November 22, 2013

To: All Active Plan Participants of the Utah Laborers Health and Welfare Trust Fund

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PARTICIPANT NOTICE

This Participant Notice will advise you of certain material modifications that have been made to the Utah Laborers Health and Welfare Fund. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

THE PRESCRIPTION DRUG NETWORK ADMINISTRATOR IS CHANGING EFFECTIVE JANUARY 1, 2014

The Prescription Drug Network administrator is changing from CVS Caremark to **Express Scripts** on January 1, 2014. The majority of retail pharmacy locations that are available through CVS Caremark will still be available when the Fund switches to Express Scripts. The new contact information for Express Scripts is as follows:

Express Scripts Customer Service: 1-866-544-6849 TDD: 1-800-899-2114 www.express-scripts.com	**Express Scripts** Mail Pharmacy Service P.O. Box 66567 St. Louis, MO 63166-6567

THE MEDICAL PLAN IS CHANGING A VARIETY OF BENEFITS AND BECOMING A NON-GRANDFATHER PLAN EFFECTIVE JANUARY 1, 2014

In the past several years, the work activity supporting the Utah Laborers Health and Welfare Trust Fund has decreased significantly. At the same time, expenses of the Trust Fund have increased because of: (1) higher costs for medical services the Trust Fund has traditionally covered; and (2) legal requirements for additional coverage. As a result, the Fund has been spending more than it takes in. Reserve assets, that accumulated when work was better, have slowly been spent down. To keep the Fund on a sound financial basis going forward, the Trustees have had to make benefit adjustments. These adjustments mean that the medical plan will become a non-grandfathered plan on January 1, 2014 and as such will need to change some benefits in accordance with Health Reform regulations. This notice outlines the changes to eligibility, the addition of enhanced wellness/preventive care benefits and other medical plan design changes:

Changes to the Eligibility Rules for Active Employees of a Contributing Employer:

- **Initial Eligibility for Employees:** An employee not eligible on January 1, 2014 will become eligible on the first day of the second calendar month following a period of not more than six consecutive calendar months during which the employee works a total of at least **450 hours** with one or more Contributing Employer(s).

- **Continuation of Eligibility:** An Active Employee will continue to maintain eligibility for coverage as long as the employee's Hour Bank contains at least **130 hours** of work credits. For each month of coverage, 130 hours will be deducted from the Active Employee's Hour Bank.

- **Accumulation of Excess Hours:** If an Active Employee works in excess of 130 hours per month in Covered Employment, such excess hours will be added to the Active Employee's Hour Bank. Active Employees will be permitted to accumulate excess hours in their Hour Bank up to a maximum of **520 hours** (individuals with greater than 520 hours on January 1, 2014 will have those hours "grandfathered," but once the Hour Bank is reduced below 520 hours, it cannot exceed this new limit).

- **Termination of Eligibility for an Active Employee: This termination provision is clarified to indicate that a**n Active Employee's eligibility under the Hour Bank system will terminate on the last day of the calendar month in which his Hour Bank contains **less than 130 hours**.

- **Reinstatement of Eligibility for Active Employee:** An Active Employee whose eligibility terminated under the Hour Bank or Self-Payment provisions shall again become eligible if he works at least **130 hours** within three consecutive months following the date of his termination. This reinstatement shall be effective on the first day of the second calendar month that follows the calendar month in which the **130-hour** requirement is met. If an employee is not reinstated within a five consecutive calendar month period, any reserve hours in his Hour Bank shall be canceled and he shall only become eligible again for coverage in the manner described in the Initial Eligibility described earlier in this Article.

- **Waiver of Initial Eligibility Requirements With Respect to Employees of a Newly Organized Employer: The Plan's waiver of Initial Eligibility wording is clarified to note the new 130 hour requirement.** The newly organized Contributing Employer will make an initial contribution equal to **130 hours** at the Fund's current contribution rate, on all employees covered under the collective bargaining agreement. This initial contribution will provide the second month's coverage. (1st month coverage is provided by the Health and Welfare Fund); and in the event the employee's monthly hour bank falls below **(130) hours** in any subsequent month of employment with a newly organized Contributing Employer, his/her eligibility will be terminated and he/she shall be eligible to continue coverage in accordance with the Self-Payment provisions of this Plan.

