan is selected instead of COBRA then COBRA may not thereafter be elected unless there is a new COBRA qualifying event.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit **www.healthcare.gov**.

Alternative Continuation Rights

There is no individual or group conversion option available for the medical, dental, or vision benefits provided by the Fund. However, your coverage may continue if you qualify for any of the alternative continuation rights set forth below.

Medical or Family Leave of Absence

A federal law known as the Family and Medical Leave Act (FMLA) may apply to family and medical leaves when you work for an employer with 50 or more employees within a 75-mile radius. All Plan benefits will continue while you are on FMLA leave. You and your dependents may be entitled to coverage for up to 12 work weeks during a 12-month period. If you think you may be eligible for a family or medical leave, contact your employer immediately. Your employer must make arrangements with the Fund to continue your coverage.

If you advise that you are not returning or if you do not return to work after your leave ends, coverage for all Plan benefits will end. You and your dependents will then be able to elect COBRA (see page 16).

Military Service

The following procedures apply for administration of coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) after an active employee enters military service.

Periods of Military Service—USERRA Continuation Coverage

If you leave employment with a contributing employer for military service, you have the following options:

- You may elect to run-out your dollar bank. When your dollar bank has less than one month of eligibility, you may elect to extend coverage by making self-payments for USERRA continuation coverage.
- You may elect to freeze your dollar bank until you return from military service. If you freeze your dollar bank, you still have the option of electing to self-pay for USERRA continuation coverage.

Notice of Military Service

You are responsible for notifying the Administration Office that you are entering military service. If you want to freeze your dollar bank, you must notify the Administration Office within 60 days of beginning military service.

If you want to run-out your dollar bank, and then elect USERRA continuation coverage, you must notify the Administration Office of your military service within 60 days of termination of your dollar bank coverage. If you fail to notify the Administration Office within the 60-day time period, you will not be entitled to elect USERRA continuation coverage.

Election of USERRA Continuation Coverage

After timely notification to the Administration Office of military service, you will be sent an election form to affirmatively elect to freeze your dollar bank and/or elect USERRA continuation coverage. Your completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. If you do not return your election forms by the due date, you will not be allowed to freeze your dollar bank or elect USERRA continuation coverage.

Length of USERRA Continuation Coverage

If you provide timely notice and properly elect to freeze your dollar bank, it will be frozen the first of the month following the month in which you begin military service.

If you properly elect to freeze your dollar bank and elect USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which you begin military service, provided the required self-payments are made.

If you decide to run-out your dollar bank before commencing USERRA continuation coverage, USERRA continuation coverage will begin the first day of the month following depletion of your dollar bank, provided the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

- 24 months following the month your dollar bank terminates or is frozen because of your entry into military service;
- The last day of the month in which you fail to return to employment or apply for a position of reemployment within the time required by USERRA; or
- The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage

You may elect to self-pay for USERRA continuation coverage for yourself, yourself and your dependents, or only your dependents.

You may elect the following coverage options:

- Medical, prescription drug, dental and vision.
- Medical and prescription drug only.

Once you elect a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated active employees. If the Fund changes its benefits, USERRA continuation coverage will also change.

USERRA continuation coverage is not available for weekly disability, life insurance, or accidental death and dismemberment benefits.

Monthly Self-Payments Required

If your military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Administration Office will notify you of the self-payment amount when it sends you the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made, at which time eligibility will be retroactive to the date your dollar bank coverage ended (or was frozen).

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Administration Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date your dollar bank coverage ended (or was frozen).

Reinstatement of Eligibility Following Military Service

If you properly elected to freeze your dollar bank when you entered military service, the balance in your dollar bank will be carried over until you have a USERRA qualifying discharge from military service. Your dollar bank eligibility will be reinstated the first of the month in which you are discharged provided you have sufficient dollars for a month of coverage. Following reinstatement, dollar bank eligibility will terminate the first day of any month your dollar bank account has less than a month of eligibility at the current dollar bank deduction rate. You are responsible for notifying the Administration Office of your discharge from military service.

If you return to employment with a contributing employer immediately following military service and within the time period required by USERRA, your dollar bank eligibility will be reinstated on the first day of the second month after your dollar bank account has the minimum required for a month of coverage. Pending reinstatement of dollar bank eligibility, you may make self-payments for coverage. If you elected to freeze your dollar bank when you entered military service and you return to employment within the time period required by USERRA, you may make self-payments if you fail to work sufficient hours to reinstate dollar bank eligibility before the previously frozen dollar bank runs out.

To request self-pay continuation coverage after leaving military service, you must notify the Administration Office within 30 days following your return to employment. After timely notification, the Administration Office will provide an election form. Your completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the date it was mailed to you. The initial payment to continue coverage must be included with the completed election form, and cover all months through which the first payment is made. The self-payment rate is the same as the COBRA continuation rate. The coverage provided will be that stated under USERRA continuation coverage.

The self-pay coverage must be continuous, and must commence the later of the first of the month in which you return to employment within the time specified by USERRA or the first of the month following the termination of your previously frozen dollar bank eligibility. The reinstated coverage terminates on the earliest of your receipt of six consecutive months of reinstated coverage, reinstatement of your dollar bank eligibility based upon your hours worked, or the last day of the month for which a timely self-payment is not received or postmarked.

If you are on the out-of-work list at the local union, it is considered a return to employment with a contributing employer for purposes of making self-payments for coverage.

Regardless of whether you want to make self-payments for coverage, you should contact the Administration Office if you return to employment within the time required by USERRA, so that your dollar bank may be credited with any dollars that remained in your account when you left for military service, and eligibility can be reinstated without satisfying the rules for initial eligibility.

Relationship of USERRA Continuation Coverage to COBRA

You may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If you have questions regarding election or duration of COBRA continuation coverage, contact the Administration Office.

Continuation Coverage for Surviving Spouses and Dependent Children

Once the continuation of coverage through COBRA is exhausted, eligible surviving spouses (and dependent children if any), may apply for continuation of coverage through self-payment of monthly contributions.

The surviving spouse may continue coverage until remarriage, death, or termination of the Plan, whichever occurs first. In order for a surviving spouse to continue coverage beyond the normal COBRA period, the surviving spouse must notify the Administration Office of his or her election and continue making the required self-payment in a timely manner. The surviving spouse must also continue to meet any other eligibility criteria defined by the Plan, as may be amended or modified. The dependent child who continues coverage under this provision will be allowed to continue coverage up to the Plan's limiting age provided the child continues to meet any other eligibility criteria under the Plan, as maybe amended or modified from time to time.

Medical Benefits

The Medical Benefits described in this section apply to active employees and their dependents. For a description of Retiree Benefits, refer to the appropriate section beginning on page 64.

The Plan provides benefits for the necessary treatment of non-occupational injury or illness for you and your eligible dependents.

Throughout the Medical Benefits section, "you" refers to any covered person (including enrolled eligible dependents), unless otherwise noted. Other important terms are defined in the Definitions section beginning on page 82.

All Medical Benefits, unless stated otherwise, are based on the PPO Allowed Amount for PPO providers or the Usual, Customary and Reasonable (UCR) Amount for Non-PPO providers.

The Plan, its third party administrator, and its utilization review organization may utilize internal guidelines or medical protocols (including guidelines and protocols used for diagnosis, treatment, prescription or billing practices) in determining whether or not specific services or supplies are covered.

Preferred Provider Organization (PPO)

When you require health care, you may choose any covered physician, hospital or health care provider. However, benefits may be more favorable if you receive care from a PPO provider.

If Medicare is your primary insurance, you do not need to use PPO providers. Medicare already has special negotiated rates with most providers.

Premera Blue Cross is the PPO in Washington and Alaska. It includes hospitals, physicians and other providers. If you plan to receive medical care in Washington or Alaska, be sure to call Premera Blue Cross at (800) 810-2583 or visit its website at **www.premera.com** for a current list of PPO providers.

Outside of Washington and Alaska, the Plan uses BlueCard nationwide network. BlueCard PPO is made up of other BlueCross/BlueShield (BCBS) carrier's providers in Clark County Washington, throughout the United States, and in Puerto Rico and the U.S. Virgin Islands. See the Out-of-Area Care section on page 103 for more details. If you plan to visit or receive medical care outside of Washington and Alaska, be sure to call Premera Blue Cross at (800) 810-2583 or visit its website at **www.premera.com** for a current list of providers.

To receive the highest level of benefits, choose PPO providers and/or hospitals and make sure all providers that may be involved in your medical treatment are PPO providers. For example, if you are expecting to have surgery, inform your physician that when providers involved in your surgery (such as an assistant surgeon or anesthesiologist) are PPO providers, you receive higher benefits from your Plan. Also, try to make sure that any freestanding lab or x-ray services used by your physician in your medical treatment are covered PPO providers.

Utilizing PPO providers can reduce your out-of-pocket expense because these providers have agreed to discount their fees. PPO providers also agree not to bill you for amounts over the discounted amount, which may save you money.

Annual Deductible (7/1 – 6/30)

The deductible is the amount of covered expenses which you must pay in one deductible period before any benefits are payable by the Plan. The deductible period is July 1 through June 30 of the next year.

Annual Deductible (July 1 through June 30)	
Each person	$300
Each family	$600

This means you pay the first $300 of covered expenses in the annual deductible period (July 1 through June 30). The deductible is limited to $600 for a family each deductible period. Once the family deductible is reached, no further deductible amounts will be required for any family member in the rest of that annual deductible period. Noncovered expenses and any copays for services received at the Coalition Health Center (see page 44) do not apply to the deductible.

If two or more enrolled eligible members of your family are injured in the same accident, only one $300 deductible will be charged against the combined total covered expenses resulting from that accident, regardless of the number of family members injured.

Coinsurance (7/1 – 6/30)

After you satisfy the deductible, you and the Plan share the remaining covered expenses; the coinsurance period is July 1 through June 30.

Coinsurance amounts are based on:

- PPO Allowed Amounts for services or supplies provided by PPO providers; these amounts are negotiated by the PPO.
- Usual, Customary and Reasonable (UCR) Amounts for services or supplies provided by Non-PPO providers. The Plan determines UCR Amounts as described on page 87.

Coinsurance amounts are shown in the following table.

Type of Provider	Coinsurance Amount
PPO providers	For most covered expenses, the Plan pays 80% of the PPO Allowed Amount until the annual out-of-pocket maximum is reached; then the Plan pays 100% of most covered expenses for the rest of that coinsurance period
Non-PPO providers	For most covered services the Plan pays 70% of the UCR Amount; see Exceptions below*

* Exceptions:

(1) If you incur covered expenses in the emergency department at a Non-PPO hospital for an Emergency Medical Condition, the Plan will pay 80%/100% of the UCR Amount.

(2) If you incur covered expenses that are not for treatment of an Emergency Medical Condition and the services are not available from a PPO provider or hospital, the Plan will pay 80%/100% of the UCR Amount. You must submit proof that the services were not available from a PPO provider or hospital, within a 50 mile radius, of the area in which you received the services and your home or work geographic area.

(3) If you incur covered expenses for treatment by a Non-PPO provider, and you had no choice in the selection of the provider or knowledge the provider was a Non-PPO provider, such expenses may be reimbursed at 80%/100% of the UCR Amount on a one-time exception basis; you must submit proof that you had no choice in provider selection or knowledge of the use of a Non-PPO provider.

Annual Medical Out-of-Pocket Maximum (7/1 – 6/30)

The Annual Medical Out-of-Pocket Maximum is the most you pay toward medical covered expenses received from PPO providers. This means that once you've reached your Annual Medical Out-of-Pocket Maximum, the Plan pays 100% of the PPO Allowed Amount for most covered medical expenses for the remainder of the coinsurance period (July 1 through June 30).

The Annual Medical Out-of-Pocket Maximum may change from time to time. The following apply as of the date of publication of this booklet.

Annual Medical Out-of-Pocket Maximum (7/1 – 6/30)	
Each person	$2,300*
Each family	$4,600*

* Including the deductible

The Annual Medical Out-of-Pocket Maximum generally includes your 20% coinsurance amount, the annual medical deductible, and any copays for Coalition Health Center services. However**, the following do not apply toward the Annual Medical Out-of-Pocket Maximum:**

- 30% coinsurance for services received from Non-PPO providers.
- Copay ($100) for nonemergency admittance to a Non-PPO hospital.
- Benefits for foot orthotics and other supportive devices of the feet.
- Expenses that are in excess of the Plan limits.
- Expenses not covered by the Plan.
- Expenses in excess of UCR Amounts (see page 87).
- Alternative Treatment benefits.

SwiftMD Telemedicine Services

SwiftMD is an affordable alternative medical treatment option to costly urgent care or emergency room visits. It provides access to U.S. board-certified doctors who can treat many of your medical issues by phone or video 24/7, 365 days a year. The Plan covers SwiftMD visits in full; they are not subject to the medical annual deductible or coinsurance provisions of the Plan. This benefit is not available to individuals for whom Medicare is primary.

SwiftMD physicians are emergency medicine and family practice doctors with a minimum of ten years of practicing medicine, expert in dealing with a range of common medical conditions such as:

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

To set up a phone or video call with a SwiftMD doctor:

- Visit **www.mySwiftMD.com** and click on "Activate Your Account". Enter Group Passcode: IUOE302&612, name, birthdate and email address and enter your medical history

Or

- Call (877) 999-7943

Coverage Requiring Preauthorization

Understanding whether medical services are considered Medically Necessary by the Plan before receiving those services is very important. The Plan only provides benefits for services that are determined to be Medically Necessary. To assist in this process, the Plan requires preauthorization of all inpatient admissions, as well as some outpatient services. This program is intended to ensure you are hospitalized, or receive certain outpatient services, only when Medically Necessary, and for the appropriate length of

stay when admitted. The Plan has contracted with First Choice Health (FCH) to review these services for Medical Necessity.

If you do not obtain preauthorization, First Choice Health (FCH) will determine Medical Necessity when the claim is submitted. If it is determined that the care you received was not Medically Necessary, benefits will not be provided.

Preauthorization will determine medical necessity only. You should contact the Administration Office to confirm eligibility for coverage, that the requested service is a covered medical expense and coverage limitations.

Note: If you have Medicare or other insurance as your primary insurance, preauthorization through First Choice Health is not required.

To obtain preauthorization of medical necessity, your provider or you should contact First Choice Health (FCH) at (800) 986-9156.

To confirm your eligibility or whether the service you are pre-authorizing is a covered expense, contact the Administration Office at (206) 441-7314 or (877) 441-1212, option 1.

The types of services which require preauthorization include but are not limited to:

- Ambulance (except in life threating circumstances)
  - Air transport – elective
  - Air transport emergent – retrospective review
- Anesthesia for dental services
- Biofeedback
- Chimeric Antigen Receptor (CAR) T-cell therapy
- Clinical trials (any interventions provided under a clinical trial)
- Dental trauma services (follow-up services)
- Dialysis – all types
- Durable medical equipment, medical supplies and prosthetics such as:
  - Bone growth simulators
  - Custom fabricated knee braces
  - Cranial orthotic devices
  - Dynamic splinting systems
  - Electrical stimulators - spinal - external
  - Oscillatory devices and cough stimulating devices
  - Neuromuscular stimulators
  - Prosthetics
    - Myoelectric prosthetic components for the upper limb
    - Powered ankle-foot prosthesis, microprocessor-controlled ankle-foot prosthesis and microprocessor-controlled knee prosthesis
  - Speech generating devices
  - Custom power operated and manual wheelchairs and supplies
    - Standard manual wheelchair rental for transition of care for up to 3 months does not need preauthorization

  - Scooters
  - Wearable defibrillators
- Facet joint injections, medial branch blocks and neurotomies (any location)
- Genetic testing over $500
- Home health care services
  - Enteral formula, medical food and associated services
  - Home health visits (for wound therapy only)
  - Hospice
- Hyperbaric oxygen therapy
- Imaging
  - Cardiac CT angiography and coronary calcium scoring
  - PET scans
- Inpatient admissions
  - Chemical dependency and mental health admissions
  - Partial hospital program admissions for chemical dependency or mental health
  - Inpatient hospice
  - Inpatient rehabilitation admissions
  - Long-term acute care facility
  - Medical/surgical admissions (excluding routine maternity deliveries)
  - Skilled nursing admissions
- Medical Injectables and other drugs. (The following list may not be all-inclusive. Newly FDA approved specialty drugs not included on the list below may also require preauthorization.) If you have questions, please call FCH at (800) 986-9156.
  - Abatacept (Orencia®)
  - Ado-trastuzumab emtansine (Kadcyla™)
  - Afibercept (Eylea®)
  - Agalisdase Beta (Fabrazyme®)
  - Alglucosidase alfa (Lumizyme®)
  - Atezolizumab (Tecentriq®)
  - Avelumab (Bavencio®)
  - Belimumab (Benlysta®)
  - Bevacizumab (Avastin®)
  - Blood clotting factors – all
  - Bortezomib (Velcade®)
  - Botulinum toxin (all types and brands)
  - Cetuximab (Erbitux®)
  - Cerliponase alfa (Brineura™)

- C1 Esterase inhibitors
- Daratumumab (Darzalex®)
- Ecallantide (Kalbitor®)
- Edaravone (MCI-186, Radicava, Radicut®)
- Elotuzumab (Empliciti™)
- Epoprostenol (Flolan®)
- Eteplirsen (Exondys 51™)
- Guselkumab (Tremfya®)
- Hyaluronan (all brands such as Synvisc®, Orthovisc®)
- Icatibant acetate (Firqzy®)
- Infliximab (Remicade®) and Biosimilar
- Inotuzumab Ozagamicin (Besponsa™)
- Intravenous immunoglobulin (IVIG) therapy (all types and brands)
- Ipilimumab (Yervoy®)
- Mepolizumab (Nucala®)
- Natalizumab (Tysabri®)
- Nivolumab (Opdivo®)
- Nusinersen (Spinraza™)
- Ocrelizumab (Ocrevus™)
- Omalizumab (Xolair®)
- Palivizumab (Synagis)
- Pegaptanib (Macugen®)
- Pembrolizymab (Keytruda®)
- Pemetrexed (Alimta®)
- Ranibizumab (Lucentis®)
- Rituximab (Rituxan®)
- Romiplostim (Nplate®)
- Sipuleucel-T (Provenge)
- Taglicerase alfa (Eleyso™)
- Tocilizumab (Actemra®)
- Trastuzamab (Herceptin®)
- Ustekinumab (Stelara®)
- Vedolizumab (Entyvio™)
- Velaglucerase alfa (VPIV®)
- Voretigene Neparvovec-Rzyl (Lustuna™)
- Ziv-aflibercept (Zaltrap®)

• Organ and bone marrow transplants

  - Notification only for evaluation
  - Pre-authorization for services of recipient and donor
  - Pre-authorization for travel and lodging
- Peripheral nerve blocks
- Radiation Therapy
  - Proton beam, neutron beam or helium ion radiation therapy
  - Stereotactic body radiation therapy (SBRT)
  - Stereotactic radiosurgery (Gamma Knife, Cyber Knife)
- Surgery
  - Abdominoplasty/panniculectomy
  - Bariatric surgery
  - Breast surgeries - selected (pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
    - Implant removal
    - Mastectomy for gynecomastia
    - Reduction mammoplasty
  - Cosmetic or reconstructive surgery
  - Cochlear implants (surgical benefit applies)
  - Deep brain stimulation
  - Eyelid surgery (i.e. blepharoplasty)
  - Fetal/intrauterine surgery
  - Gender reassignment surgery
  - Implantable spinal cord stimulator placement (trial/temporary and permanent placement of electrodes and/or generator/receiver
  - Spinal surgery - selected
    - Artificial intervertebral disc
    - Cervical fusion
    - Lumbar fusion
    - Minimally invasive, percutaneous or endoscopic spine surgery
    - Percutaneous vertebroplasty, kyphoplasty, sacroplasty and coccygeoplasty
  - Orthognathic surgery
  - Rhinoplasty
  - Surgical interventions for sleep apnea
  - TMJ surgery
  - Varicose vein procedures
  - Ventricular assist device and total heart replacement
- Transcranial magnetic stimulation

- Experimental and Investigational services are not covered, except as outlined under the Clinical Trials benefit. If a service could be considered Experimental or Investigational for a given condition, the Fund recommends you contact the Administration Office for a determination of coverage in advance of services.

