District Council 16 Northern California Health and Welfare Trust Fund

Medical, Dental, Vision and Death Benefits
Plan Document/Summary Plan Description
for
Active and Retired Employees and their Eligible Dependents

Amended, restated, and effective January 1, 2014

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MESSAGE FROM THE BOARD OF TRUSTEES

To All Participants:

This Plan Document/Summary Plan Description describes the medical, dental, vision and Employee death benefits of District Council 16 Northern California Health and Welfare Trust Fund (hereafter referred to as "the Fund" or "DC16"). The Plan described in this document is effective January 1, 2014, and replaces all other Plan Documents, Summary Plan Descriptions and applicable amendments to those documents previously provided to Plan participants.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility chapter in this document. If you have declined any of the coverage described in this document, the chapters pertaining to any declined coverage do not apply to you.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.

This document will help you understand and use the benefits provided by the Trust Fund. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverage provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions chapters.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The medical, indemnity dental, vision and death benefits of the Plan are self-funded with contributions from contributing Employers and Retirees and are held in a Trust. An independent Claims Administrator pays benefits out of Trust assets. The HMO plans are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document.

Suggestions for Using this Document

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- an overview of your benefits showing what benefits are available to which Participants;
- information on eligibility and enrollment;
- information on options for continuing coverage if you lose eligibility;
- sections on the individual benefits—medical under the Blue Cross Network (PPO) and the Blue Cross Network/Smart Choices (APPO), prescription drugs, Mental Health and Chemical Dependency Benefits provided by Beat It!, the self-funded Dental Plan, Vision Benefits, and Employee Death Benefit;
- how to file claims and appeal denials of benefits; and
- other important Plan information.

For enrollees in the Kaiser (HMO) or the Kaiser Smart Choices (HMO) or the prepaid dental HMO Plans, this booklet is meant to be used with the ***Evidence of Coverage*** brochures provided by Kaiser Permanente, DeltaCare USA or UHC Dental. Those documents govern the benefits you receive and provide your sole source of appeal if you are dissatisfied with your benefits. Where this document deviates from the certificate of coverage and summary of benefits produced by Kaiser, DeltaCare USA or UHC Dental, the insurance company documents will prevail.

Please Read This Booklet Carefully

The Board of Trustees is committed to providing quality benefits at reasonable costs to Trust Fund Participants. By reading this booklet thoroughly and keeping it handy for future reference you will benefit by understanding what the Plan offers you and your covered Dependents. If you are married, please share this booklet with your spouse or domestic partner.

Please take special note of the Plan's medical management programs for the Indemnity Medical Plan, which is funded directly by the Trust Fund and is not insured. These medical management programs include a preferred provider organization (PPO), prior authorization of hospital admissions (except for childbirth and emergencies), prior authorization of certain outpatient services, and pharmacy management programs. These programs have been implemented to help provide you with quality health care and to also help control medical cost inflation.

Questions?

If, after reviewing this booklet, you have any questions regarding eligibility or the benefits provided, please do not hesitate to contact the Trust Fund Office at 510-864-6444 or 800-922-9902.

Spanish Language Assistance:

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó con Trust Fund Office a la dirección y teléfono en el (Quick Reference Chart) de este documento.

Sincerely,

BOARD OF TRUSTEES

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Trust Fund Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in Domestic Partnership status, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Enrollment by the Participant is required in order to be eligible for coverage. That enrollment must include accurate information on all Dependents.

Failure to do so may cause you or your Dependents to lose certain rights under the Plan or may result in your liability to the Plan if any benefits are paid to an ineligible person.

Benefits provided by this Trust Fund are not in lieu of and do not affect any requirements for coverage by Workers Compensation Insurance laws or similar legislation.

The medical, indemnity dental and the vision benefits of the Plan are paid from directly out of Trust Fund assets. The Board of Trustees intends to continue these benefits as long as sufficient Trust Fund assets are available. However, the Trustees reserve the right to amend or modify any or all of the Plan benefits at any time, or terminate all Plan benefits at any time. The benefits provided by the Trust Fund are not vested.

The Board of Trustees has sole discretionary authority to determine all questions of coverage and eligibility for benefits, including sole discretionary authority to construe the terms of the Plan. Any determination or interpretation adopted by the Trustees will be binding on everyone who participates in this Trust Fund. If a decision of the Board of Trustees is challenged in court, it is the intention that such decision be upheld unless it is determined to be arbitrary or capricious.

No employer or local union, nor their representatives or agents are authorized to interpret this Plan on behalf of the Board of Trustees. Only information that is provided to you in writing, signed by the Board of Trustees or an authorized designee of the Board of Trustees acting on behalf of the Board, is binding on the Board.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Trust Fund Office • Claim Forms (Medical) • Medical Plan Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage • COBRA administration including information about COBRA coverage • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification during COBRA • Administration of Employee and Retiree Death Benefit	**Associated Third Party Administrators (ATPA)** 1640 South Loop Road Alameda, California 94502 Mailing Address: PO Box 24454 – Oakland, CA 94623 Telephone: 510-864-6444 or Toll Free: 800-922-9902 Web Site: www.dc16trustfund.org Mail self-payments to: DC16 H&W Trust Fund P.O. Box 4816 Hayward, CA 94540 If you need a copy of the Smart Choices Promise and Election Form, please call the Fund Office at the number above or go online at www.dc16trustfund.org and click on the "Smart Choices" link to get a copy of the Form.
Utilization Review for Inpatient Hospitalizations, and PPO Network for the Medical Plan **(for Active Employees, Retirees who are not eligible for Medicare and eligible Dependents enrolled in the Blue Cross Network (PPO) or the Blue Cross Network/Smart Choices (APPO))** • Provides prior authorization for inpatient Hospital admissions (except routine childbirth or emergency) for eligible Participants • Additions/Deletions of Network Providers (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price) • Compare the costs charged by different Anthem Blue Cross Network providers at www.anthem.com/ca **This PPO network is not available to Medicare eligible Retirees or their Dependents that are eligible for Medicare.**	**Anthem Blue Cross** 21555 Oxnard Street Woodland Hills, CA 91367 1-800-274-7767 For help finding network providers (PPO Physician, specialist, hospital or other Health Care Practitioner), see www.anthem.com/ca (or call the Trust Fund Office). Be sure to choose "Large Group Plan" under "plan type" and Blue Cross PPO (Prudent Buyer)" under "select a plan. **CAUTION:** Use of a **non**-PPO network hospital, facility or Health Care Practitioner could result in you having to pay a substantial balance on the provider's billing (see definition of "Balance Billing" in the Definition chapter of this document).

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Blue Card **(for indemnity medical Plan Participants outside of California)** • Help finding contracted Blue Card providers • Preauthorization for hospital admissions or surgery	**Anthem Blue Cross** 1-800-810-2583 Web Site: www.bluecares.com Use the following directions: There are certain states/geographic areas where selecting a "PPO" provider is not an option. If that occurs, please choose "Traditional" and follow the prompts. Although "Traditional" providers do not participate in a Blue Card network, they have agreed to perform services at special discounted rates for Blue Card members. You should go to a "Traditional" provider only if there are no Blue Card **PPO** providers in your area.
Care Counseling Service and Utilization Review for certain Outpatient Procedures • Outpatient Utilization Review for non-emergency care outside of your Physician's office; • Channeling of participants to the most cost effective provider; • Patient advocate services (Care Counseling); • Information about the costs for your treatment plan; • Answer any questions you may have about your illness or injury; and • Nurse line - 24 hour a day, seven days a week.	**Pacific Health Alliance (PHA)** 1350 Old Bayshore Highway Suite 560 Burlingame, CA 94010-1814 Web Site: www.pacifichealthalliance.com Toll Free: 1-855-754-7271
Wellness Program/Biometric Testing • Blueprint for Wellness biometric screenings for Active Participants in the Indemnity PPO Plan. • Physician Result Form.	**Quest Diagnostics Patient Service Center (PSC)** (866) 908-9440 Monday-Friday 7:00 AM to 8:30 P.M. (CST) Saturday 7:30AM to 4:00 PM (CST) Web Site: www.My.BlueprintForWellness.com **Note:** When you go online to the Quest Diagnostics Blueprint for Wellness scheduling tool, you will need to enter the registration key: DC16. Your Unique ID # is your last name plus the last four digits of your Social Security Number (for example, johnson1234). Your spouse's/domestic partner's Unique ID is your last name + last four digits of your Social Security Number + an "S" (for example, johnson1234S). Then follow the steps to register and schedule your screening at a nearby Quest Diagnostics PSC. Be sure to print your confirmation page when you are finished and take it with you to your appointment.
Prescription Drug Plan **(for Active/Retired Participants and eligible Dependents enrolled in the Blue Cross Network (PPO) or the Blue Cross Network/Smart Choices (APPO))** • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs (custom formulary is not applicable to Medicare Retirees) • Compare your costs for formulary vs. non-formulary drugs • Specialty Drug Program: Prior authorization and Ordering	**WellDyne Rx** PO Box 4517 Englewood, Colorado 80155-4517 Toll Free: 1-888-479-2000, option 5 www.welldyneRx.com • Find a formulary list at www.welldyneRx.com or request a copy at (888) 479-2000, option 5 • To request an exception for a medication that is not on the formulary list, you or your Physician should call WellDyne Rx.

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Mental Health and Chemical Dependency Benefits **(for Active/Retired participants and eligible Dependents enrolled in the Blue Cross Network (PPO), Blue Cross Network/Smart Choices (APPO), the Kaiser (HMO) and the Kaiser/Smart Choices (HMO))** • Referrals and prior authorization • Mental Health and Chemical Dependence Providers • Behavioral Health Claims and Appeals	**Beat it!** P.O. Box 20896 San Jose, CA 95160 1-800-828-3939 This program provides benefits for the Blue Cross Network (PPO), Blue Cross Network/Smart Choices (APPO), the Kaiser (HMO) and the Kaiser/Smart Choices (HMO) (and their Dependents). However, if you and/or your family are in Kaiser, you also have the option of using your HMO benefits.
HMO Medical Plan **(for Active/Retired participants and eligible Dependents who live in the Kaiser service area and are enrolled in the Kaiser (HMO) or the Kaiser/Smart Choices (HMO))** • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Referrals and prior authorizations • Mental Health and Chemical Dependence Providers • Claims and Appeals	**Kaiser Permanente (Group #602697)** Northern California Region 1950 Franklin Street Oakland, CA 94612 1-800-464-4000
Indemnity Dental Plan **(for all Active and Retired Employees and eligible Dependents not enrolled in a Prepaid Dental Plan)** • Dental Network Provider Directory • Dental Claims and Appeals • Prior authorization for dental services	**Delta Dental (Group # 0308)** P.O. Box 7736 San Francisco, CA 94120 (800) 765-6003 Web Site: www.deltadentalins.org **Important note to Retirees:** Retirees who elect to enroll in a dental Plan must pay the full cost of the coverage.
Fully Insured Prepaid Dental Plan #1 for California residents only **(for all Active and Retired Employees and eligible Dependents not enrolled in the indemnity dental plan)** • Dental Network Provider Directory • Dental Claims and Appeals • Prior authorization for dental services	**DeltaCare USA (Group #6123)** Department 64936 El Monte, CA 91735 (800) 422-4234 Web Site: www.deltadentalins.org **Important note to Retirees:** Retirees who elect to enroll in a dental Plan must pay the full cost of the coverage.
Fully Insured Prepaid Dental Plan #2 **(for all Active and Retired Employees and eligible Dependents not enrolled in the indemnity dental plan)** • Dental Network Provider Directory • Dental Claims and Appeals • Prior authorization for dental services	**UHC Dental (Group # 712019)** (877) 816-3596 Web Site: www.myuhcdental.com **Important note to Retirees:** Retirees who elect to enroll in a dental Plan must pay the full cost of the coverage.

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Vision Plan **(for all Active and Retired Employees and their eligible Dependents)** • Vision Network and Provider Directory • Vision Claims and Appeals	**Vision Service Plan (VSP)** 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 Web Site: www.vsp.com To file an Out-of-Network Claim for reimbursement, send it to the following address: Vision Service Plan (VSP) Attn: Out-of-Network Provider Claims P.O. Box 997105 Sacramento, CA 95899-7105
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**The Privacy Officer** Phone: (510) 864-6406 or (800) 893-2200 or Fax: (510) 337-3353 Associated Third Party Administrators 1640 South Loop Road, Alameda, CA 94502

ENROLLMENT IS REQUIRED

Before you become eligible for benefits under this Plan, You must complete a formal Plan Enrollment Form. If you will be covering eligible Dependents, you will be asked to provide the necessary documentation to prove that the Dependents are eligible for coverage.

The Trust Fund Office will not pay any claims unless it has received a completed Enrollment Form from you. If you do not complete and return an enrollment form to the Trust Fund Office, you and any eligible Dependents will be automatically enrolled in the Blue Cross Network (PPO).

If Your Family Situation Changes

You must notify the Trust Fund Office promptly if any change occurs in your family after your initial enrollment (for example, marriage, birth of a child, death of a dependent, or legal separation or divorce from your spouse or dissolution of your Domestic Partnership).

If the change means you will be covering new Dependents, you must also request a ***Plan Enrollment Form*** within 31 days of the date you acquired the new Dependent and you must complete and submit the new ***Plan Enrollment Form*** to the Trust Fund Office as soon as possible, with a copy of the necessary dependent documentation (e.g., marriage certificate and/or birth records).

Your right to enroll new Dependents is guaranteed by a law known as HIPAA (the Health Insurance Portability and Accountability Act), provided you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Address Change

Please notify the Trust Fund Office in writing promptly if you change your home address.

Changing Plans

Medical

You must reside or work in the Kaiser service area in order to enroll in the Kaiser (HMO) or the Kaiser/Smart Choices (HMO). If you do not reside in Kaiser's service area, you must enroll in the Blue Cross Network (PPO) or the Blue Cross Network/Smart Choices (APPO) if you are benefits eligible. A change in medical plan election is allowed once every 12 months. You may also change your Plan if you are continuing coverage under COBRA.

If you enroll in the Kaiser (HMO) or the Kaiser/Smart Choices (HMO) and then move out of the Kaiser service area, you may apply in writing to the Trust Fund Office for a transfer to the Blue Cross Network (PPO) or Blue Cross Network/Smart Choices (APPO). The change shall be effective on the first day of the month following approval by the Trust Fund Office.

Please refer to the Quick Reference Chart for contact information on both of your medical plan options.

Dental

There are two fully insured dental plan options that are offered as alternatives to the Indemnity Dental Plan. These dental Plans are like an HMO for dental care. Services are "prepaid," so many dental services are covered at no charge, but you may use only the dentists that participate in the network. A change in your dental plan election is allowed once every 12 months. You may also change your Dental Plan if you are continuing coverage under COBRA.

Important Note: If you have a choice of medical or dental Plans, your family must be enrolled in the same medical or dental plan option you select for yourself. For instance, if you enroll in the Kaiser (HMO) or the Kaiser/Smart Choices (HMO), your eligible Dependents must be enrolled in the same HMO Plan.

Please refer to the Quick Reference Chart for contact information on all of your dental options.

ELIGIBILITY RULES FOR BARGAINED EMPLOYEES

Health & Welfare Cash Bank System

Newly Signatory Employers

If you are an Employee of a newly signatory Contributing Employer on the effective date of your Employer's initial participation in the Fund, your eligibility for benefits will begin on the first day of the calendar month following a period of time after you work at least 130 hours for your contributing employer.

New Employee Eligibility

You become eligible for benefits from this Trust Fund when you work for an Employer who is required to make hourly contributions to this Trust Fund on your behalf. New Employees become eligible for benefits on the first day of the second calendar month following the calendar months in which you worked at least 130 hours for one or more Contributing Employers.

You will need to work a minimum of 130 hours per month in order to receive 100% employer paid coverage.

Maximum Accumulation in Cash Bank

If you work more than 130 hours in a month, the administrator will credit any excess dollars to a reserve called your "Cash Bank" that can be used to pay for your continued coverage in any month following a month in which you work less than 130 hours. The maximum amount you can accumulate in your cash bank is the amount needed to cover three (3) months of health care contributions.

How You Maintain Eligibility

Your monthly eligibility will be determined by hourly cash contributions made by your employer during each month you work. If you work 130 hours or more in a month, your employer hourly cash contributions will pay 100% of the cost of your monthly health care contribution. If you work less than 130 hours in a month, you will need to make up the dollar shortfall. The shortfall will first be withdrawn from your Cash Bank (if funds are available). If any shortfall remains, the balance may be made up through a participant self-payment directly from you. The amount of the shortfall you will need to make up in the months you work less than 130 hours will be the difference in the actual hours you worked and 130 hours at your Employer's contribution rate.

Your self-payment is due on or before the 20th of the month following the month you worked less than 130 hours in order to count towards the subsequent month of eligibility.

Self-payments should be mailed to the Trust Fund Office at the address listed on the Quick Reference Chart. The following information must accompany the self-payment:

1. Employee's name;
2. Last 4 digits of the Employee's social security number; and
3. Identify the payment as "Payment for Active Coverage".

The following are examples of the self-payment process:

Example 1

In January, you work 130 hours, your employer hourly cash contributions will pay 100% of the monthly contribution for your health care coverage for March. You do not need to make a self-payment or use any of your Health & Welfare Cash Bank money to obtain coverage for March.

Example 2

In January, you work 125 hours, your employer will pay for most of the cost of your health care premium cost for March. However, your employer's hourly cash contributions would be five hours short of covering your health care premium. You can make up the shortage by using your Health & Welfare Cash Bank (if funds are available) or by making a participant self-payment, or by a combination of Health & Welfare Cash Bank and participant self-payment. If you choose to make a participant self-payment, it would be due to the Trust Fund by February 20.

It is your responsibility to know the balance of your Cash Bank and whether or not you have enough to cover a short fall in the number of hours worked in a given month. You should carefully keep track of your hours worked in each month to make sure you are prepared to make a self-payment for the months that you work less than 130 hours and your Health & Welfare Cash Bank is insufficient to make up the difference if you wish to continue your health care coverage.

Termination of Coverage

Your eligibility will terminate on the last day of the calendar month in which:

- The total amount in your Cash Bank is not enough to pay for the subsequent month of coverage and you have not made a self-pay contribution by the 20th of the month to make up for the difference;
- You enter military service for more than 30 days;
- You die;
- You knowingly permit your Employer to contribute to the Fund for fewer hours than you actually worked. If you notify the Fund in writing within 48 hours of becoming aware of this discrepancy, then your eligibility will not be terminated.
- The date your employer ceases to participate in this Trust Fund;
- If you are 65 or over, the first day of the month following the date you elect Medicare as your only medical coverage (applies to medical coverage only);
- The date you perform any Non-Covered Employment. "Non-covered employment" is defined as work that is performed:
    * In the jurisdiction of any local union of the District Council 16 of the International Union of Painters and Allied Trades;
    * On or after the date you became eligible for benefits from this Trust Fund, and
    * For a company that is:
        - doing work of the type covered by the terms of any Collective Bargaining Agreement between a local union of the District Council 16 of the International Union of Painters and Allied Trades and any Employer participating in this Trust Fund, and
        - not signatory to a Collective Bargaining Agreement with a local union of the District Council 16 of the International Union of Painters and Allied Trades without the written authorization of the District Council 16 local union with jurisdiction over the company.

Cancellation and Reinstatement

If there are no Employer contributions made on the Employee's behalf for a 12-month consecutive period, then the Health & Welfare Cash Bank will be cancelled. It will be reinstated if the Employee returns to work within 12-months of the cancellation.

The cash bank is not vested. Participants do not have the right to receive payment of their cash bank balances in cash.

If Your Employer is Delinquent in Making Contributions

If your Employer fails to make contributions when due and has not submitted a report form, you may request that the Trust Fund Office continue your benefits based on acceptable proof (such as pay stubs) of hours worked. Please be sure to complete, review, and sign your timecard or time records every week so that you may receive benefits correctly.

ELIGIBILITY RULES FOR NON-BARGAINING EMPLOYEES

Please Note:
This is only a summary. The eligibility requirements and benefits provided to Non-Bargaining Employees are governed by the Subscriber Agreement between this Trust Fund and your signatory employer.

Initial Eligibility

If you are a full-time Employee (working a minimum of 30 hours per week) of a signatory Employer currently participating in this Trust Fund, who has also signed a Subscriber Agreement with this Trust Fund, you will become eligible for benefits on the first day of the month following a waiting period of sixty days, so long as your Employer has made the required contribution on your behalf.

If you are a full-time Employee and eligible for your Employer's benefits before your Employer begins participation in this Trust Fund, you will be eligible for benefits from this Trust Fund on the effective date of your Employer's participation in this Trust Fund, if your Employer has also signed a Subscriber Agreement and has made the required contribution on your behalf.

Benefits and Limitations Applicable to Non-Bargaining Employees

Monthly Non-Bargaining Employees are **not eligible** for death benefits. Your other benefits are the same as those for hourly Employees.

Monthly Non-Bargaining Employees do not accrue a cash bank reserve as described for hourly Employees. Their coverage terminates the first of the month following the month in which their employer fails to make the required contribution to this Trust Fund.

Termination of Coverage

Your eligibility for benefits from the Trust Fund will terminate on the earlier of the following occurrences:

- The date your employer ceases to participate in the Trust Fund;
- The date your employer fails to employ any bargaining unit Employees for nine months in a calendar year except with respect to working Employers identified as such in the Subscription Agreement;
- The end of the month in which your employer makes the last contribution for your benefit coverage under the Trust Fund; or
- The date of your death; or
- The date you perform any Non-Covered Employment. "Non-Covered Employment" is defined as work that is performed:
    * In the jurisdiction of any local union of the District Council 16 of the International Union of Painters and Allied Trades;
    * On or after the date you became eligible for benefits from the Trust Fund, and
    * For a company that:
        - Is doing work of the type covered by the terms of any Collective Bargaining Agreement between a local union of the District Council 16 of the International Union of Painters and Allied Trades and any Employer participating in the Trust Fund, and
        - Is not signatory to a Collective Bargaining Agreement with a local union of the District Council 16 of the International Union of Painters and Allied Trades without the written authorization of the District Council 16 local union with jurisdiction over the company.

ELIGIBILITY RULES FOR RETIRED EMPLOYEES

New Retiree Eligibility – Bargaining Employees

If you retire from active hourly employment as a Participant in ***District Council 16 Northern California Health and Welfare Trust Fund***, you will be eligible for benefits as a Retiree if you meet all of the following requirements:

- You are receiving pension payments from the Northern California Glaziers Pension Plan or, if you are a Production Worker, from the International Brotherhood of Painters and Allied Trades Pension Plan, the Bay Area Painters and Tapers Pension Trust Fund, or the Resilient Floor Covering Pension Plan.
- You were covered under this Health and Welfare Trust Fund's benefits program or the Health and Welfare Plan of one of the merged Trust Funds as an active bargaining Employee in the month immediately preceding your retirement date. You may use COBRA Continuation Coverage to meet this requirement.

  If you were employed by the International Union of Painters and Allied Trades, this requirement will be fulfilled if you were covered under the Health and Welfare Plan provided by the International Union of Painters and Allied Trades in the month immediately preceding your retirement date.
- In each of the 3 years immediately preceding your retirement date, you earned at least 500 hours of service, as defined in the Northern California Glaziers Pension Plan or the International Brotherhood of Painters and Allied Trades Pension Plan or the Bay Area Painters and Tapers Pension Trust Fund, or the Resilient Floor Covering Pension Plan.

  Any year you were an Employee of the International Union of Painters and Allied Trades will be considered a grace period and will not be counted for purposes of determining whether you have met this requirement.

  If you were disabled or you were on the Union's out-of-work list and were available for work in the 3-year period immediately preceding your date of retirement, you may receive credit hours for your period of disability or unemployment. For purposes of this provision, "disability" means a total and continuous disability from accidental bodily injury or illness that prevented you from performing any and every duty pertaining to your occupation and from receiving any remuneration for any other work or service.
- You pay the required monthly "self-payment" premium. The amount is determined by the Board of Trustees in their sole discretion.

Your Retiree benefits will become effective on the later of the first day of the month following:

- the date of your retirement; or
- the last month your Active benefits are covered under the Active Plan eligibility lag; or
- the last month your Active benefits are covered by use of your one-month extended coverage under your Cash Bank; or
- the last month you receive COBRA coverage under the Active Plan.