Medical Plan Annual Deductible

The medical plan deductible is changing, **starting January 1, 2014, to $750 per person per calendar year and $2,250 per family per calendar year**. The medical plan deductible applies to all medical plan benefits, except the deductible does not apply to wellness/preventive care services and outpatient prescription drugs. Copayments and non-covered expenses do not accumulate to the annual deductible.

Copay for Use of an Emergency Room (ER) and Urgent Care Facility

Effective January 1, 2014, the copayment you pay when you use an **emergency room will be $300 per person per visit,** plus you pay the deductible. There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Also, the Plan will pay a reasonable amount for non-network hospital-based emergency services, in compliance with health reform regulations.

If you use an **Urgent Care facility** for medical treatment, you pay a **$50 copayment per person per visit**, plus you pay the deductible.

Copay for Office Visits, Consultations and Second Opinion Visits

Starting January 1, 2014, you will pay a **$50 copayment per person per office visit, consultation visit or second opinion visit,** plus you pay the deductible. This applies to visits for mental health and substance abuse services also.

Under this Plan, there is no requirement to select a Primary Care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.

Enhanced Wellness/Preventive Care Benefits

Since 2012, our medical plan has covered a comprehensive list of preventive care expenses for all individuals in accordance with health reform. The wellness/preventive services payable by the plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). This website lists the types of payable preventive services: *https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and http://www.hrsa.gov/womensguidelines/*. This list includes cancer screening tests like mammograms, pap smears and colonoscopy (for adults over age 50 years) as well as routine immunizations. In addition to the preventive services on the websites above, the Plan will pay for an Annual Physical Examination for Eligible Employees and their Eligible Spouse and Eligible Children age three and older and an annual PSA lab test for men.

- There is **no charge for wellness/preventive care services obtained from an In-Network provider**. If there is no network provider who can provide the wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing.
- For use of a non-network provider for wellness/preventive care services, you pay a $50 copayment per visit plus the deductible, then you and the Plan each pay 50% coinsurance. Generally there is no out-of-pocket limit for the use of Non-PPO provider expenses.
- When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and deductible) will apply to the diagnostic or therapeutic services provided.
- Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers).
- The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. Services not covered under the wellness benefit may be covered under another portion of the medical plan.

Starting January 1, 2014, the Medical plan will add coverage for certain **additional preventive care expenses for all covered females** (in compliance with Health Reform regulations) including but not limited to well woman office visits, screening for gestational diabetes, BRCA breast cancer gene test, human papillomavirus (HPV) testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, rental of breastfeeding equipment and necessary supplies after delivery, and lactation counseling following delivery. Some prenatal services are not covered under these new women's preventive care services such as certain lab services, ultrasounds, other radiology services, and high-risk prenatal services. Normal plan cost-sharing applies to these prenatal services and to delivery related fees for a female employee and spouse.

- More information about these preventive care services for women is found on the government's website: http://www.hrsa.gov/womensguidelines/
- **These preventive care services are covered without cost sharing for a female when obtained from in-network providers**. If there is no network provider who can provide the wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing.
- **It will cost you more money out of your pocket if you use a non-network provider.** If you use a non-network provider, you pay a $50 copayment per visit, plus you pay the deductible, then you and the Plan each pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family/year), then you pay 10% coinsurance and the Plan pays 90% coinsurance. There is no Out-of-Pocket limit for cost-sharing for use of Non-PPO (out-of-network) providers.
- Also, when an in-network provider submits a bill to the plan with a billing code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses which are available to all females at no charge, and normal cost-sharing to 60% of the charges representing the delivery expenses (NOTE: certain prenatal expenses like ultrasounds, and delivery are not covered expenses for a pregnant dependent child).
- In conjunction with birth, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period, at 100%, no deductible, when provided by an in-network provider. Under this plan a trained provider is a Breastfeeding/Lactation Educator.
- **Breast Pump and Supplies:** For the first 12 months following the birth of a child, coverage is provided for one standard manual or standard electric breast pump, plus necessary breast pump supplies. Rental, purchase and repair is payable. Coverage is available at no cost from in-network providers. Standard cost-sharing applies to use of non-network providers.
- FDA approved **contraceptives are payable for all females at no charge** when obtained from in-network providers, without a dollar limit on contraceptive services.
- **Sterilization services** (e.g., vasectomy, tubal ligation, implants such as Essure) are payable. Female sterilization is payable at no charge when obtained from in-network providers. Normal cost-sharing pertains to male sterilization services and all sterilization services obtained from non-network providers.

