

2027 PPO Rate Comparison

Operating Engineers Public H&W Trust

San Mateo County BCTC

OE Anthem Gold

OE Anthem Platinum

2027 Per Month Tiered Rates (7% increase)

Employee

\$1,296

\$1,418

Employee + 1

\$2,592

\$2,835

Family

\$3,500

\$3,827

Comes With:

Medical

Anthem

Anthem

Dental

Delta Dental (\$2,500/person/year)

Delta Dental (\$2,500/person/year)

Prescription

Optum Rx

Optum Rx

Vision

VSP

VSP

Hearing Aids

\$1,350/ear/every 4 years

\$1,350/ear/every 4 years

Life Insurance

\$10,000

\$10,000

Burial Benefit

\$2,500

\$2,500

Chemical Dependency

ARP

ARP

Key Benefits

Annual Deductible

\$750 Individual / \$2,250 Family

\$0

Out of Pocket Limit (In-Network)

Medical

\$3,000 Individual / \$6,000 Family

\$1,500 Individual / \$3,000 Family

Outpatient Prescriptions

\$1,875 Individual / \$3,750 Family

\$1,875 Individual / \$3,750 Family

Prescription Home Deliver

Doctor Visits (in-network)

\$15/visit

\$10/visit

Prescriptions

Generics

\$5 Retail / \$10 Mail

\$5 Retail / \$10 Mail

Preferred Brand

10% retail (max \$100) / 5% mail (max \$100)

10% retail (max \$100) / 5% mail (max \$100)

Non-Preferred Brand

25% Retail (max \$200) / \$15% mail (max \$200)

25% Retail (max \$200) / \$15% mail (max \$200)

Specialty

20% with a maximum of:

20% with a maximum of:

\$50 for Generic

\$50 for Generic

\$100 for Preferred

\$100 for Preferred

\$200 for Non-Formulary

\$200 for Non-Formulary

Emergency Room

20%

10%

Emergency Transportation

20%

20%

Hospital Stay

20%

10%

2027 HMO Rate Comparison

Operating Engineers Public H&W Trust
San Mateo County BCTC

OE Kaiser Gold

OE Kaiser Platinum

2027 Per Month Tiered Rates

Employee

\$1,077

\$1,264

Employee + 1

\$2,157

\$2,529

Family

\$2,824

\$3,298

Comes With:

Medical

Kaiser

Kaiser

Dental

Delta Dental (\$2,500/person/year)

Delta Dental (\$2,500/person/year)

Prescription

Optum Rx

Optum Rx

Vision

VSP

VSP

Hearing Aids

\$1,350/year/every 4 years

\$1,350/year/every 4 years

Life Insurance

\$10,000

\$10,000

Burial Benefit

\$2,500.00

\$2,500.00

Chemical Dependency

ARP

ARP

EAP

Key Benefits

Annual Deductible

\$1,500 Individual / \$3,000 Family

\$100 Individual / \$200 Family

Out-of-Pocket Limit

Co-Insurance and Copayment

\$4,000 Individual / \$8,000 Family

\$3,000 Individual / \$6,000 Family

Doctor Visits (in-network)

\$20/visit

\$15/visit

Prescriptions

Generics

\$10 Retail / \$20 Mail

\$10 Retail / \$20 Mail

Preferred Brand

\$30 Retail / \$60 Mail

\$30 Retail / \$60 Mail

Non-Preferred Brand

\$30 Retail / \$60 Mail

\$30 Retail / \$60 Mail

Specialty

20% (\$200 max)

20% (\$200 max)

Emergency Room

20%

\$50

Emergency Transportation

\$150/Trip

\$0

Hospital Stay

20%

\$0

OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH & WELFARE TRUST FUND

1141 Harbor Bay Parkway, Suite 100 ★ Alameda, California 94502-6594
1-800-251-5014 ★ Fax 510-863-8373

ACTIVE ENROLLMENT FORM

CHECK ALL
THAT APPLY:

☐ NEW MEMBER

CHANGE OF:

☐ NAME

☐ ADDRESS

☐ PLAN

☐ MARITAL STATUS

☐ DEPENDENTS

PARTICIPANT DATA - EMPLOYEE INFORMATION				COMPLETE ALL INFORMATION – PLEASE PRINT IN INK			
LAST NAME		FIRST NAME		M.I.	SOCIAL SECURITY NUMBER		
MAILING ADDRESS (STREET OR P.O. BOX)					GENDER (M/F)	DATE OF BIRTH	
CITY		STATE	ZIP		TELEPHONE NUMBER ()		
EMAIL ADDRESS					CELL PHONE NUMBER ()		
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED			DATE OF MOST RECENT MARRIAGE/DIVORCE		EMPLOYER		DATE OF HIRE
CHOICE OF PLANS <u>MEDICAL SELECTION</u> – CHOOSE ONE: ☐ ANTHEM, PLATINUM ☐ ANTHEM, GOLD ☐ ANTHEM, SILVER ☐ ANTHEM, BRONZE ☐ KAISER, PLATINUM ☐ KAISER, GOLD ☐ KAISER, SILVER ☐ KAISER, BRONZE			IF APPLICABLE, REGARDLESS OF CHOICE OF MEDICAL PLAN, ALL ELIGIBLE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS HAVE: • DENTAL COVERAGE THROUGH DELTA DENTAL (800-765-6003) • VISION COVERAGE THROUGH VSP VISION SERVICES PLAN (800-877-7195)		PLAN PARTICIPANTS: PRESCRIPTION COVERAGE THROUGH OPTUMRX (855-672-3644) KAISER PLAN PARTICIPANTS • PRESCRIPTION COVERAGE THROUGH KAISER. • PARTICIPANTS MUST USE A KAISER PHARMACY.		
PERSONAL AND DEPENDENT DATA PROVIDE THE SOCIAL SECURITY NUMBER OF EACH DEPENDENT YOU ENROLL. FEDERAL REGULATIONS REQUIRE HEALTH PLANS TO REPORT THE NAMES AND SOCIAL SECURITY NUMBERS OF EVERY COVERED INDIVIDUAL TO THE IRS. BEFORE ALLOWING A DEPENDENT TO BE ADDED TO THE PLAN, THE TRUST OFFICE REQUIRES ALL DOCUMENTATION SUCH AS MARRIAGE CERTIFICATE, BIRTH CERTIFICATE, DOMESTIC PARTNER CERTIFICATE, DIVORCE, OR REMARRIAGE DOCUMENTS.							
Relation*	Last Name	First Name	Gender	Date of Birth	Social Security Number	Receiving Medicare Part A or B	Kidney Transplant or Dialysis
Self						Yes ☐ No ☐	Yes ☐ No ☐
☐ Spouse ☐ Domestic Partner**						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐
*Relation –Son, Daughter, Stepson, Stepdaughter, etc. See the General Eligibility Rules section for definition of “ELIGIBLE DEPENDENTS” **Domestic Partner – additional forms required for Domestic Partner eligibility. Contact the Trust Office.							
Complete the section below and enclose a copy of the Medicare card if you or a dependent are enrolled in Medicare							

List the individual receiving Medicare Name: _____	Receiving Part A? Yes ☐ No ☐ Receiving Part B? Yes ☐ No ☐	Effective Date A: ____/____/____ Effective Date B: ____/____/____
List the individual receiving Medicare Name: _____	Receiving Part A? Yes ☐ No ☐ Receiving Part B? Yes ☐ No ☐	Effective Date A: ____/____/____ Effective Date B: ____/____/____
Additional Insurance Information		
List ANY dependent with an address different than the member's address:		
Dependent:	Address:	City
		State
		ZIP
Dependent:	Address:	City
		State
		ZIP
List ANY dependent who is entitled to benefits from another group health care, insurance, or pre-paid medical plan:		
Dependent:	Insurance Company	Policy Number
Dependent:	Insurance Company	Policy Number
Complete this section if you checked yes to kidney transplant or receiving dialysis		
List the individual receiving Dialysis or Transplant	Received Kidney Transplant Yes ☐ No ☐ Receiving Dialysis Yes ☐ No ☐	Date of Transplant: ____/____/____ Date of first treatment: ____/____/____
Important Notice: I apply for Health Plan membership for the persons listed and agree that we shall abide by the provisions of the Health Maintenance Organization (HMO) service agreement or preferred provider plan regulations, whichever applies. I understand that the service agreement provides that all claims, including medical malpractice claims, which arise because I or someone with a relationship to me believed that some conduct in, or arising from my relationship with the HMO, HMO hospitals, or the HMO medical group, as a member or as a patient, has caused any harm, must be submitted to binding arbitration instead of court trial. <u>Kaiser Foundation Health Plan, Inc., Arbitration Agreement*</u> I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the <i>Evidence of Coverage</i>. _____ Signature Required for all Kaiser Permanente Plans _____ Date <i>*Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.</i>		

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT

By signing below, I declare that have read and understood all information on this enrollment form. I declare that all statements made on this enrollment form are complete and true. I understand that material misrepresentations, omissions, concealment of facts or incorrect statements may void my eligibility for coverage. I understand and consent that information obtained on this enrollment form will be provided to health care organizations for the purpose of providing coverage. I understand that coverage will not be provided until this enrollment is accepted and I meet all eligibility requirements.

Employee Signature _____

Date _____

***Before allowing a dependent to be added to the Plan, the Trust Office requires all documentation such as marriage certificate, birth certificate, domestic partner certificate, divorce, or remarriage documents.**

General Eligibility Rules for Dependents

(Subject to all provisions and limitations of the Trust Agreement and Plan Document as well as any rules or regulations)

The Fund considers the following to be Dependents:

- Your lawful spouse
- Your Domestic Partner as further defined below
- Your natural children up through the last day of the month in which they turn 26
- Your stepchildren up through the last day of the month in which they turn 26
- Your legally adopted children (from the time they are placed for adoption) up through the last day of the month in which they turn 26.
- Unmarried children for whom you are the appointed legal guardian as long as they are under 23 years of age and can be claimed as dependents on your federal income tax return
- Your unmarried natural, legally adopted or stepchild who is older than 26 (or 23 if a legal guardianship child) and
 - is prevented from earning a living because of mental or physical disability, AND
 - was disabled and eligible for benefits as a Dependent under this Plan at the time he/she reached the last day of the month in which he/she is turning 26, or in the case of legal guardianship, the last day of the month in which he/she is turning 23, AND
 - is primarily dependent on you for support, AND
 - for whom evidence of the child's dependence and disability was filed with the Trust Fund within 31 days after the child attained the limiting age (and for whom evidence is periodically filed upon request)
- Children as required in a Qualified Medical Child Support order and through the last day of the month in which they turn 26
- Unmarried children below the age of 23 of a Domestic Partner as long as the Domestic Partner qualifies for coverage (See Section 1.18 of the Plan's Rules and Regulations for more information)

Please keep in mind:

- A spouse of a child is not eligible for coverage under the plan
- A Domestic Partner is an individual who has a valid Declaration of Domestic Partnership or Confidential Declaration of Domestic Partnership on file with the California Secretary of State. Domestic Partner and the children of the Domestic Partner may enroll in the Plan upon submission of a copy of the Certificate of Registration of Domestic Partnership received from the State of California and payment of the required imputed income taxes to the Fund.
- Before adding an above Dependent to insurance, the Trust Fund Office will request copies of marriage certificates, birth certificates, hospital birth records, domestic partner certifications or other documents necessary to confirm eligibility
- A Dependent that is in the service of the Armed Forces is not eligible as a Dependent but is entitled to purchase COBRA continuation coverage

NOTE THE FOLLOWING:

You can be held liable for benefit payments made based on any incorrect information about your dependents, such as failing to notify the Trust Fund Office if there is a divorce, if your child's status changes, or if an adoption is rescinded. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect information. These costs include, but are not limited to, attorney fees, Trust Fund Office costs, other administrative costs and reasonable interest.

If you have questions, please contact the Trust Fund Office at 800-251-5014 or email: PUBLIC-OE3@Zenith-American.com

***ELIGIBILITY FOR ALL PERSONS ENROLLED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATIONS.**

OPERATING ENGINEERS LOCAL NO. 3 BENEFICIARY DESIGNATION FORM (PART II)
(ALL BENEFITS EXCEPT PENSION AND ANNUITY PLANS)

DESIGNATION OF BENEFICIARY

**Fringe Benefits Office, 3920 Lennane Drive, Suite 200, Sacramento, CA 95834
(510) 748-7450**

This form applies to the following benefits, as applicable:

1. OPERATING ENGINEERS LOCAL UNION 3 BURIAL BENEFIT
2. OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
3. OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND LIFE INSURANCE
4. HAWAII OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
5. HAWAII OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND LIFE INSURANCE
6. PENSIONED OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
7. OPERATING ENGINEERS PUBLIC & MISC HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
8. OPERATING ENGINEERS PUBLIC & MISC HEALTH & WELFARE TRUST FUND LIFE INSURANCE

LAST NAME		FIRST NAME IN FULL		MIDDLE NAME IN FULL	
STREET ADDRESS		CITY	STATE	ZIP	
SOCIAL SECURITY NO.		TELEPHONE NO.			
DATE OF BIRTH / /	CURRENT MARITAL STATUS (Please Circle One) Married Never Married Divorced Legally Separated Divorced & Remarried Widow(er)				
SPOUSE'S NAME (If Legally Married)			DATE OF MARRIAGE		
SPOUSE'S SOCIAL SECURITY NO.		IF DIVORCED OR LEGALLY SEPARATED, GIVE DATE (S)			

EXPLANATION REGARDING DESIGNATION OF BENEFICIARY

The term "Beneficiary" means a person (including a trust) designated by a Participant. You may designate the same person to receive all benefits named on the lower portion of this form, or different persons to receive each of them. If you list more than one beneficiary, they shall share the applicable benefits equally unless otherwise designated. You also may designate a contingent beneficiary to receive benefits in the event of the death of your primary beneficiary(ies). If you do not designate a beneficiary, then applicable benefits will be payable as provided under the Plan.

BE SURE TO COMPLETE THE ENTIRE FORM AND RETURN IT TO THE FRINGE BENEFITS OFFICE.

BENEFICIARY DESIGNATION

I, _____, Social Security No. _____ do hereby designate the following named person or persons as my beneficiary or beneficiaries to receive any monies that may be payable by reason of my death from all benefits payable from the above entities, as applicable. Part I must be completed to designate beneficiaries for the Pension Trust Fund for Operating Engineers, Operating Engineers Annuity Plan and the Hawaii Annuity Plan for Operating Engineers.

**Please note the following: a) if a trust is designated as beneficiary, please provide a complete copy of the trust document.
b) if multiple beneficiaries are desired, please provide as an attachment to this form.**

In the event of my death, pay any applicable benefits to:

PRINT NAME OF BENEFICIARY	SOCIAL SECURITY NO.	RELATIONSHIP	% of Distribution
ADDRESS		PHONE	
CONTINGENT BENEFICIARY	SOCIAL SECURITY NO.	RELATIONSHIP	% of Distribution
ADDRESS		PHONE	

DATE: _____ SIGNATURE: _____