Please note: Your coverage must remain in effect continuously. If you choose not to participate in the Retired Employees' benefits Plan immediately upon retirement, you may not enroll at a later date, except as provided in Retiree Special Late Enrollment Rights below.

Cash Bank Accumulation When You Retire

You will be allowed one month of extended coverage under your Cash Bank after your Active benefits expire under the Active Plan eligibility lag. After that time, you will need to begin self-payments in order for coverage to continue. All cash accumulation in excess of the allowed one-month extension will be permanently cancelled at retirement.

There may be some Retirees who are not eligible for Retiree health coverage. In that case, you will also be allowed to continue your Active Plan coverage by using your Cash Bank Accumulation when you retire. To continue coverage after the Cash Bank is exhausted, you would need to elect continuation coverage under

COBRA Continuation. Please refer to the COBRA Continuation Coverage section for information on your self-payments.

New Retiree Eligibility – Monthly Non-Bargaining Employees

If you are covered for benefits from the Trust Fund as a Non-Bargaining Employee, you will be eligible to continue your coverage as a Retiree only under the following conditions:

- You must have been covered under the Trust Fund (or one of the three merged Trust Funds) for at least 24 consecutive months immediately prior to your date of retirement.
- You must have been a full-time active Employee of a participating employer for at least five years.
- You must be at least 62 years of age.
- You must pay the full cost of your benefits, as determined by the Board of Trustees, each month without any lapse in coverage.

You Must Enroll in Medicare Part A and Part B

Retirees are eligible for the Blue Cross Network (PPO) which includes Prescription Drugs, Mental Health/Substance Abuse and Vision Benefits. You also have the option to pay for Dental Benefits. Once you or your Spouse or Domestic Partner become eligible for Medicare due to age, disability or renal disease, you **MUST** enroll in both Parts A and B of Medicare. If you are in the Kaiser (HMO), you must assign those benefits to Kaiser. **If you are in the Blue Cross Network (PPO), medical benefits for you or your Spouse (or Domestic Partner) will be paid as if you are enrolled in Medicare (whether you are or not) and Medicare has paid benefits first.**

You will have substantial out of pocket costs if Medicare has not paid full primary benefits before you submit your claims for secondary payment by this Trust Fund. Therefore, you and your Spouse (or Domestic Partner) should enroll in Medicare as soon as you are eligible to do so.

Retirees Who Work While Receiving a Pension

A Retiree who works 39 hours or less per month while receiving Retiree pension benefits through the Trust Fund are required to pay an additional 25% of their monthly retiree premium rate for the month in which active hours were reported.

Termination of Retiree Eligibility

Your coverage as a Retiree will terminate for any of the reasons listed below:

- You perform any work for an employer in the industry which does not have a collective bargaining agreement with any of the local unions participating in this Trust Fund or a trust fund that is signatory to a reciprocal agreement with this Trust Fund. Contact your Union Office or the Trust Fund Office for complete rules determining your rights to perform covered employment after your retirement date.
- You fail to pay the required monthly self-payment on time.
- Your pension benefits are terminated or suspended for any reason except for your return to full time covered employment.
- You cease to be a member in good standing with any local union affiliated with the District Council 16 of the International Union of Painters and Allied Trades.
- If the Board of Trustees decides to discontinue the Retiree Plan.

Once terminated, you will not again be eligible for Retiree benefits.

Retirees who work in covered employment after retirement will receive no credit towards eligibility for any employer cash contributions and will lose the benefit of the Active Participant funded 25% Retiree health care subsidy.

If You Have Cash Bank Reserves at the Time of Your Death

For Dependents whose coverage is extended due to accumulated reserves in your Cash Bank, coverage under the Plan in which you were enrolled immediately prior to your death will remain in effect for one month.

Surviving Spouse Coverage

If a Retired Employee who has elected a Joint and Survivor Pension dies, his or her surviving spouse may continue to be covered under this Trust Fund upon payment of the required self-payment. This coverage will terminate upon the re-marriage of the surviving spouse.

If on the date of death an active Employee would have been eligible for a pension if he had applied, the surviving spouse may continue to be covered under this Trust Fund upon payment of the required self-pay amount. No break in coverage is allowed. This coverage will terminate upon the re-marriage of the surviving spouse.

If the surviving spouse of a Retired or Active Employee is NOT entitled to receive pension payments from a related Pension Trust Fund, he/she may only continue receiving benefits from this Trust Fund under the COBRA continuation of coverage rules.

Retiree Special Late Enrollment Rights

A federal law known as HIPAA provides for enrollment after initial eligibility as follows:

Newly Acquired Spouse, Domestic Partner and/or Dependent Child(ren)

If you, as the Retiree, acquire a Spouse by marriage, a Domestic Partner, or if you acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for yourself, the newly acquired Spouse, Domestic Partner and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.

Loss of Other Coverage

If you declined coverage when you initially became eligible because you had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Dependents within **31 days** after the termination of the coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;
- the other plan ceasing to offer coverage to a group of similarly situated individuals;
- the loss of dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

* due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
* when the employer or other responsible entity terminates the health care Plan and there is no other COBRA Continuation Coverage available to the individual;
* when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
* because the 18-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

You and your Dependents may also enroll in this Plan if you (or your eligible Dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your Dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your Dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

- **Coverage of an individual enrolling because of loss of other coverage or because of marriage:** If the individual requests Special Enrollment **within 31 days** of the date of the event that created the Special Enrollment opportunity, (except for a newborn and newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below) generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.
- If the individual requests enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 31 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
- Individuals enrolled during Special Enrollment have the same opportunity to select Plan benefit options (when such options exist) at the same costs and the same enrollment requirements, including any pre-existing condition limitations the Plan may require, as are available to similarly-situated Employees at initial enrollment.

ELIGIBILITY RULES FOR ALL PARTICIPANTS

Eligibility Rules for Dependents

Coverage for your eligible Dependents you have at the time you become eligible for coverage as either an active Employee or a Retiree will begin on the date you become eligible **and enroll** for coverage. Coverage for Dependents acquired after your initial eligibility will begin on the date you acquire the Dependents. You must request to enroll newly acquired Dependents, including newborns, by contacting the Trust Fund Office within 31 days.

The term "Dependent" means:

- The lawful spouse or Domestic Partner of an eligible Active or Retired Employee; and
- Children of an eligible Active or Retired Employee who are under the age of 26 (whether married or unmarried), including the following:
    - Natural, adopted children, stepchildren or foster children. Adopted children shall be considered eligible under this Trust Fund when they are placed for adoption. Placed for adoption means the assumption and retention by an Employee of the legal duty for total or partial support of a child to be adopted.
    - A child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) until the earlier of 1) age 26; or 2) the date the QMCSO terminates. In accordance with ERISA Section 609(a), this Trust Fund will provide coverage for a Dependent Child of an Active Employee if required by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child. The procedures regarding medical child support orders are available free of charge upon request from the Trust Fund Office.

The Trustees may request evidence of the relationship and age, such as a marriage certificate in the case of marriage, a birth record in the case of a newborn, divorce and remarriage documents in the case of stepchildren, and any such other evidence as the Trustees may deem necessary.

- **Additional Dependent Children.** In addition to the Dependent Children defined above, the following individuals are eligible for coverage under the Plan:
    - Disabled Adult Child: An unmarried Dependent Child (as defined above) age 26 or older who is permanently and totally disabled with a disability that existed prior to the attainment of the Plan's age limit who will be claimed as a Dependent on the eligible Active or Retired Employee's tax return for each Plan Year for which coverage is provided. This Plan may require initial and periodic proof of disability.
    - An unmarried individual under age 19 with respect to whom the eligible Active or Retired Employee has legal guardianship under a court order (proof of guardianship and age may be required) and who will be claimed as a Dependent on the Eligible Active or Retired Employee's tax return for each Plan Year for which coverage is provided. Coverage may continue if the child has reached his or her 19th birthday but has not reached his or her 24th birthday and is enrolled as a full-time student in high school or in an accredited and state licensed technical school or institution of higher education. The Plan may require initial and periodic proof of student status.

      If the Plan receives a written certification from a child's treating physician that (1) the child is suffering from a serious illness or injury, and (2) a leave of absence (or other change in enrollment) from a postsecondary institution is Medically Necessary, and if the loss of student status would result in a loss of health coverage under the Plan, the Plan will extend the child's coverage for up to one year. This maximum one-year coverage begins on the first day of the Medically Necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (i) one year later, or (ii) the date on which coverage would otherwise terminate under the terms of the Plan (for example, when the child reaches the Plan's limiting age).

The following individuals are **not eligible** under the Plan: a spouse of a Dependent Child (i.e. Employee/Retiree's son-in-law or daughter-in-law) or a child of a Dependent Child (i.e. Employee/Retiree's grandchild) unless the Participant has been appointed legal guardian of the child.

- **Children of a Domestic Partner**
- If a Domestic Partner is enrolled in the Plan, the Employee may also apply for coverage for the **Domestic Partner's children** who meet the requirements set out below. For the purposes of this Plan, a Domestic Partner's Child (unless the Child is legally adopted by the eligible Active or Retired Employee) is any of the Domestic Partner's unmarried children who have the same principal place of abode as the Employee and Domestic Partner (proof of same principal place of abode may be requested by the Plan) provided:
    - The Domestic Partner's Child depends on the Domestic Partner and/or the Employee for more than one-half of their support; and
    - The child has not reached his or her 19th birthday; OR
    - The child has reached his or her 19th birthday but has not reached his or her 24th birthday and is enrolled as a full-time student in high school or in an accredited and state licensed technical school or institution of higher education; OR
    - An unmarried Dependent Child age 26 or older who is permanently and totally disabled with a disability that existed prior to the attainment of the Plan's age limit who will be claimed as a Dependent on the eligible Active or Retired Employee's tax return for each Plan Year for which coverage is provided. This Plan may require initial and periodic proof of disability.

If the Plan receives a written certification from the child's treating physician that (1) the child is suffering from a serious illness or injury, and (2) a leave of absence (or other change in enrollment) from a postsecondary institution is Medically Necessary, and if the loss of student status would result in a loss of health coverage under the Plan, the Plan will extend the child's coverage for up to one year. This maximum one-year coverage begins on the first day of the Medically Necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (i) one year later, or (ii) the date on which coverage would otherwise terminate under the terms of the Plan (for example, when the child reaches the Plan's limiting age).

It is the Domestic Partner's obligation to inform the Plan promptly if any of the requirements set out in this definition of a child of a Domestic Partner are NOT met with respect to any child for whom coverage is sought or is being provided.

The Domestic Partner and the child of a Domestic Partner may not qualify as tax Dependents and, if so, the Employee or Retiree will be taxed on the value of the benefit provided to him or her. This is called "imputed income" and the Employee or Retiree will have to pay income and payroll taxes on this amount.

Proof of Dependent Status

Specific documentation to substantiate Dependent status will be required by the Plan and may include proof of the Dependent's relationship to the eligible Active or Retired Employee, including any of the following:

- **Marriage:** the certified marriage certificate.
- **Birth:** the certified birth certificate showing biological child of Employee.
- **Stepchild:** the birth certificate plus marriage certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge showing that Employee has adopted or intends to adopt the child.
- **Foster Child:** court documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment decree or court order of a court of competent jurisdiction, and any proof of any state provided health coverage.
- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate.

- **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your Spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by judge or National Medical Support Notice.
- **Domestic Partner**: Signed affidavit by the Employee and domestic partner that they meet the requirements of this Plan's domestic partner eligibility using the Plan's state recognized Domestic Partner registration form.

Failure to Provide Proof of Dependent Status: Claims for newly added Dependents (e.g. Spouse, Domestic Partner, children) will not be considered for payment by this Plan until the Trust Fund Office receives verification/proof of Dependent status.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Trust Fund Office, the Social Security Number (SSN) of your Eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such Dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

Failure to provide the SSN or complete the CMS model form (form is available from the Claims Administrator or https://www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals cannot be processed for the affected individuals.

Newborn Dependent Children (Special Rule for Coverage)

Your newborn Dependent Child(ren) **will be covered from the date of birth** if you enroll your newborn child, within 31 days of birth. You must provide the Trust Fund Office with an updated ***Plan Enrollment Form*** within 31 days of birth and a copy of your child's birth certificate as soon as it is available. If you are in the HMO, you must update your enrollment within 31 days of the child's birth for coverage to continue.

Remember that you may not enroll a newborn Dependent Child for coverage unless you, the Employee or Retiree, are also enrolled for coverage. Submitting a claim to the Plan for maternity care/delivery for care of a newborn child is not considered proper enrollment of that child for coverage under this Plan.

Adopted Dependent Children (Special Rule for Coverage)

Your adopted Dependent Child will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, provided you enroll the child in the Plan. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

- **A Newborn Child who is Placed for Adoption** with you within 31 days after the child was born will be covered from the date the child was placed for adoption if you comply with the Plan's requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.
- **A Dependent Child adopted more than 31 days after the child's date of birth** will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, if you submit a completed written enrollment form to the Trust Fund Office and provide of proof of Dependent status (if requested) within 31 days of the child's adoption or placement for adoption.

If a child is "Placed for Adoption" with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may

not enroll an adopted child or a child Placed for Adoption for coverage unless you, the Employee/Retiree, are also enrolled for coverage.

Qualified Medical Child Support Orders (QMCSO) (Special Rule for Enrollment)

Under the Omnibus Budget Reconciliation Act of 1993, this Trust Fund must recognize any Qualified Medical Child Support Order (QMCSO) and enroll as directed by the Order any child of a Trust Fund Participant specified by the Order. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a domestic relations settlement agreement or National Medical Support Notice) issued by a court that:

- provides the child of a Trust Fund Participant with child support or directs the Participant to provide the child with coverage under a health benefits plan; 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 parent does not enroll the 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 Participant and the name and mailing address of each child covered by the order,
- the type of coverage to be provided by the Trust Fund to each such child (a reasonable description of such coverage),
- 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 Trust Fund to provide any type or form of benefit or any option not otherwise provided under this Trust Fund, except to the extent necessary to comply with section 1908 of the Social Security Act.

No eligible active Employee's or Retired Employee's child covered by a Qualified Medical Child Support Order 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.

Additional Information: For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Trust Fund Office.

Termination of Dependent (or Domestic Partner) Coverage

Dependent or Domestic Partner coverage ends on the earliest of the date in which:

- the Employee's coverage ends; or
- your covered Spouse, Domestic Partner or Dependent Child(ren) no longer meet the definition of Spouse, Domestic Partner or Dependent Child(ren) as provided in the Definitions chapter of this document; or
- for Dependents under a QMCSO, the expiration of the period of coverage stated in the QMCSO; or
- the date the Spouse, or Domestic Partner enters the Armed Forces on full-time active duty; or
- the date of the Spouse, Domestic Partner or Depending Child's death.

Notice to the Plan

You, your Spouse, your Domestic Partner or any of your Dependent Children **must notify the Plan preferably within 31 days but no later than 60 days** after the date a:

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce or legal separation);
- Dependent Child ceases to meet the Plan's definition of Dependent (such as the Dependent Child reaches the Plan's limiting age or the Dependent Child ceases to have any physical or mental disability);

- Domestic Partner ceases to meet the Plan's definition of Domestic Partner.

Failure to give this Plan a timely notice (as noted above) will cause your Spouse or Domestic Partner and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child to end when it otherwise might continue because of a physical or mental disability.

Retroactive Cancellation of Coverage

In accordance with the requirements in the Affordable Care Act, the Fund will not retroactively cancel coverage **except** in cases of fraud or intentional misrepresentation of a material fact.

If your coverage is terminated for fraud or intentional misrepresentation of a material fact, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

In such cases, You and Your Dependent(s) will be required to reimburse the Trust Fund for any benefits improperly paid and the Trust Fund may set off the amount of the improper payment from future benefits.

Leave of Absence (Special Circumstances)

Family and/or Medical Leave (FMLA)

If your employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you and your eligible Dependents will continue to be covered for medical, dental and vision benefits under the Trust Fund, provided you were eligible when the leave began and your employer makes the required contributions during your leave.

Coverage for these benefits will be continued while you are absent from work on an FMLA leave as if there were no interruption of active employment and as if you were continuing to work the number of hours required for coverage. This coverage will continue until the earlier of the expiration of the FMLA leave or the date you give notice to your employer that you do not intend to return to work at the end of the leave. If you do not return to work after the end of the FMLA leave, your employer may require you to reimburse him for the contributions made to the Trust Fund on your behalf during the leave.

It is not the role of the Trust Fund to determine whether or not an Employee is entitled to FMLA leave. Any disputes regarding entitlement to FMLA leave with continuing benefits must be resolved with your employer.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the Employee has been called to active duty in the uniformed services. USERRA protects Employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An Employee's coverage under this Plan will terminate when the Employee enters active duty in the uniformed services.

- If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the date the Employee stopped working.
- Coverage will be continued under the Trust Fund during military service with a duration of less than 31 days. If you are an hourly bargaining Employee, your Cash Bank reserve will be credited with an amount equivalent to 8 hours per day of uniformed military service, up to 40 hours per week, during such service.
- **Cash Bank**. You have two options regarding your Cash Bank when you enter military service for 31 days or more. You may use your Cash Bank to continue your coverage (and your eligible Dependents' coverage) until your Cash Bank is exhausted. Or, you may freeze your Cash Bank so the money will be available for

coverage when you return. If you wish to freeze your Cash Bank, you must notify the Trust Fund Office in writing that you wish to freeze it within 15 days of the date you enter military service.

- **Paying for up to 24 months of coverage**. Once you have exhausted your Cash Bank, or if you chose to freeze your Cash Bank, you may continue benefits for yourself and your eligible Dependents under COBRA or for up to 24 months under USERRA by paying the required "self-payment" premiums. The rules regarding payment of USERRA premiums are similar to those for continuing coverage under COBRA. For more information about self-payments under USERRA, contact the Trust Fund Office.
- **Duty to Notify the Plan:** The Plan will offer the Employee USERRA continuation coverage only after the Trust Fund Office has been notified by the Employee in writing that they have been called to active duty in the uniformed services. The Employee must notify the Trust Fund Office (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the Employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Trust Fund Office receives notice that the Employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the Employee (and any eligible Dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the Employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Trust Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

In addition to USERRA or COBRA coverage, an Employee's eligible Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the Employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the Employee returns to work provided the Employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

If you are seeking work in the jurisdiction of this Trust Fund, but are unable to find work, be sure to notify the Trust Fund Office within 90 days after your discharge or release from military service.

Assuming your return to employment after service of 31 days or more complies with the terms of USERRA, coverage after your discharge will restart as follows:

- If you froze your Cash Bank, you and your eligible Dependents' coverage under this Trust Fund will resume on the first day of the month following the month you return from military service, provided you have enough money in your Cash Bank to cover at least one month of coverage.
- If your Cash Bank was exhausted during your military service or you do not have enough money in your Cash Bank, you and your eligible Dependents' coverage under this Trust Fund will resume on the first day

of the month following the month your Cash Bank is credited with enough to pay for one month of coverage.

If you are a monthly Employee, your and your Dependents' coverage under this Trust Fund will resume the first day of the month for which your employer makes the required contributions. Questions regarding your entitlement to USERRA leave and to continuation of coverage should be referred to the Trust Fund Office.

Continuation of Coverage

See the COBRA chapter for information on continuing your health care coverage.

HIPAA Certification of Creditable Coverage When Coverage Ends

When your coverage ends, you and/or your covered Dependents are entitled by law to and will automatically be provided (free of charge) with a HIPAA Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

Procedure for Requesting and Receiving a HIPAA Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Trust Fund Office within two years after the date coverage ended under this Plan. The written request must be mailed or faxed, e-mailed to the Trust Fund Office and should include the name of the individual for whom a certificate is requested (including Spouse or Domestic Partner and Dependent Children) and the address where the certificate should be mailed. The address of the Trust Fund Office is on the Quick Reference Chart in the front of this document. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA chapter for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

The requirement on the Plan to provide a HIPAA certificate of creditable coverage will be eliminated effective December 31, 2014 because Health Reform prohibits medical plans from applying a pre-existing condition limitation starting with a plan year beginning on or after January 1, 2014.

MEDICAL NETWORKS

In-Network and Out-Of-Network Services

Plan Participants may obtain health care services from PPO or Non-PPO providers. Because health care providers are added to and deleted from networks during the year you should call the network or ask the provider to verify their contracted network status before you visit that provider to assure you will be able to receive their discounted price for the services you need.

In-Network Services

In-network health care providers have agreements with the Plan's Preferred Provider Organization (PPO) under which they provide health care services and supplies for a favorable negotiated discount fee for Plan Participants. When a Plan Participant uses the services of an In-Network health care provider, the Plan Participant is responsible for paying the applicable coinsurance on the discounted fees or copayment for any medically necessary services or supplies, subject to the Plan's limitations and exclusions.

The In-Network health care provider generally deals with the Plan directly for any additional amount due. Note that with respect to claims involving any third party payer, including auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the contract between the Health Care Providers and the PPO Network may not require them to adhere to the discounted amount the Plan pays for covered services, and the providers may charge their usual non-discounted fees.

You may also verify if your health care provider is an In-Network provider by contacting the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document.

Out-Of-Network Services

Out-of-Network health care providers (also called non-network, non-PPO and Non-participating providers) have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. If you have not signed an assignment of benefits, the Plan will reimburse the Plan Participant for the Allowed Charge (as defined in this document) for any medically necessary services or supplies, subject to the Plan's Deductibles, coinsurance (on non-discounted services), copayments, limitations and exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made.

CAUTION: Out-of-Network Health Care Providers may bill you for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing. You can avoid balance billing by using In-Network providers.

Please Note: there is no requirement under this Plan that you designate a primary care physician (PCP) provider. Additionally, you do not need prior authorization to obtain access to an OB/GYN provider.

Services outside of California

Participants who live or are traveling outside of California are able to receive PPO contracted rates when services are received from doctors and hospitals that contract with the **PPO** network in the area where services are received. It is to your advantage to use PPO contracted doctors and hospitals because your coinsurance percentage will be applied to reduced charges, resulting in lower out-of-pocket expenses to you.

To find a PPO provider outside of California you may contact the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document. If you use a Non-PPO provider when there is a PPO provider within 30 miles, (or a "traditional" provider in 30 miles), covered services will be payable at the Non-PPO level, resulting in greater out-of-pocket expenses to you. Instructions on how to locate a "traditional" provider are on the Quick Reference Chart at the beginning of this document.

Please note: "Traditional" providers do not participate in the PPO network. However, they have agreed to perform services at special discounted rates for PPO members. You should go to a "Traditional" provider only if there are no PPO providers in your area.

Preferred Provider Organization (PPO)

The Plan's Preferred Provider Organization (PPO) is a network of Hospitals, Physicians, laboratories and other Health Care Providers who are located within a Service Area and who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan Participants.

If you receive medically necessary services or supplies from a PPO Provider you will pay less out-of-pocket than if you received those medically necessary services or supplies from a Health Care Provider who is not a PPO Provider; **and** the PPO Provider has agreed to accept the Plan's payment plus any applicable out-of-pocket amount that you are responsible for paying as payment in full.

Blue Cross Network/Smart Choices (APPO) for Active Employees

If you are an Active Employee that is participating in the Smart Choices/Healthy Rewards program, you and all your covered family members must use Anthem Blue Cross "Advantage Network" PPO Providers. **Please Note:** Most Sutter-affiliated physicians, hospitals and outpatient providers are not a part of the APPO network (even though they may be part of the larger PPO Network). Be sure to verify your provider's participation in the APPO network through the Anthem Blue Cross website listed on the Quick Reference Chart at the beginning of this document or by calling the Fund Office. If you use a non-Advantage provider, Non-PPO Provider coverage will apply.

Directories of Network Providers

You are able to access the network of PPO and APPO providers by going to www.anthem.com. If you would like a hard copy of the directory of PPO or APPO providers, call the Trust Fund Office. There is no cost to you for the provider directory. If you lose or misplace your Directory, you can obtain another, at no cost, by calling the Trust Fund Office at the telephone number shown in the Quick Reference Chart in the front of this document.