Individual Case Management

Under special circumstances, First Choice Health nurses act as patient advocates to help meet the needs of patients with catastrophic or chronic medical problems. They work with you, your family and your physician to help you assess, plan and coordinate all of your health care options and find the most appropriate care for your condition. This is a voluntary program available at no cost to you.

Hospital Discharge Planning

Discharge planning helps in situations when you require continued medical care, but not necessarily care that is as intensive as in an acute setting. Case management nurses will work with you, your physician and the hospital staff to develop a plan that allows for safe release from the hospital. Working with your physician and the hospital staff, the case management nurses can also arrange home health care, skilled nursing facilities and hospice care.

Catastrophic/Chronic Illness

The case management program can help patients with long-term, high-cost illnesses and injuries to obtain needed care. A patient who chooses to participate is assigned a case manager to help coordinate care. Many times case managers identify hospital alternatives, such as home health care or skilled nursing facilities.

Other Treatment Options

Hospital confinement is not always the best environment for treating an illness. For a patient who needs significant long-term medical supervision, case management may recommend other treatment options that are:

- Not normally covered by the Plan
- Covered by this Plan, but payable on a different basis from the care and treatment they replace
- Payable on the same basis as the care and treatment they replace, once approved.

In these situations, the Plan may approve coverage for other treatment options that would otherwise not be covered, when Medically Necessary treatment can be delivered most cost-effectively.

Contact the Administration Office when you need details about how any case management service applies to you.

BridgeHealth Medical Surgery Benefit

For participants residing in Alaska, the Fund has contracted with BridgeHealth to provide access to high quality providers across the United States. This benefit is not available for individuals for whom Medicare is primary.

BridgeHealth Medical provides access to a wide range of tools and resources to help you make medical decisions – like whether or not to have major surgery. Many times there are viable alternatives to surgery. The BridgeHealth Medical program empowers you to understand all of your options. It gives you the tools to make informed decisions and confidently discuss with your doctor the treatment that is best for you. With the BridgeHealth Medical program you get:

- Access to the BridgeHealth website. Use the interactive tools and resources to better understand your diagnosis and treatment options.
- Access to CareChex® quality ratings. CareChex is an independent hospital rating service available through the BridgeHealth website.

If surgery is necessary and BridgeHealth accepts the case, you will have access to Centers of Excellence facilities across the country.

Upon acceptance of your case, the following enhanced Plan provisions apply when you utilize BridgeHealth network providers:

- Your Medical Benefits deductible and coinsurance will be waived;
- Airfare and hotel are covered for the patient and companion, if medically required;
- A meals and incidentals allowance will be provided; and
- A BridgeHealth care coordinator will help coordinate all aspects of your surgery by helping collect the required medical records, assisting with provider selection and making travel arrangements.

Certain non-medical benefits under BridgeHealth may be taxable and you may receive a Form 1099 in the event you receive these non-medical benefits – please consult your tax advisor with questions.

You should contact BridgeHealth for information about the program if you or your dependents have planned major surgeries such as:

- Hip surgery
- Knee surgery
- Shoulder surgery
- Back surgery
- Heart surgery
- Women's health surgery
- Bariatric surgery
- General surgery

BridgeHealth does not cover all surgeries. The services and provider must be approved by BridgeHealth before access is provided.

To obtain more information about this benefit, contact BridgeHealth at (855) 423-1294 and identify yourself as a Locals 302 & 612 Health and Security Fund participant or email them at **iuoe@bridgehealthmedical.com**.

Covered Medical Expenses

Most Medically Necessary services and supplies required for the treatment of non-occupational illness or non-occupational accidental injury are considered covered expenses under the Medical Benefits. All covered medical expenses are subject to the exclusion sections beginning on pages 41 and 75.

Air Transportation/Air Ambulance is covered and will be provided to the nearest facility available with the appropriate services when immediate and rapid transport is required due to the nature and severity of the patient's illness or injury. Medical necessity and appropriateness is only established when the patient's condition is such that use of any other method of transportation poses a threat to the patient's survival or seriously endangers the patient's health.

Air ambulance will be provided in lieu of ground ambulance as follows:

- For transfers to a medical facility for treatment when other transportation is not medically feasible, and
- When transportation is Medically Necessary and appropriate and other means of transportation would endanger the patient's health, and
- The purpose of the transportation is not for personal or convenience reasons.

Transportation within the United States on a regularly scheduled commercial airline flight is also covered for the patient only, and limited to round trip coach airfare, if:

- Special and unique covered services are required which cannot be provided by a local provider, and
- Transportation is Medically Necessary, and
- Transportation is to the nearest hospital equipped to furnish the services.

Alternative treatments listed below are covered at 50% of the PPO Allowed Amount or UCR Amount for covered expenses to a maximum of $50 per visit and $300 maximum inclusive for all treatments per calendar year. Your share of the coinsurance does not apply to the Annual Medical Out-of-Pocket Maximum.

- Hypnosis
- Acupuncture
- Dietary Counseling
- Nutritional Counseling

Benefits are only provided for alternative treatment if it is otherwise a covered expense under the Plan and performed by a provider licensed to perform the services. Diabetic education by a registered dietician is not subject to the $300 calendar year maximum.

Ambulance (Ground) by a professional ground ambulance service is covered when used to transport you or your enrolled dependent to or from the nearest facility available with the appropriate services, when necessary to protect you or your dependents' life or health. Transportation within the United States by a professional ground ambulance is also covered if:

- Special and unique covered services are required which cannot be provided by a local provider, and
- Transportation is Medically Necessary, and
- Transportation is the nearest hospital equipped to furnish the services.

Anesthesia and its administration.

Assistant surgeon charges for Medically Necessary surgical assistance by a physician or a physician assistant (PA); the benefit payable will be based on 20% of the PPO Allowed Amount or the UCR Amount for the corresponding surgery.

Preauthorization is required for inpatient admissions and some surgical services. See Coverage Requiring Preauthorization on page 26.

Cancer screenings – see the Preventive Care benefits on page 39

Clinical Trials. The Plan does not provide benefits for services and supplies which are Experimental or Investigational. However, routine patient costs for items and services furnished in connection with an approved clinical trial will not be considered Experimental or Investigational if the item or service would otherwise be a covered expense for an eligible individual who is not enrolled in the clinical trial.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

Routine patient costs for items and services furnished in connection with an approved clinical trial must be preauthorized by First Choice Health (FCH). If you do not obtain preauthorization, First Choice Health (FCH) will determine medical necessity when the claim is submitted. If it is determined that the care you received was not Medically Necessary, benefits will not be provided.

Cochlear implants, and any associated hearing exams, are covered for adults with severe to profound hearing loss due to non-occupational illness or non-occupational injury and who otherwise meet required medical criteria. Benefits are also provided to children (under age 18) who meet required medical criteria.

Preauthorization is required for cochlear implants. See Coverage Requiring Preauthorization on page 26.

Diagnostic x-ray and laboratory examinations. Charges for routine/preventive x-rays and laboratory examinations may be covered under the Preventive Care benefit (see page 39).

Durable medical equipment rental and supplies, including, but not limited to, wheelchair, hospital bed, and crutches, which are:

- Ordered by a physician.
- Of no further use when medical need ends.
- Usable only by the patient.
- Not primarily for the comfort or hygiene of the patient.
- Not for exercise.
- Manufactured solely for medical use.
- Approved as effective and usual and customary treatment of the condition (as determined by the Plan).
- Not for prevention purposes.

Preauthorization is required as described under Coverage Requiring Preauthorization on page 26.

Rental charges (or purchase when approved by the Fund) that exceed the reasonable purchase price of the equipment are not covered. Batteries and/or equipment maintenance costs are not covered. Deluxe items are not covered.

Expenses for equipment prescribed while eligible under the Plan will be covered if delivered within 30 days of your loss of eligibility.

Emergency room outpatient treatment in a hospital. For an illness you must pay a $75 copay per visit for emergency room services.

You must notify FCH about hospital inpatient admissions from the emergency room. See Coverage Requiring Preauthorization on page 26.

End stage renal disease (ESRD) may make you eligible for Medicare coverage by nature of the diagnosis. You are not obligated to apply for and enroll in Medicare Part A and/or Part B if you have ESRD, but Plan benefits will be based on the assumption that you enroll in Medicare when eligible to do so. Enrolling in Medicare when eligible may also offer some protection from balance billing by the provider of ESRD services. Balance billing means the difference between the billed amount and the amount paid by the Plan and/or Medicare.

The Plan provides the following benefits for outpatient kidney dialysis for treatment of ESRD:

- If you are not yet eligible to enroll in Medicare (months 1-3 post diagnosis), benefits are subject to the annual deductible and coinsurance of 20% of the PPO Allowed Amount for PPO providers or 30% of the UCR Amount for Non-PPO providers.
- If you are enrolled in, or are eligible to enroll in Medicare (months 4-34 post diagnosis), and Medicare becomes or is eligible to become the secondary payer for ESRD services and supplies (regardless of whether you are actually enrolled in Medicare), benefits for kidney dialysis are provided at 150% of the current Medicare allowance, and are also subject to the annual deductible and coinsurance of 20% of the PPO Allowed Amount for PPO providers or 30% of the UCR Amount for Non-PPO providers.
- Whether you enroll in Medicare or not, when Medicare becomes the primary payer for ESRD service (or should have become the primary payer but for your failure to enroll in Medicare), the Plan pays secondary to Medicare benefit levels and coordinates benefits up to 100% of the then current Medicare allowed amount for kidney dialysis.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD

services than listed above, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

If you or your dependent is diagnosed with ESRD, contact the Administration Office for assistance.

Foot orthotics or other supportive devices of the feet are limited to braces, splints, insoles and supports prescribed by a physician for the treatment of an illness or injury to the foot. Impression casts required for the fitting of these devices are also covered. The device must be worn at all times that shoes are worn and not just for specific activities. Shoes that accompany these braces are not covered.

The calendar year maximum benefit payable is $350 per person. Your share of the coinsurance for these devices does not apply toward the Annual Medical Out-of-Pocket Maximum.

Gender dysphoria treatment will be considered a covered expense, provided that all of the relevant terms of the Plan are met. Preauthorization for surgical services related to the diagnosis is required.

Covered services may include supportive mental health counseling and treatment of any additional co-morbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, as well as genital reconstructive surgery, medically necessary medications and certain surgical procedures where those interventions and treatments comply with the Plan provisions.

Covered services will not include any service considered to be cosmetic or not Medically Necessary as determined by the Plan.

Hearing care expenses (for active and retired employees only) are limited to a maximum benefit payable of $1,000 per ear during any three-year period. Covered hearing care expenses include:

- Hearing exam, if that exam results in your purchase of a hearing aid device.
- Hearing aid devices prescribed by a legally qualified physician or a certified audiologist, if the examining practitioner certifies in writing (within three consecutive calendar months immediately before the purchase of the device) that you are suffering a hearing loss and the device may serve to lessen that loss.
- Replacement of hearing aid devices, if you meet the above requirements and a three-year period has elapsed since you received your last hearing aid device.

No benefits are paid for batteries or other ancillary equipment not obtained when you purchase a hearing aid device. In addition, repairs, servicing or alteration of a hearing aid device is not covered.

The charges for a hearing aid device prescribed and ordered prior to termination of your eligibility and delivered within 30 days following your date of termination will be covered.

Cochlear implants are covered under a separate benefit (see page 33). Bone Anchored Hearing Aids (BAHAs) are not covered by the Plan.

Home health care benefits for patients who are Homebound are paid in the same manner as for any other covered expenses. Home health care is limited to a calendar year maximum of 130 visits per person. Each visit by a member of the home health care team is considered one home health care visit.

Preauthorization is required for certain home health care services. See Coverage Requiring Preauthorization on page 26.

Covered home health care expenses include the following when provided by a licensed or certified provider:

- Physical, occupational, inhalation or speech therapy.
- Skilled nursing care provided on a part-time basis (less than an eight-hour shift).
- Home health aide services provided on a part-time basis (less than an eight-hour shift) which:
  - Are performed by a home health aide under the supervision of a registered nurse (RN) or a licensed therapist.

  - Consist mainly of medical care and therapy for the eligible person.
  - May include helping the patient with personal care, taking medications, movement or exercise, and making reports on the patient's condition.
- Medical social services by a licensed social worker with a master's degree in social work.
- Professional ambulance service, which is:
  - Certified by a physician to be necessary because of the patient's medical condition, or
  - Required because of a medical emergency.
- The following equipment and supplies, which are ordered or prescribed by a physician and would be covered as a hospital inpatient expense:
  - Drugs and medicines (including insulin) requiring a physician's written prescription.
  - Medical supplies such as oxygen, catheters, syringes, dressings, antiseptics, irrigation solutions and intravenous fluids.
  - Prosthetic devices, casts, splints, trusses, crutches and braces.
  - Rental (up to the purchase price) of a wheelchair, hospital bed for patient care, or other durable medical equipment.

Hospice care received as a result of a terminal illness. Hospice care benefits are paid in the same manner as any illness, but not to exceed:

- Six months of inpatient and outpatient hospice care services combined in any patient's lifetime.
- UCR charges of the hospice agency.

Preauthorization is required for hospice care. See Coverage Requiring Preauthorization on page 26.

Payment of hospice care benefits is not in lieu of hospital or medical benefits under the Plan. However, the Plan will not pay hospice and medical benefits for the same services and supplies.

When hospice care benefits are payable, the Plan also pays for:

- Counseling of the patient and immediate family, up to a maximum benefit payable of $500 for all family members combined.
- Bereavement counseling of the patient's immediate family, up to a maximum benefit payable of $250 for all family members combined.

Counseling and bereavement counseling must be provided by a psychiatrist, a licensed psychologist, or a licensed social worker. Benefits for counseling and bereavement counseling for the patient's immediate family members are payable whether or not the family members are also eligible for benefits described in this booklet.

Immediate family members include the patient's:

- Spouse and children under the limiting age (see page 14 for details on the limiting age).
- Parents, brothers and sisters, in the case of a terminally ill dependent child.

Benefits for bereavement counseling are paid even if eligibility ends before the counseling is received.

No hospice care benefits are paid for:

- Services and supplies which are not part of the home health care treatment plan or the hospice care treatment plan.
- Services which consist mainly of housekeeping, companionship or sitting.
- Services which are not directly related to the patient's medical condition, including (but not limited to):

- Estate planning, drafting of wills or other legal services.
- Pastoral counseling or funeral arrangements or services.
- Nutritional guidance or food services such as "meals on wheels."
- Transportation services (except necessary ambulance services).

- Expenses for which benefits are paid under any other provisions of the Plan.

Hospital room, board, services and supplies. Room and board benefits are limited to the hospital's average semi-private room rate. Benefits for confinement in an intensive care or coronary care unit are limited to the hospital's average charges for such unit. Nursery charges for routine care of a newborn dependent and an initial physical exam while the baby is confined are covered.

For a nonemergency admittance to a Non-PPO hospital, you must pay a $100 copay. (The copay will not apply to the Annual Medical Out-of-Pocket Maximum.)

Preauthorization is required for inpatient hospital stays. See Coverage Requiring Preauthorization on page 26.

Immunizations – see the Preventive Care benefit on page 39.

Infusion Therapy. Benefits are provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy.

Infusion therapy is the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not limited to, antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain, gastrointestinal diseases, or disorders, which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more.

Preauthorization is required for certain infusion therapy services. See Coverage Requiring Preauthorization on page 26.

Mental health is covered as follows:

- Physician charges and charges for mental health treatment by providers who are approved or certified in the state in which they practice for outpatient treatment are paid as any other condition. Telemedicine services for mental health treatment are also covered.
- Charges for full-day or part-day programs at a residential treatment facility.
- Inpatient treatment is paid as any other condition.

Preauthorization is required for inpatient and residential mental health treatment. See Coverage Requiring Preauthorization on page 26.

Multiple surgeries performed during the same operative session, which are not incidental, or not part of some other procedure, and which add significant time or complexity to the complete procedure, as determined by the Fund. The allowed amount shall be:

- 100% of the PPO Allowed Amount or UCR Amount for the primary procedure;
- 50% of the PPO Allowed Amount or UCR Amount for the secondary or any additional procedures.

Procedures or services that are designated as a "separate procedure" per guidelines in the Current Procedural Terminology (CPT), will be handled as a separate procedure, not subject to the above rules.

Preauthorization is required for surgical services. See Coverage Requiring Preauthorization on page 26.

Naturopathic services are covered for Medically Necessary treatment of an injury or illness. Only the office visit and Medically Necessary lab work and x-rays are covered; charges for prescribed vitamins and supplements are not covered.

Obesity surgical treatment is covered if Medically Necessary. Approval is based on specific Plan criteria such as body mass index, age, prior attempts to lose weight; contact First Choice Health (FCH) for those criteria. Also, participants must receive care from a Center of Excellence facility designated by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

Preauthorization is required for surgical treatment of obesity. See Coverage Requiring Preauthorization on page 26.

Organ transplant expenses are covered provided the transplant is preauthorized by First Choice Health (FCH). See Coverage Requiring Preauthorization on page 26.

FCH pre-certification approval for transplants is based on these criteria:

- Your provider submits a written recommendation and supporting documentation.
- Your medical condition requires the requested transplant based on medical necessity.
- The requested procedure is not considered Experimental or Investigational.
- The procedure is performed at a facility and by a provider approved by FCH.

After FCH pre-certification, the following list of Natural Organs, Natural Organ Parts and Artificial Organ Parts are included:

- Natural Organs:
  - Heart
  - Heart/Lung (combined)
  - Kidney
  - Kidney/Pancreas (combined)
  - Lungs (single/bilateral)
  - Liver
- Natural Organ Parts:
  - Cornea
  - Skin, bone and tendons
- Bone marrow/stem cell
- Artificial Organ Parts:
  - Skin, heart valves, grafts and patches (vascular), pacemaker, metal plates, and eye lens.

For donor organ procurement costs, up to a maximum of $25,000 per transplant is available, provided the organ recipient is covered for the transplant under this Plan. Donor organ procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and such other Medically Necessary procurement costs as determined by the Fund.

Please note: Donor benefits are *not* provided when they are available through other group coverage, when the donor is eligible under this Plan and the recipient is not, or for donor and procurement services and costs incurred outside the United States, unless specifically approved by the Fund.

Benefits are *not* provided for:

- Nonhuman, artificial or mechanical transplants, except as specifically provided under Artificial Organ Parts above.
- Experimental or Investigational procedures as defined on page 83.
- Services in a non-approved transplant facility.
- Transplant expenses when government funding of any kind is available, or when the recipient is not eligible under this Plan.
- Lodging, food or transportation costs, unless specifically approved by the Fund.
- Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas.

More than one retransplant if the transplant is not successful.

Osteotomy as determined to be Medically Necessary by the Fund.

Oxygen and its administration.

Physical exam – see the Preventive Care benefit on page 39.

Physician services, including expenses for a second surgical opinion. Covered expenses for spinal manipulation and alternative treatments, are described in those sections.

Note: As an alternative, you can use the services of a SwiftMD physician at no cost to you. See page 26 for information about contacting a physician by phone or video.

Pregnancy-related expenses, including sterilization procedures and abortions, for a female employee or a dependent spouse of an employee are covered on the same basis as for any other illness or injury, whether or not the pregnancy begins while the person is covered under the Plan. Covered expenses are those incurred while the person is covered under the Plan. Coverage for pregnancy of a dependent daughter is limited to those routine prenatal services listed under the Women's Preventive Care Act and does not include labor and delivery services.

Pursuant to Federal law, no hospital stay in connection with childbirth for either the mother or newborn child, is limited to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, unless there is agreement between the patient and the attending physician that the length of stay shall be less than the above periods.

Prescription drugs are covered under a separate program as described on page 45.