Coinsurance for the Medical Plan is Changing

Effective January 1, 2014, the amount of coinsurance that you and the Plan pay is changing as shown in the chart below:

PREFERRED PROVIDERS (PPO)	Plan pays 80% (you pay 20%) of the first $10,000/year then Plan pays 90% (you pay 10%) thereafter, up to the Out-of-Pocket Limit
Individual pays	$2,000 per calendar year then you pay 10% thereafter up to the Out-of-Pocket Limit
Family Aggregate pays	$6,000 per calendar year then you pay 10% thereafter up to the Out-of-Pocket Limit
NON-PREFERRED PROVIDERS (NON-PPO)	Plan pays 50% (you pay 50%) of the first $10,000/year then Plan pays 10% thereafter
Individual pays	$5,000 per calendar year then you pay 90% thereafter
Family Aggregate pays	$15,000 per calendar year then you pay 90% thereafter

To help you understand what this new coinsurance change could mean, we have provided an example below showing the hospital charges if you use a PPO hospital or if you use a NON-PPO hospital:

EXAMPLE	PPO Hospital	Non-PPO Hospital
Hospital Billed Charges	$5,000	$5,000
PPO Discount Amount	50% = $2,500	No discount
Plan's Allowed Amount before Your Deductible is Met	$2,500	$5,000
Deductible the Member Pays	$750	$750
Plan's Allowed Amount after Deductible Paid by the Member	$1,750	$4,250
Amount Our Fund Pays toward the Allowed Amount	80% of $1,750 (or $1,400)	50% of $4,250 (or $2,125)
Amount You Pay including your Deductible and Coinsurance	You pay your deductible of $750 plus 20% coinsurance, which is $350. **This means you pay this Total: $1,100**	You pay your deductible of $750 plus 50% coinsurance, which is $2,125. **This means you pay this Total: $2,875**

Here is an example of what the Plan pays when you have wellness/preventive services obtained from a PPO provider or if you use a NON-PPO provider:

EXAMPLE	PPO Provider	Non-PPO Provider
Billed Charges for a Provider Office Visit, Laboratory services and Immunizations	$860	$860
PPO Discount Amount	50% = $430	No discount
Plan's Allowed Amount before Your Deductible is Met	$430	$860
Deductible the Member Pays	None for wellness/preventive services	$750
Office Visit Copayment You Owe	None	$50 copay/visit
Subtotal	Plan pays 100% of $430	You pay $750 + $50 ($800) leaving a balance due to the provider of $60
Amount Our Fund Pays toward the Allowed Amount	100% of $430	50% of $60 or $30
Amount You Pay including your Deductible and Coinsurance	You pay no money out of your pocket. Wellness/preventive services from PPO providers are FREE. **This means you pay this Total: $0.00 and Plan pays $430**	You pay a $50 copayment/visit plus your deductible of $750 plus 50% coinsurance of $60 (or $30). **This means you pay this Total: $830 and Plan pays $30.**

Out-Of-Pocket Limit (Annual Limit on In-Network Preferred Provider Cost Sharing)

Starting January 1, 2014, in compliance with Health Reform regulations, this Plan is adding an Out-of-Pocket Limit which limits your annual cost-sharing for covered essential health benefits **received from in-network providers** related to Medical and Dental Plan deductibles, coinsurance, and copayments.