Physicians and Health Care Providers who participate in the Plan's Networks are added and deleted during the year. It is best if you ask your health care provider if they are still participating with the PPO or APPO or contact the network each time BEFORE you seek services or contact the PPO at their telephone number or website shown on the Quick Reference Chart in the front of this document.

Nondiscrimination in Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

"No Choice" (Special Reimbursement) Provisions

The following chart explains the Plan's special reimbursement for services when Non-PPO providers are used. The Board of Trustees or its designee determines if and when the following special reimbursement circumstances apply to a claim. Medical records may be requested in order to assist with a determination on the need for special reimbursement provisions.

SPECIAL REIMBURSEMENT PROVISIONS	WHAT THE PLAN PAYS (toward eligible claims submitted by a Non-PPO provider)
• Non-PPO anesthesiologist when surgery is performed by a PPO surgeon providing services at a PPO facility. • Non-PPO assistant surgeon when surgery is performed by a PPO surgeon providing services at a PPO facility. • Non-PPO emergency room physician services received at a PPO facility. • A PPO physician refers you for an initial consultation to a Non-PPO specialist. • You receive diagnostic testing (laboratory or radiology services) at a PPO facility and ordered by a PPO physician, but the professional services to interpret the test results are performed by a Non-PPO provider. • When a PPO provider is not available to provide the necessary treatment. • When the closest facility is a Non-PPO provider and the condition meets the Plan's definition of an "Emergency Medical Condition." • When you live 30 miles from any provider eligible to receive PPO reimbursement. • The Plan does not have a PPO provider qualified or available to provide the preventive services required by Health Reform so the participant must use the services of a Non-PPO provider.	The charges will be paid as if the care was provided by a PPO provider. However, the allowance for bills will be reimbursed according to the Allowed Charge for non-network providers. This means you may be billed for any amounts over the Allowed Charge. Please keep in mind that you need to call the Care Counseling Service at the number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office. See the definition of Allowed Charge in the Definitions chapter.
• Use of a Non-PPO provider when a PPO provider was available to be used. For example, if you receive services from a Non-PPO provider who is more distant from your home than a PPO provider who could have provided the services, the Plan will reimburse you at the Non-PPO level of benefits.	As if the care was provided Out-of-Network including Deductible, coinsurance, copays and Out-of-Pocket maximums.

UTILIZATION REVIEW

Purpose of the Utilization Review Program

Your Plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Fund to afford the cost of maintaining your plan.

To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a Utilization Review program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the plan's Utilization Review program, you may avoid some Out-of-Pocket costs. However, if you don't follow these procedures, your Plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

Management of the Utilization Review Program

The Plan's inpatient Utilization Review Program is administered by an independent professional Utilization Review Company operating under a contract with the Plan (hereafter referred to as the UM Company). The name, address and telephone number of the UM Company appears in the Quick Reference Chart in the front of this document.

The health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of this Plan.

Elements of the Utilization Review Program

The Plan's Utilization Review Program consists of:

1. **Prior Authorization (pre-service) review**: review of proposed health care services before the services are provided;
2. **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility or continued duration of healthcare services;
3. **Second and third opinions**: consultations and/or examinations designed to take a second, and when required, a third look at the need for certain elective health care services; and
4. **Retrospective (post-service) review**: review of health care services after they have been provided.

Restrictions and Limitations of the Utilization Review Program (Very Important Information)

1. The fact that your Physician recommends surgery, hospitalization, confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered medically necessary for determining coverage under the Medical Plan.
2. The Utilization Review Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a service is medically necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if the UM Company does not certify the proposed surgery/treatment/service or admission as medically necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the UM Company.

4. With respect to the administration of this Plan, the Fund, the Claims Administrator and the UM Company are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as medically necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Company as medically necessary.

Prior Authorization (Pre-service) Review

NOTE: If you are a Retiree or a Retiree's Dependent that is **eligible for Medicare** or if this Plan is the secondary payer of your benefits (see *Coordination of Benefits*) the requirements for Prior authorization (described below) and Care Counseling (described later in this chapter) do not apply to you.

How Prior Authorization Works

Prior Authorization is administered by the UM Company, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are medically necessary. The Plan's prior authorization requirements are summarized below:

Situation	Prior Authorization Requirement
Elective, non-emergency hospitalization	UM Company must approve the hospital stay before admission.
Hospitalization as a result of an Emergency Medical Condition	You or someone acting on your behalf must contact the UM Company for approval of the hospital stay within 48 hours of admission (at the telephone number listed on the Quick Reference Chart).
Admission for childbirth that exceeds the federal required time periods	You do **not** need pre-authorization for a hospital stay for mother and newborn of less than 48 hours following a normal vaginal delivery or a stay of less than 96 hours following a cesarean section. **Note**: prior authorization is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
Participation in a Clinical Trial	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.

How to Request Prior Authorization (Pre-service Review)

While a contract physician should automatically take care of this, it is your responsibility to assure that prior authorization occurs when it is required by this Plan. Any penalty for failure to request prior authorization is on you, not the health care provider.

1. **Calls for Elective services should be made at least 7 days before the expected date of service.**
2. The caller should be prepared to provide all of the following information: Employee's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. When calling to request prior authorization, if the pre-service review process was not properly followed the caller will be notified as soon as possible but not later than 5 calendar days after your request.
4. If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as

medically necessary. The UM Company will usually respond to your treating Physician or other Health Care Provider **by telephone within 3 working days (but not later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.

5. If your admission or service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeal Information chapter regarding appealing a UM determination.

Concurrent (Continued Stay) Review

How concurrent (continued stay) review works:

1. When you are receiving medical services in a hospital or other inpatient health care facility, the UM Company will monitor your stay by contacting your physician or other health care providers to assure that continuation of medical services in the health care facility is medically necessary, and to help coordinate your medical care with benefits available under the plan.
2. Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your physician or other health care providers of various options and alternatives for your medical care available under this plan.
3. If at any point your stay or services are found to NOT be medically necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your physician will be notified. This does not mean that you must leave the hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay or services were not medically necessary, no benefits will be paid on any related hospital, medical or surgical expense.

Retrospective (post-service) Review

All claims for medical services or supplies that have not been reviewed under the Plan's Prior authorization, Concurrent (Continued Stay) Review, or Second and Third Opinion Programs may, at the option of the Claims Administrator, be subject to retrospective review to determine if they are medically necessary. If the Claims Administrator receives a determination from a UM Company or other designated medical review firm that services or supplies were not medically necessary, **no benefits will be provided by the Plan for those services or supplies.** See also the section of this chapter regarding Appealing a UM Determination. For complete information on Claim Review and Claim Appeals, see the Claim Filing and Appeals Information chapter of this document.

Appealing a UM Determination (Appeals Process):

You may request an appeal of any adverse review decision made during the prior authorization, concurrent review or retrospective review process described in this chapter. To appeal a denied claim/bill, see the Claim Filing and Appeal Information chapter of this document.

If You Do Not Comply With Requirements or Disregard the Decision

If prior authorization is not obtained before a non-emergency admission (other than the allowed stay following childbirth) or an elective surgery **the Plan will pay only 75% of its usual reimbursement for the facilities charges.**

If the UM Company determines that a hospital confinement is not medically necessary for all or a portion of your stay, **benefits are not payable from this Plan for any days that were not medically necessary.**

Additionally, unauthorized confinement periods billed by a PPO hospital are contractually written off and are not the responsibility of the Plan or the Participant.

The difference between the amount you would be responsible for paying based on the benefits that would be payable if the review procedure had been followed and the actual benefits payable because the review procedure was not followed will not count toward the Plan's Deductible or Annual Out-of-Pocket Maximum.

Maximum Allowable Charges Apply for Certain Surgical Procedures

Charges for surgical procedures can vary greatly among hospitals and facilities. For example, at in-network facilities within 50 miles of San Jose, the costs for knee replacement surgery can range from $19,000 to over $75,000. Yet, there is little evidence of a higher quality of care at a higher cost facility. The Fund will allow a Maximum Allowable Charge ("MAC") for the following five surgical procedures in the state of California:

1. Routine total hip replacements;
2. Routine total knee replacements;
3. Arthroscopic surgeries;
4. Cataract surgeries; and
5. Colonoscopies at an outpatient Hospital.

The MAC is the highest amount your plan will pay for these procedures (in the state of California). Any amount over the MAC will be your responsibility. This benefit design applies ONLY to routine total hip or knee replacements, arthroscopies, cataract surgery and colonoscopies **in the state of California**.

Procedure	* Maximum Allowable Charge per Surgery
At an inpatient Hospital	
Routine Total Hip Replacement Surgery	$30,000
Routine Total Knee Replacement Surgery	$30,000
At an Outpatient Hospital (instead of an ambulatory surgical center)	
Arthroscopy	$6,000
Cataract Surgery	$2,000
Colonoscopy	$1,500

* Please note: Amounts denied as over the MAC for a procedure will not accumulate toward your Out-of-Pocket Maximum.

Value Based Site

For hip and knee replacements, there are many California hospitals that will hold costs under the MAC. There are over 100 ambulatory surgical centers (ASCs) that are keeping their costs for arthroscopies, cataract surgeries, and colonoscopies under the thresholds, as well. We call these facilities "Value-Based Sites." For surgeries done outside the state of California normal surgery benefits will apply.

You can find a Value-Based Site, by calling the Care Counseling Service at the phone number listed on the Quick Reference Chart. Here is how the benefit works.

Receive care at a PPO Value-Based Site	Receive care at a PPO facility (but not a Value-Based Site)	Receive care at a Non-PPO facility
You pay your copay (applies to outpatient services; it's waived if you call the Care Counseling Service prior to receiving the services); and the Fund pays the remaining balance.	You pay your copay (applies to outpatient services and waived if you call the Care Counseling Service prior to receiving the services). The Fund pays 100% of the remaining MAC; and you are responsible for payment of 100% of charges above the MAC up to the PPO contracted rate.	You pay your deductible plus 50% of the MAC. In addition, you are responsible for payment of 100% of charges above the MAC. In addition, if you have an outpatient surgery at a Non-PPO facility (hospital or surgical center), there is a maximum payment of $350.

This benefit design applies ONLY to routine total hip/knee replacements, arthroscopies, cataracts and colonoscopies for providers in California. Here is an example of how the benefit design will work for arthroscopic knee surgery:

	PPO Value Based Site (Ambulatory Surgical Center)	PPO Outpatient Hospital	Non-PPO Surgery Center	Non-PPO Hospital
Provider Charges	$6,000	$8,500	$11,000	$11,000
MAC	$6,000	$6,000	N/A	N/A
Your share of MAC	$0 (your $20 copay is waived as you preauthorized the procedure with the Care Counseling Service)	$0 (Your $20 copay is waived because you preauthorized the procedure with the Care Counseling Service)	N/A	N/A
Fund Share of MAC	$6,000	$6,000	$350 maximum	$350 maximum
Your additional obligation	$0	$2,500 (charges over MAC)	$10,650 (charges over $350 maximum)	$10,650 (charges over $350 maximum)
Your total share	**$0**	**$2,500**	**$10,650**	**$10,650**

How can I make sure my costs are under the MAC?

Clearly, it makes sense to have your procedure done at a Value-Based Site. You'll receive quality care at an affordable price for you and your Benefit Trust Fund. To make sure you keep your costs under the MAC (or at a price you can afford if you decide not to go to a Value-Based Site for your care), take these actions BEFORE you receive your care:

Preauthorize your care through the Care Counseling Service at the telephone number listed on the Quick Reference Chart. Your Care Counselor will review your treatment plan and talk with you about the Value-Based Sites who provide the services you need. Be sure to ask your Care Counselor about the average costs for the different providers you are considering.

Use the online PPO Network "Care Comparison" tool to research providers whose average costs are at or below the maximum allowable charge. You can also review different quality measures through this tool. Go to the website listed on the Quick Reference Chart to access this tool. You need to be a registered member, so be sure to have your member ID card handy when you go to the site.

If you need an overnight stay in the hospital, be sure to preauthorize it with UM company that reviews inpatient Hospitalizations by calling the telephone number listed on the Quick Reference Chart.

Contact the Trust Fund Office if you have questions or need help. To receive the highest level of benefits, have the service preauthorized by the Care Counseling Service and plan to have your procedure at a Value-Based Site.

What if I don't live near a Value-Based Site?

We are including a "safety net" for participants who need to travel to a Value-Based Site. Here's how it works:

- **For a Routine Total Hip or Knee Replacement Surgery:** If the Value-Based Site is over 50 miles from your home, you may request reimbursement for up to $750 in travel expenses, including mileage, hotel expenses, and meals. **Note:** Your reimbursement may be considered taxable income by the IRS.
- **For an Arthroscopy, Cataract Surgery; or Colonoscopy:** If you live over 30 miles from a Value-Based Site, the MAC does not apply. The Fund's regular benefits apply for your care.

CARE COUNSELING

Before you get any kind of non-emergency treatment outside of your primary doctor's office (including any procedure or test), you need to call the Care Counseling program. Primary doctors include family/general practice physicians, internists, pediatricians, and OB-GYNs. The Care Counseling program is provided through the company listed on the Quick Reference Chart.

Your conversations with a Care Counselor are completely confidential. You will talk with your Care Counselor about the different PPO providers who offer the services you need and their costs. The costs for the same service may be very different among providers. You can still visit any provider, but we think most of you will choose a lower cost option if you know about it.

You will also discuss the recommended treatment for your injury or illness. **Note that you must call PHA prior to receiving the following services:**

- All outpatient surgeries and procedures;
- Ancillary testing (e.g. MRI, PET and CT scans);
- Physical therapy visits;
- Durable medical equipment; and
- Chemotherapy or radiation.

The Care Counseling Service typically completes its outpatient review within one business day. You or your doctor can call for you to begin the preauthorization process at the number of the Care Counseling Service listed on the Quick Reference Chart. When you call prior to receiving these services and you receive your care from a PPO provider, your outpatient copay will be waived.

Calling a Care Counselor can help you learn more about your illness or injury. Your call helps to make sure you are receiving the appropriate care.
It also can save the Trust Fund thousands of dollars for your care. If you have questions, contact the Trust Fund Office at number listed on the Quick Reference Chart.

24 Hour Nurse Line

A nurse line is available 24 hours a day, seven days a week. Through the nurse line, you can connect with a registered nurse who will answer any questions you have about your health. You can also discuss your Physician's recommended treatment for your injury or illness. The nurse will be able to answer any questions you may have and let you know what to expect as you proceed with treatment. Please call the Care Counseling Service at the number listed on the Quick Reference Chart to speak with a nurse.

SMART CHOICES/HEALTH REWARDS PROGRAM

Your choice to participate in the Smart Choices/Healthy Rewards Program is voluntary.
If you make the Smart Choices Promise, you become eligible to earn Healthy Rewards.

The Smart Choices/Healthy Rewards Program only applies to active employees (both Bargaining and Non-Bargaining) and their Dependents. The program does **NOT** apply to Retirees and Dependents.

Smart Choices/Healthy Rewards is a program designed to bring high quality care to Participants and, at the same time, make care more affordable for everyone.

When you make the Smart Choices Promise, you commit to take certain actions to learn about and improve your health. When you do, you become eligible to earn Healthy Rewards, including an increased hour bank for Bargained Employees and the ability to earn additional funding for health care expenses.

Step 1: Complete the Smart Choices Promise and Election Form

When you agree to the Smart Choices Promise, you become eligible for the programs Healthy Rewards. By completing and signing the Smart Choices Promise and Election form, you are making a commitment to your health—and taking one step closer to being eligible to earn HEALTHY REWARDS. If your spouse/domestic partner is covered by Fund benefits, he/she must also make and complete the Smart Choices Promise. Be sure to have him/her complete and sign the Form. If you need a copy of the Smart Choices Promise and Election Form, please call the Fund Office at (510) 864-6444 or (800) 922-9902 or go online at www.dc16trustfund.org and click on the "Smart Choices" link to get a copy of the Form.

By completing the Form, you (and your covered spouse/domestic partner) agree to:

- Get a biometric health screening.
- Keep your contact information up to date. Provide an email address or cell phone number as a supplemental way for the Fund to contact you with general information about the Smart Choices/Healthy Rewards and other Trust Fund programs. Keeping you informed of important health messages is part of our role in the Smart Choices Promise. That's why we need to have current contact information for you and your covered spouse/domestic partner and a supplemental way to communicate with you. So, as part of the Promise, we are asking you to provide an email address or cell phone number that accepts text messages, if you have one.
- Provide the name and contact information for your primary doctor.

Blue Cross Network/Smart Choice (APPO) Participants- Step 2: Get a biometric health screening

As part of the Smart Choices Promise, you (and your covered spouse/domestic partner) need to get a biometric health screening by the annual deadline. This screening is provided at no cost to you. It can help identify your potential health risk factors that can lead to chronic illness. Knowing this information and then working with your doctor to improve your health can help you live a healthier and more productive life. The requirement to complete a biometric health screening does not apply to children.

You can get your biometric health screening through the Wellness Program/Biometric Testing vendor listed on the Quick Reference Chart at the beginning of this document or through your doctor. If you go to your doctor for your screening, be sure to bring a Physician Result Form. Your doctor will need to fill it out and send it to the Biometric Testing vendor. Once you complete your screening, you'll receive the Quest Diagnostics Blueprint for Wellness MyTest Profile report. We encourage you to share this with your doctor and determine the best course of action for your health.

Quest Diagnostics will notify the Fund Office that you successfully completed the second step of the Smart Choices Promise by getting a biometric health screening. Your personal health information will not be shared with the Trust Fund, Trustees, Union, or Your Employer - only the fact that You (and Your covered spouse/domestic partner) completed a screening will be communicated to the Fund Office. The Trustees and Trust Fund may receive aggregate data about the group, in order to help with benefit planning, but will not receive individual information on screening results.

Kaiser/Smart Choice (HMO) Participants - Step 2: Get a biometric health screening

You can get your biometric health screening through your doctor or through Kaiser. A list of Kaiser On-the-Job® Centers is available on the Trust Fund website (www.dc16trustfund.org), or you may call Kaiser at the phone number listed on the Quick Reference Chart.

Be sure to sign and bring the Kaiser Proof of Biometric Screening Form and the Occupational Health and Safety Services Referral Form (that has been provided to you). If your spouse/domestic partner is covered under Fund benefits, he/she will need a form too. If you need another form, please call the Trust Fund Office or you may download one from the Trust Fund website (www.dc16trustfund.org).

To schedule a screening with your doctor, call Kaiser at the telephone number listed on the Quick Reference Chart. Be sure to bring the Kaiser Proof of Biometric Screening Form (included with this Guide) with you. Your doctor will need to fill it out and send it to Kaiser. If you already had your annual screening, simply ask your doctor to complete the Kaiser Proof of Biometric Screening Form, sign it and fax it to Kaiser at the number on the Form.

Watch your mailbox for your results. Kaiser will mail a copy of the results to you, and forward them electronically to your doctor. Kaiser will also send you an email with a link to access your results through your online medical record—all good reasons to keep all contact information current, as required in Step 1 of the Promise.

Step 3: Agree to the terms of the Program

You must agree to the Smart Choices Promise, you are agreeing to the following:

- **Blue Cross Network/Smart Choices (APPO) members:** You and all your covered family members agree to use **"Advantage Network" PPO Providers**. Note: Most Sutter-affiliated physicians, hospitals and outpatient providers are not a part of the Advantage PPO network. Be sure to verify your provider's participation in the Advantage PPO network through the Anthem Blue Cross website (www.anthem.com/ca), or by calling the Fund Office. If you use a non-Advantage provider, Non-PPO Provider coverage will apply (in most cases, the plan pays 50% of covered charges and you pay the balance).
- **Blue Cross Network/Smart Choices (APPO) members:** You agree to call the Care Counseling service before you receive outpatient care. The phone number for the Care Counseling service can be found on the Quick Reference Chart at the beginning of this document.
- You agree to remain in this plan for the full calendar year.

Step 4: Earn Healthy Rewards (Bargained Employees)

When you agree to the Smart Choices Promise and complete the required promise commitments, you become eligible for the program's Healthy Rewards including additional contributions to your cash bank and a Health Reimbursement Arrangement (HRA). The HRA is intended to comply with the requirements of IRS Notice 2013-54 and shall be interpreted to accomplish that objective.

- You can bank an additional three months of excess contributions in your cash bank, for up to six months total.
- After reaching that six month maximum, you can bank up to 20% of contributions in excess of 130 hours per month into a Health Reimbursement Arrangement (HRA). You can use your HRA funds to pay for eligible health care expenses, as explained in more detail below.

HEALTHY REWARDS			
The Rewards	**What it is**	**How it works**	**Maximum accumulation allowed***
First, you'll receive…	A three-month extension of cash bank accumulations to a maximum of six months.	Hours worked over 130 per month are used to calculate your cash bank dollar amount, up to a maximum amount that will purchase six months of coverage.	You can continue to accumulate dollars in your cash bank until you reach the six month maximum.
After the six-month maximum is reached…	Additional amounts will be contributed to an HRA on your behalf.	20% of hours worked over 130 hours per month will be used to calculate the dollar amount to be contributed to your HRA.	The amount you can accumulate in your HRA is unlimited. However, it may only be used for eligible health care expenses.

How Your HRA works.

- HRA contributions are tax-free to you.
- You can use your HRA balance to pay for eligible health care expenses. The federal government determines the types of expenses that are eligible for reimbursement.
- HRA contributions may roll over from year to year. You may use your HRA funds as long as you maintain active hourly eligibility and you are enrolled in the Smart Choices/Healthy Rewards plan.
- Unlike a regular bank account, HRA contributions do not earn interest and can't be invested.
- You forfeit your HRA balance when your plan eligibility terminates for any reason; however, your HRA balance will be reinstated if you return to covered employment and re-establish plan eligibility within 12 months from the date your eligibility terminated.

Upon termination of coverage, you have the option to opt out of the HRA. This means that you will forfeit any remaining HRA balance and you will be able to apply for a premium assistance tax credit in a health insurance Marketplace. Whether you qualify for a tax credit will depend upon your eligibility under the rules of the Affordable Care Act. **Please note:** If you retain any balance in your HRA, you will not be eligible for the tax credit.

A Participant is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, in a time and manner determined by the Board of Trustees. Upon termination from the Fund, the Participant may opt out of and waive future reimbursements from the HRA. Please note that reinstatement of any HRA balances is not permitted if the Participant has opted out of HRA coverage.

- When you retire, you forfeit your HRA balance at the same time your active eligibility terminates. This is typically one month after your retirement date.
- The HRA has no cash value.
- You may not participate in the HRA unless you are actually enrolled in a group health plan that provides minimum value pursuant to Internal Revenue Code § 36B(c)(2)(C)(ii). A group health plan provides minimum value if the coverage is at least 60 percent of the actuarial value of a standard plan as determined by the IRS.
- You are permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, in a time and manner determined by the Board of Trustees, and upon termination of coverage under the plan.

Medical Care Expenses

You may use some or all of the money in your Account to pay for services such as hospitalization, doctors and dentists, prescription drugs and amounts you pay for deductibles, copays or coinsurance, However, not all medical care expenses will be considered "Covered Expenses" that qualify for reimbursement under the Fund. Generally, only expenses within the meaning of Section 213 of the Internal Revenue Code are eligible.

Common medical care expenses include: acupuncture, contraceptives, chiropractic services, contact lenses/eyeglasses, crutches, dental treatment but not teeth whitening, diabetic supplies, eye examination by an optometrist, device to measure blood pressure, fertility treatment, surgical dressing supplies, elastic bandages like an Ace wrap, hearing aids, immunizations and flu shots, laboratory tests, LASIK eye surgery, tobacco cessation drugs, orthodontia treatment/dental braces and walker/wheelchair and weight loss programs/weight loss drugs only if recommended by a Physician to treat a specific medical condition (e.g. diabetes, obesity, heart disease). However, not all medical care expenses will be considered "Eligible Medical Care Expenses" that qualify for reimbursement under the Fund. Generally, only medical care expenses within the meaning of Section 213 of the Internal Revenue Code are eligible.

If you have any questions as to whether an expense is reimbursable, call the Fund Office.