Preventive care services will be covered at 100%, with no coinsurance or deductible, when performed by a PPO provider. Preventive services performed by a Non-PPO provider will be covered, subject to the Plan's deductible and coinsurance. The following services are covered:

- Preventive care services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. Covered procedures include such services as blood pressure and cholesterol screening, various cancer and sexually transmitted infection screenings, as well as counseling in defined areas. A complete list of these services and screenings can be reviewed at **www.uspreventiveservicestaskforce.org**.
- Routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at **www.cdc.gov/vaccines**.
- Preventive care services and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA).
- Preventive care services and screenings for women recommended by the Health Resources and Services Administration (HRSA). A complete list of these services can be reviewed at **www.hrsa.gov/womens-guidelines.**

Note: Physical exams, including associated x-rays and lab tests, for a commercial driver's license necessary/required for covered employment will be reimbursed at 100% of the PPO Allowed Amount or 70% of the UCR Amount, and not subject to the annual medical deductible.

Prosthetic devices to replace natural limbs and eyes that are:

- Prescribed by the patient's physician
- Approved by the Fund as both effective and the usual and customary treatment of the condition
- Manufactured solely for medical use

Examples of noncovered items include:

- Deluxe equipment
- Items not intended to be worn for general activities of daily living such as for exercise, sports or swimming.

Preauthorization is required as described under Coverage Requiring Preauthorization on page 26.

Reconstructive breast surgery following or coinciding with a mastectomy that is performed as a result of an illness or injury. In accordance with the Women's Health and Cancer Rights Act of 1998, such benefits include reconstruction of the breast on which a mastectomy was performed, one surgery on the other breast to produce symmetrical appearance following a mastectomy, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. Benefits are not provided for reconstructive breast surgery for complications arising from a cosmetic augmentation or reduction mammoplasty.

Preauthorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer.

Rehabilitative facilities, including hospital room, board, services and supplies. Confinement must be recommended by a legally qualified physician for actual rehabilitative treatment following an illness or accidental injury. Custodial care is not covered under any circumstances.

Preauthorization is required for inpatient rehabilitative facilities. See Coverage Requiring Preauthorization on page 26.

Skilled nursing facilities, including room, board, services and supplies. Custodial care is not covered under any circumstances.

Preauthorization is required for inpatient admissions. See Coverage Requiring Preauthorization on page 26.

Spinal manipulation visits**,** including the initial evaluation, limited to a calendar year maximum of 20 visits per person.

Sterilization procedures, such as vasectomy or tubal ligation, are covered for an employee or dependent spouse of an employee; this treatment for dependent children is not covered.

Substance abuse treatment, including expenses of a physician and hospital or an approved treatment facility. Also included are charges for full-day or part-day programs at a residential treatment facility.

Preauthorization is required for inpatient substance abuse treatment. See Coverage Requiring Preauthorization on page 26.

Temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD), including diagnosis, treatment and/or surgery, if Medically Necessary as determined by the Plan.

Therapy services for habilitative and rehabilitative services as follows:

- Habilitative therapy services, including occupational therapy, speech therapy, physical therapy and related therapies, to improve a mental health condition or congenital birth defect.

- Rehabilitative therapy services on an outpatient basis, including occupational therapy, speech therapy and physical therapy, to the extent that the therapy will significantly restore and improve a lost function(s) following a severe illness, injury or surgery.
- Habilitative and rehabilitative services are subject to the following conditions;
  - The service must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy;
  - The services must be prescribed by the attending physician and administered by a physician or provider performing the prescribed services which he or she is licensed to perform. The Plan may periodically request a review of the services by a physician and the patient must continue under the care of the attending physician during the time the therapy is being provided; and
  - The services must not be custodial in nature.

Rehabilitative and habilitative therapy services unrelated to a mental health condition are limited to 20 visits per condition per calendar year. Benefits for rehabilitative and habilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of therapy.

Well child care – see the Preventive Care benefit on page 39.

X-ray, radium and radioactive isotope therapy.

Expenses Not Covered

No Medical Benefits are payable for:

- Acupuncture treatment that exceeds the limit described in the alternative treatment benefit (page 33), except when used as an anesthetic agent for covered surgery.
- Alternative treatment except as specifically covered under the alternative treatment benefit described on page 33.
- Any services or supplies that are not provided in accord with generally accepted professional medical standards.
- Charges that exceed UCR Amounts (see page 87 for details).
- Charges incurred while you are confined in a hospital operated by the United States of America or an agency thereof (except as otherwise required by law).
- Charges which are primarily for your convenience or comfort or that of your caretaker, physician or other medical provider.
- Charges on account of donating your human organ or tissue. However, if you are the recipient of a donated human organ, the donor's medical expenses are covered up to a maximum of $25,000.
- Chelation therapy (except for acute arsenic, gold, mercury or lead poisoning).
- Contact lenses (except for initial placement of contact lenses following cataract surgery and initial lens implant required because of cataract surgery). See Vision coverage, beginning on page 58.
- Cosmetic surgery or treatment, unless such surgery is for the repair of a congenital birth defect, repair due to an accidental injury and performed within one year of the injury, or for reconstructive breast surgery unless covered by the Women's Health and Cancer Rights Act of 1998.
- Custodial care or rest cares.
- Dental work, unless such work is for the repair of an accidental dental injury to sound natural teeth, provided such work is done within one year of the injury. Benefits for work which is done after the one year period will be provided if the Plan receives certification from the treating physician that treatment could not have been completed earlier due to the severity of the patient's condition. Dental benefits under this provision will be paid first under the Scheduled Dental Benefits and then under the Medical Benefits. (See dental benefits beginning on page 52.)

- Eating disorder or obesity treatment, including appetite control, food addictions or other eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, and present significant symptomatic medical problems), or except as specifically listed under Covered Medical Expenses including expenses for mental health, preventive care, and obesity surgical treatment, or as otherwise noted in the Plan.
- Education or training services, or treatment for dyslexia; attention deficit disorders; behavioral or conduct disorders; learning disabilities and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, except as described under Therapy Services on page 40. This exclusion does not apply to prescription medication and professional charges for management of such medication.
- Education, training or development of skills needed to cope with an injury or illness, except as specifically provided under the rehabilitation, home health or hospice care benefit.
- Education, training, room and board while you are confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Expenses for services and supplies not required for treatment of an injury or illness unless specifically listed in this Plan as a Covered Expense.
- Eye refractions or the fitting or cost of visual aids, vision therapy, training or orthoptics.
- Fertility treatment including (but not limited to):
  - Fertility tests.
  - Reversal of surgical sterilization.
  - Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.
  - Genetic testing except when there are symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment, or as otherwise required to be covered by law.
- Hospital or anesthesia charges due to dental work, unless such charges are deemed to be Medically Necessary as determined by the Fund.
- Implantation, unless the person is totally edentulous (without teeth) and the gum is severely resorbed and cannot support regular dentures or when necessary due to an accidental injury to sound natural teeth, provided treatment is done within one year of the injury or the Plan receives certification from the treating physician that treatment could not be completed earlier due to the severity of the patient's injuries.
- Massage therapy, except when part of a chiropractic or physical therapy treatment plan, under the supervision of the provider prescribing the treatment plan and billed under the same clinic/tax ID number of the prescribing provider.
- Marriage or family counseling, except family counseling for the treatment of a minor child's mental illness.
- Maternity benefits for dependent children (except as required by the Women's Preventive Care Act), including complications of pregnancy and voluntary termination of pregnancy. Complications of pregnancy means all physical effects suffered which have been directly caused by the pregnancy, but which would not be considered from a medical viewpoint the effects of a normal pregnancy, and will include, but are not limited to conditions such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy which terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, and similar medical and surgical conditions.
- Organ transplant expenses (except as described in the Organ Transplant Section beginning on page 38).

- Refractive eye surgeries or similar surgery to correct vision (except for corneal graft or when visual acuity cannot be improved to at least 20/20 in the better eye). See Vision Benefits beginning on page 58.
- Routine eye examinations, lenses, frames, and fitting fees (see Vision Benefits starting on page 58).
- Routine footcare, including callus, corn paring or excision; toenail trimming; orthopedic or diabetic inserts or shoes; foot orthotics or other supportive devices for the feet (except as specified in the Foot Orthotics and Other Supportive Devices section on page 35).
- Routine immunizations, except as specifically provided under the preventive care benefit.
- Services, supplies and durable medical equipment not necessary or reasonable for treatment of illness or injury, not prescribed by a provider acting within the scope of his/her license.
- Services or supplies that are not Medically Necessary for the care and treatment of illness or injury (except as provided under the Preventive Care benefit, Diagnostic X-ray and Laboratory Examination benefit, and Alternative Treatments benefit).
- Services, supplies and associated expenses for procedures intended primarily for treatment of obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and health services of a similar nature, except as specifically provided under the Obesity Surgical Treatment benefit or as otherwise required by law. Obesity includes, but is not limited to morbid or gross obesity.
- Shipping fees or charges.
- Travel, transportation, whether by professional ambulance or otherwise (except as provided by the Air Transportation/Air Ambulance and Ambulance (Ground) benefit section beginning on page 32), lodging, meals, rental car expense or other related charges, fees or expenses.
- Treatment or surgery related to sexual dysfunction, except for the Medically Necessary treatment of gender dysphoria.
- Vitamins, minerals, herbs, over the counter food supplements, or prescription food supplements that are not the primary source of caloric intake.
- Charges that are excluded under the General Exclusions on page 75.

Coalition Health Center

As an alternative to visiting your regular provider, the Coalition Health Center in Fairbanks, Alaska is also available to Plan participants.

Charges for services provided at the Center do not apply towards your annual medical deductible. Also, the medical reimbursement percentages do not apply. Instead, you will be charged a flat dollar copay for each visit and these copays will be applied towards your Annual Medical Out-of-Pocket Maximum.

Summary of Health Center Services

The Coalition Health Center is staffed by experienced master's level trained Advanced Nurse Practitioners (ANP) providing the following services:

- Acute episodic care and symptom relief (strains, sprains and pains).
- Cholesterol, hypertension, and diabetes screenings, treatment, and management.
- Treatment of sore throats, earaches, headaches.
- Treatment of cough and sinus.
- Treatment of rashes and allergies.
- Treatment of acute urinary symptoms.
- Well-woman, well-man and well-child exams.
- Treatment of minor injuries.
- Physicals (annual, school and sports).
- Health education.
- Standard immunizations and flu shots.

In addition, labs are performed on site and some generic prescriptions are dispensed at no cost to you.

Cost of Service

- $20 copay per visit per person.
- $50 copay if three or more family members visit the clinic at the same time for services.
- $0 copay per visit for preventive care services required under the Affordable Care Act.

The copay includes the visit and any lab work needed as well as any prescription medications dispensed at the Health Center.

Payment is due at the time of services and you will not have to fill out a claim form.

Location of the Health Center

The Coalition Health Center is located in Fairbanks, Alaska at the Riverview Business Park, 575 Riverstone Way, Unit 1.

It can be reached by phone at (907) 450-3300 or online at **coalitionhealthcenter.com** if you have any questions or want to schedule an appointment.

Walk-in visits may be available if the Health Center's schedule permits.

Services Not Covered

- Treatment for children under age 2.
- Treatment for eligible retirees or their spouses who are eligible for Medicare.
- Treatment for employees or their dependents who are enrolled in Medicare.

Prescription Drug Program

This section applies to active employees and their dependents as well as non-Medicare eligible retirees and non-Medicare eligible dependents of retirees. Prescription drug benefits for Medicare eligible retirees and Medicare eligible dependents of retirees is described on page 70.

Please note that benefits may change from time to time. As of the date of this booklet, prescription drug coverage is available in two convenient ways: either through the Retail Pharmacy Card Program or the Mail Order Program. Both programs are administered by OptumRx. You can contact OptumRx directly for information about participating pharmacies, mail-order prescriptions and to order refills:

- The toll free Customer Service number is (866) 887-0234 or (866) 328-2005. You can call Customer Service 24 hours a day, 7 days a week.
- The OptumRx website is **www.optumrx.com**.

Throughout the Prescription Drug Program, "you" refers to covered employees, retirees and dependents.

The Plan's pharmacy benefit providers may utilize internal guidelines or medical protocols, or guidelines or medical protocols adopted by the Plan, in determining whether a specific drug or supply is covered.

Retail Pharmacy Card Program

The Retail Pharmacy Card Program provides a 34-day supply of medication per prescription or refill at a pharmacy.

This program offers you the convenience of local participating pharmacies for your short-term and immediate prescription drug needs. You can use a participating pharmacy in the OptumRx network or you may purchase your drugs at any pharmacy, the choice is yours each time you need a prescription filled.

Under this program, the following copays apply:

Type of Prescription Drug	Participating Pharmacy	Nonparticipating Pharmacy*
Generic	$10 copay	$10 copay
Preferred brand	$25 copay	$25 copay
Non-preferred brand	$40 copay	$40 copay

* These copays also apply if an OptumRx participating pharmacy is used but your prescription drug card was not presented at the time of purchase.

When you use an OptumRx network participating pharmacy, you have the advantage of receiving discounted prices and there are no claim forms to file. At participating pharmacies, the pharmacist will use a computerized system to confirm your eligibility for benefits and determine the discounted cost of your prescription. Simply present your prescription card and make your appropriate copay. Your copay depends on whether the prescription is for a generic or brand-name drug. The copay is waived for diabetic syringes and test strips. Copays are shown in the table above.

If you use a non-participating pharmacy, you will have to pay the full cost of the prescription and file a claim with OptumRx to be reimbursed for the cost minus the copay amount shown in the table above. Claim forms may be obtained from OptumRx or the Administration Office. A claim form must be submitted with copies of the prescription receipt (not cash register receipts) and sent to the address on the form.

Mail Order Program

The Mail Order Program provides a 90-day supply of medication per prescription or refill.

The mail order program is designed for maintenance medications for ongoing or chronic conditions. Your copay depends on whether the prescription is for a generic or brand-name drug. The copay is waived for diabetic syringes and test strips. The copay amounts are shown in the following table.

Type of Prescription Drug	
Generic	$20 copay
Preferred brand	$40 copay
Non-preferred brand	$60 copay

How to Use the Mail Order Program

To use the mail order program for the first time, complete a patient profile questionnaire. The questionnaire asks for information about your medical history, blood type, allergies and any other drugs you are taking (prescription and over-the-counter). OptumRx keeps this information and checks it every time you send a prescription. You may update your profile as you like by including any health condition changes with your prescription. Follow these steps:

- Obtain a form (from OptumRx, the Administration Office or your Local Union). Complete the information requested on the form, including your physician's name. OptumRx automatically fills your prescriptions with a generic alternative whenever possible.
- If you are getting a new prescription filled, have your physician prescribe up to a 90-day supply of the maintenance drug with the appropriate number of refills. If your physician specifies a brand-name drug and writes "Dispense as Written" (DAW) on the prescription, the pharmacist will fill your prescription with the brand-name drug rather than filling it with a generic drug. However, the pharmacist may call your physician to request approval of filling your prescription with a generic drug.
- If you are requesting a refill, you should request your refill at least two weeks before your prescription runs out. With each prescription, OptumRx sends a postage-paid envelope (for your future use) and a notice showing how many refills you have left. Be sure to contact your physician when you request your last refill from OptumRx.
- Send your prescription (and questionnaire if it's your first order) or request for a refill and the appropriate copay in the postage-paid envelope to OptumRx. You can pay by check, money order, MasterCard or Visa. If you use a credit card, include the card number and expiration date. DO NOT SEND CASH.

Within three weeks after ordering a new prescription or two weeks on a refill, your prescription will arrive, at the address you indicated on the envelope, by United Parcel Service (UPS) or U.S. Mail.

Specialty Drugs

Optum Specialty Pharmacy/BriovaRx Specialty Pharmacy is your Plan's provider for specialty medications. Specialty drugs are very high cost prescriptions that can include some injectables, inhalants and oral medications. Specialty drugs must be filled using the Optum Specialty Pharmacy/BriovaRx Specialty Mail Order Pharmacy and will be limited to a 30-day supply per fill. Shipping is at no charge to you for your 30-day supply. Participants taking HIV/AIDS medications can opt out of this program by calling (866) 803-8570.

Optum Specialty Pharmacy/BriovaRx clinical pharmacists, who specialize in specialty therapies, are available twenty-four hours a day, seven days a week to answer your specialty medication questions. These pharmacists and nurses are available for first-fill consultations as well as assisting with enrollment in clinical management if needed. Some benefits under Specialty Pharmacy may require prior authorization to ensure clinically appropriate prescribing. If you have any specialty drug questions, please call the specialty team at (855) 4BRIOVA or go online to **www.BriovaRx.com.**

The Optum Specialty Pharmacy /BriovaRx pharmacy provides ongoing support through phone and online. BriovaCommunity™ is a program available at no cost where you can learn more about your condition through videos about peer experiences, expert advice and current research. The service provides customized online videos to help members better understand their condition. BrioLive™ allows you to participate in on demand video consultations that ensure members are informed and educated about their medications and ongoing treatment via a secure setting with a registered pharmacist. To request a

BrioLive™ consultation, talk to your clinical pharmacist or go online to **www.BriovaRx.com** for additional information.

To help you better manage a condition requiring specialty medication, the Clinical Management Program (CMP) provides extra support at no cost. If you enroll in a CMP you will receive regularly scheduled phone calls with a personal clinician. These calls focus on helping you to better understand your condition and medications, teach ways to manage side effects, and provide other resources to help you take a more active role in your treatment. Participation is completely voluntary.

To enroll in CMP, call the BriovaRx Specialty Pharmacy at (877) 839-7045 or (855) 4BRIOVA. Ongoing support includes:

- One-to-one phone consultations with a pharmacist or nurse who is specially trained in your condition.
- During the first consultation, the nurse or pharmacist collects important background and medical information from you in order to learn about your unique needs and determine the best method of support for you.
- Follow-up consultations are scheduled as necessary.
- Education materials and resources.

The Clinical Management Program (CMP) is available for a number of conditions including:

- Inflammatory conditions
  - Ankylosing spondylitis
  - Crohn's disease
  - Juvenile rheumatoid arthritis
  - Psoriasis
  - Psoriatic arthritis
  - Rheumatoid arthritis
  - Ulcerative colitis
- Hepatitis C
- HIV/AIDS
- Multiple sclerosis
- Transplant

BriovaRx Therapy Solutions offers everything the CMP program offers with the additional feature of end to end patient care and management taking place in one therapy specific team that includes specialty customer service agents and clinicians specifically trained to focus on specific therapies. This nearly eliminates the need for internal transfers between departments. There is no need to enroll or opt in; the Therapy Solutions team is dedicated and responsible for the following conditions;

- Oncology
- Hemophilia
- Cystic fibrosis
- Hereditary angioedema

Annual Prescription Drug Out-of-Pocket Maximum (7/1 to 6/30)

The Plan has a maximum amount you will pay for prescription drugs each year. Once you have reached this Annual Prescription Drug Out-of-Pocket Maximum, the Plan pays 100% for most covered prescription drugs for the remainder of the year (July 1 through June 30).

The Annual Prescription Drug Out-of-Pocket Maximum may change from time to time. The following applies as of the date publication of this booklet.

Annual Prescription Drug Out-of-Pocket Maximum (7/1 – 6/30)	
Each person	$4,300
Each family	$8,600

Prescription drugs filled at retail or mail order apply to the Annual Prescription Drug Out-of-Pocket Maximum. However, **the following charges will not apply to the Annual Prescription Drug Out-of-Pocket Maximum:**

- Your copay if you purchase drugs from a pharmacy not participating in the OptumRx network, or
- Your copay if you purchase a non-preferred brand drug, or
- Your copay if you purchase a drug from an OptumRx network participating pharmacy but your prescription drug ID card was not presented at the time of purchase.

Special Reimbursement Procedures

Special procedures through the Administration Office will apply for the following situations:

- Once you meet your Annual Medical Out-of-Pocket Maximum (not your deductible), your copays per prescription or refill will be reimbursed by the Plan. Please send copies of your prescription drug receipts (not cash register receipts) to the Administration Office showing the amounts paid so you can be reimbursed for those expenses. Refer to page 25 for information about the Annual Medical Out-of-Pocket Maximum.
- If you or your dependents are covered under another prescription drug plan, and you submit your prescription claims to the other plan first, this Plan will reimburse you for any copays or coinsurance that you were required to pay under the other plan. For reimbursement, submit proof of the other plan's payment amount and the itemized drug receipt, to the Administration Office.