All deductibles, copayments and coinsurance related to In-Network essential Medical and Dental Plan benefits accumulate to this new Out-of-Pocket Limit, which is as follows:

- **$6,350 per person per calendar year and $12,700 per family per calendar year**. These amounts may be adjusted annually in accordance with Health Reform regulations.

This means that this new Out-of-Pocket Limit is the most money that you will have to pay for covered services received from an in-network provider. Under this Plan the Out-of-Pocket Limit also accumulates dental plan benefits because the dental plan does not contain any network providers. See the information below on the services that are not included in the Out-of-Pocket Limit.

The Out-of-Pocket Limit is accumulated on a calendar year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan. Out-of-Network emergency services performed in an Emergency Room will apply to meet the in-network Out-of-Pocket Limit.

The Out-of-Pocket Limit **does not** include or accumulate:

a. Premiums,

b. Expenses for medical or dental services or supplies that are not covered by the Plan,

c. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers,

d. Penalties for non-compliance with Utilization Management/Medical Review programs,

e. Expenses for the use of **non-network providers**, (except dental plan benefits and non-network emergency services performed in an Emergency Room),

f. Charges in excess of the Medical or Dental Plan's Maximum Benefits,

g. Expenses that are not considered to be essential health benefits,

h. Outpatient prescription drug expenses.

Note that the medical **plan does not have an out-of-pocket limit on the use of non-network providers**.

Outpatient Prescription Drug Benefits are Changing

There are some changes in the amount you will pay for outpatient prescription drugs starting on January 1, 2014. These changes are as follows:

- For a 30-day supply of **Generic drugs** at a Retail Pharmacy you will still pay the greater of $10 or 20%.
- For a 30-day supply of **Formulary Brand drugs** you will pay the greater of $40 or 20% of the drug cost and for **Non-formulary Brand drugs** you will pay 50% coinsurance.
- For **Specialty Drugs** you pay 50% up to a maximum of $120 for a 30-day supply. These drugs must be preapproved and ordered through the Specialty Drug Program manager of the Prescription Drug Network, whose phone number is listed on the Quick Reference Chart in the front of this

document. These drugs often require special handling, are date sensitive and are generally available only in a 30-day quantity.

- **FDA-approved contraceptives** are payable for females as follows: No charge for generic drugs purchased at an In-network Retail or Mail Order location when submitted with a prescription. No charge for a formulary brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate. No coverage of contraceptives from a Non-Network retail pharmacy.

When you use the Home Delivery/Mail Order pharmacy for a 90-day supply of medication, the copays are also changing as follows:

- **Generic Drug**: $30 copay (**No charge for FDA approved contraceptives for females**)
- **Formulary Brand Drug**: $60 copay
- **Non-formulary Brand Drug**: $120 copay

As always though, **your greatest cost-savings is when you and your doctor select Generic drugs** to treat your conditions and when you order your maintenance medication (such as to treat arthritis, high blood pressure, high cholesterol, asthma, etc.) through the **Home Delivery/Mail Order pharmacy**.

Coverage of Certain Over-the-Counter (OTC) Drugs

In accordance with Health Reform, **certain over-the-counter (OTC) drugs** are payable at no charge when prescribed by a Physician or Health Care Practitioner. **For an over-the-counter drug to be covered by the Plan, the drug must be:**

1. obtained through the outpatient Prescription Drug Program at a participating network retail pharmacy and
2. presented to the pharmacist with a prescription for the OTC drug from your Physician or Health Care Practitioner.

(Note that while these OTC drugs require a prescription, certain types of insulin are payable by the Plan without a prescription).

The following chart outlines the OTC drugs that are payable by this non-grandfathered medical plan, **at no charge when purchased at a network retail pharmacy location**, in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC drugs, this Plan will comply with the new requirements on the date required.

OTC Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Generic OTC Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Aspirin	For men 45-79 years of age to reduce chance of a heart attack and for women 55-79 years of age to reduce the chance of a stroke.	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months
OTC Contraceptives for females, such as spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of prescription contraceptives per purchase (or 3 month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program for females younger than 60 years of age. Generic FDA approved contraceptives are no cost. Brand contraceptives are payable only if a generic alternative is medically inappropriate.