Excludable Expenses

The following expenses are examples of the kinds of expenses that are not reimbursable, as they do not meet the definition of "medical care" under Code Section 213. This is not intended to be a complete list of all services that are not payable under the plan, but an example of more commonly submitted services that are not reimbursed from the plan. The plan does not pay for/reimburse any item that does not constitute "medical care" as defined under Internal Revenue Code §213.

1. Long-term care (LTC) services.
2. Cosmetic surgery/services, ear piercing, hair removal or other similar cosmetic procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
3. Funeral and burial expenses.
4. Massage therapy to improve general health.
5. Custodial care.
6. Babysitting and child care expenses.
7. Costs for sending a problem child to a school for benefits that the child may receive from the course of study and/or disciplinary methods.
8. Health club or fitness program dues.
9. Social activities, such as dance lessons and swimming lessons to improve general health.
10. Cosmetics, toiletries, toothpaste, etc.
11. Vitamins, food supplements, diet food, even if prescribed by a physician.
12. Uniforms or special clothing, such as maternity clothing.
13. Automobile insurance premiums.
14. Transportation expenses except in certain circumstances where transportation is necessary to receive medical care.
15. Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
16. Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars.
17. Over-the-Counter drugs and medicine unless prescribed by a health care provider or physician.

In no event are premiums for individual health insurance payable, whether purchased in the individual insurance market or in a Health Insurance Marketplace.

MEDICAL EXPENSE BENEFITS

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expense." Eligible Medical Expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

1. **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the Definitions chapter of this document); and
2. **Not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this document); and
3. **Not services or supplies in excess** of the overall Annual Maximum Plan Benefit or any maximums on specific Plan benefits as shown in the Schedule of Medical Benefits and
4. **For the diagnosis or treatment of an injury or illness** (except where preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document).

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have incurred a maximum Out-of-Pocket cost each calendar year, applicable only to the Coinsurance, no further Coinsurance will be applied for that calendar year.

Non-Eligible Medical Expenses

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be medically necessary, determined to be in excess of the Allowed Charge, not covered by the Plan, in excess of the Annual Maximum Plan Benefit or payable on account of a penalty because of failure to comply with the Plan's Utilization Review requirements as described later in this document.

PPO In-Network Health Care Provider Services

- **In-Network:** If you receive medical services or supplies from a Health Care Provider that is contracted with the Plan's PPO you will be responsible for paying less money out of your pocket. Health Care Providers who are under a contract with the PPO have agreed to accept the discounted amount the Plan pays for covered services, plus any additional copayments, Deductibles or coinsurance you are responsible for paying, as payment in full, except with respect to claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Health Care Providers with the PPO do not require them to adhere to the discounted amount the Plan pays for covered services, and they may charge in excess of what this Plan considers an Allowed Charge.
- **Out-of-Network (also called Non-Network or Non-PPO):** refers to providers who are not contracted with the PPO Network. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the Allowed Charge payable by the Plan, also called balance billing. See also the Medical Networks chapter of this document.

Overview of Medical Plan Design

Deductibles

The Deductible is the amount you must pay each calendar year before the Plan pays benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan.

Each calendar year, you (and **not** the Plan) may be responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are received by the Plan. Deductibles under this Plan are accumulated on a Calendar Year basis. Only Eligible Medical Expenses can be used to satisfy the Plan's

Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles. Copayments do not accumulate to meet the Deductible.

Please note that there are different Deductibles based on whether or not you elect to enroll in the Smart Choices Program.

- **For families that elect to participate in the Smart Choices program,** there is no Deductible when you use Anthem Blue Cross "Advantage Network" PPO providers. However, there is a $500 Individual/$1,000 family Deductible for services with Non-PPO providers. Please Note: Most Sutter-affiliated physicians, hospitals and outpatient providers are not a part of the APPO network (even though they may be part of the larger PPO Network). **If you use a non-Advantage provider, Non-PPO Provider coverage will apply.**
- **For families that elect not to participate in the Smart Choices program**, there is a $1,000 individual/family Deductible that applies to all eligible expenses (PPO and Non-PPO except for PPO Preventive Care that is required to be covered under Health Reform, Chiropractic Benefits and Prescription Drugs).

Deductible Carry-Forward Provision

If an individual incurs expenses in the last three months of the Calendar Year that are applied toward their required Calendar Year Deductible, those charges will also be applied toward the following year's Deductible.

Common Accident Provision

If more than one covered family member is injured in the same accident, applicable Calendar Year Deductibles will be limited to one individual Deductible per year for all Allowed Charges related to that accident, providing the services are rendered within six consecutive months of the accident date.

Coinsurance

Once you've met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. If you use the services of a Health Care Provider who is a member of the Plan's PPO, you will be responsible for paying less money out of your pocket. This feature is described in more detail in the Medical Network chapter of this document.

Copay

A copay is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur certain Eligible Medical Expenses. The Plan's copayments are indicated in the Schedule of Medical Benefits. Copayments are not used to satisfy the Deductible or Out-of-Pocket maximum. Copayments will continue to be your responsibility even after you reach your annual Out-of-Pocket maximum.

Maximum Out-of-Pocket Limit on Coinsurance

Each Calendar Year, after an individual or family has incurred a maximum Out-of-Pocket limit for coinsurance as outlined in the Schedule of Medical Benefits, no further coinsurance will apply to covered Eligible Medical Expenses. As a result, the Plan will pay 100% of <u>covered</u> Eligible Medical Expenses, **<u>except for</u>** the Out-of-Pocket Expenses listed below, that are incurred during the remainder of the Calendar Year after the Out-of-Pocket Maximum has been reached.

Out-of-Pocket Expenses You Always Pay: This Plan rarely pays benefits equal to **all** the medical expenses you may incur. You are **always** responsible for paying for certain expenses for medical services and supplies yourself. Under the Plan, each year, you will be responsible for paying the following expenses out of your own pocket **and** these expenses do not accumulate to meet the Out-of-Pocket maximum:

1. Any Plan **Deductible or Copayment**.
2. All expenses for medical services or supplies that are **not covered** by the Plan.
3. All charges in **excess of the** Allowed Charge determined by the Plan. See the definitions of Allowed Charge and balance billing in the Definitions chapter of this document. **Please note that if you use PPO providers, you are not responsible for amounts in excess of the Allowed Charge.**

4. All charges in excess of the MAC (**Maximum Allowable Charge (MAC).** The Maximum Allowable Charge (MAC) is the highest amount that the Fund will pay for routine total hip/knee replacements, arthroscopic surgeries, cataract surgeries and colonoscopies (for providers in the state of California). The MAC will not apply to colonoscopies at an outpatient surgical center.
5. All charges in **excess of the Plan's Maximum Benefits**, or in excess of any other limitation of the Plan.
6. Any additional other amounts you have to pay because you **failed to comply with the Utilization Review Program** described in the Utilization Review chapter of this document.
7. All expenses for **medical services or supplies in excess of Plan benefits** or that are incurred with respect to Outpatient Prescription Retail and Mail Order Drugs.
8. All expenses for **medical services or supplies obtained from Out-of-Network providers,** except for service provided by Out-of-Network providers that is directly related to an Emergency Medical Condition.

Out-Of-Pocket Limit (Annual Limit on PPO Cost Sharing)

This Plan has an Out-of-Pocket Limit (also referred to as an Out-of-Pocket Maximum) which limits your annual cost-sharing for covered Essential Health Benefits received from PPO providers related to Medical Plan deductibles, coinsurance, and copayments to the amounts permitted under the Affordable Care Act and implementing regulations. This annual cost-sharing limit includes the Coinsurance Maximum described above.

- 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.
- The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.
- Covered emergency services performed in a Non-PPO Emergency Room will apply to meet the PPO Out-of-Pocket Limit on cost-sharing.
- The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.

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

a. balance-billed charges,
b. Expenses for medical 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 programs,
e. Amounts that are excluded for exceeding the reference based price,
f. Excluded amounts for using a provider that is not in the APPO network, and
g. Non-PPO deductibles, copayments and coinsurance except ER visit in cases of an emergency.
h. Outpatient prescription drug expenses (only until January 1, 2015).
i. Expenses for the self-funded dental and vision plans (only until January 1, 2015).

Maximum Plan Benefits

- **Limited Overall Maximum Plan Benefits:** Certain Plan benefits are subject to limitations that are not considered Annual maximums, and are called Limited Overall Maximums. An example would be Home Health Care. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the Schedule of Medical Benefits.

  Once the Plan has paid the Limited Overall Maximum Plan benefit for any of those services or supplies on behalf of any Covered Individual, no further Plan benefits will be paid for those services or supplies on account of that Covered Individual.

Medicare Eligible Retirees and Dependents

For eligible Retirees and their covered Dependents eligible for Medicare the Plan will pay 100% of Allowed Charges not paid by Medicare. This primarily represents amounts for Medicare deductibles and the balance for Medicare coinsurance percentages of Medicare approved charges. The Plan will process claims only after receipt of the Medicare Explanation of Benefits.

IMPORTANT: You must enroll in both Part A and Part B of Medicare when you first become eligible. The Plan will estimate Medicare Part A & B benefits if you fail to enroll for Medicare when eligible.

Medicare eligible Retirees and Dependents are subject to all Plan Provisions and Limitations <u>except</u> that:

- You are not required to receive Preauthorization prior to an inpatient hospitalizations;
- You are not required to talk with a Care Counselor before receiving outpatient care;
- The "maximum allowable charges" for routine total hip replacement, routine total knee replacement, cataract, colonoscopy and arthroscopy do not apply;
- The Reference Based Pricing on Prescription Drug coverage does not apply; and
- The Smart Choices program does not apply.

If Medicare denies a claim that would normally be considered an Allowed Charge, the Plan will pay in accordance with the Schedule of Benefits shown below.

Schedule of Medical Benefits

A schedule of the Plan's Medical Benefits, appears on the following pages in a chart format. Each of the Plan's Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided In-Network (when you use PPO Network Providers) and Out-of-Network (when you use Non-PPO Providers) are shown in the subsequent columns.

Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are the first services listed (after Annual Maximum, Deductible and Out-of-Pocket Maximum) because these two categories of benefits apply to most (but not all) health care services covered by the Plan. They are followed by descriptions, appearing in **alphabetical** order, of all other benefits for specific health care services and supplies that are frequently subject to limitations and exclusions.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, <u>and</u> you should also check the Exclusions chapter of this document to see if they are excluded.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Annual Deductible for families that participate in the Blue Cross Network/Smart Choices (APPO) Plan	• The amount you must pay each calendar year before the Medical Plan pays benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be allowed under this Plan.	None (if you use a provider in the APPO network)	$500 Individual $1,000 Family If you use a provider that is not in the APPO network (even though they may be part of the larger PPO Network), Non-PPO benefits will apply.	Not applicable (as the Smart Choice Program applies only to Active Employees and Dependents)	
Deductible for families that do NOT participate in the Blue Cross Network/Smart Choices (APPO) Plan	• The amount you must pay each calendar year before the Medical Plan pays benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be allowed under this Plan	$1,000 individual/family The $1,000 Deductible applies **to all eligible charges** (PPO and Non-PPO) except for PPO Preventive Care that is required to be covered under Health Reform, Chiropractic Benefits and Prescription Drugs.		$300 Individual $600 Family Note that both PPO and Non-PPO expenses accumulate separately to meet the annual deductible	
Annual Out-of-Pocket Maximum on Coinsurance	• The maximum amount of coinsurance that you are responsible for paying each calendar year, in addition to the Deductible, before the Plan pays 100% of your covered eligible medical expenses. • Certain expenses do not accumulate toward the Annual Out-of-Pocket Maximum as explained in the Medical Expense Benefits chapter.	Not applicable	None (services are never paid at 100%)	$2,000 per person * Applies only to inpatient hospital confinements * Does not include the Calendar Year Deductible	None (services are never paid at 100%)
Annual Out-of-Pocket Limit on Cost Sharing	• There is a limit to the amount of deductibles, copayment and coinsurance that you have to pay under the medical plan. • Certain expenses do not accumulate toward the Annual Out-of-Pocket Limit on cost sharing as explained in the Medical Expense Benefits chapter.	$6,350/ person/year $12,700/ family/year	None (services are never paid at 100%)	$6,350/ person/year $12,700/ family/year	None (services are never paid at 100%)

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related medically necessary ancillary services (e.g., prescriptions, supplies). • Newborn care.	• Elective Hospitalization is subject to prior authorization (unless you are eligible for Medicare). See the Utilization Review chapter for details. • If prior authorization is not obtained before a non-emergency admission (other than the federally required stays following childbirth) or an elective surgery, the Plan will pay only 75% of its usual reimbursement for the facilities charges. • Total hip and knee replacements are subject to the MAC (Maximum Allowable Charges). See the Utilization Review chapter for details and also see the rows of this chart titled Total Hip Replacement and Total Knee Replacement. • See the Eligibility chapter for how to properly enroll Newborns so coverage can be considered. • If your condition is Life-Threatening (refer to the Definition Section) and you are admitted to the Hospital or Skilled Nursing Facility (PPO or Non-PPO) directly from the emergency room, the Plan will pay 100% of Allowed Charges. If you are in a Non-PPO facility, the level of payment will continue only until the UM Manager determines that it is medically safe to move you. Benefits will then drop to the level applicable to Non-PPO hospitals unless you agree to a transfer to a PPO hospital.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	After Deductible, 80%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Physician and Other Health Care Practitioner Services • Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, emergency room (ER), urgent care facility or other covered health care facility location. • Please see the definition of "Health Care Practitioner" in the Definitions chapter for a complete list of covered practitioners.	• The services of one or more Assistant Surgeons will be reimbursed only for Medically Necessary services to a maximum of 20% of the eligible expenses allowed for the primary surgeon. • Lab services are covered as part of the physician office copay only when such services are obtained, processed and interpreted within the Physician's office. Lab services obtained in the physician's office but sent to a free-standing lab for processing require the separate lab copay. Lab services obtained and processed by a free-standing lab require the separate lab copay per date of service. • Arthroscopy, cataract surgery and colonoscopies at an outpatient surgical center have MAC (Maximum Allowable Charges). • Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office. • 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.	**Office Visit** 100% after $20 copay **Inpatient Hospital Visit:** 100% **Surgery and Anesthesiology services (Inpatient)** 100% **Surgery and Anesthesiology services (Outpatient)** 100% after $20 copay to each provider Outpatient Copay waived If the Care Counseling Service is called prior to receiving services (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Office Visit** 100% after $20 copay **Inpatient Hospital Visit:** 100% **Surgery and Anesthesiology services (Inpatient)** 100% **Surgery and Anesthesiology services (Outpatient)** 100% after $20 copay to each provider Outpatient Copay waived if the Care Counseling Service is called prior to receiving services	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Acupuncture • Covered services must be performed by a licensed acupuncturist.	• Limited to 25 visits per calendar year • Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office.	100% after $20 copay per visit Copay waived If the Care Counseling Service is called prior to receiving services. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50%. (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100% after $20 copay per visit Copay waived If the Care Counseling Service is called prior to receiving services	After Deductible, 50%
Ambulance Services • **Ambulance service within the United States** is covered if it is necessary to transport you from the place where you are injured or stricken by illness to the first hospital where treatment is given.	• Ambulance service will be covered only when the patient's medical condition requires paramedic support. • A **licensed air ambulance** is also covered if the Fund determines that the location and nature of the Illness or Injury made air transportation cost effective or necessary to avoid the possibility of serious complications or loss of life	$100 copay per trip		$100 copay per trip, no Deductible	
Ambulatory Surgical Center	See the Outpatient (Ambulatory) Surgery Facility row in this Schedule				

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Arthroscopy (Outpatient) • MAC (Maximum Allowable Charge) is the highest amount the Fund will pay.	• The MAC **only** applies to providers in the **state of California.** Any surgery outside the state of California will be subject to normal surgery benefits. • Have your surgery performed at a PPO Ambulatory Surgical Center (ASC) Value-Based Site in order to receive the highest possible benefit reimbursement. • Find a Value-Based Site by calling the Care Counseling Service at their number listed on the Quick Reference Chart. • Amounts that are denied as over the MAC will not be applied to your annual Out-of-Pocket limit on cost sharing. • Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office.	**Value Based PPO Facility** after $20 copay for each provider, 100% **PPO Facility (but not a Value-Based facility)** After $20 copay for each provider, 100% up to $6,000. You are responsible for 100% of any charges above $6,000 Copay waived if the Care Counseling Service is called prior to receiving services (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	**Hospital** After Deductible, 50% up to a maximum of $350. In addition, you are responsible for 100% of any charges above $350. **Surgical Center** The Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350. (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Value Based PPO Facility** after $20 copay for each provider, 100% **PPO Facility (but not a Value-Based facility)** After $20 copay for each provider, 100% up to $6,000. You are responsible for 100% of any charges above $6,000 Copay waived if the Care Counseling Service is called prior to receiving services	**Hospital** After Deductible, 50% up to a maximum of $350. In addition, you are responsible for 100% of any charges above $350 **Surgical Center** The Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350.
Behavioral Health Services (Mental Health and Substance Abuse Treatment)	Please refer to the section of this document that addresses Mental Health and Substance Abuse benefits that are available for all Participants.				
Birthing Center/Facility	See the Maternity Services row of this Schedule.				

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Blood Transfusions • Blood transfusions and blood products and equipment for its administration including expenses related to autologous blood donation (patient's own blood).	• Covered only when ordered by a Physician. • Call the Care Counseling Service at the number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	After Deductible, 80%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Cataract Surgery (Outpatient) • MAC (Maximum Allowable Charge) is the highest amount the Fund will pay.	• The MAC **only** applies to providers in the **state of California.** Any surgery outside the state of California will be subject to normal surgery benefits. • Have your surgery performed at a PPO Ambulatory surgical center (ASC) Value-Based Site in order to receive the highest possible benefit reimbursement. • Find a Value-Based Site by calling the Care Counseling Service at the number listed on the Quick Reference Chart. • Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office. • Amounts that are denied as over the MAC will not be applied to your annual Out-of-Pocket limit on cost sharing.	**Value Based PPO Facility** after $20 copay for each provider, 100% **PPO Facility (but not a Value-Based facility)** After $20 copay for each provider, up to $6,000 Copay waived if the Care Counseling Service is called prior to receiving services. You are responsible for 100% of any charges above $6,000 if you do not go to a Valued-Based facility. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	**Hospital** After Deductible, 50% up to a maximum of $350. In addition, you are responsible for 100% of any charges above $350 **Surgical Center** The Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350. (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Value Based PPO Facility** after $20 copay for each provider, 100% **PPO Facility (but not a Value-Based facility)** After $20 copay for each provider, up to $6,000 Copay waived if the Care Counseling Service is called prior to receiving services You are responsible for 100% of any charges above $6,000 if you do not go to a Valued-Based facility	**Hospital** After Deductible, 50% up to a maximum of $350. In addition, you are responsible for 100% of any charges above $350 **Surgical Center** The Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Chemotherapy, Radiation Therapy and Hemodialysis • Chemotherapy drugs and Hemodialysis or Peritoneal Dialysis drugs and supplies administered under the direction of a Physician in a Hospital, Specialized Health Care Facility, Physician's office, or at home.8i	• Benefit payments may vary depending on the location in which the services are delivered or received by the patient. For example, if services are delivered in a Hospital, the Hospital Services coverage applies; if it is delivered at home or in a Physician's office, see Physician's and Other Health Care Practitioners (above) in this Schedule of Medical Benefits.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100%	After Deductible, 50%
Chiropractic Benefit	• Chiropractic visits are limited to 25 visits per Calendar Year; • Chiropractic X-ray maximum per Calendar Year is $200; and • Chiropractic Medical Supply benefit maximum per Calendar Year is $50. • Call the Care Counseling Service at the number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office (not applicable to Kaiser participants).	**PPO Chiropractic visits** $20 copay per visit (Deductible waived) Copay waived if the Care Counseling Service is called prior to receiving services (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	**Non-PPO Chiropractic visits (including coverage for all eligible Kaiser Enrollees:** 100% of Allowed Charges after a $20 copay per visit (Deductible waived) (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**PPO Chiropractic visits** $20 copay per visit (Deductible waived) Copay waived if the Care Counseling Service is called prior to receiving services	**Non-PPO Chiropractor (including coverage for all eligible Kaiser Enrollees:** 100% of Allowed Charges after a $20 copay per visit (Deductible waived)

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Colonoscopy • MAC (Maximum Allowable Charge) is the highest amount the Fund will pay for services received at a facility that is not a "Value-Based Facility".	• The MAC **only** applies to providers in the **state of California.** Any surgery outside the state of California will be subject to normal surgery benefits. • A colonoscopy at a PPO Ambulatory Surgical Center (ASC) that is a Value-Based Site is covered under Health Care Reform and will be payable at 100%, no Deductible. • Find a Value-Based Site by calling the Care Counseling Service at the number listed on the Quick Reference Chart. • Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office. • Amounts that are denied as over the MAC will not be applied to your annual Out-of-Pocket limit on cost sharing.	**Value Based PPO Facility** 100% of Contracted Rates **PPO Facility (but not a Value-Based facility)** Up to $1,500 after a $20 copay for each provider Copay waived If the Care Counseling Service is called prior to receiving services You are responsible for 100% of any charges above $1.500 if you do not go to a Valued-Based facility. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	**Hospital** After Deductible, 50% up to a maximum of $350. In addition, you are responsible for 100% of any charges above $350. **Surgical Center** The Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350. (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Value Based PPO Facility** 100% of Contracted Rates **PPO Facility (but not a Value-Based facility)** Up to $1,500 after a $20 copay for each provider Copay waived If the Care Counseling Service is called prior to receiving services You are responsible for 100% of any charges above $1.500 if you do not go to a Valued-Based facility	**Hospital** After Deductible, 50% up to a maximum of $350. In addition, you are responsible for 100% of any charges above $350 **Surgical Center** The Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350.