Covered Prescription Drugs

The Prescription Drug Program covers prescription drugs and medications when prescribed by a physician or other lawful prescriber. This includes:

- Federal legend drugs.
- State restricted drugs.
- Compounded medications of which at least one ingredient is a legend drug.
- Insulin.
- Insulin needles and syringes.
- Over the counter (OTC) diabetic supplies.
- Oral contraceptives, contraceptive jellies, creams, foams, devices, implants or injections.
- Retin-A through age 25. After age 25 prior authorization is required.
- Legend prenatal vitamins.
- Growth hormones with prior authorization.
- Immunosuppressants.

Preventive Care Prescription Drugs

In accordance with federal law, the Plan covers preventive care drugs at 100% with no copay when purchased at an OptumRx network participating pharmacy. Preventive care drugs may include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other

products. Gender, age and/or other limits may apply. **Please note that over the counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.**

A complete and up-to-date list of preventive care drugs can be found at **www.hhs.gov/healthcare**. This list may be subject to change.

Routine Immunizations

Routine immunizations are available at many retail pharmacies.

The Plan provides benefits for routine immunizations at a $0 copay when received at an OptumRx network participating pharmacy. Included immunizations are those recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at **www.cdc.gov/vaccines.** Not all ACIP recommended immunizations are available at OptumRx network participating pharmacies.

In addition, the Plan covers the following immunizations when received at an OptumRx network participating pharmacy:

- Travel vaccines (Japanese Encephalitis, Typhoid, Yellow Fever)
- Rabies

For these immunizations, you will be charged the brand copay or the pharmacy's advertised cost, whichever is less.

Prescription Drug Management Programs

The Plan has adopted the following prescription drug management programs to assist you in obtaining the most effective coverage, with treatment, cost and safety all taken into account.

Step Therapy

For certain prescription therapies, you must use lower cost brand or generic equivalents when appropriate, as a first step. If, after using the lower cost brand or generic equivalent, your physician determines that you still require the higher cost treatment, coverage will be provided. However, the initial prescription must be this step prescription. Step therapy is intended to provide you with coverage that is most effective, both on a treatment and financial basis. Prescription therapies (conditions) subject to the step therapy program are:

- Angiotensin II receptor antagonists-A2s (high blood pressure)
- Branded NSAIDS (pain/arthritis)
- Cyclooxygenase-2 inhibitors-COX2s (pain/arthritis)
- Calcium channel blockers (hypertension)
- Leukotriene pathway inhibitors (asthma/allergies)
- Proton pump inhibitors-PPIs (acid reflux/ulcers)
- Selective serotonin reuptake inhibitors-SSRIs (depression)
- HMG-CoA reductase inhibitors (cholesterol)
- Topical immunomodulators (dermatitis, eczema)
- Other antidepressants (depression)

Prior Authorization

Under prior authorization, prescriptions for certain medications require coverage review before the Plan will cover the medication. If your physician prescribes one of these medications, your pharmacist or your physician must call OptumRx customer service. OptumRx will work with your physician(s) office to get

the information for the coverage review. If your physician does not return the required information, the prior authorization request will be denied. Prescriptions may otherwise be denied under this process for not meeting clinical or other requirements. OptumRx will notify you and your physician if the request is denied. The benefits of prior authorization include:

- Promoting safe use of medications,
- Helping manage expensive and/or highly used drug categories

Here are examples of some conditions for which drugs may be prescribed, and drug classes that require a prior authorization. This not a complete list:

- Blood formation agents
- Growth hormone
- Hepatitis C
- Psoriasis
- Pulmonary hypertension
- Rheumatoid arthritis,
- Testosterone replacement
- Sleep disorder
- Weight loss
- Select pain medications

Some medications may require prior authorization based on age, gender or quantity limits.

Quantity Limit

A Quantity Limit is the greatest amount of a medication that is allowed to be dispensed for each prescription or over a certain period of time. The benefits of Quantity Limit include:

- Preventing over prescribing or taking medication longer than needed.
- Managing unsafe medication use.
- Reducing risks of misuse and abuse of certain medications.

Here are some examples of conditions for which drugs may be prescribed and of drug classes that are subject to Quantity Limits. This is not a complete list:

- Anti-fungal
- Anti-emetic
- Erectile dysfunction,
- Hypnotic
- Migraine
- Smoking cessation medications

When you present a prescription for a drug that requires review, the OptumRx claims system automatically searches your medical and drug profile to determine if the drug meets the required criteria. If the drug does not meet the requirement, the dispensing pharmacist receives a system message and the pharmacist may discuss the appropriateness of the requested medication with you and contact the prescribing physician or the OptumRx customer service department.

Expenses Not Covered

- Non-federal legend drugs.
- Non-insulin needles and syringes, except as covered for Specialty drugs under the BriovaRx program.
- Fertility agents.
- Anorexiants.
- Therapeutic devices or appliances.
- Cosmetic drugs.
- Dietary supplements.
- Over the counter items (except as specifically listed in Covered Prescription Drugs or Preventive Care Prescription Drugs, or as required by law).
- Drugs whose sole purpose is to promote or stimulate hair growth (Rogaine®) or for cosmetic use.
- Biologicals, blood or blood plasma.
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medicare Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while the individual is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operated on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- Vitamins other than prenatal vitamins.
- More than six doses per month of prescription impotence medication.
- Expenses not covered under General Exclusions.

Dental Benefits

As an active employee covered under the Plan, you have a choice between either the scheduled dental benefits described in this section or coverage under the Willamette Dental of Washington, Inc. pre-paid dental plan (described on page 57) if you live in the Willamette Dental Group service area.

Both the scheduled Dental Benefits and Willamette Dental Group Plan generally provide coverage for similar services, but vary in the way they pay benefits and the flexibility of provider choice. You may only change coverage during the annual open enrollment period.

Note: If you previously had coverage under the Plan and then again attain eligibility, you will be enrolled in your previous dental option. You will be able to change your dental option at the next open enrollment.

Scheduled Dental Benefits

The Scheduled Dental Benefits provides benefits for the diagnosis and treatment of the gums, teeth and supporting structures. You do not have to satisfy a deductible before the Plan pays the amount listed in the Covered Expenses section beginning on page 53.

Throughout the Scheduled Dental Plan, "you" refers to any covered active employee and dependent of an active employee, unless otherwise noted. **Retired employees and their dependents are not eligible for these dental benefits.**

Maximum Benefit

The maximum benefit for all covered dental expenses (except orthodontics) incurred during any one calendar year is $2,500 for treatment received in Washington (and all other areas outside of Alaska) and $3,000 for treatment received in Alaska. This maximum is waived for eligible dependent children under age 18.

Covered orthodontic expenses (including related oral examinations, surgery and extractions) have a separate maximum benefit. For orthodontic care, the maximum *lifetime* benefit payable is $2,500 for treatment received in Washington (and all other areas outside of Alaska) or $3,000 for treatment received in Alaska. Only dependent children under age 19 are eligible for orthodontic benefits unless required before or in conjunction with Medically Necessary orthognathic surgery, which is covered under Medical Benefits. This benefit does not apply to active and retired employees and their spouses.

Predetermination of Benefits

Predetermination of benefits allows for review of a proposed treatment plan in advance and provides a chance to resolve any questions before the service has been provided to you. As a result, both you and your dentist will know in advance which procedures are covered and the estimated amount of benefits the Plan will pay.

If the total charges are expected to be more than $600, it is recommended that your dentist's proposed course of treatment be reviewed by the Administration Office before dental work begins. Your dentist can submit a treatment plan to the Administration Office. The Administration Office will respond to your dentist with a copy to you, showing the estimated covered expenses under the Scheduled Dental Benefit.

A treatment plan is the dentist's report that:

- Itemizes recommended services.
- Shows the charge for each service.
- Is accompanied by supporting x-rays and other diagnostic information when required or requested by the Administration Office.

Covered Expenses

Covered dental expenses are the necessary dental services and supplies, most of which are listed in the following table. Services of a denturist within the scope of his or her license are covered.

Certain dental procedures may be covered even though they are not listed in the following schedule. The Plan determines the benefit for unlisted procedures by taking into account the nature and complexity of the procedure. The amount will be consistent with those listed in the table.

All covered dental expenses, listed or not listed, are subject to the limitations and exclusions sections beginning on page 56.

The following Scheduled Dental Benefits are effective as of the date of publication of this booklet. These scheduled benefits may change from time to time.

Scheduled Dental Benefits			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
	DIAGNOSTIC		
	Examinations		
0120	Periodic oral exam	$59	$71
0140	Limited oral exam	$99	$119
0150	Comprehensive oral exam	$104	$125
	Radiographs (X-Rays)		
0210	Intraoral–complete series (including bitewings)	$132	$158
0220	Single, first film	$26	$31
0230	Each additional film	$24	$29
0270	Bitewing–single film	$27	$32
0272	Bitewings–two films	$44	$53
0274	Bitewings–four films	$62	$74
0330	Panoramic film	$106	$127
	PREVENTIVE		
	Prophylaxis		
1110	Age 13 and over	$106	$127
1120	To age 13	$74	$89
	Fluoride Treatment: To age 18		
1208	Topical application of fluoride	$41	$49
	Fissure Sealants: Ages 6 to 18		
1351	Topical application of fissure sealant (per tooth)	$52	$62
	Space Maintainers: To age 19		
1510	Fixed–unilateral type	$341	$409
1515	Fixed–bilateral type	$477	$572
	MINOR RESTORATIONS		
2140	Amalgam–1 surface	$128	$154
2150	Amalgam–2 surfaces	$166	$199
2160	Amalgam–3 surfaces	$201	$241
2161	Amalgam–4 or more surfaces	$245	$294
2951	Pin retention–exclusive of amalgam	$37	$44
2330	Resin–1 surface anterior	$116	$139
2331	Resin–2 surfaces anterior	$148	$178
2332	Resin–3 surfaces anterior	$182	$218
2335	Resin–4 or more surfaces anterior	$215	$258
2391	Resin–1 surface posterior	$136	$163

Scheduled Dental Benefits			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
2392	Resin–2 surfaces posterior	$178	$214
2393	Resin–3 surfaces posterior	$221	$265
2394	Resin–4 or more surfaces posterior	$271	$325
	MAJOR RESTORATIONS		
	Inlays and Onlays		
2510	Inlay, metallic–1 surface	$500	$600
2520	Inlay, metallic–2 surfaces	$567	$680
2530	Inlay, metallic–3 surfaces	$654	$785
2542	Onlay, metallic–2 surfaces	$641	$769
2543	Onlay, metallic–3 surfaces	$670	$804
2544	Onlay, metallic–4 or more surfaces	$697	$836
2642	Onlay, porcelain–2 surfaces	$643	$772
2643	Onlay, porcelain–3 surfaces	$693	$832
2644	Onlay, porcelain–4 or more surfaces	$735	$882
2910	Re-cement inlay	$62	$74
	Crowns		
2720	Resin with high noble	$674	$809
2721	Resin with predominantly base metal	$632	$758
2722	Resin with noble metal	$646	$775
2740	Porcelain/ceramic noble metal	$692	$830
2750	Porcelain fused to high noble metal	$683	$820
2751	Porcelain fused to predominantly base metal	$636	$763
2752	Porcelain fused to noble metal	$651	$781
2780	¾ cast high noble metal	$655	$786
2781	¾ cast base metal	$616	$739
2782	¾ cast noble metal	$637	$764
2783	¾ cast porcelain	$673	$808
2790	Full cast high noble metal	$659	$791
2791	Full cast predominantly base metal	$624	$749
2792	Full cast noble metal	$636	$763
2930	Stainless steel – primary tooth	$170	$204
2970	Temporary crown	$154	$185
2950	Crown buildup	$163	$196
2920	Re-cement crown	$63	$76
	Endodontics		
3110	Pulp cap–direct	$59	$71
3120	Pulp cap–indirect	$47	$56
3220	Vital pulpotomy	$121	$145
	Root Canal Therapy (includes treatment plan, clinical procedures, follow-up care; excludes final restoration)		
3310	Single-rooted	$605	$726
3320	Bi-rooted	$742	$890
3330	Tri-rooted	$920	$1,104
3410	Apicoectomy (as a separate surgical procedure)	$693	$832

Scheduled Dental Benefits			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
	PERIODONTICS		
	Non-Surgical Services		
4910	Periodontal maintenance	$125	$150
4341	Periodontal scaling and planing (per quadrant)	$203	$244
	Surgical Services		
4210	Gingivectomy (per quad)	$637	$764
4241	Gingival flap procedure (per quad)	$467	$560
4260	Osseous surgery (per quad)	$1,346	$1,615
4263	Bone replacement graft	$482	$578
	PROSTHODONTICS		
	Dentures (includes six months post-delivery care)		
5110-20	Complete upper or lower	$1,034	$1,241
5130-40	Immediate upper or lower	$1,128	$1,354
5211-12	Partial upper or lower, acrylic base (and conventional clasps/rests)	$873	$1,048
5213-14	Partial upper or lower, predominantly cast base with acrylic saddles (and conventional clasps/rests)	$1,143	$1,372
	Related Denture Services		
5410-22	Denture adjustment (complete or partial)	$57	$68
5510	Repair denture damage (no teeth)	$113	$136
5520	Replace missing or broken teeth in complete denture–per tooth	$95	$114
5710	Rebase denture	$420	$504
5730	Reline denture–office	$237	$284
5750	Reline denture–lab	$316	$379
	Implant Services		
6010	Surgical placement of implant	$1,728	$2,073
6065	Implant supported porcelain/ceramic crown	$921	$1,105
6066	Implant supported porcelain fused to metal crown	$709	$851
6067	Implant supported metal crown	$997	$1,196
	Bridgework		
6210	Pontic–cast	$665	$798
6240	Pontic–porcelain	$657	$788
6250	Pontic–resin	$649	$779
6930	Re-cement bridge	$95	$114
	ORAL SURGERY		
	Extractions (includes local anesthesia, routine postoperative care)		
7140	Single tooth	$120	$144
7210	Erupted tooth–surgically removed	$209	$251
7220	Impacted tooth–soft tissue	$262	$314
7230	Impacted tooth–partially bony	$348	$418
7240	Impacted tooth–completely bony	$409	$491
7250	Root recovery–per tooth	$220	$264
	Related Oral Surgical Procedures		
7310	Alveoloplasty–per quadrant	$452	$542
7510	Incision, drainage of abscess intraoral	$486	$583
7960	Frenectomy (separate procedure)	$256	$307

Scheduled Dental Benefits			
ADA Code	**Procedure**	**Washington & other areas**	**Alaska**
9223	General anesthesia	$301	$361

If dental coverage ends for you and/or for your dependents for any reason, charges for prosthodontic devices (including bridges and crowns) may be covered. To be covered, the devices must have been ordered while you were covered and installed or delivered within 60 days after termination of eligibility.

Orthodontia

Covered orthodontic expenses are paid at 60% of the UCR Amounts up to a $2,500 lifetime maximum benefit for treatment received in Washington (and all other areas outside of Alaska) or $3,000 for treatment received in Alaska. However, for the initial stage of treatment, not more than 25% of the treatment cost is allowable. The remaining benefit provided by the Plan will be pro-rated over the course of the treatment after the initial stage and will be provided only as long as you remain otherwise eligible for coverage. This orthodontia benefit does not apply to active participants who have enrolled in the Willamette Dental Group Plan.

Covered orthodontic expenses include diagnostic procedures and treatment consisting of surgical therapy, appliance therapy, and function/myofunctional therapy (including related oral examinations, surgery and extractions).

Orthodontic benefits under the Scheduled Dental Benefits are available for your covered dependent children under age 19 only. Participants age 19 and over are eligible *only* if required before or in connection with Medically Necessary orthognathic surgery which is covered under Medical Benefits.

Scheduled Dental Benefit Limitations

The following limitations apply:

- **Diagnostic:** The maximum benefits for a complete series of x-rays are payable once during any 36 consecutive month period. Benefits for periodic examinations and a maximum of four bitewings are payable once during any six consecutive month period.
- **Preventive:** Benefits for dental prophylaxis and fluoride treatments are provided once during any six consecutive month period. Topical application of sealants (for children ages 6 to 18) are payable once every 36 months for permanent posterior unrestored teeth.
- **Periodontics:** Periodontal maintenance is provided once during any four consecutive month period. Periodontal scaling and root planing is provided once during any six consecutive month period.
- **Prosthodontics:** Adjustments to dentures are covered only after they have been installed for at least six months. Denture relining and/or rebasing is covered only after six months have elapsed since installation. Crowns, bridges and dentures are limited to one appliance during any 36 consecutive month period.

  Replacement of an existing crown, bridge or denture is covered only if the existing prosthodontic is unserviceable and cannot be made serviceable. Replacement of prosthodontic appliances is covered only if at least 36 months have elapsed since the date of the initial installation of that appliance under this Plan.
- **Occlusal/Nightguard:** Covered once per lifetime.
- **Oral Surgery:** Alveoplasty is payable only when performed on the same day as extractions and followed by immediate placement of dentures.
- **Orthodontics:** Treatment is available to dependent children under age 19. Participants age 19 and over are eligible for orthodontic benefits *only* if required before or in connection with Medically Necessary orthognathic surgery which is covered under Medical Benefits.

If orthodontic treatment ends for any reason before the treatment is complete, Plan benefits also end. If orthodontic treatment resumes, benefits for any remaining services also resume. However, benefits are only payable for expenses incurred while covered by the Plan.

Expenses Not Covered

No Scheduled Dental Benefits are payable for:

- Analgesics (such as nitrous oxide) or euphoric drugs, injections or application of desensitizing medicines, except during oral surgery.
- Appliances or restorations necessary to increase vertical dimension or restore the occlusion.
- Charges that exceed scheduled amounts (see the schedule beginning on page 53).
- Cosmetic services or supplies including personalization or characterization of dentures.
- Diagnosis, treatment or surgery for temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD).
- Duplicate appliances or prosthetic devices.
- Hospital or related anesthesia charges due to dental work.
- Oral hygiene and dietary instructions.
- Orthodontic treatment, except as specifically provided.
- Plaque control.
- Prosthetic devices (including bridges and crowns) and fittings, if ordered while the patient was covered, but installed or delivered to the patient more than 60 days after coverage ends.
- Replacement of a lost, missing or stolen prosthetic device.
- Treatment by other than a dentist (except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the dentist). Covered services provided by a denturist that are within the scope of his or her license are covered.
- Expenses not covered under General Exclusions.

Willamette Dental Group Benefits

If you live within Willamette Dental Group's coverage area, you may choose dental coverage through this program. To receive the benefits of the Willamette Dental Group Plan, you must receive care from a Willamette Dental Group dentist or specialist. Visit Willamette Dental Group's website at **www.WillametteDental.com** for the most up-to-date locations and doctor profiles.

If you are enrolled in the Willamette Dental Group program, orthodontic coverage is included for all ages.

To find out more about Willamette Dental coverage, including details on the service area, call the Administration Office.

Willamette Dental of Washington, Inc. offers a certificate of coverage that details benefits which you may request from the Administration Office.

Vision Benefits

As of the publication of this booklet, the Plan includes vision coverage through a third party vendor. The Vision Plan, administered by VSP, provides benefits for an eye exam, lenses and frames or contact lenses. You do not have to satisfy a deductible before the Plan pays the amount listed in the following Covered Expenses section.

Throughout the Vision Plan, "you" refers to covered employees, retirees and dependents.

Covered Expenses

For maximum benefits, it is to your advantage to see a VSP member doctor.

When you go to a VSP member doctor, there are no claim forms for you to file. When you go to a non-VSP provider, you must pay for vision services at the time you receive them and then file a claim with VSP.

To locate a VSP doctor, contact VSP at **www.vsp.com** or (800) 877-7195.