OTC Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Generic OTC Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Folic acid supplements containing 0.4 - 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily folic acid supplement.	None, if payment parameters are met	Excludes women >55 years of age, and products containing > 0.8mg or < 0.4mg of folic acid.
Iron supplements	For children ages 6-12 months who are at increased risk for iron deficiency.	None, if payment parameters are met	OTC coverage excludes intravenous iron products and bulk iron products.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of 100 tablets every 3 months
Tobacco cessation products	All adults who use tobacco products.	None, if payment parameters are met	Prescription tobacco cessation drugs are payable under the plan's Prescription Drug Program, up to two 12-week courses of treatment per year, which applies to all products.
Fluoride supplements	For preschool children older than age 6 months when recommended by provider because primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy.

Changes to the Chiropractic Services Benefit

Benefits from a chiropractor are payable when services are medically necessary to a maximum of 20 visits per person per calendar year/. You pay **a $50 copayment per person per visit** plus you pay the deductible.

Habilitation Services Not Covered

The plan has clarified that expenses for Habilitation services are not covered. Habilitation services are designed to help individuals attain certain functions that they never have acquired including treatment of delays in childhood speech and physical development. Habilitation services are not covered even if the delay in development is a direct result of an injury, surgery or as a result of a treatment that is the type that is covered by this Plan.

External Review of Claims Added to the Plan's Claim Appeal Process

The Plan has added an optional voluntary External Review process that is intended to comply with the requirements of the Affordable Care Act (ACA). This External Review is an optional additional review that you may seek if you want. If requested, your case will be reviewed by an Independent Review Organization ("IRO").

This External Review option is only available in the situation where your appeal of a health care claim (medical plan and dental plan benefits), whether urgent, concurrent, pre-service or post-service claim is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a

denial involves a medical judgment; and/or

- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this external review process does not pertain to claims for life/death benefits, AD&D, or disability. The Plan assumes responsibility for fees associated with External Review.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

- If the IRO's external review decision reverses the Plan's denied claim determination, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the IRO's external review decision upholds the Plan's denied claim determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

THE DENTAL PLAN IS CHANGING SOME BENEFITS EFFECTIVE JANUARY 1, 2014

The Dental Plan is **adding an annual $25 per person deductible** effective January 1, 2014. This deductible does not apply to routine diagnostic and preventive dental services such as dental exam, dental cleaning and certain dental x-rays.

Additionally, effective January 1, 2014, the maximum amount of dental benefits payable each calendar year will be **$200 per person.** This calendar year maximum does not apply to individuals under age 19.

Also, **there is NO coinsurance and no deductible for Routine (Diagnostic and Preventive) Dental Services.** This means that a **dental cleaning is free** up to $200 per person age 19 years and older per year. Basic Dental Services and Major Dental Services will be payable at 50% coinsurance after the deductible is met.

ROUTINE COSTS ASSOCIATED WITH CLINICAL TRIALS TO BE COVERED EFFECTIVE JULY 1, 2014

Effective July 1, 2014 under the medical plan, **routine costs will be payable when associated with certain approved clinical trials related to cancer or other life-threatening illnesses.** This means that for individuals who participate in an approved clinical trial, routine costs, services and supplies will be payable during the time the eligible individual is participating in the clinical trial.

- **"Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

- An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded (like a trial funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS)); (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.
- For individuals who will participate in a clinical trial, **precertification is required** in order to notify the Plan that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
- The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

ANNUAL NOTICE: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the Medical Plan.

If you would like more information on WHCRA benefits, please contact the Administrative Office at (801) 973-1010 or toll free at (800) 928-1001.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you would like to view or receive a copy of the actual amendments or have any questions, please contact the Administrative Office at (801) 973-1010 or toll free at (800) 928-1001.

Sincerely,

Board of Trustees

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Administrative Office at (801) 973-1010 or toll free at (800) 928-1001.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.