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental) Subject to the limitations shown in the Explanations and Limitations column, coverage is provided for medically necessary: • External prosthetic devices to replace a missing body part. • Purchase of standard model. • Replacement is covered only as necessitated by a physiological change in the patient that renders the prosthetic non-functional. • Medically Necessary repair, adjustment or servicing of the Prosthetics. • Cochlear implants and similar internally implanted prosthetic devices to improve hearing are covered only for eligible Dependent children who are born with a severe congenital hearing deficit.	• See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. • Custom made orthotics that are medically necessary to treat a symptomatic disorder of the foot or prevent infection in insulin dependent diabetic patients are limited to the initial placement of orthotics, not to exceed a maximum benefit of $150 per foot. • Casts, Splints, Binders, and Braces and other Medically Necessary orthopedic appliances and devices are covered unless specifically excluded. • Jobst Stockings prescribed for vascular disorders, limited to four pairs per calendar year. • Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100%	After Deductible, 50%
Diabetic Special Services	• Diabetes Self-Care instruction provided by a Registered Dietitian, Certified Diabetes Educator or other qualified health care professional with special training in diabetes. • Podiatry services to prevent infection of the feet in insulin dependent diabetic patients are specifically covered in the absence of acute infection. • Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50%. (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Dialysis • Hemodialysis or peritoneal dialysis drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **It is important that individuals with end stage kidney/renal disease promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible. • Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Drugs (Outpatient Prescription Medicines) Coverage is provided for the following prescription drugs dispensed by a licensed pharmacist: • FDA-approved contraceptives; • Self-injectable drugs; • Physician administered drugs and infusion drugs provided under a Home Health program that has been preapproved (drugs must be obtained through Specialty program. • Compounded dermatological preparations (ointments and lotions that must be prepared by a pharmacist), Elixir Terpin Hydrate plus codeine (N.F.) cough mixtures, anti-acids: (aluminum hydroxide, aluminum hydroxide with magnesium trisilicate, aluminum and magnesium hydroxide gel, calcium carbonate, magnesium carbonate suspension, dihydroxyaluminum aminoacetate), medically necessary therapeutic vitamins for a diagnosed condition. If you have a prescription from your physician, the following are covered at no charge: • Aspirin: ages 45 – 79 years; • Folic acid: females ages 10-55 years; • Fluoride – for children to age 6; • Iron supplements: infants up to 1 year in age; • Medically appropriate FDA-approved smoking cessation medications (90-day supply). • Preparation "prep" Products for a Colon Cancer Screening Test 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.	• **Retail Drugs**: To obtain up to a 30-day supply of medicine for the copay noted to the right present your ID card to any In-Network retail pharmacy. • **Mail Order (Home Delivery) Drug Service:** Mail order service is the easiest/ least expensive way to obtain many medications. <u>You get a 90-day supply for two copays.</u> Have your physician write a prescription for up to a 90-day supply plus refills. If you need to take your medication immediately, also ask for a prescription for a 30-day supply to be filled at your retail pharmacy. (Processing time for a new medication may take up to 7 business days to process once they receive the prescription.) Mail your prescription with your copay to the Prescription Drug Plan. The first time you or your eligible Dependents use the mail service you must include a patient profile. When you need to order a refill, you can do so by mail, by telephone or online. Copays for refills ordered by telephone or online must be charged to a credit card. • Ten tablets is considered to be a 30-day supply of any oral drug for the treatment of erectile dysfunction. • Refills are not covered if dispensed prior to the end of the prescription's length of supply, except during a grace period shortly before the end of the length of supply. **Exception:** Vacation supplies are provided. • If you are taking non-formulary medications, talk with your Physician. Ask if there are alternative medications available to treat your illness. If appropriate, ask your Physician if you can try an alternative. If your Physician has determined that your non-formulary drug is Medically Necessary, he or she can request an exception. If approved, you pay the copay for formulary drugs. Your Physician should call the Prescription Drug Program at the phone number on the Quick Reference Chart to begin this process.	**<u>If you are taking a drug that is on the formulary list:</u>** Retail Drugs $4 copay Mail Order Drugs $8 copay (no charge for FDA approved formulary contraceptives) **<u>If you take a drug that is not on the formulary list</u>**: You must pay the full cost for the drug. **Specialty Drugs purchased at a retail pharmacy:** $20 copay plus 20% of cost of the drug	Participant will have to pay the full cost of the prescription and submit a claim to the Prescription Drug Program for reimbursement. Plan will reimburse, after the applicable copay, what it would have paid had the prescription been filled at a network pharmacy. Therefore, if the drug obtained is not on the Plan's formulary, then there is no coverage available.	**<u>If you are taking a drug that is on the formulary list:</u>** Retail Drugs $4 copay Mail Order Drugs $8 copay (no charge for FDA approved formulary contraceptives) **<u>If you take a drug that is not on the formulary list</u>**: You will pay the full cost for the drug. **Specialty Drugs purchased at a retail pharmacy** $20 copay plus 20% of cost of the drugs	Participant will have to pay the full cost of the prescription and submit a claim to the Prescription Drug Program for reimbursement Plan will reimburse, after the applicable copay, what it would have paid had the prescription been filled at a network pharmacy. Therefore, if the drug obtained is not on the Plan's formulary, then there is no coverage available

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Durable Medical Equipment (DME) Coverage is provided for: • Rental not to exceed the allowed purchase price of Durable Medical Equipment; • Purchase of standard models is at the option of the Plan Administrator or its designee; • Medically Necessary replacement of the Durable Medical Equipment due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired but only if due to normal wear and tear. • Medically Necessary repair, adjustment or servicing of the Durable Medical Equipment.	• Replacement for damaged or lost items will not be covered. • Internally placed prosthetic devices are covered under surgery benefits. • Purchase of a wig is covered when hair loss is the direct result of chemotherapy treatment. • Oxygen and the Medically Necessary equipment and supplies required for its administration is covered. • Coverage is provided for diabetic glucose meters. • Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office. • 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. Coverage is available at no cost from PPO providers.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100%	After Deductible, 50%
Emergency Room Facility • Hospital emergency room (ER) for "Emergency Services" as that term is defined in this Plan. • Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• **Emergency room facility services** are **not** subject to the Plan's Deductibles, and are payable subject to an emergency room copay, which will be waived if you were transported to the Hospital by professional ambulance (you would need to pay the ambulance copayment). • There is no requirement to request prior authorization of an emergency room visit. Also, the Plan will pay a reasonable amount for emergency services performed out-of network, in compliance with health reform regulations. See the definition of Allowed Charge or contact the Trust Fund Office for more details on what the Plan allows as payment to out-of-network emergency service providers.	**Emergency Room** $100 copay (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	**Emergency Room** $100 copay (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Emergency Room** $100 copay	**Emergency Room** $100 copay, no Deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Family Planning, Reproductive, Contraceptive Services • Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure). • Prescription contraceptives such as oral birth control pills/patch, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm and other injectable devices. • Oral contraceptives are payable under the Prescription Drug Program.	• See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Exclusions chapter. • There is no cost-sharing for female sterilization when performed by PPO providers. • Reversal of surgical sterilization is not covered. • Treatment of infertility is not covered (including services to induce pregnancy and complications resulting from those services). • Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100%	After Deductible, 50%
Habilitation services Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.		Not Covered		Not Covered	
Hearing Aids	• **Hearing aids** are payable up to $800 per device every 48 months.	90%		90% , no Deductible	

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Home Health Care • The Plan will provide benefits for Medically Necessary, non-custodial Home Health Care from a licensed home health care agency (or a visiting nurse in areas where there are no licensed home health care agencies) for services and supplies furnished in your home, in accordance with a written home health care plan. • Covered home health care services include services for part-time or intermittent skilled nursing care by a registered nurse (R.N.) or licensed vocational nurse.	• Care must be pursuant to a written Home Health Care Plan. • Maximum number of visits is 100 per calendar year. • A home health aide must have completed a home health aide training course and be under the supervision of a registered nurse. • Each visit by a member of a home health care team is considered one home health care visit, and 4 hours of home health aide service is considered one home health care visit. • Physical therapy, occupational therapy, and speech therapy are covered (subject to the limits shown under Rehabilitation Services). • Prescribed medical supplies are covered. Please Note: the Plan may require that Specialty Pharmacy drugs be obtained through the Specialty Pharmacy Program of the Prescription Drug Manager listed on the Quick Reference Chart. • Custodial care is **not covered**.	$10 copay (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	$10 copay	After Deductible, 50%
Hospice • The Plan will pay for hospice services provided by a licensed hospice Provider recognized as such by the Centers for Medicare and Medicaid Services.	Covered for terminally ill Participants	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	100%	50% (Deductible is waived)

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Laboratory Services (Outpatient) • Technical and professional fees associated with laboratory examinations authorized by the attending Physician or surgeon as the result of an injury or Illness.	• Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Wellness benefits in this Schedule. • Lab services are covered under the physician office copay **only** when such services are obtained, processed and interpreted within the Physician's office. Lab services obtained in the physician's office but sent to a free-standing lab for processing (e.g. Pap smear, blood for a chemistry panel, wound culture) require the separate lab copay. Lab services obtained by a free-standing lab require the separate lab copay per date of service (unless the service is preauthorized by the Care Counseling Service). • Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.	$20 copay per procedure Copay waived if the Care Counseling Service is called prior to receiving services (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	$20 copay per procedure Copay waived if the Care Counseling Service is called prior to receiving services	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Certified Nurse Midwife fees for medically necessary maternity services. • Breastfeeding supplies and rental of breast feeding equipment is payable. In conjunction with birth, the Plan pays for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period.	• Pregnancy-related care is not covered for Dependent Children except for certain prenatal care/maternity related preventive care expenses are payable as listed on the government websites http://www.hrsa.gov/womensguidelines/ or http://www.healthcare.gov/law/about/provisions/services/lists.html. including but not limited to screening for gestational diabetes, HPV testing starting at age 30, breastfeeding supplies and rental of breastfeeding equipment, and in conjunction with birth, coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period). These services are covered under the Wellness/Preventive Services category without cost sharing for all females (including Dependent Children). • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending physician, after consultation with the mother, discharges the mother or newborn earlier. In addition, the Plan may not, under federal law, require that a Physician obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). • **Elective induced abortion** is covered (for Employee or Spouse/Domestic Partner) only when the attending Physician certifies that the mother's health would be endangered if the fetus were carried to term, or where medical complications arise from an abortion. • 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.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	After Deductible, 80%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO

Nondurable Supplies
• Coverage is provided for medically necessary nondurable supplies dispensed and used by a Physician or health care practitioner in conjunction with treatment of the covered individual.
• Coverage is provided for up to a 31-day supply of home/personal use:
  • Sterile surgical supplies used immediately after surgery.
  • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Colostomy supplies.
  • Diabetic drugs and supplies including insulin, syringes, needles, sugar test tablet, sugar test tape, acetone test tablets, blood glucose testing strips, urine diagnostic strips and sterile lancets.
	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.
	• Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.
		100%
		
		(For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)
			After Deductible, 50%
			
			(For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)
				100%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO

Oral, Craniofacial Services
• Accidental Injury to Teeth/Jaw
	• Subject to all other provisions of the Plan, expenses unreimbursed by the Participant's Dental Plan will be subject to benefits for the following expenses:
	  • charges related to treatment of an injury to the jaw or teeth provided treatment occurs within six months after the date of an accident applied without respect to when the individual is enrolled in the Plan;
	  • charges in connection with teeth, gums, or alveolar processes are covered only for Medically Necessary care and treatment of tumors;
	  • charges for general anesthesia and associated facility charges for children under age seven, developmentally disabled individuals, or people with underlying medical conditions that require general anesthesia in order to safely perform the dental procedure.
	• Treatment of Temporomandibular Joint Disorder is specifically not covered under this benefit.
	• Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.
		100%
		
		(For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)
			After Deductible, 50%
			
			(For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)
				100%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Outpatient Ambulatory Surgery Facility • Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery, outpatient surgery). • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• Arthroscopy, cataract surgery and colonoscopies at an outpatient surgical center have a MAC (Maximum Allowable Charges). Please see the appropriate row in this Summary of Benefits for the MAC on each procedure. Amounts denied as over the MAC will not accumulate to your Out-of-Pocket Limit on cost sharing. • Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office. • If prior authorization is not obtained before an elective surgery the Plan will pay only 75% of its usual reimbursement for the facilities charges.	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, The Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to a $350/day maximum. (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services	After Deductible, the Plan will **reduce** the Allowed Charges **by 50%** The Plan will then **pay 75%** of this reduced Allowed Charge up to $350/day maximum

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Outpatient Hospital Services	• Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office.	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% Outpatient surgery in a Hospital: The Plan will **reduce** the Allowed Charges **by 50% any pay** up to a maximum of $350. You are responsible for 100% of any charges above $350. (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services	After Deductible, 50% Outpatient surgery in a Hospital: After Deductible, the Plan will **reduce** the Allowed Charges **by 50%** up to a maximum of $350. You are responsible for 100% of any charges above $350.
Radiology (X-Ray) • Technical and professional fees associated with diagnostic services for x-ray and imaging procedures authorized by the attending Physician or surgeon as the result of an injury or illness.	• Covered only when ordered by a Physician or Health Care Practitioner. • Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that states for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Most Cosmetic and Dental services are excluded from coverage.
	• Reconstructive Surgery is covered only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly or prior covered therapeutic procedure that causes a functional defect.
	• Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.
	• Elective Hospitalization is subject to prior authorization (unless you are eligible for Medicare). See the Utilization Review chapter for details.
	• If prior authorization is not obtained before a non-emergency admission (other than the federally required stays following childbirth) or an elective surgery the Plan will pay only 75% of its usual reimbursement for the facility charge.
		Outpatient Surgical Facility
		$20 copay (in addition to the $20 copay for the surgeon's fee)
		
		Copay waived if the Care Counseling Service is called prior to receiving services
		
		Inpatient
		100%
		
		(For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)
			After Deductible,
			
			Outpatient Hospital
			The Plan will **reduce** the Allowed Charges **by 50%** up to a $350/day maximum
			
			Outpatient Surgical Facility
			The Plan will **reduce** the Allowed Charges **by 50%**
			
			The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350.
			
			Inpatient
			50%
			
			(For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)
				Outpatient Surgical Facility
				$20 copay (in addition to the $20 copay for the surgeon's fee)
				
				Copay waived if the Care Counseling Service is called prior to receiving services
				
				Inpatient
				After Deductible, 80%
					Outpatient Hospital
					The Plan will **reduce** the Allowed Charges **by 50%** up to a $350/day maximum
					
					Outpatient Surgical Facility
					The Plan will **reduce** the Allowed Charges **by 50%**
					
					The Plan will then **pay 75%** of this reduced Allowed Charge up to a maximum of $350. You are responsible for 100% of any charges above $350.
					
					Inpatient
					After deductible, 80%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Rehabilitation Services (Cardiac and Pulmonary) • Cardiac Rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). • Pulmonary Rehabilitation is available to those individuals who are able to actively participate in a Pulmonary Rehabilitation program which is likely to improve their pulmonary function, as determined by the Plan Administrator or its designees. • Benefits are subject to the limitations and Maximum Plan Benefit shown in the Explanations and Limitations column to the right.	• Cardiac and/or Pulmonary Rehabilitation programs must be ordered by a Physician. • The Maximum Plan Benefit for Cardiac Rehabilitation is limited to a combined maximum of 25 visits per calendar year. • The Maximum Plan Benefit for **Pulmonary Rehabilitation** a combined maximum of 25 treatments per lifetime • Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office. • Habilitation services are not covered.	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	$20 copay each provider Copay waived if the Care Counseling Service is called prior to receiving services	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO

Rehabilitation Services (Physical, Occupational & Speech Therapy)
 	
• Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) following an acute injury or illness and provided by a licensed:
  • Physical Therapist
  • Occupational Therapist
  • Speech Therapist
• All benefits are subject to the limitations and the Limited Overall Maximum Plan Benefits shown in the Explanations and Limitations column.
	• Inpatient Rehabilitation services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility may be covered for short term, active, progressive Rehabilitation Services that cannot be provided in an outpatient or home setting. Any admission requires prior authorization (unless you are eligible for Medicare). See the Utilization Review chapter for details.
	• Maintenance Rehabilitation and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation in the Exclusions chapter and the definition of Maintenance Rehabilitation in the Definitions chapter.
	• Rehabilitation services are covered only when ordered by a Physician.
	• The Plan covers a maximum of 25 visits for Rehabilitation Services per calendar year. Visits in excess of 25 **MUST** be authorized in advance by the Care Counseling Service.
	• Call the Care Counseling Service at their number on the Quick Reference Chart for authorization before you receive outpatient non-emergency treatment (including a procedure, test or durable medical equipment) outside of your doctor's office.
	• No benefits will be provided for pervasive developmental delay, learning disabilities or services that are primarily provided to enhance academic achievement in Dependent Children.
		$20 copay each provider
		
		Copay waived if the Care Counseling Service is called prior to receiving services.
		
		(For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)
			After Deductible, 50%
			
			(For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)
				$20 copay each provider
				
				Copay waived if the Care Counseling Service is called prior to receiving services
					After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Routine Total Hip Replacement Surgery • MAC (Maximum Allowable Charge) is the highest amount the Fund will pay.	• The MAC **only** applies to providers in the **state of California.** Any surgery outside the state of California will be subject to normal surgery benefits. • Amounts denied as over the MAC will not accumulate to your Out-of-Pocket limit on cost sharing. • Have your surgery done at a **PPO Value-Based Facility** in order to receive the highest possible benefit reimbursement. • Find a Value-Based Site by calling the Care Counseling Service at the number listed on the Quick Reference Chart. • Elective Hospitalization is subject to prior authorization (unless you are eligible for Medicare). See the Utilization Review chapter for details. • If prior authorization is not obtained before an elective surgery the Plan will pay only 75% of its usual reimbursement for the facilities charges.	**Value Based PPO Facility** 100% **PPO Facility (but not a Value-Based facility)** Up to $30,000 You are responsible for 100% of any charges above $30,000 if you do not go to a Valued-Based facility (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% up to $30,000 In addition, You are responsible for 100% of any charges above $30,000 (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Value Based PPO Facility** After Deductible, 80% **PPO Facility (but not a Value-Based facility)** Up to $30,000 You are responsible for 100% of any charges above $30,000 if you do not go to a Valued-Based facility	After Deductible, 50% up to $30,000 In addition, You are responsible for 100% of any charges above $30,000

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits of the Plan. See also the Exclusions and Definitions chapters of this document for important information.

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Routine Total Knee Replacement Surgery • MAC (Maximum Allowable Charge) is the highest amount the Fund will pay.	• The MAC **only** applies to providers in the **state of California.** Any surgery outside the state of California will be subject to normal surgery benefits. • Amounts denied as over the MAC will not accumulate to your Out-of-Pocket limit on cost sharing. • Have your surgery done at a PPO Value-Based Facility in order to receive the highest possible benefit reimbursement. • Find a Value-Based Site by calling the Care Counseling Service at the number listed on the Quick Reference Chart. • Elective Hospitalization is subject to prior authorization (unless you are eligible for Medicare). See the Utilization Review chapter for details. • If prior authorization is not obtained before an elective surgery the Plan will pay only 75% of its usual reimbursement for the facilities charges.	**Value Based PPO Facility** 100% **PPO Facility (but not a Value-Based facility)** Up to $30,000 You are responsible for 100% of any charges above $30,000 if you do not go to a Valued-Based facility (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% up to $30,000 In addition, You are responsible for 100% of any charges above $30,000 (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Value Based PPO Facility** After Deductible, 80% **PPO Facility (but not a Value-Based facility)** Up to $30,000 You are responsible for 100% of any charges above $30,000 if you do not go to a Valued-Based facility	After Deductible, 50% up to $30,000 In addition, You are responsible for 100% of any charges above $30,000
Skilled Nursing Facility (SNF) or Subacute Facility • Inpatient rehabilitation services at a Skilled Nursing Facility (SNF) are covered only for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting.	• Admission to a Skilled nursing facility or Subacute facility requires Prior Authorization. See the Utilization Review chapter for details. • Services must be ordered by a Physician. To determine if a facility is a skilled nursing facility, see the Definitions chapter of this document. • Skilled Nursing Facility confinement is payable up to 100 days per calendar year.	100% (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	After Deductible, 80%	After Deductible, 50%
Spinal Manipulation Services	See the Chiropractic Benefit row of this Schedule.				

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Transplants (Organ and Tissue): • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs, tissue or bone marrow including facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Reasonable and necessary medical expenses incurred by a donor who **is covered** by this Plan, are payable without any Deductibles and Coinsurance applicable to those expenses. • Reasonable and necessary medical expenses incurred by a donor who **is not covered** by this Plan, are payable without any Deductibles and Coinsurance applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.	• **Transplant services are subject to prior authorization. See the Utilization Review chapter for details**. • The transplant must be performed in a major medical center approved by the Federal government or the appropriate state agency to perform the transplant. • The Limited Overall Maximum Plan Benefit for all expenses of a **person(s) who donate an organ(s) or tissue** to the Plan Participant is $25,000. Benefits are limited to reasonable charges for medical services incurred by the donor of an organ or tissue or the search for a bone marrow match and only to the extent that the services are not covered by the donor's own medical coverage. • Transplant Related Travel Benefit: When preapproved by the Trust Fund Office, travel expenses for one family member will be covered with reimbursement up to the IRS maximum daily amount allowed by the IRS as a deduction of a medical expense. • See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter. For Plan Participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.	**Office Visit** 100% after $20 copay **Inpatient Hospital Visit:** 100% **Surgery and Anesthesiology services (Inpatient)** 100% **Surgery and Anesthesiology services (Outpatient)** 100% after $20 copay to each provider Outpatient Copay waived if the Care Counseling Service is called prior to receiving services (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	After Deductible, 80%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Urgent Care Facility	• Call the Care Counseling Service at their number on the Quick Reference Chart before you receive outpatient non-emergency treatment (including a procedure, or a test) outside of your doctor's office.	**Urgent Care Facility** $20 copay Copay waived if the Care Counseling Service is called prior to receiving services (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**Urgent Care Facility** $20 copay Copay waived if the Care Counseling Service is called prior to receiving services	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Weight Management • Surgical treatment of morbid obesity **may** be covered if preauthorized and approved by Utilization Review Company as Medically Necessary. • Elective Hospitalization is subject to prior authorization (unless you are eligible for Medicare). See the Utilization Review chapter for details. • If prior authorization is not obtained before a non-emergency admission or an elective surgery, the Plan will pay only 75% of its usual reimbursement for the facilities charges.	The term "morbid obesity" means the presence of morbid obesity that has persisted for at least 5 years, defined as either: • body mass index exceeding 40; or • BMI greater than 35 in conjunction with ANY of the following severe co-morbidities: 1. coronary heart disease; or 2. type 2 diabetes mellitus; or 3. clinically significant obstructive sleep apnea (as determined by the Plan Administrator or its designee); or 4. high blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); **AND** Individual has completed growth (18 years of age or documentation of completion of bone growth); **AND** Individual has participated in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This nutrition and exercise program must meet ALL of the following criteria: Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; AND Nutrition and exercise program must be 6 months or longer in duration; AND Nutrition and exercise program must occur within the two years prior to surgery; AND Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. Note: A physician's summary letter is not sufficient documentation.	**Office Visit** 100% after $20 copay Inpatient Hospital Visit: 100% **Surgery and Anesthesiology services (Inpatient)** 100% **Surgery and Anesthesiology services (Outpatient)** 100% after $20 copay to each provider Outpatient Copay waived If the Care Counseling Service is called prior to receiving services. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	After Deductible, 80%	After Deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Preventive Care for Children Covered Services include but are not limited to: • Newborn screening lab tests (typically payable as part of hospitalization at birth); • At least 11 office visits payable during first 30 months of age, then annual office visits are payable from age 3 years through age 18 years; • Hemoglobin and lead blood tests in first year of life; • Tuberculosis (TB) skin test in first year of life; • Hemoglobin blood test in second year of life; and • Childhood immunizations that are FDA approved and in accordance with the CDC recommendations for children in the US. The wellness/preventive services payable by this 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, including immunizations: http://www.healthcare.gov/law/about/provisions/services/lists.html with more details at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.html • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share 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, the diagnostic or therapeutic cost share will apply. • 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 - such as age, location for service and test frequency - for consideration of payable preventive services. Services not covered under the wellness benefit may be covered under another portion of the medical plan.		**In-Network Preventive Services** that are required to be covered under Health Care Reform will be payable at 100%, no Deductible. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**In-Network Preventive Services** that are required to be covered under Health Care Reform will be payable at 100%, no Deductible.	After deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Preventive Care for Men Covered Services include but are not limited to: • Abdominal aortic aneurysm screening; • Colonoscopy at a Value Based Site, sigmoidoscopy or fecal occult blood test; • Bowel prep medication prescribed for use prior to a screening colonoscopy; • Polyps removed during a screening colonoscopy; • Four blood tests for cholesterol/lipid, blood sugar, HIV, syphilis; and • CDC recommended immunizations. The wellness/preventive services payable by this 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, including immunizations: http://www.healthcare.gov/law/about/provisions/services/lists.html with more details at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.html • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share 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, the diagnostic or therapeutic cost share will apply. • 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 - such as age, location for service and test frequency - for consideration of payable preventive services. Services not covered under the wellness benefit may be covered under another portion of the medical plan.		**In-Network Preventive Services** that are required to be covered under Health Care Reform will be payable at 100%, no Deductible. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**In-Network Preventive Services** that are required to be covered under Health Care Reform will be payable at 100%, no Deductible.	After deductible, 50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Active Plan		Non-Medicare eligible Retiree Plan	
		PPO	Non-PPO	PPO	Non-PPO
Preventive Care for Women (including pregnant women) Covered Services include but are not limited to: • Screening mammogram for breast cancer; • Pap smear and Chlamydia screening; • Osteoporosis screening x-ray; • Colonoscopy at a Value Based Site, sigmoidoscopy or fecal occult blood test; • Bowel prep medication prescribed for use prior to a screening colonoscopy; • Polyps removed during a screening colonoscopy; • Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; • BRCA 1 and 2 lab test with family history of breast cancer; and • CDC recommended immunizations. The wellness/preventive services payable by this 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, including immunizations: http://www.healthcare.gov/law/about/provisions/services/lists.html with more details at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.html or http://www.hrsa.gov/womensguidelines/). • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share 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, the diagnostic or therapeutic cost share will apply. • 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 - such as age, location for service and test frequency - for consideration of payable preventive services. Services not covered under the wellness benefit may be covered under another portion of the medical plan.		**In-Network Preventive Services** that are required to be covered under Health Care Reform will be payable at 100%, no Deductible. (For Blue Cross Network/Smart Choice (APPO) participants, you must utilize hospitals and providers that are in the Advantage Network in order to get PPO benefits)	After Deductible, 50% (For Blue Cross Network/Smart Choice (APPO) participants, any PPO hospital or provider that is not in the Advantage Network will be reimbursed at the Non-PPO rate)	**In-Network Preventive Services** that are required to be covered under Health Care Reform will be payable at 100%, no Deductible.	After deductible, 50%

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

The benefits described on this page are provided to <u>all</u> eligible Active and Retired Participants in this Trust Fund and their eligible Dependents regardless of whether they are enrolled in the Blue Cross Network (PPO), Blue Cross Network/Smart Choices (APPO), Kaiser (HMO) or Kaiser/Smart Choices (HMO).