The Vision Plan covers eye exams, lenses and frames as shown in the following tables:

If you see a VSP member doctor...	
Copay	$20 per eye exam and/or glasses
Eye Exam (once every 12 months)	Paid in full after the copay
Lenses (once every 24 months) Single vision Lined bifocal Lined trifocal Lenticular Tints, Photochromic Polycarbonate (children under 18 only)	Paid in full after the copay*
Frames (once every 24 months)	Paid in full (up to $120) after the copay**
Contacts – instead of lenses and frames (once every 24 months)	You pay up to a $60 copay for contact lens exam (fitting and evaluation). The plan pays up to $145 for contact lenses.

* *VSP may authorize payment for new lenses after 12 months if the new prescription differs from the original by at least a 0.50 diopter sphere or cylinder, there is a change in the axis of 15 degrees or more, there is a 0.50 prism diopter change in at least one eye or the new prescription improves visual acuity by at least one line on the standard eye chart.*

** *A 20% discount is available on any out-of-pocket costs for frames that exceed the frame allowance from a VSP member doctor.*

If you see a non-VSP provider...†		
	in Washington and all other areas	**in Alaska**
Eye Exam (once every 12 months)	Up to $60.50	Up to $72.50
Lenses (once every 24 months)		
Single vision	Up to $49.50	Up to $59.50
Lined bifocal	Up to $81.50	Up to $98.00
Lined trifocal	Up to $125.50	Up to $150.50
Lenticular	Up to $143.00	Up to $171.50
Tints, Photochromic	Up to $22.00	Up to $26.50
Frames (once every 24 months)	Up to $71.50	Up to $86.00
Contacts (instead of lenses and frames)	Up to $121.00	Up to $145.50

† *If you see a non-VSP doctor, you pay the provider in full and have 12 months to submit a claim to VSP for partial reimbursement.*

Additional Discounts

In addition to the benefits listed above, VSP member doctors have also agreed to provide the following:

- An average 30% savings on noncovered lens options, like progressives and scratch-resistant and anti-reflective coatings.
- 30% discount off additional glasses and sunglasses, including lens options from the same VSP doctor on the same day as your eye exam. Or get 20% off from any VSP doctor within 12 months of your last eye exam.
- 15% discount off the cost of contact lens exam (fitting and evaluation).
- An average of 15% off the regular price of laser vision correction (or 5% off the promotional price) from contracted facilities; after surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Low Vision Benefit

A low vision benefit is available for severe visual problems that are not correctable with regular lenses. This benefit requires a prior approval from VSP. Please discuss your options with your provider. Coverage includes:

- Complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions. Including the prescription of corrective eyewear or vision aids where indicated.
- Subsequent low vision aids as visually necessary or appropriate.

	VSP Member Doctor	**Non-VSP Provider**
Supplementary Testing	Paid in Full	Up to $125
Supplemental Care Aids	75% of Cost	75% of Cost
Benefit Maximum (every 2 years)	$1,000	$1,000

Low vision benefits secured from a non-VSP provider are subject to the same time limits and copay arrangements as described above for a VSP member doctor. You should pay the non-VSP provider's full

fee. You will then be reimbursed up to the amount that would have been paid to a VSP member doctor in similar circumstances.

Expenses Not Covered

Limitations

This Plan is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses

Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±.50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or materials above Plan benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan benefits;
- Expenses not covered under General Exclusions.

Weekly Disability Benefits

If you are an active employee and you become totally disabled and are unable to work as a result of nonoccupational illness or injury, you may be entitled to a benefit of $300 per week for a maximum of 39 weeks for any one period of disability.

Benefits begin on the first day of total disability due to an accident and the eighth day of total disability due to an illness. However, if you are confined as an inpatient in a hospital or have outpatient surgery, benefits begin on the first day for total disability due to either illness or accident.

Total disability or totally disabled, as it applies to this benefit only, means you (the employee) are prevented from performing any and every duty pertaining to your occupation. House confinement during your disability is not required.

Successive periods of disability separated by less than two weeks of continuous, active, full-time work will be considered as one period of disability unless the periods of disability are due to entirely unrelated causes and begin after you have returned to active full-time work.

Exclusions

No weekly disability benefits will be paid for:

- Any period of disability during which you are not under the care of and certified as totally disabled by a legally qualified physician.
- Any disability which arose out of or in the course of employment.
- Any disability for which you are entitled to benefits under any workers' compensation law or similar law.
- Any disability which began prior to your becoming covered under the Plan or which began during a month in which you did not have active eligibility.
- Any period of disability during which you are receiving unemployment compensation or compensation (other than for vacation or holiday) from your employer even though no duties are performed.
- Charges incurred for any illness or injury caused by the act or omission of another person (known as a third party), and where an opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. The Plan may advance payment of benefits pending recovery from the third party or insurers pursuant to the Right to Reimbursement provisions.

Taxes

Your Weekly Disability benefit payment is subject to both FICA (Social Security) taxes and FIT (Federal Income Tax). The Plan will automatically withhold the appropriate FICA taxes from your weekly check. You also have the option of having the Plan withhold Federal Income Taxes from your weekly check. (Contact the Administration Office for details). The Administration Office will send you a W-2 at year end so you will be able to file your Federal Income Taxes.

Life Insurance Benefits

Life insurance benefits are available to eligible active employees only; retirees and dependents are not eligible for this benefit.

Life insurance benefits are underwritten by United of Omaha. A life insurance benefit of $50,000 is paid as soon as the Administration Office receives proof of your death. Payment will be made in the event of your death at any time or place or from any cause.

You may elect to have your life insurance paid either in one sum or in monthly installments. If you elect to have your life insurance paid in one sum, the beneficiary may change that election (after your death but before payment is made) and elect to have the insurance paid in monthly installments.

Designation of Beneficiary

Payment will be made to your designated beneficiary or beneficiaries. You may designate a beneficiary or change your designation of beneficiary by written request, which is filed with the Administration Office.

A beneficiary designation of a spouse will be automatically revoked at the time a marriage is dissolved or invalidated. You should complete a new beneficiary designation following a dissolution or invalidation of marriage, even if you intend to redesignate your former spouse.

If you do not name a beneficiary, your benefits will be paid to your spouse, children, parents, brothers and sisters, in that order. If none of the beneficiaries are living, the benefits will be paid to your estate.

Total and Permanent Disability

If you become totally and permanently disabled before age 60, and if the disability continues after life insurance premiums are no longer payable, your life insurance will remain in force (without payment of premium) during the disability for up to twelve months. United of Omaha must receive written proof (within twelve months after premiums discontinue) that you have been disabled for at least nine months. Your premium is waived for successive further periods of one year while disabled, if proof of continuing disability is submitted in writing to United of Omaha within the three months preceding each year.

It is your responsibility to initially apply for this waiver of premium, and to submit continued proof of disability to United of Omaha.

You are considered to be “totally and permanently disabled” under this benefit only if illness or injury prevents you from engaging in your own or any other gainful occupation and continues to prevent you from engaging in any reasonable occupation for which you are, or may reasonably become, fitted by education, training, or experience.

Converting Coverage

If your life insurance coverage ends because you are no longer eligible you may convert your group life insurance (without providing evidence of good health) to any United of Omaha individual policy (except term insurance).

You must apply to United of Omaha and pay the applicable premium within 31 days after the date you are no longer eligible.

Your group life insurance is payable if you die within the 31-day conversion period whether or not you have made application for an individual policy.

If you convert coverage, the provisions and benefits will not necessarily be the same as under your current plan. Plan information and premium rates can be obtained from United of Omaha when coverage described in this booklet ends. Conversion applications are available from the Administration Office.

Accidental Death and Dismemberment (AD&D) Benefits

This benefit is available to eligible active employees only; retirees and dependents are not eligible for this benefit.

Accidental death and dismemberment benefits are underwritten by United of Omaha.

If you suffer death or dismemberment as a result of accidental bodily injuries (including bodily injuries arising out of or in the course of employment), you will be paid a benefit, as described in the table below, if the loss occurs within 365 days after the date of the accident.

In the event of loss of:	Your AD&D benefit is:
Life	$50,000
Both hands or both feet	$50,000
Both eyes	$50,000
One hand and one foot	$50,000
One foot and one eye	$50,000
One hand and one eye	$50,000
One hand or one foot	$25,000
One eye	$25,000

Loss of a hand or a foot means dismemberment by severance through or above the wrist or ankle joint. Loss of an eye means the entire and irrecoverable loss of sight of the eye.

Not more than $50,000 will be paid for all losses sustained by you through one accident. Payment is made for permanent losses only.

Designation of Beneficiary

Payment will be made to you, if living, otherwise to your designated beneficiary. You may designate a beneficiary or change your designation of beneficiary by written request, which is filed with the Administration Office.

A beneficiary designation of a spouse will be automatically revoked at the time a marriage is dissolved or invalidated. You should complete a new beneficiary designation following a dissolution or invalidation of marriage, even if you intend to redesignate your former spouse.

If you do not name a beneficiary and you die, your benefits will be paid in the same manner as your life insurance benefit.

Exclusions

AD&D insurance does not cover losses caused or contributed to by:

- Bodily or mental infirmity.
- Disease, ptomaines or bacterial infections (except a pus forming infection resulting directly from an injury not excluded under this benefit).
- Intentionally self-inflicted injury.
- Medical or surgical treatment, except a loss resulting directly from a surgical procedure required for treatment of an injury not excluded under this benefit (treatment must be performed within 365 days after the date of injury).
- Suicide or a suicide attempt (whether sane or insane).
- War or any act of war, declared or undeclared, or international armed conflict.

Retiree Benefits

This Program is Not Guaranteed.

The Board of Trustees is providing this program of retiree benefits to the extent that monies are currently available to pay for the cost of such programs. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for this program and to determine the expenditure of such monies for the program. The program is not guaranteed to continue indefinitely. The program may be terminated or modified at any time by the Board of Trustees.

Summary of Benefits

The following charts provide a brief summary of benefits for eligible retired employees and their dependents. For a complete description of the benefits listed below, refer to the following pages in this section.

Retired Participants Not Eligible for Medicare

Medical Benefits Plan A	
Annual Deductible (7/1 – 6/30)	$300 per person $600 per family
Coinsurance (7/1 – 6/30)	**PPO Providers** – Plan pays 80% of the PPO Allowed Amount for most covered expenses until the out-of-pocket maximum is reached (see below), then the Plan pays 100% of most covered expenses for the rest of the coinsurance period **Non-PPO Providers** – Plan pays 70% of the Usual, Customary and Reasonable (UCR) Amount for most covered expenses (these expenses do not apply to the out-of-pocket maximum)
Out-of-Pocket Maximum (7/1 – 6/30)	$2,300 per person (including deductible) $4,600 per family (including deductible) Refer to page 25 for expenses that do not apply to the out-of-pocket maximum

Prescription Drug Benefits Plan A		
Retail Pharmacy Card (34 day supply maximum)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic	$10 copay	$10 copay
Preferred brand	$25 copay	$25 copay
Non-preferred brand	$40 copay	$40 copay
Mail Order (90 day supply maximum)		
Generic	$20 copay	
Preferred brand	$40 copay	
Non-preferred brand	$60 copay	
Out-of-Pocket Maximum (7/1 – 6/30)	$4,300 per person $8,600 per family Refer to page 48 for expenses that do not apply to the out-of-pocket maximum	

Medical Benefits Plan B	
Annual Deductible (7/1 – 6/30)	$800 per person $1,600 per family
Coinsurance (7/1 – 6/30)	**PPO Providers** – Plan pays 80% of the PPO Allowed Amount for most covered expenses until the out-of-pocket maximum is reached (see below), then the Plan pays 100% of most covered expenses for the rest of the coinsurance period **Non-PPO Providers** – Plan pays 70% of the Usual, Customary and Reasonable (UCR) Amount for most covered expenses (these expenses do not apply to the out-of-pocket maximum)
Out-of-Pocket Maximum (7/1 – 6/30)	$2,800 per person (including deductible) $5,600 per family (including deductible) Refer to page 25 for expenses that do not apply to the out-of-pocket maximum

Prescription Drug Benefits Plan B		
Retail Pharmacy Card (34 day supply maximum)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic	$10 copay	$10 copay
Preferred brand	$25 copay	$25 copay
Non-preferred brand	$40 copay	$40 copay
Mail Order (90 day supply maximum)		
Generic	$20 copay	
Preferred brand	$40 copay	
Non-preferred brand	$60 copay	
Out-of-Pocket Maximum (7/1 – 6/30)	$3,800 per person $7,600 per family Refer to page 48 for expenses that do not apply to the out-of-pocket maximum	

Retired Participants Eligible for Medicare

Medical Benefits	
Medicare Supplemental	Assumes you are enrolled in Parts A and B of Medicare when eligible, regardless of whether you enroll; Plan covers the Medicare deductibles and coinsurance not paid by Medicare. Also, some Additional Covered Medical Expenses are covered by the Plan, subject to an annual deductible (see page 71).

Prescription Drug Benefits	
Retail Pharmacy Card (30 day supply maximum)	**Participating Pharmacy**
Generic	$10 copay
Preferred brand	$25 copay
Non-preferred brand or Specialty	$40 copay
Mail Order (90 day supply maximum)	
Generic	$20 copay

Prescription Drug Benefits	
Preferred brand	$40 copay
Non-preferred brand or Specialty	$60 copay

Note: Prescriptions obtained at a nonparticipating pharmacy are not reimbursable, except for very limited situations.

All Retired Participants

Vision Benefits	Schedule (see page 58)

Dental Benefits – Optional
Three dental plans available through Delta Dental, with entire premium paid by the retiree

Eligibility Provisions

If you are a retired employee who meets the eligibility requirements described below, you are eligible for benefits on the first day of the month following or coinciding with the date you retired (or, if later, the first day of the month following or coinciding with the termination of your eligibility as an active employee under the Plan).

Retirees Age 60 and Older

If you are a retired employee age 60 or older, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving a Normal, Early, or Late Retirement Benefit from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan or you worked for 10 consecutive years under a Local 302 or 612 of the I.U.O.E. collective bargaining agreement.

  If you qualify for coverage by receiving a Retirement Benefit, you must have at least 10 years of credited service or 15,000 hours in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan.

  If you qualify for coverage by receiving a pro-rata pension, you must have at least 10 years of credited service in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan. Related plan credits cannot be used.
- You had contributions made on your behalf to the Plan during at least 12 months of the 48 months immediately before age 60 (or your actual retirement date, if it is after age 60).
- You enroll in the Plan and make the required retiree self-payments.
- You refrain from employment which is: in the industry, which means working 50 or more hours per month for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and in a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or as an employee.

Retirees Under Age 60

If you are a retired employee between ages 52 and 60, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving an Early Retirement Benefit from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan or you worked for 10 consecutive years under a Local 302 or 612 of the I.U.O.E. collective bargaining agreement.

If you qualify for coverage by receiving a Retirement Benefit, you must have at least 10 years of credited service or 15,000 hours in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan.

If you qualify for coverage by receiving a pro-rata pension, you must have at least 10 years of credited service in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan. Related plan credits cannot be used.

- You had contributions made on your behalf to the Plan during at least 12 months of the 48 months immediately before your retirement.
- You enroll in the Plan and make the required retiree self-payments.
- You refrain from employment which is: in the industry, which means working 50 or more hours per month for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and in a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or as an employee.

Disabled Retirees

If you are a disabled retired employee age 40 or older, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving a Disability Retirement Benefit from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan or you worked for 10 consecutive years under a Local 302 or 612 of the I.U.O.E. collective bargaining agreement.

  If you qualify for coverage by receiving a Retirement Benefit, you must have at least 10 years of credited service or 15,000 hours in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan.

  If you qualify for coverage by receiving a pro-rata pension, you must have at least 10 years of credited service in the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan. Related plan credits cannot be used.
- You had contributions made on your behalf to the Plan during at least 12 months of the 48 months immediately before your date of disability.
- You enroll in the Plan and make the required retiree self-payments.
- You refrain from employment which is: in the industry, which means working 50 or more hours per month for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and in a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or as an employee.

Former Associate Employees

If you are a retired employee who participated as an associate employee and you do not satisfy the rules for retiree eligibility because you are not receiving a pension from the Locals 302 and 612 I.U.O.E. Employers Construction Industry Retirement Plan, you are eligible for retiree benefits if you meet each of the following requirements:

- You are receiving benefits from a Taft-Hartley pension plan.
- You participated in the Plan as an associate employee for at least 60 months immediately preceding your retirement date.
- You enroll in the Plan and make the required retiree self-payments.

How and When to Enroll

You must enroll at the time you retire to receive retiree benefits; coverage is not automatic. You may also enroll your dependents at the time of your retirement. Enrollment forms are available from the Administration Office.

Retiree benefits become effective on the first day of the calendar month after the completed request for enrollment is received by the Administration Office or when you become eligible, if later.

Participants Not Medicare Eligible

If, at your pension effective date or loss of medical coverage if later, you do not enroll for retiree health coverage, you may not enroll yourself or your dependents until you are eligible for Medicare, unless you satisfy the special enrollment provisions described below.

Medicare Eligible Participants

If you and/or your spouse did not enroll at the time of retirement, you may enroll within 31 days of becoming eligible for Medicare. You must notify the Administration Office in writing, submit a photocopy of your Medicare card and enroll in the Medicare Supplemental Plan.

If you do not enroll at the time of retirement or Medicare eligibility, you and your dependents may not enroll at a later date, except under special enrollment provisions described below.

Special Enrollment Provisions

If you decide not to enroll yourself or a dependent at retirement or when you (or your spouse) become eligible for Medicare, you may only enroll yourself or a dependent at a later date if one of the following special enrollment provisions is satisfied:

(1) Special Enrollment Upon Termination of Other Group Coverage. If you decline to enroll yourself or your dependent in the retiree plan at the time of retirement or Medicare eligibility because of other group health coverage, you may enroll yourself or your dependent upon termination of the other coverage. However, to qualify for enrollment, the other coverage must have terminated due to:

- loss of eligibility, including loss due to legal separation, divorce, death, termination of employment or reduction in work hours;
- termination of employer contributions; or
- if the other coverage was COBRA coverage, the maximum coverage period was exhausted.

You must enroll yourself and your dependent in the retiree plan within 31 days of the termination of the other group health coverage to qualify for special enrollment. Eligibility is effective the first day of the first calendar month following the month in which the other group coverage terminated.

(2) Special Enrollment Upon Acquiring a New Dependent. If a retiree is already enrolled in retiree medical, and then acquires a new dependent, he or she will be allowed to enroll that dependent within 30 days from the date acquired.

Also, if a retiree who is not currently enrolled in retiree health acquires a new dependent, he or she will be allowed to enroll themselves and that dependent within 30 days from the date the dependent is acquired, provided they met the eligibility rules for retiree coverage at the time of retirement.

COBRA Continuation Option

Instead of the retiree coverage described in this section, you may temporarily elect COBRA coverage, provided you satisfy the requirements for that coverage. (See page 16 for more information on self-pay coverage.) Following termination of COBRA, you may elect retiree coverage if you met the retiree eligibility requirements at the time of your retirement.

Cost

Monthly self-payments are required from all retirees. You may make your payments one of the following ways:

- Deductions from the retirement payments received from the Locals 302 and 612 I.U.O.E. - Employers Construction Industry Retirement Plan for those who elect such deductions.
- Monthly payments to the Administration Office for those who do not elect deductions from their pension checks.
- Automatic deductions from your checking account.

Monthly self-payments are a percentage of the actual cost, as determined by the number of hours worked by the retiree prior to retirement while an active participant in this Plan, the retiree's age and the plan selected. The Board of Trustees may change the amount of self-payments from time to time. Contact the Administration Office for details about monthly self-payment amounts.

When Coverage Ends

If you commence retiree benefits, your coverage will end if you work 50 or more hours during a calendar month:

- In the industry, which means work for a non-contributing employer that engages in any business activity of the type engaged in by contributing employers; and
- In a position or job classification which would otherwise be covered by an IUOE Labor Agreement, whether as a self-employed person or an employee.

Termination of retiree benefits will be effective the first day of the month following notification sent by the Administration Office to your address of record.

In addition, retiree coverage ends when:

- You die;
- The Plan terminates, or no longer provides retiree coverage;
- You fail to make any required contributions.

Following termination of coverage, you will not be allowed to re-enroll in such coverage.

Your dependents' coverage ends on the last day of the month in which:

- Your coverage ends (unless your dependents elect to continue coverage by self-pay as described in the next section).
- In the case of a spouse, you become divorced.
- In the case of a dependent child, the child no longer meets the definition of an eligible dependent (see page 14).
- You terminate your dependents' coverage. You may terminate your dependents' coverage by contacting the Administration Office.

If your dependents' coverage ends, your dependents may be eligible to continue coverage as described in the next section.

Self-Pay Coverage for Dependents

If you are covered by this Plan and you die or become divorced, your spouse and enrolled dependent children who would otherwise lose coverage may continue coverage as follows:

- Surviving spouses may elect to continue coverage through self-payment until they remarry, die, or until the Plan terminates or no longer provides retiree coverage, whatever occurs first.

- Enrolled dependent children may also continue coverage through self-payments until they reach the limiting age. Thereafter, they can elect COBRA continuation coverage.
- Divorced spouses may continue coverage under the COBRA continuation coverage provisions (see page 16).

When the dependent child of a retired employee no longer meets the definition of an eligible dependent, he or she may continue coverage under COBRA (see page 16).

In order to continue coverage under COBRA, you must provide timely notice. See page 17 for details.

Benefits – Not Medicare Eligible

As an eligible retiree or enrolled dependent of a retiree who is not yet eligible for Medicare, you have the following coverage under this Plan.

Medical – The same benefits as an active employee, as described beginning on page 24. However, you have a choice between two plans:

- Plan A (regular). Under Plan A, you are covered by the same medical benefits as active participants. The deductible (as described on page 24) and the out-of-pocket maximum (as described on page 25) apply to all covered medical benefits.
- Plan B (low option). Under Plan B, you have the same covered expenses with the same limitations and exclusions as Plan A. However, your annual deductible is $800 per person and $1,600 per family; the annual medical out-of-pocket maximum is $2,800 per person and $5,600 per family.

Prescription Drugs – The same benefits as an active employee, as described beginning on page 45. However, the annual prescription drug out-of-pocket maximum under Plan B is $3,800 per person and $7,600 per family.

Vision Care – The same benefits as an active employee, as described beginning on page 58.

Optional Dental Plan – As described on page 72.

Benefits – Medicare Eligible

As an eligible retiree or enrolled dependent of a retiree who is eligible for Medicare, you have the following coverage under this Plan.

Medicare Supplemental Plan – This plan pays a portion of those expenses not presently covered by Medicare; see below for more details.

Prescription Drug Benefits – The Plan covers prescription drugs under a Medicare Prescription Drug Plan (Part D Plan) administered by UnitedHealthcare. A separate booklet will be provided to you each calendar year describing these benefits.

Vision Care – The same benefits as an active employee, as described beginning on page 58.

Optional Dental Plan – As described on page 72.

Medicare Supplemental Plan

When benefits are determined under the Medicare Supplemental Plan, it is assumed you enrolled in Medicare and that benefits are payable from Part A (the hospital insurance portion) and Part B (the medical insurance portion). Even if you don't enroll in Medicare, benefits are paid as if you did. As a result, it is important that you enroll in Medicare on a timely basis.

The Medicare Supplemental Plan provides benefits as follows:

Hospital Benefits

The hospital benefits listed below may refer to a "benefit period." A benefit period begins the first day you enter a hospital or skilled nursing facility and ends as soon as you have not been a bed patient in any hospital or skilled nursing facility for 60 consecutive days.

- The Plan pays the current initial deductible required by Medicare for each inpatient admission per benefit period.
- The Plan pays the current per day deductible required by Medicare for the 61st through the 90th day in each benefit period.
- After the 90th day of confinement, Medicare provides you with an additional lifetime reserve of 60 hospital days. The Plan pays the current per day deductible Medicare requires you to pay when you use these extra days.
- After you have used all your Medicare benefits, the Plan will pay the current per day benefit if you remain in the hospital.

Any excess of a hospital's room and board charge over the semi-private room rate will not be considered a covered medical expense if private accommodations are used.

Skilled Nursing Facility Benefits

When you are in a Medicare-approved skilled nursing facility, the Plan pays the current coinsurance required by Medicare for the 21st through the 100th day of your stay. No further benefits will be provided.

A "skilled nursing facility" is one defined as such under Medicare, and which participates under Medicare.

Benefits for Medicare Part B Expenses

Medicare Part B expenses include physician services, hospital outpatient services, diagnostic x-ray and laboratory tests, radiation therapy, durable medical equipment, ambulance services and any other expenses recognized by Part B of Medicare.

- The Plan pays the annual Part B deductible required by Medicare.
- If your physician accepts an assignment of Medicare benefits, the Plan pays 20% of the Medicare allowed amount for the medical and other health services covered under Part B of Medicare.
- If your physician has not agreed to accept an assignment of Medicare benefits, the Plan pays 20% of Medicare's limited charge. Medicare's limiting charge means the maximum charge determined by Medicare for covered physician services. This means that physicians who do not participate in Medicare or who do not accept assignment must accept Medicare's limiting charge as full payment. The limiting charge may be more than the Medicare allowed amount.

Additional Covered Medical Expenses

You must pay the deductible before Plan benefits for additional covered expenses are payable. The deductible period runs 7/1 – 6/30 and is $100 for each person eligible for Medicare. When you and your dependents who are eligible for Medicare have incurred a combined deductible expense of $200, no further deductible is required for any family member during the deductible period.

During the initial year under the Medicare Supplemental Plan, any deductible recognized under Medical Benefits will be applied toward this deductible.

After you have satisfied the deductible, the Plan pays 80% of the UCR Amount (defined on page 87) for the following services not covered by Medicare:

- A registered graduate nurse (RN), excluding charges of a nurse who ordinarily resides in the patient's home or who is a member of your or your spouse's family.
- Blood, or units of packed red blood cells that a patient receives.

- Hearing care expenses for retirees only, as described on page 35.
- Cochlear implants, as described on page 33.
- Naturopathic covered expenses (see page 38).
- Services for the following alternative treatments:
  - Hypnosis
  - Acupuncture
  - Dietary Counseling
  - Nutritional Counseling

  up to a maximum of $50 per visit and $300 maximum, inclusive of all providers, per calendar year. Benefits are only provided for alternative treatments if it is otherwise a covered expense under the Plan and performed by a provider licensed to perform the services. Diabetic education by a registered dietician is not subject to the $300 calendar year maximum.

Annual Medical Out-of-Pocket Maximum (7/1 – 6/30)

The Annual Medical Out-of-Pocket Maximum is the most you will pay toward medical covered expenses during the year. This means that once you have reached your Annual Medical Out-of-Pocket Maximum, the Plan pays 100% of the allowed amount for the remainder of the coinsurance period (July 1 through June 30).

Annual Medical Out-of-Pocket Maximum (7/1 – 6/30)	
Each person	$6,600
Each family	$13,200

The Annual Medical Out-of-Pocket Maximum may change from time to time. The above Out-of-Pocket Maximums apply as of the date of publication of this booklet.

Medical services you receive that are not covered by Medicare do not apply to this Annual Medical Out-of-Pocket Maximum.

Optional Dental Plan

The Plan offers three optional dental plans. These programs are voluntary and the entire premium is paid by the retiree. For details of these plans, please contact the Administration Office at (206) 441-7314 or (877) 441-1212. These plans are available to retirees who participate in the retiree Medical Plan. Open enrollment is held once a year and retired participants may join or terminate dental coverage during this period. Dental coverage may not be terminated other than at open enrollment.

What is Medicare?

Medicare includes:

- Part A (hospital insurance) which helps cover inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Generally, there is no cost for Medicare Part A.
- Part B (medical insurance) which helps cover doctor's services and outpatient hospital care. It may also cover some services that Medicare Part A does not cover. You must generally pay a monthly premium for Medicare Part B. You must also pay a deductible before Medicare starts to pay.
- Part D (prescription drug coverage) which helps cover prescription drugs at participating pharmacies. You must generally pay a monthly premium and an annual deductible. You also pay a part of the cost of your prescriptions. Costs will vary depending on which plan you choose.

Who is Eligible

You are eligible to enroll in Medicare if:

- You are age 65 or older;
- You are under age 65 and receiving disability benefits from Social Security or the Railroad Retirement Board. (There may be a waiting period before you can commence Medicare); or
- You have end-stage renal disease (ESRD). If while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of ESRD, this Plan generally pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Then starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Medicare Enrollment

If you are receiving benefits from Social Security or the Railroad Retirement Board, you should be automatically enrolled in Medicare the first day of the month you turn age 65. If you are under age 65 and disabled, you should be automatically enrolled after you have received disability benefits from Social Security or the Railroad Retirement Board for 24 months (although a shorter waiting period may apply in some instances). If you do not want Medicare Part B, you must follow the instructions that come with your Medicare card. **However, if you are a retiree or dependent of a retiree and you are eligible for Medicare Part B, Plan benefits are provided as if you are enrolled in Medicare Part B, regardless of whether you actually enroll.**

If you are turning age 65 and you are not receiving Social Security or Railroad Retirement benefits, you must apply for Medicare. **Even if your Social Security age is older than age 65, you are still eligible to enroll in Medicare at age 65.**

There is an initial enrollment period for Medicare Part B, which begins three months before the month you turn age 65, and ends three months after the month you turn age 65. However, your starting date for Medicare Part B will be delayed if you do not sign up before the month you turn age 65.

If you do not sign up for Medicare Part B during the initial enrollment period, you may sign up during the general enrollment period which runs from January 1 through March 31 of each year. Medicare Part B will start on July 1 of the year you sign up. The cost of Medicare Part B generally increases for each 12-month period that you could have taken Medicare Part B, but did not.

There is a special enrollment period if you waited to enroll in Medicare Part B because you or your spouse was working and had other group health plan coverage based upon your employment. The special enrollment period is anytime you are still covered in the group health plan, or during the eight months following the earlier of the month that the group health plan ends or employment ends.

Retirees and their spouses are expected to enroll in both Medicare Part A and Part B when first eligible. Even if you retire and elect COBRA coverage in lieu of Retiree Benefits, you must enroll in Medicare Part A and Part B. If you are eligible to enroll in Medicare Part A and Part B, benefits are provided by the Plan as if you are enrolled, regardless of whether you actually did

Medicare Part D Prescription Drug Plans

If you and/or your dependents are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D prescription drug benefits.

The Locals 302 and 612 Health and Security Fund provides Medicare Part D coverage to Medicare eligible retirees and dependents of retirees through the UnitedHealthcare MedicareRx for Groups (PDP). UnitedHealthcare has a contract with Medicare and administers the plan. As a result, you do not have to enroll in another Medicare prescription drug plan (Part D plan) in order to avoid a late penalty under Medicare.

For your information, there is a penalty applied by Medicare if you fail to have continuous prescription drug coverage that is considered creditable. If you go 63 continuous days or longer without prescription drug coverage, that is "creditable coverage," your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

Please contact the Administration Office before you enroll in any Medicare Part D prescription drug plan.

If you enroll in another Medicare Part D prescription drug plan, it is important to note that you and your dependents will lose your current prescription drug coverage under the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund and you will not be reimbursed for your Part D premiums.

Medicare & You Handbook

More detailed information about Medicare is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

General Exclusions

No Medical, Dental or Vision Plan benefits are payable for:

- Any claim under this Plan if you were injured as the result of your commission of an assault, battery, or felony, or if you were an aggressor against another person, or if you were engaged in any acts of violence or physical force that would not be performed by a reasonably prudent person in similar circumstances, provided that this exclusion does not apply to injuries sustained as a victim of domestic violence.
- Charges for services or supplies for which benefits are furnished, paid for or for which benefits are provided or required under any law of a government (this does not include a plan established by a government for its own employees or their dependents).
- Charges for services or supplies (including drugs) which are:
  - Not Medically Necessary.
  - Not provided in accord with generally accepted professional medical standards, or
  - For Experimental or Investigational treatment.
- Charges in connection with injury or illness arising out of or in the course of employment, or which are compensable under any workers' compensation or occupational disease act or law, whether or not a claim was filed.
- Charges incurred for any illness or injury caused by the act or omission of another person (known as a third party), and where a potential opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. The Plan may advance payment of benefits pending recovery from the third party or insurers pursuant to the Right to Reimbursement provisions.
- Charges that are made only because the benefit plan exists, or charges that no covered person is legally obligated to pay.
- Charges which result from intentionally self-inflicted injuries, including suicide or attempted suicide, unless the injuries or illnesses were the result of a documented medical condition or the result of being a victim of domestic violence.
- Conditions caused by or arising out of an act of war, declared or undeclared, armed invasions or aggression, riot or insurrection.
- Phone calls or missed appointments or filling out forms. Services where a patient is not physically seen by a physician or other covered provider except as provided under the Telemedicine benefit.
- Services or supplies by a provider who normally resides in your home or is related to you by blood or marriage.
- Services or supplies provided or incurred before the effective date of your or your dependents' coverage or delivered after coverage ends except as specifically provided.
- Services, supplies and prescription drugs that are outside of or contrary to internal guidelines or medical protocols utilized by the Board of Trustees, the Plan's third-party administrator, the Plan's PPO, the Plan's preauthorization review provider, or the Plan's Pharmacy Benefit Manager, in determining coverage for the service, supply or drug, including guidelines or protocols used for diagnosis, treatment, prescription, or billing practices, or for determining industry standards.
- Charges for services of supplies that are limited or excluded under the specific benefit.
- Charges for claims that are submitted or completed with all supporting documentation more than one year from the date of service.

- Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, and excessive or improperly coded billing charges.
- Charges for services or supplies billed or charged in breach of or contrary to the provider's PPO agreement or in breach of or contrary to provider guidance or policies established by the PPO.

Coordination of Benefits

This Plan is designed to help you meet the cost of medical, dental and vision care expenses. Since it is not intended that you receive greater benefits than the actual expenses incurred, the amount payable under this Plan will take into account any coverage you have under other "plans," as defined below. This means the benefits under this Plan will be coordinated with the benefits of the other "plans."

The Willamette Dental Group Plan has a separate policy on coordination of benefit rules. Please refer to the Willamette Dental Group Plan certificate of coverage for a complete description of its coordination of benefits rules.

When coordinating with other plans, this Plan will pay either its regular benefits in full, or a reduced amount. This reduced amount plus the benefits payable by the other plans will equal 100% of "allowable expenses." "Allowable expenses" mean any necessary, usual, customary and reasonable expense partially or completely covered under any other plan during the calendar year while the person is covered under this Plan.

If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase your later claim payments under the Plan in the same calendar year, to the extent there are allowable expenses that otherwise would not be fully paid by this Plan and the other plans. Therefore, on a later claim you may receive a greater benefit under our Plan than would normally be allowed.

"Plan" means any of the following, even if it does not have its own coordination of benefits provisions:

- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization agreements issued by insurers, health care service contractors and health maintenance organizations.
- Labor-management trustee plans, labor organization plans, or employee benefit organization plans.
- Government programs which provide benefits for their own civilian employees or their dependents (including Medicare).
- Coverage required or provided by any statute, including automobile insurance policies required by statute to provide medical benefits.

The following guidelines have been established to ensure that all plans coordinate benefits in a consistent manner. The primary plan pays benefits first. The secondary plan pays benefits second (after the primary plan has paid).

This plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than as dependent, for example, as an employee, retiree, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (i.e., a retired employee), then the order of benefits is reversed, so that the

plan covering the person as a dependent pays first, and the plan covering the person as an employee, retiree, member or subscriber pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose birthday falls earlier in the calendar year pays first: and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

   1. The parents are married;
   2. The parents are not separated (whether or not they ever have been married); or
   3. A court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision applies to claim determination periods commencing after the plan is given notice of the court decree.

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expense, the order of benefit determination among the plans of the parents and their spouses (if any) is:

   1. The plan of the custodial parent pays first; and
   2. The plan of the spouse of the custodial parent pays second; and
   3. The plan of the non-custodial parent pays third; and
   4. The plan of the spouse of the non-custodial parent pays last; and
   5. If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither self-pay, laid-off, or retired, or in a non-active capacity), or as that active employee's dependent, pays first; and the plan that covers the same person as a self-pay, laid-off or retired, or non-active employee, or as that self-pay, laid-off or retired, or non-active employee's dependent, pays second.

B. If the other plan does not have this rule, and if, as result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a self-pay, laid-off, retired or non-active employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to the same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

   1. In the amount or scope of a plan's benefits;
   2. In the entity that pays, provides or administers the plan; or
   3. From one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: Other Plan Has No COB Rule

If the other coverage has no COB rules, this Plan will always pay secondary.

If you or your dependents are covered by another group or individual medical, dental or vision plan, claims should be filed under this Plan and the other plan(s) at the same time to avoid delays in claim payments due to coordination of benefits.

Coordination of Benefits with Medicare

If you are an active employee, this Plan is your primary plan and Medicare will be your secondary plan. You may select Medicare as your primary plan for yourself and your Medicare-eligible spouse. However, if you select Medicare as your primary plan, this Plan will not pay any of your medical expenses not paid by Medicare. If you have questions about this election, please contact the Administration Office.

If you are a retired employee, your benefits are provided under the terms of the Retiree Plan. If you and your spouse are eligible for Medicare, Medicare is always your primary plan, and any benefits from the Retiree Plan will only be available after Medicare has processed your claim. See Retiree Benefits starting on page 64 for more information on the Retiree Plan.

If your coverage is based on COBRA and you are entitled to Medicare based on age or disability and you no longer have current employment status, Medicare will pay first and the Fund will only pay secondary and coordinate with Medicare.

If you have Medicare coverage based on end stage renal disease and have Plan coverage (based on COBRA or otherwise), the Fund will pay primary during the 30-month coordination period provided by statute.

Right to Information

In determining how to coordinate benefits, the Fund, without consent of or notice to anyone, may release or obtain any information it determines reasonably necessary. A person claiming Plan benefits must furnish, upon written request, information to help the Administration Office implement this provision.

Right to Correlate Payments

A payment made under another health plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made the payment. The amount is treated as though it were a benefit paid under this Plan and the Plan will not pay that amount again.

Right to Reimbursement (Third Party Liability)

The Plan excludes charges incurred for any illness or injury caused by the act or omission of another person (known as a "third party"), and where a potential opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. If a covered person has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the covered person, may advance benefits pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits in excess of $5,000, the covered person agrees that the Plan is entitled to reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan (including the first $5,000 of such benefits), but not to exceed the amount of the recovery. The Plan is entitled to reimbursement, regardless of whether the covered person is made whole by the recovery, and regardless of the characterization of the recovery, except that the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount as described below, if the covered person complies with the terms of the Plan and the agreement to reimburse.
- The Plan can require a covered person and the covered person's attorney or legal representative to execute and deliver instruments and papers, disclose the circumstances resulting from the injury or illness, and do whatever else is necessary to secure the Plan's right to reimbursement (including an assignment of rights). The Plan may require the covered person and the covered person's attorney or legal representative to sign an agreement to reimburse the Plan from the proceeds of any recovery before the Plan will advance any benefits.
- A covered person must do nothing after payment of benefits to prejudice the Plan's right of reimbursement.
- When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other way, an amount sufficient to satisfy the Plan's reimbursement amount must be paid by the covered person into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. The obligation to place the reimbursement amount in escrow or trust is independent of the obligation to reimburse the Plan. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in an escrow or trust account, the covered person will be personally liable for any loss the Fund suffers as a result.
- If reasonable attorney fees are incurred in recovering from the third party or insurer, the Plan agrees to pay a percentage of attorney fees on the amount reimbursed to the Plan, not to exceed the percentage actually charged by the attorney to the covered person. If reasonable costs are incurred in recovering from the third party insurer, the Plan agrees to pay a pro rata share of the costs, based upon the Plan's share of the gross recovery to the total gross recovery. Costs incurred solely for the benefit of the covered person shall be the responsibility of the covered person. Notwithstanding the foregoing, the Plan's payment of attorney fees and costs is contingent on compliance with the Plan's reimbursement provisions and/or the agreement to reimburse.
- The Plan may cease advancing benefits if there is a reasonable basis to determine that this provision is not enforceable, or if there is a reasonable basis to believe the parties involved will not honor the terms

of the Plan or the agreement to reimburse, or the Board of Trustees modifies the Plan provisions related to the advancement of benefits. The Plan may also deny coverage for expenses incurred after recovery on the third-party claim, if such expenses are related to the third-party recovery.