If you are enrolled in one of the Kaiser plans, you may have additional benefits through Kaiser.

<table>
<tr><th colspan="3">Mental Health and Chemical Dependency Benefits
for Active Employees and their Dependents</th></tr>
<tr><th></th><th>Beat It! Or Anthem
(Contract Providers)</th><th>Non-PPO Providers</th></tr>
<tr><td><u>Annual Deductible for families that participate in the Blue Cross Network/Smart Choices (APPO) Plan</u></td><td>None</td><td>$500 Individual
$1,000 Family</td></tr>
<tr><td><u>Deductible for families that do NOT participate in the Blue Cross Network/Smart Choices (APPO) Plan</u></td><td colspan="2">$1,000 Individual/Family
The $1,000 Deductible applies to all eligible charges (PPO and Non-PPO) except for PPO Preventive Care that is required to be covered under Health Reform and Prescription Drugs.</td></tr>
<tr><td>Inpatient Services</td><td>After Deductible, 100% of Contracted Rates</td><td>After Deductible, 50% of Allowed Charges</td></tr>
<tr><td></td><td colspan="2">Prior Authorization by either Anthem Blue Cross or Beat it! is required except for Emergencies</td></tr>
<tr><td>Outpatient Services</td><td>$20 Copay, then 100% of Contracted Rates</td><td>After Deductible, 50% of Allowed Charges</td></tr>
<tr><td>Hospital Emergency Room</td><td colspan="2">Plan pays 100% (after Deductible) of Covered Expenses after you pay a $100 Copay (waived if admitted or under certain other conditions). If you are admitted to the Hospital, you must notify Anthem Blue Cross or Beat it! within 48 hours of admission.</td></tr>
</table>

Mental Health and Chemical Dependency Benefits for Non-Medicare Retired Employees and their Dependents		
	Beat It! Or Anthem (Contract Providers)	**Non-PPO Providers**
Deductible	$300 Individual/$600 Family	
Annual Hospital Out-of-Pocket Maximum	$2,000 per person (does not include Calendar Year Deductible)	None
Inpatient Services	80% of Contracted Rates	After Deductible, 50% of Allowed Charges
	If you are not yet eligible for Medicare, prior authorization by either Anthem Blue Cross or Beat it! is required except for Emergencies	
Outpatient Services	$20 Copay, then 100% of Contracted Rates	After Deductible, 50% of Allowed Charges
Hospital Emergency Room	Plan pays 100% (no Deductible) of Covered Expenses after you pay a $100 Copay (waived if admitted or under certain other conditions). If you are admitted to the Hospital, you must notify Anthem Blue Cross or Beat it! within 48 hours of admission.	

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage included in the Indemnity Medical Plan and the HMO are "creditable." "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all Plan Participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (October 15th through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If however you keep this Plan coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare prescription drug plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare prescription drug plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage (a copy is available from the Trust Fund Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

If you or a Medicare eligible Dependent are enrolled in the HMO and you enroll in a Medicare prescription drug plan, you will automatically be disenrolled from the HMO. If you do this, you will either have to pay an additional cost for your HMO medical coverage or file an appeal with the HMO to be re-enrolled in the HMO and disenrolled from your Medicare Drug Plan.

MEDICAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Blue Cross Network (PPO) or the Blue Cross Network/Smart Choices (APPO) Plans**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusion.

General Exclusions (applicable to all medical services and supplies)

1. **Costs of Reports, Bills, etc.:** Charges by a physician or institution for furnishing necessary information to the Trust Fund, including charges for broken appointments, preparing medical reports, bills or claim forms.
2. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
3. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Trust Fund Office or its designee to exceed the Allowed Charge as defined in the Definitions chapter of this document.
4. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. See the provisions relating to Third Party Liability in the chapter on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
5. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical and/or dental program; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
6. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
7. **Military service related injury/illness:** Services and supplies furnished by a Hospital or facility operated by the federal government or any authorized agency thereof, or furnished at the expense of such government or agency, except to the extent that such services are reimbursable to the Veterans Administration for non-service connected conditions under 38 U.S.C. 629**.**
8. **No cost Hospital or medical services:** Any hospital or medical services that are furnished without charge, paid for or reimbursable by or through a national, state, provincial, county, or municipal governmental or other political subdivision or any instrumentality or agency thereof, other than a charitable research hospital. This includes any service for which the Participant does not legally have to pay (or would not have been charged) if the Participant had no medical coverage. In addition, this Trust Fund does not pay benefits when the Participant has no out-of-pocket expenses, such as services provided by an HMO or any other pre-paid basis, except that the Indemnity Medical Plan will reimburse the copayments required of the Participant under the pre-paid plan.
9. **Illegal Act:** Charges you incur for any injury or illness you receive while committing or attempting to commit a felony or any other illegal activity unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor.

10. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in the Definitions chapter of this document, except for certain wellness benefits as outlined in the Schedule of Medical Benefits.
11. **Services Not Prescribed by a Physician**: Expenses for services/supplies that are not provided or authorized by a licensed Physician as defined in the Definition section of this SPD.
12. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those travel expenses are related to a Plan approved transplant as outlined under Transplantation in the Schedule of Medical Benefits.
13. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** Medical care and treatment that is due to an accidental bodily injury or illness that arises out of or in the course of employment for profit or gain or for which you are entitled to benefits under a Workers' Compensation law or similar legislation or would have been entitled to such benefits if protection under any such statute could have been in force on a voluntary or elective basis.

    NOTE: Plan benefits for such expenses will be advanced while you are pursuing your Workers' Compensation claim, provided you assign all rights to medical reimbursement under such laws to the Trust Fund. If your Workers' Compensation claim is settled or compromised in such a manner that the Trust Fund is reimbursed in an amount less than the proper lien claim submitted by it, or in a manner that results in the Workers' Compensation carrier being relieved of any future liability for medical costs, no further benefits will be paid by the Trust Fund in connection with the medical condition forming the basis of the claim unless the Trustees or their duly authorized representatives have previously approved the settlement or compromise in writing as one that is not unreasonable from the standpoint of the Trust Fund. (Refer also to the Subrogation section of this booklet).
14. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home.
15. **Relatives Providing Services:** Charges made by a relative or by a member of the Participant's household except for Allowed Charges which constitute out-of-pocket expenses to such providers.
16. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions chapter of this document.
17. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.
18. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Review Company, or any representative of the Plan for any purpose.
19. **War or Similar Event:** Expenses incurred as a result of an injury or illness resulting from insurrection or war, either declared or undeclared, or any act incident thereto, or participation in a riot.
20. Any injury or illness sustained or aggravated while you are in the **service of any military, navy or air force**.
21. Expenses related to **complications of a non-covered service.**
22. Charges for any claim for **medical treatment or services and or supplies which is not filed within 12 months** from the later of the date the expense was incurred or the date of payment under another plan that is primary payer.
23. Charges for massage therapy, hypnotism, stress management, biofeedback treatment or any other **goal oriented behavior modification therapy**, such as to quit smoking except as specifically mentioned as a covered benefit.
24. **Educational or Occupational Testing**.
25. Expenses for **court-ordered services** except those that the Mental Health and Substance Abuse vendor would have deemed clinically necessary and appropriate were the court not involved.

26. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. 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 eligible individual during their participation in the clinical trial.

Exclusions Applicable to Specific Medical Services and Supplies

A. Allergy/Alternative/Complementary Health Care Services Exclusions

1. Expenses for chelation therapy.
2. Expenses for prayer/faith, religious healing, or spiritual healing.
3. Expenses for naturopathic and/or homeopathic services or treatments/supplies.

B. Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

1. Rental or purchase of ramps, elevators, stair lifts, pools, spas, hot tubs, filtering systems, saunas, car hand controls, air purifiers, air conditioning, exercise equipment and supplies for comfort, hygiene or beautification or modifications to your home, property or vehicle regardless of their therapeutic or ease of access value.
2. Orthopedic shoes (except when joined to braces), air purifiers, air conditioners, humidifiers and supplies for comfort or beautification, except as specifically provided for.
3. Expenses for non-standard Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.

C. Cosmetic Services Exclusions

1. Cosmetic surgery or services, except for repair of damage caused by accidental bodily injury or as required by the Women's' Health and Cancer Rights Act of 1998. Restorative surgery performed during or following mutilative surgery which was required as a result of Illness or Injury shall not be considered cosmetic. Refer to the Definition chapter of this document for a more complete definition of Cosmetic Surgery.

D. Custodial Care Exclusions

1. Expenses for Custodial Care as defined in the Definitions chapter of this document.
2. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are medically necessary.

E. Dental Services Exclusions

1. Expenses for Dental services or supplies of any kind. Please note that there may be benefits available as outlined in the Dental chapter.
2. Expenses for the diagnosis, treatment or prevention of Temporomandibular Joint (TMJ) Dysfunction or Syndrome.

F. Drugs, Medicines and Nutrition Exclusions

1. Prescriptions dispensed by a licensed Hospital or Skilled Nursing Facility during confinement (including "take-home" prescriptions).
2. Drugs or medications which may be procured without a Physician's written prescription as designated by the FDA, regardless of state law, except as specifically mentioned as a covered benefit.
3. Injectable immunization agents unless obtained through the Plan's Specialty Pharmacy Program.

4. Injectable drugs administered by a Physician or nurse and drugs dispensed directly by a Physician unless obtained through the Plan's Specialty Pharmacy Program.
5. Prescriptions for conditions arising out of or caused by employment, including self-employment.
6. Any non-drug item, except as specifically mentioned as a covered benefit.
7. Progesterone used in the treatment of Premenstrual Syndrome (PMS).
8. Drugs used for cosmetic purposes.
9. Drugs dispensed for the treatment of infertility.
10. Drugs for weight loss and appetite suppressants.
11. Biological sera, blood or blood plasma, or any prescription requiring parenteral administration, except as specifically provided for.
12. Any prescription drug provided by or paid for by the United States government or any instrumentality of the United States government except as required by federal law.
13. Lost, stolen, spilled or broken prescriptions.
14. Prescription drugs that are not on the Formulary (unless an exception is filed by your Physician and approved by the Prescription Drug Program).
15. Appliances, prosthetics or Durable Medical Equipment.

G. Durable Medical Equipment Exclusions

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

H. Fertility and Infertility Services Exclusions

1. Expenses for the reversal of surgical sterilization, treatment of infertility along with services to induce pregnancy and complications resulting from those services, including, but not limited to: services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of egg/sperm, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and adoption expenses are not covered.
2. Charges incurred by a Plan Participant for a pregnancy that is expected to result in the adoption of the newborn by another party (surrogate pregnancy).

I. Foot Care/Hand Care Exclusions

1. Routine treatment of corns or calluses, paring of nails, or orthotics and casting of the feet except as specifically provided for under ***Durable Medical Equipment and Prosthetics*** and ***Special Services for Diabetic Patients***.

J. Genetic Testing and Counseling Exclusions

1. Expenses for and related to **Genetic Testing or Counseling** except for genetic testing and counseling required as a Preventive service, in accordance with Health Reform regulations.

K. Home Health Care Exclusions

1. **Expenses for "Custodial Care"** which means care and/or services which are provided to help a person to perform activities of daily living, including personal hygiene. Custodial care services include personal care, homemaking services, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered. Such services will be considered custodial regardless of who recommends, orders, provides or directs the care or of the setting the care is provided in.

L. Maternity/Family Planning/Contraceptive Exclusions

1. **Pregnancy related expenses of an eligible Dependent child**, or resulting complications except for all ACA-required pregnancy related services, including prenatal care.

2. **Termination of Pregnancy:** Expenses incurred in connection with an elective abortion, except for expenses directly attributable to complications arising from an elective abortion. ("Elective abortion" means any abortion other than one where the mother's life would be endangered if the fetus were carried to term).

For Nondurable supplies (see Corrective Appliances)

M. Mental Health and Substance Abuse Exclusions

1. The Trust Fund will not pay for services and supplies for which patients are not required to pay, or which are furnished by a hospital or facility operated by the federal government or any authorized agency thereof, or furnished at the expense of such government agency.
2. No payment will be made for court ordered services except those that Behavioral Health program would have deemed clinically necessary and appropriate were the court not involved.
3. This benefit excludes mental retardation, pervasive developmental disorders, and learning disabilities.

N. Nursing Care Exclusions

1. Expenses for services of private duty nurses/health care personnel.

O. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

1. Expenses for massage therapy and related services.
2. Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development.

P. Sexual/Erectile Dysfunction Services Exclusions

1. **Sex Change Counseling, Therapy and Surgery:** Charges for services associated with sexual reassignment or change or resulting complications, non-congenital transsexualism or gender dysphoria. Therapy, supplies or counseling for any type of sexual dysfunction or inadequacies.

Q. Transplant (Organ and Tissue) Exclusions

1. Expenses for transplants that are Experimental and/or Investigational.
2. For Plan Participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.

R. Vision Care Exclusions

1. Eye refractions, fitting of eyeglasses, or the cost of eyeglasses. (These benefits are provided under the Vision Benefit.)
2. Any surgical procedure to correct refractive errors of the eye, i.e. nearsightedness or farsightedness.
3. Orthoptics (Visual Therapy).

S. Weight Management and Physical Fitness Exclusions

1. Charges for weight control, weight reduction or treatment of obesity, including health club memberships, exercise and physical fitness programs, exercise equipment or spas. Surgical treatment of morbid obesity may be covered if preauthorized and approved by the Plan Administrator or its designee as Medically Necessary.
2. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, work hardening and/or weight training services.

VISION PLAN

Overview of the Vision Plan

The Vision Plan is designed to provide for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. Vision benefits are administered by an independent Vision Plan Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.

Eligibility for Vision Plan Benefits

You and your eligible Dependents are eligible for vision benefits on the date your medical Plan benefits become effective.

Vision Network

The Vision Plan contracts with an independent network of vision providers who extend a discount to you for covered vision services. Covered vision expenses are noted in the Schedule of Vision Benefits in this chapter and refer to the Allowed Charge for covered services up to the maximum allowed as payable under this Vision Plan.

Network Providers

Network providers have a contract to provide discounted fees to you for services covered under this Vision Plan.

Steps for using a Network provider are as follows:

Call any participating doctor to make an appointment. Identify yourself as a member of the Vision Plan and provide your member identification number (usually the last 4 digits of the Social Security Number of the Employee) and the name of the group Plan (***District Council 16 Northern California Health and Welfare Trust Fund***).

If you need assistance locating a participating doctor, call the Vision Plan at the number listed on the Quick Reference Chart at the front of this document or log on to the Vision Plan website and use the "Find a doctor" feature.

After you have scheduled an appointment, the participating doctor will contact the Vision Plan to verify your eligibility and coverage.

When you go for your visit, if you receive new lenses or frames you should pay the participating vision provider your copayment and charges for any costs not covered (see ***What Is Covered***, ***Optional Extras***, and ***Exclusions from Coverage*** below). The Vision Plan will pay the vision provider directly for the balance of the charges.

NOTE: You must identify yourself as a member of this Vision Plan at the time that you make the appointment with the in-network provider or you may not receive the in-network discounted rates.

Non-Network Providers

You may choose to use a Non-Network provider (any licensed and qualified vision care provider) instead of a Network provider. However, your benefits will then be limited to the applicable reimbursement allowances (after the copayment).

If you use a Non-Network provider, you will need to pay the doctor in full at the time of your visit. You may then file a claim with the Vision Plan for reimbursement according to a fixed schedule, which will not cover all of your vision expenses.

SCHEDULE OF VISION BENEFITS This chart shows what the Plan pays.			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Plan Exclusions section.*	**Plan Pays**	
		In-Network Provider	**Non-Network Provider**
Vision Examination	• One vision exam is payable once every 12 months.	100% after a $20 copay per exam.	After a $20 copay the Plan pays 100%, not to exceed $43 per exam.
Frames for Eyeglasses	• One frame is payable once every 24 months. • You are responsible for any amount of a frame that costs more than the Plan allowance.	100% after a $20 copay up to the Plan allowance. If you choose a frame whose cost exceeds the Plan allowance, you will be responsible for the additional cost.	After a $20 copay, Plan pays 100% to a maximum of $40.

Lenses for Eyeglasses	• Standard lenses are covered meaning you will be responsible for any of the additional costs of the following options:
	  • oversize lenses
	  • photochromic lenses or tinted lenses except Pink #1 and Pink #2
	  • progressive multifocal lenses
	  • coating of the lens or lenses
	  • laminating of the lens or lenses
	  • cosmetic lenses
	  • optional cosmetic processes
	  • ultraviolet protected lenses
	  • low vision care items not covered by your vision care benefits
		Single Vision (Standard): 100%
		Bifocals 100%
		Trifocals: 100%
			After a $20 copay the Plan pays:
			Single Vision: 100%, up to $26
			Bifocals: 100%, up to $43.
			Trifocals: 100%, up to $60
			Lenticular 100% up to $100
			If only one lens is needed, the allowance will be one-half the pair allowance.

SCHEDULE OF VISION BENEFITS This chart shows what the Plan pays.			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Plan Exclusions section.*	**Plan Pays**	
		In-Network Provider	**Non-Network Provider**
Contact Lenses: Contact Lenses will be considered Medically Necessary if you obtain prior authorization from the Vision Plan. Your eye care provider will need to furnish VSP with the information it needs to decide whether contact lenses are necessary for you. VSP providers will have a prior authorization form they can use for this purpose. Non-VSP providers should contact VSP to find out what is needed. Once a request for prior authorization is received (assuming it has all the required information), a decision is generally made within 3 to 5 days. If VSP decides contact lenses are not necessary for you, you may appeal the decision as explained in ***Claims Review Procedures*** in this booklet. You also have the option of having your lenses covered as elective contact lenses instead.	• The participant is to pay the difference between the cost of contact lenses and the amount allowed under this Vision Plan. • One set of medically necessary contact lenses are payable each calendar year. • One set of not medically necessary contact lenses are payable in lieu of all other exam, lens and frame benefits described in this chapter.	*Cosmetic Lenses (not medically necessary):* 100% after a $20 copay, up to $130 for the contact lens fitting and evaluation as well as materials. *Contact Lenses (medically necessary):* 100% after a $20 copay	Plan pays: *Cosmetic Lenses (not medically necessary):* 100%, up to $43 for the comprehensive exam and up to $100 for the contact lens fitting and evaluation as well as materials. *Contact Lenses (medically necessary):* After a $20 copay, 100%, up to $45 for the exam and up to $210 for materials and other fees.
Low Vision Benefit The Plan includes a low vision benefit for severe vision problems not corrected with regular lenses.	Benefits under this Plan include, but are not limited to: • supplemental testing for low vision evaluation • low vision prescription services • optical and non-optical aids.	Contact the Vision Plan for more information on available benefits.	

Note*: The limitations on frequency of services do not apply to VSP member doctor services for Dependent Children up to age 19.*

Additional Discounts

In addition to the benefits stated above, members are eligible for the following <u>with a Network Provider</u>:

- 20% discount on non-covered lens options;

- 20% discount on additional complete pairs of glasses and non-prescription sunglasses (including lens options);
- 15% off cost of contact lens exam (evaluation and fitting); and
- Discounts on Laser Surgery.

Vision Plan Exclusions

The following is a list of services and supplies or expenses **not covered (excluded) by the Vision Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Vision Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

1. Vision services and supplies that cost more than the Plan's allowance as noted in the Schedule of Vision Benefits.
2. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
3. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.
4. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK) except that this Vision Plan does offer a discount on laser eye surgery when performed by In-network Vision providers.
5. Services or materials provided as a result of any Workers' Compensation Law, or similar occupational health legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.
6. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
7. Experimental and/or investigational treatment or procedure.
8. Benefits incurred beyond the termination date of the Plan, unless COBRA coverage is in place.
9. Expenses related to complications of a non-covered service.

Filing a Vision Claim/Appealing a Denied Claim

NOTE: The discussion below applies to "post-service claims"—claims you submit after you have received a service. Requests for required pre-authorization to have contact lenses covered as "necessary" are also considered claims. See the box ***Obtaining Prior Authorization for Coverage of Necessary Contact Lenses*** above and ***Claims Filing and Appeal*** section of this booklet for more information.

If you use a Network provider, you will not need to file a claim form. You will pay your copayment at the end of your visit, and your provider will take care of billing the Vision Plan for the remainder.

If you use a Non-Network provider, you will need to file a claim for reimbursement of the applicable amount(s). Call the Vision Plan at the phone number listed on the Quick Reference Chart to have an Out-of-Network Reimbursement Form mailed or faxed to you (*you can also fill out the form online and print it out*). Mail the completed form with your itemized receipt to Vision Plan at the address listed on the Quick Reference Chart

NOTE: You must submit your claim **within 180 days** from the date on which covered expenses were incurred. Benefits will not be allowed if you submit your claim more than 180 days after the date on which covered expenses were incurred.

If you have any questions about submitting your claim, contact the Vision Plan.

For information on what to do if you disagree with the decision made in regard to your claim, see ***Claim Filing and Appeal Information*** chapter of this booklet***.***

DENTAL EXPENSE COVERAGE

Important note to Retirees: ***Retirees who elect to enroll in a dental Plan must pay the full cost of the coverage. The Trust Fund Office will provide you with information on the cost of each plan. If you do not enroll in a dental Plan when you retire, you will not be able to enroll at a later date.***

You have a choice between the Dental PPO Plan or one of two Pre-Paid Dental Plans listed on the Quick Reference Chart at the front of this document. If you choose one of the Pre-Paid Dental Plans, you and your eligible Dependents must receive your dental care from the dental office(s) in which you enroll.

Choice of Dental Plans

The Trust Fund offers active Employees and their eligible Dependents a choice between three dental plans: a self-funded Dental PPO Plan and two prepaid Dental Plans.

Dental PPO Plan

This Plan works like the Blue Cross Network (PPO) Plan. When you receive services, the Plan pays a percentage of covered costs; you pay the remaining percentage and any costs that aren't covered. The Plan is self-funded by the Trust Fund and administered by the Dental Plan listed on the Quick Reference Chart at the front of this document.

You may use any dentist you choose, but you will generally pay less out of pocket if you use a PPO dentist.

	Delta Dental Contracted Dentist	**Non-PPO Premier or Non-Delta Dental Dentist**
Calendar Year Maximum Active Plan	$2,000 (does not apply to Dependent Children of Active Employees up to age 19)	
Calendar Year Maximum Retiree Plan	$2,000	
Calendar Year Deductible	$50 per individual $100 per family	
Plan Paid Coinsurance	*Based on Delta Contracted Rates*	*Based on the Allowed Charges as determined by the Dental Plan*
• ***Diagnostic & Preventive***	100%, No Deductible	80%, No deductible
• ***Restorative***	80%	60%
• ***Oral Surgery***	80%	60%
• ***Periodontal***	80%	60%
• ***Endodontics***	80%	60%
• ***Prosthodontic***	80%	60%

	Delta Dental Contracted Dentist	Non-PPO Premier or Non-Delta Dental Dentist
Orthodontics • **provided only to Dependent Children** • **Limitations apply**	50% of Allowed Charges up to a Lifetime Maximum of $2,500 Benefits are payable in 3 installments automatically issued over the course of 12 months, beginning with the date of banding. The first installment is 50% of the orthodontic benefit and the remaining two installments of 25% are issued at 6 months and 12 months. If orthodontic treatment began before you become eligible, the Dental Plan's payments will begin with the first payment due to the dentist following your eligibility date.	

Covered Benefits in the Indemnity Dental Plan

Payment of Allowed Charges is based on the Dental Plan's contract with their network provider or the Dental Plan's determination of the Allowed Charges for non-PPO dentist. Non-PPO dentists may balance bill you for any billed charges that exceed that amount.