- If the Plan is not reimbursed upon recovery on a third party claim, the Plan may bring an action against the covered person to enforce its right to reimbursement and/or the agreement to reimburse or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefit payments of the covered person and the covered person's family members, or by requesting provider refunds, or by recovery from the source to which benefits were paid, or by exercising other options for reimbursement under the Right of Recovery section on page 102.
- In any legal action under this provision venue may be laid in King County Superior Court or in the United States District Court for the Western District or Washington, at Seattle at the option of the Plan.

After recovery on a third party claim, the Plan is relieved from any obligation to pay further benefits for the illness or injury up to the amount of the balance of the recovery.

Disputed Workers' Compensation Claims

The Plan does not provide benefits for expenses incurred in connection with accidental bodily injury or illness arising out of or in the course of employment, or which are compensable under any workers' compensation or occupational disease act or law, even if the covered person fails to make a claim for such workers' compensation or occupational disease law benefits. If a dispute arises concerning whether an injury or illness is work-related, and the covered person appeals the denial of the claim by a state or federal workers' compensation agency or insurer, the Plan may advance payment of benefits pending resolution of the appeal, provided the covered person submits documentation indicating the basis for denial of the claim and signs and returns an agreement to reimburse the Plan 100% of the amount of such benefits, or the amount recovered if less, upon recovery on the workers' compensation claim. Reimbursement is required regardless of whether recovery is through acceptance of the claim, award, settlement, or disputed claim settlement, or any other method of recovery, and regardless of whether the covered person is made whole by the recovery. The amount to be reimbursed to the Plan shall not be reduced for attorney fees or costs incurred by the covered person. The covered person shall do nothing to prejudice the Plan's right to reimbursement. If the Plan is not reimbursed, the Plan may elect to recoup the reimbursement amount by offsetting future benefit payments of the covered person and the covered person's family members, or by requesting provider refunds, or by recovering from the source to which benefits were paid, or by exercising other options for reimbursement under the Right of Recovery section (see page 102). Following recovery on the workers compensation claim, no further benefits will be provided related to the injury or illness.

Definitions

For the purpose of this Plan, the following definitions will apply:

Approved Treatment Facility

An approved treatment facility means an institution providing treatment for substance abuse and mental disorders which is operating under the direction and control of the Washington State Department of Social and Health Services or the equivalent department of another state. If the facility does not operate under the direction and control of the Department, then it must provide effective treatment for chemical dependency through a contract with the Department, be included in the Department's current list of approved public and private treatment facilities, and meet all applicable government standards.

Board of Trustees

Board of Trustees means the persons and their successors established by the Trust Agreement.

Cosmetic Surgery

Cosmetic surgery is surgery that is performed primarily to alter:

- Texture or configuration of the skin, or
- Configuration or relationship with contiguous structures of any feature of the human body when performed primarily for psychological purposes and not to correct or materially improve a bodily function.

Custodial Care

Custodial care is services and supplies provided to a person in or out of an institution, primarily to assist the person in daily living activities, whether or not the person is disabled, and independent of who recommends or provides the services or supplies.

Dental Injury

A dental injury is an injury to sound natural teeth cause by an external force such as a blow or fall. It does not include tooth breakage while chewing.

Dentist

A legally qualified dentist or a physician authorized by license to perform the particular dental procedure rendered. The term dentist shall also include a denturist who is performing services within the scope of their license.

Emergency Medical Condition

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

Employer

Employer means an employer that satisfies the requirement of the Trust Agreement and of the Board of Trustees and is obligated to make contributions to the Fund for the purpose of providing welfare benefits to employees.

Experimental or Investigational

Experimental or Investigational means a service or supply if any of the following apply:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished.
- The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status.
- Federal law classifies the drug, device or medical treatment under an investigational program.
- Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below).
- Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below).

For this section, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Exceptions: A service or supply will not be considered Experimental or Investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets the criteria in either Category 1 or 2 or 3 below:

- Category 1
  - The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center
  - The trial has been reviewed and approved by a qualified institutional review board
  - The facility and personnel have sufficient experience or training to provide the treatment or use the supplies
- Category 2
  - The trial is to treat a condition too rare to qualify for approval under Category 1
  - The trial has been reviewed and approved by a qualified institutional review board
  - The facility and personnel have sufficient experience or training to provide the treatment or use the supplies
  - The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy
  - There is no therapy that is clearly superior to the trial treatment
- Category 3

  The trial is a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The eligible individual must be

eligible to participate in the approved clinical trial according to the trial protocol. The following are not covered:

- The actual clinical trial or the investigational team;
- Items and services solely for data collection that are not directly used in the clinical management of the patient; or
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular condition.

The Administration Office investigates each claim for benefits that might include Experimental or Investigational treatment. The Administration Office may consult with medical professionals, including its own staff, to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as one of the exceptions stated above.

Fund

Fund is defined by the Trust Agreement, and includes all money and property held by the Trustees, including contract rights and records of the Trustees.

Homebound

Homebound means that leaving home involves a considerable and taxing effort and the patient is unable to use public transportation without the assistance of another.

Home Health Care Agency

Home health care agency means a public or private agency or organization that administers and provides home health care and is either:

- A Medicare-certified home health care agency, or
- Certified as a home health care agency by the Washington State Department of Social and Health Services (or equivalent department of another state).

Home Health Care or Hospice Care Treatment Plan

A home health or hospice treatment plan is a program for continued care and treatment established in writing by the patient's attending physician.

Hospital

A hospital is an institution which meets each of the following requirements:

- It is primarily engaged in providing facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians.
- It continually provides 24-hour registered graduate nursing (RN) services.
- It is not, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

Illness

Illness means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a mental health disorder for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered mental health treatment. Illness does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could

be available if application were made under a workers' compensation or occupational injury law or similar legislation.

Injury

Injury means physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident. Injury does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational injury law or similar legislation.

Medically Necessary

A medically necessary procedure is a service or supply that meets all of the following criteria:

- Is essential and appropriate for the diagnosis and/or treatment of illness or injury.
- Is professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating illness or injury.
- Is not primarily for the convenience of the patient or provider.
- When applied to an inpatient, cannot safely be provided to an outpatient.

Medically necessary procedures, services or supplies may be necessary in part only. The fact that a procedure, service, or supply may be furnished, prescribed, recommended, or approved by a physician does not make it medically necessary.

Month

The period of time beginning on the first day of any calendar month and ending on the last day of the same calendar month.

Necessary Service or Supply

A service or supply is considered necessary only if it is broadly accepted professionally as essential to the treatment of the illness or injury.

Occupational Therapist

An occupational therapist is a person who is duly licensed in the state where the services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified by the American Occupational Therapy Association.

Physical Therapist

A physical therapist is a person who is duly licensed in the state where the services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered physical therapist by the American Physical Therapy Association. Also included is a physical therapy assistant who is practicing within the scope of their license.

Physician

A physician is a practitioner of the healing arts who practices within the scope of his or her license. For purposes of this Plan, a physician may be a medical doctor (MD) or an osteopathic physician (DO).

If the practitioner performs services covered under the Plan and within the scope of his or her license, a physician may also be a licensed: dentist (DDS), podiatrist (DPM), psychologist (PhD), optometrist, chiropractor, certified midwife, registered nurse, licensed practical nurse, or Religious Non-Medical Health Care Practitioner, registered naturopath, registered certified hypnotherapist, acupuncturist, occupational therapist, physical therapist or speech therapist, registered dietician, certified nutritionist or a licensed

mental health provider. Before you receive treatment from any practitioner other than an MD or DO, check with the Administration Office to find out if the expenses will be recognized as covered expenses.

Note: For Weekly Disability benefits, only a medical doctor (MD), osteopathic physician (DO), chiropractor (DC), naturopath (ND), physician's assistant (PA), dentist (DDS) and advanced registered nurse practitioner (ARNP) can certify disability.

Preferred Provider Organizations (PPO)

Premera Blue Cross is the PPO in Washington and Alaska. Outside of Washington and Alaska, the BlueCard PPO networks are the PPO.

PPO Allowed Amount

The fee negotiated by the PPO, if a service or a supply is provided by a PPO provider.

Rehabilitative Facility

A rehabilitative facility is an institution that:

- Is licensed.
- Provides facilities for the diagnosis and inpatient rehabilitative treatment of illness or injury with the objective of restoring physical function to the fullest extent possible. (Examples of conditions treated in a rehabilitative hospital are: amputations, spinal cord injuries, head injuries, paraplegia and quadriplegia, CVA, severe arthritis and paralysis.)
- Has facilities or a contractual agreement with a hospital in the area for emergency treatment, surgery, and any other diagnostic or therapeutic services that might be required during a confinement.
- Provides all normal infirmary level medical services required for the treatment of any illness or injury occurring during confinement.
- Has a staff of physicians specializing in physical medicine and rehabilitation directly involved in the treatment program, one of whom is present at all times during the treatment day.
- Is accredited as a medical inpatient rehabilitation hospital by the Joint Commission On Accreditation of The American Hospital Association and/or the Commission on Accreditation of Rehabilitation Facilities.
- Is not a place for rest, the aged, drug addicts or alcoholics, a chronic disease facility, a nursing home or sheltered workshop.
- Does not provide as its primary purpose custodial care, treatment of mental disorders, special education, vocational counseling, job training, or social adjustment services.

Residential Treatment Facility

A treatment facility that provides full-day and part-day programs to treat substance abuse or mental disorders but that is not licensed to provide inpatient care. The center must be licensed or otherwise approved to provide this care by the state in which it is located.

Routine Physical Exam

A routine physical exam is a medical exam performed by a physician when there are no signs of illness or injury.

Skilled Nursing Facility

A skilled nursing facility is an institution (or distinct part thereof) which meets each of the following tests:

- It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons recovering from injury or illness, professional nursing services provided by a registered graduate nurse (RN) or by a

licensed practical nurse (LPN) under the direction of a registered graduate nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

- Its services are provided for compensation from its patients and under the full-time supervision of a physician or registered graduate nurse.
- It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse.
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

Sound Natural Teeth

Teeth which are:

- Wholly or properly restored.
- Without impairment or periodontal disease.
- Not in need of the treatment provided for reasons other than dental injury.

Speech Therapist

A speech therapist is a person who is duly licensed in the state where the services are performed and who is practicing within the scope of such license. In the absence of such licensing requirements, the therapist must be certified as a registered speech pathologist by the American Speech and Hearing Association.

Trust Agreement

Trust Agreement means the Trust Agreement establishing the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund and any modification, amendment, extension or renewal thereof.

Usual, Customary and Reasonable (UCR) Amounts

Usual, Customary and Reasonable (UCR) Amount means the amount payable to a Non-PPO provider subject to the following:

- Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR regardless of the amount billed;
- In no event will the UCR charge exceed the amount billed or the amount for which the covered person is responsible;
- UCR may not necessarily reflect the actual billed charges and does not take into account the professional service provider's training, experience or category of licensure;
- The Plan's UCR methodology may vary from one particular claim to the next based on the facts and circumstance of the claim, the services provided and expected cost-savings;
- The Plan may utilize a third-party reviewer to determine the UCR Amount consistent with this provision; and
- Regardless of the Plan's methodology or UCR Amount determination, the Trustees reserve the right to negotiate an acceptable UCR Amount directly with a provider.

For properly billed non-PPO professional service provider charges, the UCR charge will not exceed the 90th percentile identified by a commercially available database selected by the Plan. When there is, in the Plan's

determination, minimal data available from the database for a covered service, the Plan will determine the UCR Amount by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare). In the event of an unusually complex covered service, a covered service that is a new procedure or a covered service that otherwise does not have a relative value that is in the Plan's determination applicable, the Plan will assign one.

For properly billed non-PPO facility charges, the UCR Amount will be determined by the Preferred Provider Organization.

Non-PPO providers (including both professionals and facilities) which claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Fund, notwithstanding any internal rules they may have to the contrary. In the event a non-PPO provider refuses or delays a reasonable audit request by the Plan, the Plan has the right to withhold payment to the non-PPO provider on the claim in question and on other pending or future claims from the non-PPO provider.

Filing a Claim

Only claims incurred during periods of eligibility will be processed.

Medical and Dental Claims

All claims with all supporting documentation must be submitted within one year following the date expenses were incurred. Incomplete claims will not be considered until all the required information has been provided. Claims submitted or completed more than one year from the date of service will not be considered for payment and are excluded from coverage.

Payment can be handled as follows:

- PPO providers will submit claims for you. All benefit payments for expenses incurred at a PPO hospital or provider will always be made directly to the hospital or provider, as required under the provider's PPO contract.
- If services or supplies are received from a Non-PPO provider, the Non-PPO provider will generally submit the claim on your behalf. However, if the Non-PPO provider fails to submit a claim, you will need to file the claim. Payments to Non-PPO providers will be made, at the Plan's option, to you, to your estate, to the provider or as required under federal law, including Qualified Medical Child Support Orders. No assignment to a Non-PPO provider, whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Plan, unless otherwise required by federal law.

Be sure to save all bills for any items of covered expense and, in each case a record of the date the expense was incurred (not the date of the bill).

To receive prompt payment, file a claim as described below:

- Obtain a claim form on line at **www.engineerstrust.com** or from your Local Union Office or the Administration Office.
- Complete the Employee Statement section of the form, and sign your name on the line specified.
  - For doctor's services, attach an itemized copy of your doctor's bill or have your doctor complete his or her portion of the claim form.
  - For hospital services, attach an itemized copy of the hospital bill which lists all services and supplies received.
- Keep separate records of medical expenses incurred for yourself and each of your dependents, since the deductible amounts, the maximums and other provisions apply separately to each individual.
- Forward the completed claim form along with itemized bills to the following addresses:

Medical and Dental Benefits
Operating Engineers Locals 302 and 612
P.O. Box 34684
Seattle, WA 98124-1684
(206) 441-7314 or (877) 441-1212

Prescription Drugs

For prescription drugs obtained at a network pharmacy you will not need to submit a claim; the pharmacist will do it for you.

For Actives and non-Medicare retirees/spouses of retirees: For prescriptions obtained at a non-network pharmacy, attach itemized pharmacy receipts showing the date of purchase, name of the individual for whom the drugs were prescribed, the prescription number, name of drug prescribed and charge for each drug as well as the name of the doctor prescribing the drug and send them to.

Non-Participating Pharmacy Prescription Drug Benefits
OptumRx Claims Department
P.O. Box 29044
Hot Springs, AR 71903

For Medicare eligible retirees/spouses of retirees: Prescriptions obtained at a non-network pharmacy may be covered in very limited circumstances.

For mail order prescription drugs, see page 45.

Vision Care

If you see VSP member doctor, there are no claim forms for you to file.

If you see a non-VSP provider, you must pay for vision services at the time you receive them and then file a claim with VSP at the following address:

Non-VSP Member Vision Benefits
VSP
Out of Network Provider Claims
P.O. Box 385018
Birmingham, AL 35238-5018
(800) 877-7195

Willamette Dental

Active participants who have enrolled in the Willamette Dental Group Plan do not need to submit claims for dental services provided by Willamette Dental Group dentists. Please refer to the Willamette Dental Group certificate of coverage for details.

Weekly Disability, Life Insurance and AD&D

Claim forms are available from your Local Union Office or the Administration Office. Weekly Disability claim forms are also available on the Fund's website at **www.engineerstrust.com**. Completed forms should be returned to the Administration Office.

If you are disabled and your insurance ends while you are disabled, you must contact the Administration Office to receive a premium waiver claim form for life insurance. This form must be submitted within one year. See page 62 for more information on life insurance benefits related to disability.

Questions

If you have any questions regarding your claim, call the Administration Office at (206) 441-7314 or (877) 441-1212. Be sure to provide them with your identification number as listed on your ID card.

Processing of Claims

Claims that are properly and timely filed with all supporting documentation will be processed in accordance with the following guidelines.

Health Claims

Claims for medical, dental, vision or prescription drug benefits will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension of time for making the determination is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Weekly Disability Claims

Claimants will be notified of a determination on a claim for weekly disability benefits within 45 days after receipt of the claim by the Plan. This period may be extended for up to 30 days (to a total of 75 days) if the Plan determines that an extension of time for making the determination is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the Plan determines that an additional extension of time for making the benefit determination is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be extended by the Plan for an additional 30 days (to a total of 105) days.

If an extension is necessary due to the claimant's failure to submit information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Life Insurance and Accidental Death and Dismemberment Claims

A determination on a claim for life insurance or accidental death and dismemberment will be made within a reasonable period of time. If the Plan needs additional information to make a decision, the claimant will be notified as to what information must be submitted.

Notification of Benefit Denial

If a claim is denied or partly denied, you will be notified in writing and given an opportunity for review. The written denial will give:

- The specific reasons for the denial.
- Specific reference to pertinent Plan provisions on which the denial is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and explanation of why such material or information is necessary.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.

- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request.
- An explanation of the Plan's claim review procedure, including a statement of the claimant's right to bring a civil action under ERISA § 502(a).

Appeal to the Board of Trustees

Notice of Appeal

Any employee, retired employee or beneficiary (hereafter claimant) who applies for benefits under this Plan and is ruled ineligible by the Trustees (or by the Administration Office acting for the Trustees) or who believes he or she did not receive the full amount of benefits to which he or she is entitled or who is otherwise adversely affected by any action of the Trustees or the Administration Office, shall have the right to appeal the matter to the Board of Trustees, provided a written notice of appeal is filed within 180 days after receipt of the adverse decision. A failure to file a written notice of appeal within the applicable time period will serve as a waiver of and bar the further right to appeal the adverse determination.

In certain circumstances, the Trustees or their representatives may require an authorization to release health care information relevant to the denied claim.

The appeal shall be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees which has been allocated the authority for making a final decision in connection with the appeal.

Scheduling of Appeal

The Trustees shall review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within thirty (30) days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustee's receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination shall be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustee's receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for a hearing on the appeal, then prior to the commencement of the extension, the Plan shall notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

Appeal Procedures

The claimant is generally entitled to present his position and any evidence in support thereof, at an appeal hearing. The claimant may be represented by an attorney or by any other representative of his choosing at his own expense.

The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to his or her claim for benefits.

The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained

on behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Decision After Appeal Hearing

The Trustees will issue a written decision on review of a claim as soon as possible, but not later than 5 business days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits.
- A statement of the claimant's right to bring a civil action under ERISA § 502(a).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.

External Review

Some appeals may be eligible for external review. If a claimant remains dissatisfied after the Board of Trustees issues its decision on a claim appeal, he or she may request an external review by an Independent Review Organization (IRO), or bring a civil action under ERISA §502(a). If the claimant requests an external review, such request is subject to the following:

- The Plan's internal claim appeal process must be exhausted before external review can be sought.
- External review is only available if the claim on appeal involves medical judgement or the retroactive rescission of health coverage. There is no external review for non-health claims, such as weekly disability, accidental death and dismemberment or life insurance.
- A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

  Attn: Appeals
  WPAS, Inc.
  P.O. Box 34203
  Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

Preliminary Review of External Request

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the request. The preliminary review will be expedited if the claimant requests an expedited external review of the Trustees' decision and the claimant has a medical condition where 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 Trustees' decision 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 the facility. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

Review by Independent Review Organization

If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a). A claimant must exhaust the Plan's Appeal Procedures prior to filing a civil action.

Review of Trustees' Decision

The Plan does not provide for any voluntary alternative dispute resolution procedures. If a claimant remains dissatisfied with the Plan's determination after exhausting the claim appeal procedures, or after a decision by an IRO, the claimant may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than one year after the date of issuance of the Trustees' decision on an appeal. A failure to commence a civil action within the applicable time period will operate as a waiver and bar the right to further review and the Trustees' determination will be final and binding. The question on review of the Trustees' determination will be whether, in the particular instance, the Trustees abused their discretion.

Sole and Exclusive Procedures

The Plan's appeal procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. The appeal procedures must be exhausted prior to filing a legal action.