The Plan covers "Dentally Necessary" treatment that meets all of the following conditions:

- The care and treatment is appropriate given the symptoms, and is consistent with the diagnosis, if any. "Appropriate" means that the type, level, and length of service and setting are needed to provide safe and adequate care and treatment;
- It is rendered in accordance with generally accepted dental practice and professionally recognized standards;
- It is not treatment that is generally regarded as experimental or unproven; and
- It is specifically allowed by the licensing statutes which apply to the provider who renders the service.

In instances where there are optional methods of treatment, the allowance for the least expensive procedure will be paid.

Diagnostic and Preventive Care

The Dental Plan provides benefits for all necessary procedures to assist the dentist in evaluating the existing condition and the dental care needed by the patient. The following limitations apply:

- Diagnostic and preventive services are not subject to the annual Deductible.
- Charges for examinations and consultations are covered twice in a calendar year.
- Full mouth x-rays are covered once in each five year period while covered under any Dental Plan.
- Bitewing x-rays are covered twice in a calendar year for children under age 18 and once in a calendar year for adults, and are not payable as a separate benefit in the same year as a full-mouth series.
- Dental prophylaxis is covered twice per calendar year.
- Fluoride treatment is covered twice in a calendar year while covered under any Dental Plan.
- Space maintainers are covered through age 12 and not more than once every five years.
- Oral pathology charges for the examination of oral tissue are covered.
- Diagnostic casts are covered only as an orthodontic benefit.

Oral Surgery

The Plan provides benefits for extractions and other oral surgery including the following:

- Benefits for extractions include local anesthesia, x-rays and postoperative care.
- Benefits for the removal of tumors, cysts and neoplasms when a copy of the histopathological report is submitted.

Restorative Dentistry

The Dental Plan provides amalgam, synthetic porcelain and plastic restorations. The following services and limitations apply:

- Composite (resin) restorations are covered on anterior teeth and the facial surface of bicuspids. Posterior composite restorations are an optional benefit and payment is limited to the cost of the equivalent amalgam restoration.
- Sealants are covered for permanent non-restored teeth every 2 years. Restorations in teeth where sealants have been applied are covered after 12 months have elapsed since the application of the sealants. Replacement of sealants on non-carious teeth is covered only after two years.
- Replacement of an existing filling is covered after the previous filling has been in place for 24 months.
- Multiple fillings on a single tooth surface are covered as a single surface filling.
- Benefits for crowns, inlays, onlays and cast restorations are provided only when the tooth shows extensive coronal destruction, as documented by x-rays or study models, and the tooth cannot be restored with an amalgam or composite filling.
- Replacement of a cast restoration is limited to once every five years while covered under any Dental Plan unless the Dental Plan determines that the replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissue since the original placement.
- Benefits will be paid for repair or re-cementation of an inlay, onlay, bridge or crown after 12 months or more have elapsed since the initial placement or previous re-cementation or repair.

Endodontics

The Plan provides for pulpal therapy and root canal filling subject to the following:

- Endodontic therapy includes initial treatment, interim and final x-rays, temporary fillings and follow-up care.
- Pulpotomies are provided when performed on primary teeth that have not begun to exfoliate.
- Root canal therapy is covered once in a 12-month period.

Periodontics

The Plan provides benefits for procedures necessary for the treatment of diseases of the gums and bones supporting the teeth with the following limitations:

- If full quadrants do not require treatment, the benefit payable for root planing and gingival curettage is determined by the number of teeth that require treatment.
- Benefits for periodontal surgery are payable when need is documented following visits for non-surgical periodontal therapy and a subsequent re-evaluation.
- Covered non-surgical periodontal therapies include root planing and gingival curettage are covered no more frequently than every 24 months in each quadrant.

Prosthodontics

The Plan provides benefits for bridges, partial dentures and complete dentures. The Plan provides for replacement of missing teeth using standard techniques. The following are limitations on prosthodontic benefits:

- Prosthodontic appliances are covered only once every five years while eligible under any Dental Plan unless the Dental Plan determines that there has been such an extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory.
- Replacement of a second molar is covered only as part of a prosthesis that replaces adjacent missing teeth.
- The allowance for a removable partial denture includes all teeth and clasps.
- For patients under age 16, the Plan covers interim dentures.
- The Plan provides for a rebase once every two years.
- The Plan provides for a reline 12 months after a rebase or a previous reline.
- The Plan provides for a reline six months after the placement of a denture.
- The Plan provides for an office reline three months following placement of an immediate denture.

The following are **excluded** from prosthodontic benefits:

- Specialized techniques, personalization and characterization.
- Precision attachments.
- Experimental procedures.
- Surgical correction by grafts for denture retention purposes.
- Inter-occlusal recording or analysis.
- Unusual diagnostic techniques.
- Procedures associated with overdentures.
- Stress-breakers
- Appliances to alter vertical dimension.

General Limitations and Exclusions on PPO Dental Plan Benefits

- Charges for services with respect to congenital or developmental malformations, jaw repositioning, cosmetic surgery, or dentistry for solely cosmetic reasons except as specifically provided for under Orthodontic Care below.
- Services and supplies for which patients are not required to pay, or which are furnished by a hospital or facility operated by the federal government or any authorized agency thereof, or furnished at the expense of such government agency except to the extent that such services are reimbursable to the Veterans Administration for non-service connected conditions under 38 U.S.C. 629.
- Services and supplies which are furnished by any person, hospital or organization who or which, regardless of the patient's financial ability, normally makes no charge therefore in the absence of eligibility for dental benefits.
- Dental expenses incurred which may be paid under any other benefit provided by this Trust Fund.
- Any hospital costs or any fees charged by the dentist for hospital treatment.
- Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery.
- Charges made by a relative of the Participant, except for Allowed Charges which constitute out-of-pocket expenses to such providers.
- Services or supplies received as a result of accidental bodily injury or sickness arising out of, or in the course of, employment, including self-employment.
- Services not performed by a Dentist, except x-rays ordered by a Dentist and services by a licensed dental hygienist under the Dentist's supervision.
- Services or supplies which are not Dentally Necessary, not customarily provided for dental care, or that are primarily for cosmetic purposes.
- Dietary planning or oral hygiene instruction.
- Surgical Implants (materials implanted into or on bone or soft tissue) or the removal of implants. However, the Dental Plan will make an allowance for the appliance actually placed on the implant(s), i.e. crowns, bridges, partial or full dentures. Single crowns will be paid as a pontic. The Plan would then not pay for any replacement for at least 5 years.
- Athletic mouthpieces.
- Appliances, surgical procedures or restorations to restore tooth structure lost due to abrasion, erosion or attrition or to alter vertical dimension or for rebuilding or maintaining chewing surfaces due to teeth being out of alignment or occlusion, or for stabilizing teeth (such services include but are not limited to equilibration and periodontal splinting)
- Full mouth reconstruction and treatment of congenital malformations.
- Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

- Prosthodontic services or any single procedure started prior to the date you became eligible for services under this Trust Fund.
- Replacement of lost or stolen appliances which are less than five years old.
- Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues.
- Replacement of existing restorations for any purpose other than restoring structure damaged by active tooth decay.
- Laminate veneers.
- Outpatient prescription medication related to dental or orthodontic treatment (except for fluoride for children up to age 6 with a prescription).
- Charges for completion of claim forms.

Orthodontic Care under the PPO Dental Plan

The Plan provides benefits for orthodontic services <u>for Dependent children only</u> when rendered by a licensed dentist.

If care is terminated for any reason during the course of treatment, the obligation of the Plan will cease with payment to the date of termination. If, in the combined judgment of the attending orthodontist and the orthodontic consultant, the reason for termination of treatment was because of the failure of the patient to cooperate with the treatment plan, the patient would not be eligible for any further orthodontic benefits under the Indemnity Dental Plan.

The Plan provides benefits for corrective, interceptive and preventive orthodontic treatment to realign natural teeth, to correct malocclusion, to provide pre-orthodontic guidance and to provide growth and development evaluation.

Exclusions and Limitations on Orthodontics

Orthodontic treatment will not be provided for the following:

- Replacement of lost or broken appliances or retainers.
- Treatment rendered by an orthodontist who is not licensed.
- Orthodontic expenses incurred which may be paid under any other benefit provided by this Trust Fund.
- Orthodontic treatment arising out of, or in the course of, employment, including self-employment.
- Extended orthodontic treatment due to the Participant's failure to comply with treatment instructions.

How to File a Claim for PPO Dental Plan Benefits

You can obtain dental claim forms from the Trust Fund Office or the Dental Plan. Your dentist's office should also have standard claim forms that can be used.

If the treatment plan proposed by your dentist is extensive and involves crowns or bridges, or if the services will cost more than $300, you are encouraged to ask your dentist to request a predetermination, which will provide you with an <u>estimate</u> of the amount the Dental Plan will pay, assuming you are eligible at the time the services are actually provided.

If you go to a participating dentist and show your Delta Dental I.D. card, the dentist's office will complete the claim for you and send it directly to the Dental Plan. The Dental Plan will directly reimburse the dentist for the portion of covered expenses provided under the Plan.

If you use a non-participating dentist, you will usually need to file a claim yourself. Fill out your part of the claim form. Have the dentist's office complete its part of the claim form. Check the claim form to be certain that all applicable parts of the form are completed and that you are submitting all itemized bills. Your completed claim must be mailed to the Dental Plan at the address on the Quick Reference Chart at the front of this document.

You will be reimbursed directly from the Dental Plan for the percentage of Allowed Charges payable under the Plan. You will be responsible for your portion of the coinsurance and any billed charges that exceed the allowance made by Delta.

You must submit your claim to the Dental Plan within 6 months of the date services were provided.

For information on what to do if you disagree with the decision made in regard to your claim, see ***Claims Review Procedures*** section of this booklet.

PREPAID DENTAL PLAN OPTIONS

This section provides a brief summary of the fully insured dental Plan coverage available under the Fund. However, where this chapter deviates from the certificate of coverage and summary of benefits produced by the Dental Plan Insurance Company, the Insurance Company documents will prevail.

Please note that the two Pre-Paid Dental Plans are fully insured and are <u>not</u> subject to the requirements of Health Care Reform. Therefore, the calendar year and lifetime maximums will apply to <u>all</u> Plan Participants. In addition, Dependent Children are only eligible for dental coverage until the end of the month that they turn age 19 (or age 24 if a fulltime student).

Prepaid Dental Plan #1 (California only)

This Plan works like an HMO, which means that it is a "pre-paid" plan. There are no Deductibles, no claims forms to file, no annual maximums (except for accidental injury). The program provides the benefits described in the ***Description of Benefits and Copayments***, subject to the limitation and exclusions.

You must receive all of your services from your selected panel dentist. Services are covered as follows when you use a panel dentist:

- Diagnostic and preventive care, basic fillings, and endodontics are covered at no cost.
- You will be charged a copayment for a partial bony extraction or a completely bony extraction. Other oral surgery procedures are covered at no cost.
- You will be charged a copayment for a gingiovectomy, osseous or mucogingival surgery, and a visit for emergency periodontic treatment. Other than these costs, periodontic care is covered at no cost.
- You must pay the actual lab costs of precious metals used in prosthodontics. Other prosthodontic procedures are covered at no cost.
- You will be charged a copayment for orthodontia benefits plus a start-up fee. Both adults and children are eligible for benefits for orthodontia.
- You will be charged a copayment for emergency visits after hours and for failure to cancel and appointment.

The Group Dental Service Contract must be consulted to determine the exact terms and condition of coverage. An ***Evidence of Coverage*** will be sent to you upon enrollment.

No claim forms are necessary. Appeal procedures are provided in the ***Evidence of Coverage*** booklet provided by the Prepaid Dental Plan.

Prepaid Dental Plan #2

If you enroll in this Prepaid Dental Plan, you must complete an Enrollment Card. You do not need to select a specific dental clinic. However, services are only available from dentists who are contracted with Dental Insurance company listed on the Quick Reference Chart at the front of this document. Each time you receive services, it is your responsibility to confirm that the dentist providing the services is currently in the network. Call the Customer Service number on your ID card for up-to-date directory information. You must also show your ID card at the time of service.

You have no out-of-pocket cost for most covered services except for orthodontic care. There is also a fee for after-hours visits. No benefits are paid for services received from any dentist who is not a contracted dentist at the time the services are received. No claim forms are required.

Appeal procedures are provided in the ***Evidence of Coverage*** booklet provided by the Prepaid Dental Plan.

EMPLOYEE AND RETIREE DEATH BENEFITS

The benefits described in this section are available only to beneficiaries of active bargaining Employees and Retired bargaining Employees. No death benefits are payable for persons covered under this Trust Fund as non-bargaining Employees or as Dependents. Death benefits are funded directly by the Trust Fund.

Amount of Benefit

If you die from any cause while eligible for the death benefit provided by this Trust Fund, the Plan will pay your designated beneficiary a benefit as follows;

Active Bargaining Employee	$5,000
Retired Bargaining Employee	$2,500

Exclusions

If you are not actively at work or available for work on the day that you first become eligible for medical benefits from this Trust Fund, your death benefits will not become effective until you are actively at work. In addition, no death benefits will be paid for any loss that is caused directly or indirectly by:

- participation in, or the result of participation in, the commission of a felony, or a riot, or a civil commotion
- war or act of war, declared or undeclared, or any act related to war, or insurrection
- service in the armed forces of any country

Death Benefits During a Period of Disability

If you become totally disabled before you reach age 60 and while eligible for death benefits, your death benefits can be continued without any cost to you during that disability. For you to be eligible for this continuation, your condition must meet the Trust Fund's definition of total disability and you must submit satisfactory written proof of such disability. Contact the Trust Fund Office for more information.

When Eligibility for Death Benefit Ends

Your eligibility for the Death Benefit will terminate on the date you enter military service.

Your Beneficiary

Your designated beneficiary is the individual named on your ***Plan Enrollment Form***. If you designate more than one beneficiary and you do not specify the portion to be paid to each, the beneficiaries will share equally.

If a beneficiary is not living on the date the benefit becomes payable, then payment will be made equally to any remaining beneficiaries named by you, unless you had made written request to the contrary. In the event no designated beneficiary is living on the date the benefit becomes payable, payment will be made to the first individual(s) listed in the following order:

- to your legal spouse at the time of your death
- in equal portions to your surviving children
- in equal portions to your surviving parents, if both are living; if only one parent is living, to that parent
- in equal portions to your brothers and/or sisters
- to your estate

Upon final dissolution of your marriage, your designation of your former spouse as your beneficiary will be automatically revoked unless you provide the Trust Fund Office with an updated ***Plan Enrollment Form*** again designating your former spouse as your beneficiary.

You may change your designated beneficiary at any time. To do so, request a ***Plan Enrollment Form*** from the Trust Fund Office. Complete the card and return it to the Trust Fund Office. The beneficiary change will become effective upon receipt of the completed form by the Trust Fund Office.

How To File a Claim for Death Benefits

Your beneficiary should obtain a claim form from the Trust Fund Office. The completed form should be returned with any required documentation to the Trust Fund Office at the address listed on the Quick Reference Chart. The Trust Fund Office should receive notice of the claim within 90 days of your death or as soon thereafter as is reasonably possible. Any claim forms submitted over one year after Your death will not be covered under the Plan.

CLAIMS REVIEW PROCEDURES

The information in this section applies to the benefits provided under the ***Blue Cross Network (PPO) and the Blue Cross Network/Smart Choices (APPO) Plans and the Mental Health and Chemical Dependency Plan*** benefits that are paid directly by the Trust Fund.

The ***PPO Dental Plan*** is administered by Delta Dental and the ***Vision Care Plan*** is administered by VSP. You must first complete the claims appeals procedures of Delta Dental or VSP before making a voluntary appeal directly to the Board of Trustees as described in his section.

If you are in ***Kaiser (HMO), Kaiser/Smart Choices (HMO), DeltaCare USA*** or ***UHC Dental***, any applicable procedures for filing claims will be described in the ***Evidence of Coverage*** booklet provided by Kaiser, DeltaCare USA or UHC Dental. Those organizations also have their own review and appeals procedures, which are described in their materials and which You must follow.

Please note that **all questions and appeals regarding eligibility for coverage should be submitted to the Trust Fund Office.**

Guide to Using This Section for Retirees Eligible for Medicare or Retirees' Dependents Eligible for Medicare

If you are enrolled in the ***Blue Cross Network (PPO) Plan*** and you are a Retiree eligible for Medicare or a Retiree's Dependent eligible for Medicare:

- The claims involving prior approval (pre-service or urgent care claims) and the concurrent claims discussed below apply to you only for inpatient mental health or chemical dependency treatment and vision care.
- The post-service claims discussed below (claims for health care services already received) do apply to you. Note, however, the following points regarding medical claims:
  - You must submit your post-service medical claims to Medicare before submitting them to the Trust Fund.
  - The Trust Fund will provide medical benefits only as the secondary payer of medical benefits that have been paid primarily by Medicare.
  - The post-service claims procedures discussed below will apply to these secondary-payment benefits.
  - A claim regarding a rescission of coverage will be treated as a Post-Service Claim.

Types of Claims

Pre-service claims: A pre-service claim is a request for authorization of care or treatment that requires approval in whole or in part before the care or treatment is obtained (also called "prior authorization").

Under this Trust Fund, prior approval of services is required for:

- non-emergency hospital admissions (unless the stay is for childbirth, in which case no prior approval is required for a stay of up to 48 hours following a vaginal delivery or 96 hours following a cesarean section, or the Trust Fund is the secondary payer of benefits),
- all inpatient mental health or chemical dependency treatment, and
- contact lenses to be covered on a "necessary" basis.

If you fail to obtain prior approval for these services, your benefits may be reduced.

Urgent care claims: Your request for a required prior authorization will be considered an urgent care claim if it needs expedited handling—if applying the time frames allowed for a pre-service claim (generally 15 - 30 days for a request submitted with sufficient information):

- could seriously jeopardize your life or health or your ability to regain maximum function; or

- in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

The applicable urgent care claim reviewer, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine, will determine whether your claim is an urgent care claim. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an urgent care claim within the meaning above will be treated as an urgent care claim.

Concurrent care (ongoing treatment) decisions: A concurrent care decision is a decision that is reconsidered after an initial approval was made, resulting in a reduction, termination, or extension of a benefit. (For example, an inpatient hospital stay originally prior approved for 5 days is subjected to concurrent review at 3 days to determine if the full 5 days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved as an urgent care claim.

Post-service claims: Any other type of health care claim is considered a post-service claim—for example, a claim submitted for payment after health care services and treatment have been obtained. A claim regarding rescission of coverage will be treated as a post-service claim.

What is NOT a "Claim"

The following are not considered claims and are thus not subject to the requirements and time frames described in this section:

- Simple inquiries about a Plan's provisions that are unrelated to any specific benefit claim.
- A request for an advance determination regarding this Trust Fund's coverage of a treatment or service that does not require prior authorization.
- A prescription you present to a pharmacy to be filled. (However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures in this section).

Filing Claims

Information on how to file claims is included in the chapters covering each Plan of benefit described in this booklet. The information is summarized below.

- **Pre-service claims for hospital admissions not involving mental health or chemical dependency**: Have your physician call Anthem Blue Cross at **800-274-7767** to request pre-authorization. If your physician thinks your condition warrants handling of your request as an urgent care claim, make sure the representative who takes your call is advised of this.
- **Pre-service claims for hospital admissions involving mental health or chemical dependency treatment**: Call BEAT IT at **800-828-3939** or Anthem Blue Cross at **800-774-7767** to request prior authorization. If your condition warrants handling of your request as an urgent care claim, make sure the representative who takes your call is advised of this.

"Urgent Care Claim" Does Not Mean Emergency Care or Care at an Urgent Care Facility

Urgent care claims should not be confused with emergency care or treatment at an urgent care facility, which do not require prior authorization. See ***Urgent Care Claims*** under ***Types of Claims*** above for an explanation of when a request for prior authorization might need to be handled as an urgent care claim.

- **Pre-service claims for contact lenses to be covered on a "necessary" basis**: VSP providers will have a prior authorization form they can use for this purpose. Non-VSP providers should contact VSP to find out what information they need to submit to VSP.

- **Post-service claims for medical benefits**: All claims for medical benefits should be submitted directly to Anthem Blue Cross electronically. For services rendered outside the state of California, claims should be submitted to the local Blue Cross in the state where the service is rendered.
- **Post-service chiropractic benefits for Kaiser (HMO) and Kaiser/Smart Choices (HMO) participants:** if you have received services for chiropractic care, have your provider send the bill to the following address:

  District Council 16 Northern California Health and Welfare Trust Fund
  P.O. Box 24454
  Oakland, CA 94623

- **Post-service claims for prescription drugs:** *(necessary only if you do not present your WellDyne ID card when you have prescriptions filled or you use a non-participating pharmacy).* Send your claim with a prescription receipt (not just a cash register receipt) to the following address:

  WellDyne Rx
  PO Box 4517
  Englewood, Colorado 80155-4517

- **Post-service claims for mental health or chemical dependency benefits**: Check with your provider; he or she may submit claims to Anthem Blue Cross or Beat-IT on your behalf. If not, send the claim to the following address:

  District Council 16 Northern California Health and Welfare Trust Fund
  P.O. Box 24454
  Oakland, CA 94623

- **Post-service claims for dental benefits under the PPO Dental Plan**: Obtain a claim form from Delta Dental, the Trust Fund Office, or your dentist's office. After you and your dentist have completed it, it should be sent to the following address:

  - ***Delta Dental Plan of California***
    P.O. Box 7736
    San Francisco, CA 94120

- **Post-service health care claims for vision care benefits**: No claim form will be necessary if you use a VSP provider. If you use a non-VSP provider, send your Out-of-Network Reimbursement Form (available at **www.vsp.com** or **800-877-7195**) with your itemized receipt to the following address:

  Vision Service Plan
  Attn: Out-of-Network Provider Claims
  P.O. Box 997105
  Sacramento, CA 95899-7105

- **Death Benefit claim**. Your beneficiary should contact the Trust Fund Office to obtain a death benefit claim form. The form should be completed and returned with a certified copy of the death certificate.

Using an Authorized Representative

An authorized representative, such as your spouse, may complete a claim submission for you if you have previously designated the individual to act on your behalf (you can obtain a form from the Trust Fund Office to designate an authorized representative). The Trust Fund may request additional information to verify that this person is authorized to act on your behalf.

In the case of an urgent care claim, a Physician with knowledge of your condition may act on your behalf even without written authorization.

When Claims Must Be Filed

Your claim will be considered to have been filed as soon as it is received by the applicable review authority: Anthem Blue Cross for pre-service/urgent care claims, and concurrent care decisions involving medical benefits, and post-service claims, BEAT IT for pre-service/urgent care claims, concurrent care decisions and post-service claims involving mental health and chemical dependency benefits, VSP for pre-service claims for necessary contact lenses, the Trust Fund Office for Kaiser chiropractic claims, WellDyne for post-service prescription drug claims, Delta Dental for post-service dental claims, VSP for post-service vision care claims, the Trust Fund Office for life insurance claims.

Pre-service and urgent care claims must be filed before services are obtained. (*Remember that an urgent care claim is not to be confused with emergency care or care received at an urgent care facility.)*

You must submit all other medical, prescription drug or mental health and chemical dependency claims **within 90 days** of the date of service and all other vision care claims **within 180 days** of the date of service. Dental claims must be submitted **within 6 months** of the date of service. Benefits will not be paid for any claims not filed within 12 months from the later of the date the expense was incurred or the date of payment under another plan that is primary payer.

Claims for death benefits should be submitted to the Trust Fund Office to allow sufficient time for processing **within 90 days** of the death or as soon thereafter as reasonably possible but not later than one year. Benefits will not be paid for any claims not filed within 12 months from the date of the death.

Notification That Your Pre-Service or Urgent Care Claim Has Not Been Properly Filed

If your **pre-service** health care claim has been improperly filed, Anthem Blue Cross, BEAT IT, or VSP will notify you as soon as possible but no later than **5 days** after receipt of the claim of the proper procedures to be followed in filing a claim.

If your **urgent care** claim has been improperly filed, Anthem Blue Cross or BEAT IT will notify you as soon as possible but no later than **72 hours** after receipt of the claim of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim.