HIPAA Privacy Disclosures and Certification

Protected Health Information

"Protected Health Information" (PHI) has the same meaning as in 45 CFR § 164.501. This section will be administered by the Trustees in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR Part 164.

Request, Use and Disclosure of PHI by Trustees

The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following administrative functions:

- To make or obtain payment for care received by covered persons.
- To facilitate treatment which involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to covered persons.
- In connection with judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other plan administrative functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.
- For authorized activities by health oversight agencies, including audits, civil, administrative or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to a covered person's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
- For specified government functions under 45 CFR Part 164.
- To the extent necessary to comply with laws related to workers compensation or similar programs.

Trustee Certification

The Plan will disclose PHI to a Trustee based upon the following certification, which was agreed to by the Trustees, as Plan sponsor:

Prohibition on Unauthorized Use or Disclosure of PHI The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this Article or required by law.

Subcontractors and Agents The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.

Permitted Purposes The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.

Reporting The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by this Article of which they become aware.

Access to PHI by Individuals The Trustees will make PHI available to the Plan to permit individuals to inspect and copy their PHI contained in a designated record set pursuant to 45 CFR § 164.524.

Amendment of PHI

The Trustees will make an individual's PHI available to permit the individual to amend or correct PHI contained in a designated record set that is inaccurate or incomplete and the Trustees will incorporate the amendments pursuant to 45 CFR § 164.526.

Accounting of PHI The Trustees will make an individual's PHI available to permit the Plan to provide an accounting of disclosures pursuant to 45 CFR § 164.528.

Disclosure to Government Agencies The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services (DHHS) or its designee for the purpose of determining the Plan's compliance with HIPAA.

Return or Destruction of Health Information When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests

The Trustees will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Adequate Separation

The Trustees represent that adequate separation exists between the Plan and the Trustees so that PHI will be used only for Plan administration. Each Trustee will certify as to the employees, or other persons under his control, that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Pursuant to regulations issued by the federal government, the Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes PHI as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

PROTECTED HEALTH INFORMATION

PHI generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearing house; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization in the following situations:

To Make or Obtain Payment: The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication of reimbursement of your health claims.

To Facilitate Treatment: The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.

To Conduct Health Care Operations: The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants.

Health care operations include: making eligibility determinations; contacting health care providers; providing Participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning-related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees: The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors which assist the Board of Trustees in performing Plan administration functions, such as handling claim appeals. The Trust also may provide

Summary Health Information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans.

Summary Health Information is information which summarizes Participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative: When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required By Law: In addition, the Trust will disclose your health information where applicable law requires. This includes:

1. *In Connection With Judicial and Administrative Proceedings.* The Trust may disclose your health information to a health oversight agency for authorized activities (including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary action); government benefit programs for which health information is relevant; or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

2. *When Legally Required and For Law Enforcement Purposes.* The Trust will disclose your protected health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by state law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, such as identifying a suspect or to provide evidence of criminal conduct.

3. *To Conduct Public Health and Health Oversight Activities.* The Trust may disclose your protected health information to a health oversight agency for authorized activities (including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law.

   The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

4. *In the Event of a Serious Threat to Health or Safety.* The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

5. *For Specified Government Functions.* In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

6. *For Workers' Compensation.* The Trust may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information without your written authorization.

Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below.

If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. Psychotherapy notes do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct Treatment, Payment and Health Care Operations.

Additionally, your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Trust.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request unless the disclosure at issue is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid by you out-of-pocket and in full.

Right to Inspect and Copy Your Health Information: You have the right to inspect and copy your health information. You also have the right to have the Trust transmit a copy of your health information to another entity or person of your choosing. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic format shall not be greater than the Trust's labor costs in responding to the request.

Right to Receive Confidential Communications: You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend the Your Health Information: If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment.

The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

Right to an Accounting: You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you or any one authorized by you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. If the Trust participates in fundraising, you have the right to opt-out of all fundraising communications.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You will be able to obtain a copy of the current version of the Trust's Notice at its website**,** www.engineerstrust.com. If this Notice is modified you will be mailed a new copy.

Privacy Contact Person/Privacy Official: To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

Privacy Contact Person
Assistant Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: (206) 441-7314
Toll Free: (877) 441-1212
Fax No: (206) 441-9110

Privacy Official
Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: (206) 441-7314
Toll Free: (877) 441-1212
Fax No: (206) 441-9110

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

EFFECTIVE DATE

This Notice was originally effective April 14, 2003, as amended September 3, 2013**.**

General Provisions

Right to Amend

In order that the Fund may carry out its obligation to maintain within the limits of its resources, a program dedicated to providing the maximum possible benefits for all employees, the Board of Trustees reserves the right, in its sole discretion, and at any time and from time to time, but upon a nondiscriminatory basis, to modify, add, reduce, or eliminate, in whole or in part, any or all provisions of the Plan including, but not limited to, any benefit, benefit structure, condition for or method of payment, and rate of contribution whether applicable to all or a category of individuals.

Right to Terminate

The Board of Trustees reserves the right, and at any time, to terminate the Plan, even though such termination may affect the claims which have already accrued. Termination of the Plan is subject to the applicable laws.

Construction of Plan

The Trustees have the exclusive right to construe the provisions of the Plan and to determine any and all questions arising thereunder or in connection with the administration thereof, including the right to remedy possible ambiguities, inconsistencies, or omissions, and any such construction or determination by the Trustees made in good faith shall be conclusive on all persons affected thereby.

Scope of Rights and Benefits

No employee, retiree or dependent shall have any rights or claims to benefits under the Plan, except in accordance with the provisions of the Plan. Neither the Employers, any signatory association, the Union, nor any Trustee shall be liable for the failure or omission for any reason of the Fund to pay any benefits under the Plan.

Right to Receive and Release Necessary Information

As a condition to receiving benefits under this Plan, the covered person agrees to:

- Provide, on request, information necessary to review and process a claim for benefits under the Plan.
- Authorize any physician, hospital, or other provider of services or party having knowledge to disclose to the Plan any medical information it requests.
- Authorize the Plan to examine any medical records of the patient at the offices of any physician, hospital or other provider of services for the purpose of verifying services or supplies.
- Waive any claim of privilege or confidentiality that might be asserted in any action by or against the Plan or the party furnishing such information.

Right of Recovery

Payment of a claim due to error or incomplete or inaccurate information does not constitute a waiver by the Plan of any provisions, limitations or exclusions of this Plan, or a waiver of the Plan's right to recover such payment when the error is discovered or when complete or accurate information is received. The Plan may recover overpaid amounts by:

- requesting refunds from providers;
- offsetting any future benefit payments, including those of family members, by denying such payments until the amount of benefits provided in error has been repaid;
- offsetting against the employee's dollar bank balance up to the amount of benefits provided in error; and/or
- offsetting against monthly employer contributions received on behalf of the employee which exceed

the amount required for a month of coverage until the amount of benefits provided in error has been repaid.

Misrepresentation

An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to eligibility for benefits will be subject to liability for reimbursement of the claim, for audit fees, attorney fees, and costs incurred by the Plan on account of such misrepresentation, as well as potential criminal liability. The Plan may also utilize the Right of Recovery provisions to recover overpaid amounts.

Protection of Trust Fund, Contributions and Benefits

No part of the Fund (including the contributions) or the benefits payable under the Plan shall be subject in any manner by an employee, dependent or other beneficiary to anticipation, alienation, sale, transfer, assignment, encumbrance, or charge, and any such attempt shall be null and void, provided that the Trustees may recognize assignment of benefits from an employee, dependent or other beneficiary to a doctor, hospital, or other person or institution that has treated or cared for, or provided services or goods to the employee, dependent, or other beneficiary, and provided further that the Trustees shall recognize the assignment of benefits, or an alternate payee's right to receive benefits, under a Qualified Medical Child Support Order, and the assignment of rights under a state plan for medical assistance approved under Title XIX of the Social Security Act. No part of the Fund (including contributions, or the benefits payable under the Plan) shall be liable for the debts of an employee, dependent or beneficiary, nor be subject in any manner to garnishment, attachment, lien, charge or any other legal process brought by any person against an employee, dependent or other beneficiary and any attempt shall be null and void.

Correlation with State Plans

Payment of benefits by the Plan will be made in accordance with any assignment of rights made by or on behalf of the employee or dependent as required by a State plan. If payment has been made under a State plan, and the Plan has legal liability to make payment, benefits by the Plan shall be paid in accordance with any applicable State law which provides that the State has acquired the rights of the employee or dependent to such payment.

In determining eligibility or providing benefits, the Plan shall not take into account that an employee or dependent is eligible for or provided medical assistance under a State plan.

For purposes of this Section, State plan means a plan for medical assistance approved under Title XIX of the Social Security Act. This Section shall be administered pursuant to ERISA § 609(b).

Out-of-Area Care

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera Blue Cross has arrangements with other Blue Cross and Blue Shield Licensees ("Host Blues") for care outside our service area. These arrangements are called "Inter-Plan Arrangements." Premera's Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' network providers. The Host Blue is responsible for its PPO providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (non-contracted providers). This Out-Of-Area Care section explains how the plan pays both types of providers.

Your getting services through those Inter-Plan Arrangements does not change what the plan covers, benefit levels, or any stated eligibility requirements. Please call First Choice Health if your care needs prior authorization.

BlueCare Program

Except for copays, Premera will base the amount you must pay for claims from Host Blues' network providers on the lower of:

- The provider's billed charges for your covered services; or
- The allowable charge that the Host Blue made available to Premera.

Often, the allowable charge is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

Host Blues may use a number of factors to set estimated or average prices. These may include settlements, incentive payments, and other credits or charges. Host Blues may also need to adjust their prices to correct their estimates of past prices. However, Premera will not apply any further adjustments to the price of a claim that has already been paid.

Clark County Providers. Services in Clark County, Washington are processed through the BlueCard Program. Some providers in Clark County do have contracts with Premera. These providers will submit claims directly to Premera, and benefits will be based on Premera's allowable charge for the covered service or supply.

Value-Based Programs. You might have a provider that participates in a Host Blue's value-based program (VBP). Value-based programs focus on meeting standards for treatment outcomes, cost and quality, and for coordinating care when you are seeing more than one provider. The Host Blue may pay VBP providers for meeting the above standards. If the Host Blue includes charges for these payments in the allowable charge for a claim, you would pay a part of these charges if a deductible, or coinsurance applies to the claim. If the VBP pays the provider for coordinating your care with other providers, you will not be billed for it.

Taxes, Surcharges and Fees.

A law or regulation may require a surcharge, tax or other fee be added to the price of a covered service. If that happens, Premera will add that surcharge, tax or fee to the allowable charge for the claim.

Non-Contracted Providers.

It could happen that you receive covered services from providers outside Premera's service area that do not have a contract with the Host Blue. In most cases, Premera will base the amount you pay for such services on either Premera's allowable charge for these providers or the pricing requirements under applicable law.

In these situations, you may owe the difference between the amount that the non-contracted provider bills and the payment the plan makes for the covered services as set forth above.

Blue Cross Blue Shield Global® Core

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core. Blue Cross Blue Shield Global Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global Core helps you access a provider network, you will most likely have to pay the provider and send in the claim yourself in order for the plan to reimburse you. See Filing A Claim, page 89, for more information. However, if you need hospital inpatient care, the service center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at (800) 810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at (804) 673-1177.

More Questions

If you have questions or need to find out more about the BlueCard Program, please call Premera's Customer Service Department. To find a provider outside Premera's service area, go to **www.premera.com** or call (800) 810-BLUE (2583). You can also get BlueCard Worldwide information by calling the toll-free phone number.

Special Disclosure Information

Name of Plan

This Plan is known as Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Plan. The trust fund through which the Plan is funded is the Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund.

Board of Trustees - Plan Administrator

The Name and Address of the Joint Board of Trustees is:

Board of Trustees Locals 302 and 612 of the International Union of Operating Engineers Construction Industry Health and Security Fund
c/o Welfare & Pension Administration Service, Inc.
7525 SE 24th St., Suite 200
Mercer Island, WA 98040

or

P.O. Box 34203
Seattle, WA 98124
Phone: (206) 441-7314 (877) 441-1212

Identification Number and Plan Number

The employer identification number assigned to the Plan Sponsor by the Internal Revenue Service is EIN 91-6028570. Plan Number 501.

Type of Plan

This Plan can be described as a welfare plan providing the following benefits: medical, prescription drug, mail order prescription drug, dental, vision, weekly disability, life and accidental death and dismemberment.

Type of Administration

This Plan is administered by a joint labor-management Board of Trustees with the assistance of a contract administrative organization.

Agent for Service of Legal Process

The Administrative Manager at the Administrator's Office is designated as agent for purposes of accepting service of legal process on behalf of the Plan. Each member of the Joint Board of Trustees is also authorized to accept service of legal process on behalf of the Plan.

The names, titles, and addresses of the individuals currently serving on the Joint Board of Trustees are:

Employer Trustees	Union Trustees
Andrew Ledbetter AGC of Washington 1200 Westlake Ave. N, Suite 301 Seattle, WA 98109-3528 Phone: (206) 284-0061	**Daren Konopaski** Operating Engineers Local 302 18701 120th Ave. NE Bothell, WA 98011-9514 Phone: (425) 806-0302
Corey Christensen KLB Construction 3405 121st St. SW Lynnwood, WA 98087 Phone: (425) 355-7335	**Jason Alward** Operating Engineers Local 302 4001 Denali St., Suite A Anchorage, AK 99503 Phone: (907) 561-5288
Mike Lee Lakeside Industries 6600 230th Ave. S.E. Issaquah, WA 98027-2524 Phone: (425) 313-2600	**Sean Jeffries** Operating Engineers Local 302 403 S. Water St. Ellensburg, WA 98926-3620 Phone: (509) 933-3020
Mike Miller c/o WPAS, Inc. 7525 SE 24th St., Suite 200 Mercer Island, WA 98040 Phone: (907) 248-2171	**Curt Koegen** Operating Engineers Local 302 510 South Elm Spokane, WA 99220 Phone: (509) 624-5365
Mike Tucci Tucci and Sons, Inc. 4224 Waller Rd. E. Tacoma, WA 98443-1623 Phone: (253) 922-6676	**Todd Mickelson** Operating Engineers Local 612 1555 S Fawcett Ave. Tacoma, WA 98401-1735 Phone: (253) 572-9612

Source of Contributions

The Plan is funded through employer contributions, the amount of which is determined through collective bargaining between participating employers and labor organizations, and which is specified in the underlying collective bargaining agreements. Self-payments are also permitted, as outlined in the booklet, for retiree coverage and to continue employee and dependent coverage.

Description of Collective Bargaining Agreements

The Plan is maintained pursuant to many separate collective bargaining agreements between participating employers and participating labor organizations. A copy of such agreements may be obtained by participants and beneficiaries at the Administration Office, and at Local Union Offices, upon 10 days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. You may wish to inquire as to the amount of the charges before requesting copies.

Entities Used for Accumulation of Assets and Payment of Benefits

The employer contributions and employee and retiree self-payments are received and held by the Board of Trustees in trust pending payment of insurance premiums and/or claims and administrative expenses. Life and Accidental Death and Dismemberment benefits are insured by United of Omaha. Optional dental benefits for active employees are insured by Willamette Dental of Washington. Optional dental benefits for retired employees are insured by Delta Dental of Washington. A closed group of retirees have insured medical/prescription drug benefits through Kaiser. All other benefits are funded by the Plan.

The following are the names and addresses of companies under contract with the Plan:

United of Omaha
1601 Fifth Avenue, Suite 2201
Seattle, WA 98101

Provides fully insured life insurance and accidental death and dismemberment benefits and administers those benefits.

Kaiser Foundation Health Plan of WA
601 Union Street, Suite 3100
Seattle, WA 98101

Provides services to retirees currently enrolled in the HMO alternative.

Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983

Provides optional dental services to retirees.

Willamette Dental of Washington, Inc.
6950 N.W. Campus Way
Hillsboro, OR 97124

Provides dental services to participants electing this alternative.

First Choice Health Network
600 University Street, Suite 1400
Seattle, WA 98101-3124

Provides utilization review, pre-authorization, and case management services.

OptumRx
2300 Main Street
Irvine, CA 92614

Provides prescription drug network and claims administration services to active employees and retirees/spouses of retirees not eligible for Medicare.

UnitedHealthcare MedicareRx for Groups (PDP)
P.O. Box 29046
Hot Springs, AR 71903

Provides prescription drug network and claims administration services for retirees and spouses of retirees eligible for Medicare.

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Provides vision network and vision claims administration.

Premera Blue Cross
7001 220th Street S.W.
Mountlake Terrace, WA 98043

Administers the PPO Provider network.

BridgeHealth Medical
6000 E. Evans Ave., Suite 2-400
Denver, CO 80222

Administers the medical surgery benefit for Alaska participants

SwiftMD
801 Springdale Drive
Exton, PA 19341

Provides telemedicine services to Plan participants.

Coalition Health Center
575 Riverstone Way, Unit 1
Fairbanks, AK 99709

Provides health clinic services to active employees and non-Medicare retirees/spouses of retirees.

Eligibility and Benefits

You become eligible for benefits of this Plan in accordance with the eligibility rules described beginning on page 10. Retiree eligibility rules are described beginning on page 64.

Termination of Eligibility

For medical, prescription drug, mail order prescription drug, dental, vision, weekly disability and life, coverage will terminate on the earliest of the following days:

- On the last day of the month following the month in which you fail to meet the eligibility requirements set by the Plan.
- On the last day of the month after you enter the Armed Services of the United States, except for periods of Reservist Training unless you elect to run-out your eligibility.
- In case of dependents, on the last day of the month that the dependent ceases to be a dependent within the definition given.
- Upon termination of the Plan.
- On the last day of the month in which you fail to make any required self-contributions.

Circumstances Which May Result in Ineligibility or Denial of Benefits

The circumstances which may result in disqualification, ineligibility, denial, or loss of benefits appear throughout this booklet.

The Future of the Plan and Trust Fund

The Board of Trustees has the authority to terminate the Trust Fund. The Trust Fund will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust Fund.

In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

End of the Plan Year

The Plan year end is March 31.

Your ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to you as a participant of this Plan. ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Administration Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with

the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, 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 rights.

Prudent Action 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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees. If you are dissatisfied with the determination of the Trustees, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, contact the Department of Labor at one of the following addresses:

Employee Benefits Security Administration
U.S. Department of Labor
Seattle District Office
300 Fifth Avenue, Suite 1110
Seattle, WA 98104
Phone: (206) 757-6781

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Amendment and Termination

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all participants, the Board of Trustees expressly reserves the right, in their sole discretion at any time and from time to time, but upon a nondiscriminatory basis, to:

- Terminate or amend the Plan;
- Alter or postpone the method of payment of any benefit;
- Construe the provisions of the Plan and determine any and all questions pertaining to administration, eligibility, and benefit entitlement, including the right to remedy possible ambiguities and inconsistencies or omissions. Any construction or determination by the Trustees made in good faith shall be conclusive on all persons affected thereby;
- Reduce or eliminate any Plan subsidy; and
- Amend or rescind any other provision of this Plan.

The Fund may be terminated by the employers and union by an instrument in writing executed by mutual consent at any time, subject, however, to all of the requirements and procedures for plan termination under ERISA and all regulations issued thereunder. Upon voluntary termination of the Fund, all assets remaining in the Fund after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets have been depleted.

Benefits Not Guaranteed

None of the benefits provided by this Plan are insured by any contract of insurance, except the life insurance and accidental death and dismemberment benefits, certain dental benefits, and certain medical benefits for retirees. There is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amount in the Fund collected and available for such purpose. No employee or dependent shall have any accrued or vested rights to benefits under this Plan.

Information Available to You

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the administrative office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Plan Administrator will state the charge for specific documents on request so that you can find out the cost before ordering.

Administered by:

WELFARE & PENSION ADMINISTRATION

SERVICE, INC.

7525 S.E. 24th St., Suite 200
Mercer Island, WA 98040
Or
P.O. Box 34203
Seattle, WA 98124-1203
(206) 441-7314
(877) 441-1212

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