You or your provider will receive notice that you have improperly filed your claim only if the claim includes your name, your specific condition or symptom, and a specific treatment, service, or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

Timing of Initial Claims Decisions

A determination on your claim will be made within the following time frames:

- **Pre-service claims**: If your pre-service health care claim has been properly filed, Anthem Blue Cross, BEAT IT, or VSP will notify you of its decision within **15 days** from the date your claim is received, unless additional time is needed. The time for response may be extended by up to **15 days** if necessary due to matters beyond the control of Anthem Blue Cross, BEAT IT, or VSP. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which Anthem Blue Cross, BEAT IT, or VSP expects to make a decision.

  If an extension is needed because Anthem Blue Cross, BEAT IT, or VSP needs additional information from you, Anthem Blue Cross, BEAT IT, or VSP will notify you as soon as possible, but no later than **15 days** after receipt of the claim, of the specific information necessary to complete the claim. In that case you and/or your doctor will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). Anthem Blue Cross, BEAT IT, or VSP then has 15 days to make a decision and notify you of the determination.

- **Urgent care claim**: You will be notified of a determination by telephone as soon as possible, taking into account the exigencies of your situation, but no later than **72 hours** after receipt of the claim by Anthem Blue Cross or BEAT IT. The determination will also be confirmed in writing.

If your urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, Anthem Blue Cross or BEAT IT will notify you as soon as possible, but no later than **72 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must respond to this request within **48 hours**. Notice of a decision will be provided no later than **48 hours** after Anthem Blue Cross or BEAT IT receives your response, but only if it is received within the required time frame.

- **Concurrent care decision**: A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than by Plan amendment or termination) will be made by Anthem Blue Cross or BEAT IT as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

  A request by you to extend approved urgent care treatment will be acted upon by Anthem Blue Cross or BEAT IT within **72 hours** of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment.

- **Post-service claims**: Ordinarily, you will be notified of the decision on your post-service health care claim within **30 days** of the date the Trust Fund Office, WellDyne, BEAT IT, Delta Dental, or VSP receives the claim. This period may be extended one time by up to **15 days** if the extension is necessary due to matters beyond the control of the Trust Fund Office, WellDyne, BEAT IT, Delta Dental, or VSP. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Trust Fund Office, WellDyne, BEAT IT, Delta Dental, or VSP expects to make a decision.

  If an extension is needed because the Trust Fund Office, WellDyne, BEAT IT, Delta Dental, or VSP needs additional information from you, the Trust Fund Office, WellDyne, BEAT IT, Delta Dental, or VSP will notify you as soon as possible, but no later than **30 days** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor or dentist will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Trust Fund Office, WellDyne, BEAT IT, Delta Dental, or VSP then has **15 days** to make a decision on your post-service claim and notify you of the determination.

- **Death Benefit claims**: The Trust Fund will ordinarily make a decision on a claim for death benefits within **90 days** of receipt of the claim. This period may be extended by up to **90 days** if the extension is necessary due to matters beyond the control of the Trust Fund. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Trust Fund expects to make a decision.

Denied Claims (Adverse Benefit Determinations)

It is not unusual that some of the charges submitted for a particular claim are not payable by this Trust Fund. Some examples of reasons for denial are: (1) the expense is incurred during a month the Participant is not covered by this Trust Fund, (2) the expense is related to an on-the-job injury, or (3) the expense is not recognized as a Covered Charge under the Plan. Of course, these are not all the possible reasons a claim may be denied; they are only examples.

You will be provided with written notice of an adverse benefit determination, whether your claim is denied in whole or in part. This notice will include the following:

- identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
- the specific reason(s) for the determination, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

- reference to the specific Plan provision(s) on which the determination is based
- a description of any additional material or information needed to perfect your claim and an explanation of why the material or information is needed
- a description of the Trust Fund's internal appeal procedures and external review process and the time limits applicable to such procedures
- if an internal rule, guideline, protocol, or other similar criterion was relied upon, a copy of the rule, guideline, protocol, or criterion or a statement that it is available upon written request at no charge
- if the decision was based on the absence of Medical Necessity or the treatment's being Experimental or Investigational or other similar exclusion, an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your claim, or a statement that such an explanation is available upon written request at no charge;
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Trust Fund Office to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 510-864-6444 or 800-922-9902.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 510-864-6444 or 800-922-9902.
- CHINESE (**中文**): **如果需要中文的帮助**，请拨打这个号码510-864-6444 or 800-922-9902.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 510-864-6444 or 800-922-9902.

For urgent care claims, the notice will describe the expedited review process applicable to urgent care claims. For urgent care claims, the required determination may be provided orally and followed with written notification.

For pre-service and urgent care claims, you will receive notice of the determination even when the claim is approved.

Request for Review of an Adverse Benefit Determination

Information on appeals for Indemnity Dental Plan benefits or Vision Care benefits is omitted from the discussion that follows. For Indemnity Dental or Vision claims, you must exhaust the appeals process with Delta Dental or VSP first. (See the materials from Delta Dental or VSP.) You may then file an appeal with the Trust Fund's Board of Trustees. If your prescription drug claim is denied by WellDyne you should contact the Trust Fund Office.

If you disagree with the decision made on a claim, you may ask for a review (appeal the decision). Your request for review must be made in writing (or by telephone, for urgent care claims appeals).

Appeals of decisions on urgent care claims or concurrent care decisions should be submitted to Anthem Blue Cross or BEAT IT, as applicable. **All other appeals of adverse determinations based on benefits or eligibility should be submitted to the Trust Fund Office.** You must submit your appeal by the applicable deadline below:

- within **180 days** after you receive the notice of denial for a claim involving health care (or, in the case of a concurrent care decision, within a reasonable time, given the exigencies of your situation); or
- within **60 days** after you receive the notice of denial for other claims.

When appealing, you must state your reason for disputing the denial and furnish any pertinent material not already furnished. You have the right to submit comments, documents, records, and other information in support of your claim for benefits.

Failure to file an appeal that meets the criteria above will constitute a waiver of your right to a review of the denial of your claim.

Please note that a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time is considered an adverse benefit determination. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Review Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record, or other information is relevant if it was relied upon in making the decision; it was submitted, considered, or generated in connection with the claim (regardless of whether it was relied upon); it demonstrates compliance with this Trust Fund's administrative processes for ensuring consistent decision-making; or it constitutes a statement of this Trust Fund's policy regarding the denied treatment or service. You will be provided reasonable access to such documents or copies of them free of charge upon written request. Such documents will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Upon written request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on your claim, regardless of whether their advice was relied upon.

Your appeal will be decided by an individual or individuals who did not take part in the original claim denial and are not subordinates of the person who originally denied the claim. No deference will be given to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments as may be submitted by you.

The Trust Fund Office will send pre-service claim appeals to an independent review organization before providing all relevant information to the subcommittee of the Board of Appeals that will make the decision.

If your claim involves a medical judgment, a health care professional with training and experience in the relevant field of medicine will be consulted (one who did not take part in the claim denial and who is not the subordinate of such a person).

Notice of Decision on Appeal

You will receive notice of the decision made on your appeal according to the following timetable:

- **Pre-service claims**: You will be sent a notice of a decision on review within **30 days** of receipt of the appeal by the Trust Fund Office.
- **Urgent care claims**: You will be sent a notice of a decision on review within **72 hours** of receipt of the appeal by Anthem Blue Cross or BEAT IT.
- **Concurrent care decisions**: You will receive notice of a decision on review within a reasonable amount of time for the type of care.
- **Post-service claims**: Ordinarily, decisions on appeals will be made **at the next regularly scheduled meeting of the Board of Trustees** after your request for review is received. However, if your request for review is received at the Trust Fund Office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. If such a delay is necessary, you will be advised in writing of the special circumstances and the date by which a decision will be made. You will be notified of the decision no later than **5 days** after it is reached.
- **Death Benefit claims**: Decisions will ordinarily be made within **60 days** of receipt of the appeal by the Trust Fund Office. The period for making a decision may be extended by up to **60 days,**

provided the Trust Fund notifies you, prior to the expiration of the first 60 days, of the circumstances requiring the extension and the date as of which the Trust Fund expects to render a decision.

If Your Appeal is Denied

NOTE: If your appeal of a decision on an urgent care claim is denied by Anthem Blue Cross or BEAT IT, you may voluntarily resubmit your appeal to the Trust Fund Office under the pre-service claim rules. It will then be reviewed by the appeals subcommittee of the Board of Trustees.

If your appeal is denied, you will receive written notice of that appeal determination including:

- information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an external review;
- the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- an explanation of the Plan's external review process, along with any time limits and information regarding how to initiate the next level of review;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Trust Fund Office to find out if assistance is available.

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- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 510-864-6444 or 800-922-9902.
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- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 510-864-6444 or 800-922-9902.

The denial of a claim to which the right to review has been waived, or the decision of the Board or its designated appeals committee with respect to a petition for review, is final and binding upon all parties, including the claimant or the petitioner, subject only to any civil action you may bring under ERISA or any External Review rights. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration.

If you are not satisfied with the decision made on your appeal, you may file a civil lawsuit in Federal court against the Trust Fund under ERISA. However, no legal action for benefits from this Trust Fund shall be brought unless and until you have

- submitted a claim for benefits,
- been notified that the claim is denied (or the claim is deemed denied),
- filed a timely appeal for review, and
- been notified in writing that the denial of the claim has been confirmed (or the claim is deemed denied on review).

("Deemed denied" means that you filed a claim or an appeal and had not received any response by the expiration of the response time allowed for the type of claim.)

External Review of Claims

This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements as set forth in Interim Final Regulations implementing the ACA and in Technical Release 2010-01. For purposes of this section, references to "you" or "your" include you, your covered Dependent(s), and you and your covered Dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

You may seek further, external review by an Independent Review Organization ("IRO"), if your appeal of a health care claim, 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, 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 if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.**

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.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

External Review of Standard (Non-Urgent) Claims.

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an Initial Claim Benefit Determination or adverse Appeal Claim Benefit Determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

Because the Plan's internal review and appeals process, generally, must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

An external review request on a standard claim should be made to the Trust Fund Office.

Preliminary Review of Standard Claims

Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

(a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(b) The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

(c) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

(d) You have provided all of the information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

(a) If your request is complete and eligible for external review; or

(b) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

(c) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review of Standard Claims by an Independent Review Organization (IRO)

If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

(b) Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

(c) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals,

appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(e) The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review.

1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, 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.

2) If the final external review upholds the Plan's Adverse 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).

(f) The assigned IRO's decision notice will contain:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

2) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

4) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

5) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

6) A statement that judicial review may be available to you; and

7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

8) The IRO will also provide the Notice in Spanish, upon request.

External Review of Expedited Urgent Care Claims

You may request an expedited external review if:

(a) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

(b) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review for an Expedited Claim

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g. telephonically) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

Review of Expedited Claim by an Independent Review Organization (IRO)

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (e.g. meaning via telephone, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(a) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan my, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(b) If the final external review upholds the Plan's Adverse 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).

Limitation on When a Lawsuit may be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision.

No lawsuit may be started more than three years after the end of the year in which services were provided.

Discretionary Authority for Plan Benefit Interpretation, Administration and Operation

The Board of Trustees of the Trust Fund is the named fiduciary with the authority to control and manage the operation and administration of the Trust Fund. The Board shall make such rules, interpretations, and computations and take such other actions to administer the Plans of Benefits offered by the Trust Fund as the Board, in its sole discretion, may deem appropriate. The rules, interpretation, computations, and actions of the Board shall be binding and conclusive on all persons. The Board of Trustees, and/or persons appointed by the Board of Trustees, shall have full discretionary authority to determine eligibility for benefits and to construe terms of the Plans of Benefits payable, and any rules adopted by the Board of Trustees.

The Trust Fund recognizes that new technologies may develop which are not specifically addressed. The Trust Fund reserves the right to determine whether or not a service or supply is covered, and if covered, to determine Allowed Charges. If a Participant selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Trust Fund reserves the right to consider alternate professionally acceptable services and supplies as the basis for benefit consideration.

The Board of Trustees may engage such Employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or other persons to render advice and/or perform services with regard to any of its responsibilities under the Trust Fund, as it shall determine to be necessary and appropriate.

Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by this Trust Fund because you are incompetent, incapacitated or in a coma, this Trust Fund may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Trust Fund benefits will completely discharge this Trust Fund's obligations to the extent of that payment. Neither this Trust Fund, the Plan Administrator, Trust Fund Office, nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

COORDINATION OF BENEFITS (COB)

How Duplicate Coverage Occurs

This chapter describes the circumstances when you or your covered Dependents may be entitled to health care benefits under this Plan and may also be entitled to recover all or part of your health care expenses from some other source. In this chapter the term "you" references all covered Plan Participants. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. Duplicate coverage can occur if you or a covered Dependent is also covered by:

- Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage); or
- Medicare; or
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Workers' compensation.
- Coverage resulting from a judgment at law or settlement.
- Any responsible third party, its insurer, or any other source on behalf of that party.
- Any first party insurance (e.g. medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage).
- Any policy from any insurance company or guarantor of a third party
- Any other source (e.g. crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party.

Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

This chapter describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this chapter). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

Coverage Under More Than One Group Health Plan

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits chapter, the word "Plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Covered Individual or that provides health care services to the Covered Individual. A "Group Plan" provides its benefits or services to Employees, Retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA Continuation Coverage).

2. Many families have family members covered by more than one medical or dental Plan. If this is the case with your family, **you must let this Plan and its Claims Administrators know about <u>all</u> medical and dental Plan coverage's when you submit a claim.**

3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the Plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

A. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. 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-insured plans. **Any group plan that does not use these same rules always pays its benefits first. This Plan does not coordinate benefits with an individual plan including a plan purchased through the Health Insurance Marketplace.**

B. When two group 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 a 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 as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), 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 (that is, the plan covering the person as 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 other than as a dependent (that is, as a Retired Employee) 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 does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that 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 expenses, 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.

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 laid-off nor retired), or as that active Employee's dependent, pays first; and the plan that covers the same person as a laid-off or Retired Employee, or as that laid-off or Retired Employee's dependent, 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 as a laid-off or Retired 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 that 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 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 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.

How Much This Plan Pays When It Is Secondary:

Secondary Liability of this Plan: When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that paid first. In no case will this Plan pay more in benefits for each claim as it is submitted than it would have paid had it been the Plan that paid first. This has the effect of maintaining this Plan's Deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the health care services.

"Allowable Expense" means a health care service or expense, including Deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or

service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest allowed charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits on the basis of an Allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the Fund's payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Review in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of COB

1. To administer COB, the Plan reserves the right to:
   - exchange information with other plans involved in paying claims;
   - require that you or your Health Care Provider furnish any necessary information;
   - reimburse any plan that made payments this Plan should have made; or
   - recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.
2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
4. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.
5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowed charge.
6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must

execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Coordination of Benefits With Medicare

A. Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).

B. Medicare Participants May Retain or Cancel Coverage Under This Plan: If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible Employee remains actively employed, that Employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an Employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of the eligible Employee's Dependents are covered by Medicare and the Employee **cancels** that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the Employee. Neither this Plan nor the Employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

C. Coverage Under Medicare and This Plan When Totally Disabled: If an eligible Employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible Employee will no longer be considered to remain actively employed. As a result, once the Employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible Dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that Dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more Employees.

D. Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan 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.

How Much This Plan Pays When It Is Secondary to Medicare

1. **When Covered by this Plan and also by Medicare Parts A and B:** When an eligible individual under this Plan is also covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active Employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.

2. **When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits:** If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will **not coordinate** with the Medicare Advantage plan, meaning that this plan will not pay any expenses that are not otherwise payable by the Medicare Advantage plan.

   Also, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, prior authorization, or utilization of In-Network provider requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

3. **When Covered by this Plan and Eligible for but Not Covered by Medicare:** When the Covered individual is covered by this Plan and is also eligible for, but is not enrolled in Medicare Parts A, B and/or D, this Plan pays the same benefits provided for active Employees less the amounts that would have been paid by Medicare had the individual been covered by Medicare Parts A, B and/or D.

   IMPORTANT: You must enroll in both Part A and Part B of Medicare when you first become eligible. The plan will estimate Medicare Part A and B benefits if you fail to enroll for Medicare when eligible. Your out-of-pocket expense will be greatly increased if you fail to enroll in Medicare Part B.

4. **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

5. **When Covered by this Plan and also by a Medicare Part D Prescription Drug Plan:** If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:
   a. For Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage is primary and this group health plan pays secondary. Note that dual coverage may affect your Out-of-Pocket maximum under your Medicare prescription drug plan.
   b. For Medicare eligible Active Employees and non-Medicare eligible Retirees and individuals no longer actively employed but still receiving benefits based on hours accumulated when they were working and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

   For more information on Medicare Part D refer to www.medicare.gov or contact the Trust Fund Office.

Coordination with Government and other Programs

A. **Medicaid**: If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

B. **TRICARE**: If a Dependent is covered by both this Plan and the TRICARE Program (formerly known as the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS) that provides health care services to Dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this

Plan, TRICARE is primary and this plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

C. **Veterans Affairs/Military Medical Facility Services**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are Allowed Charges.

D. **Motor Vehicle Coverage Required by Law**: If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

E. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

F. **Other Coverage Provided by State or Federal Law**: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Worker' Compensation

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Plan Administrator, the Board of Trustees or the Claims Administrator of their rights to recover any payments that the Plan has advanced.

Subrogation and Reimbursement

If a Participant is injured through the act or omission of another party, benefits are provided only on certain conditions. A Participant is required to promptly reimburse the Trust Fund from any proceeds received by way of settlement, verdict, judgment or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of a medical claim by the Participant or his heirs, parents or legal guardians, to the extent of benefits paid or to be paid by the Trust Fund for which the third party is responsible.

Any Participant who accepts Trust Fund benefits agrees that by doing so he is making a present assignment of his rights against a third party to the extent of the payments made by the Trust Fund (and any attorney's fees and costs incurred by the Trust Fund). These rules are automatic, but the Trust Fund will require that a Participant sign an agreement to reimburse or assignment of recovery form(s). Any Participant who refuses to sign an agreement or assignment shall not be eligible for Trust Fund benefit payments related to the injury involved. Any Participant who receives benefits and later fails to reimburse the Trust Fund will be ineligible for future Trust Fund benefits until the Trust Fund has withheld an amount equal to the amount which the Participant failed to reimburse. This amount may also include reasonable interest on such unpaid funds and reimbursement for any attorney fees and costs incurred by the Trust Fund.

By accepting benefits provided by the Plan, a Participant agrees that:

- The Plan has the right to intervene, independently of the Participant, in any legal action brought against the third party or any insurance company, including the Participant's own carrier for uninsured motorist's coverage.
- An equitable lien by agreement shall exist in favor of the Trust Fund upon all funds recovered by the Participant against the third party. The lien shall apply whether or not the recovery is in the possession of

the Participant, including situations in which the recovery has been placed in a special needs trust. The lien may be filed with the third party, the third party's agent, or the court. The Participant shall provide the Trust Fund with all relevant information or documents requested.

- The Trust Fund's Subrogation and Reimbursement rights shall be considered as a first priority claim against another person or entity, to be reimbursed before any other claims (including claims for general damages).
- The Participant will not release any party from liability for payment of medical expenses without first obtaining written consent from the Trust Fund.
- If the Participant enters into litigation or settlement negotiations regarding obligations of or claims against another party, the Participant will notify the Trust Fund and shall take no action to prejudice the Trust Fund's rights.
- The Participant agrees that the Trust Fund shall be responsible only for those legal fees and expenses to which the Trust Fund agrees in writing. Unless the Trust Fund agrees otherwise, the rights of the Trust Fund to recover the amount of benefits issued shall in no way be diminished by the cost of a Participant's legal representation.
- The Participant agrees to hold proceeds of any settlement, verdict, judgment, or other recovery in trust for the benefit of the Trust Fund, and that the Trust Fund shall be entitled to recover reasonable attorney fees incurred in collecting reimbursement of benefits issued.
- In addition to all other remedies that the Trust Fund may have, the Trust Fund shall be subrogated to the rights of the Participant or his beneficiary against the responsible third party or its insurer.
- Any "make-whole" rule of federal or state law is expressly rejected and shall not be applicable to this Trust Fund, so that a Participant need not be made whole before the Trust Fund can enforce its Right of Reimbursement.

Rights of the Board of Trustees (Authority to Make Changes)

The Board of Trustees of the ***District Council 16 Northern California Health and Welfare Trust Fund*** expressly reserves the right to amend, modify, revoke, or terminate the benefits provided, in whole or in part, at any time. Benefits provided under this Trust Fund are not vested. The Board of Trustees expressly reserves the right, in its sole discretion, to:

- terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
- alter or postpone the method of payment of any benefit; and
- amend, terminate or rescind any provision of the Trust Fund; and
- merge the Trust Fund with other plans, including the transfer of assets.

The authority to make any such changes to the Trust Fund rests solely with the Board of Trustees. Any amendment, modification, revocation, or termination of the Trust Fund is made by a resolution adopted by the Board of Trustees. No individual Trustee, Union representative, or Employer representative is authorized to interpret the Benefit Plans offered by this Trust Fund on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees. The provisions of the Trust Fund are subject to and controlled by provisions of the Trust Agreement, and in the event of any conflict between provisions of this ***Summary Plan Description*** and provisions of the Trust Agreement, provisions of the Trust Agreement shall prevail.

Right to Recover Excess Payments

If a benefit payment has been made by this Trust Fund which exceeds the amount that should have been paid under the Trust Fund, the Trust Fund has the right to recover (including the right to offset against future benefit payments) overpaid amounts from any person or organization to, or for whom, said payments were made, or from any person whose intentional or negligent acts, omissions, or representations caused overpaid amounts to be paid. No Participant shall be required to pay more than the amount actually overpaid. In the event the Trust Fund brings legal action to recover any overpayment, the Trust Fund is entitled to recover its costs and attorney's fees incurred in such action. (Refer also to ***Subrogation and Reimbursement*** above).

COBRA: TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

Continuation of Coverage (COBRA)

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible Employees, eligible Retirees and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

IMPORTANT:

This chapter serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to all covered Employees Retirees, and their covered Spouses and is intended to inform them (and their covered Dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this notice carefully and be familiar with its contents.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered Employees and Retirees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Employee or Retiree or the Spouse or Dependent Child of an Employee or Retiree who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   - A child of the covered Employee or Retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee's or Retiree's period of employment, is entitled to the same rights under COBRA as an eligible Dependent Child.
   - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces (or legal separation) before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event"**: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* Employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	**Duration of COBRA for Qualified Beneficiaries[1]**		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the same coverage). This is if you lose eligibility due to working less than 100 hours in a month and having less than 100 hours in your hour bank reserve.	18 months	18 months	18 months
Employee or Retiree dies.	N/A	36 months	36 months
Employee or Retiree becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or coverage is substantially reduced within one year before or after the employer files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Retiree: for Life	Varies[2]	Varies[2]

1: When a covered Employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Children who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

2: Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain Retirees and their related Qualified Beneficiaries such as COBRA coverage for the life of the Retiree. The Retiree's Spouse and Dependent Children are entitled to COBRA for the life of the Retiree and if they survive the Retiree, for 36 months after the Retiree's death. If the Retiree is not living when the Qualifying Event occurs, but the Retiree's surviving Spouse is alive and covered by the Group Health Plan, then that surviving Spouse is entitled to coverage for life.

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that failure to continue your group health coverage will affect your future rights under federal law, You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap. Some group health plans are permitted to continue their pre-existing condition limitation up to the first day of their plan year in 2014.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Medicare benefits within the time period prescribed by law. Generally a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs.**

That written notice should be sent to the Trust Fund Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name and Social Security number, the name of the Fund (***District Council 16 Northern California Health and Welfare Trust Fund***), the event you are providing notice for, the date of the event, and the individual(s) affected by the Qualifying Event and their relationship to you.

If the Qualifying Event is your divorcing your spouse, you must provide a copy of the divorce decree as soon as it becomes available.

If you have any questions about how to notify the Trust Fund of one of these events, please call the Trust Fund Office.

NOTE: If such a notice is not received by the Trust Fund Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Officials of the Employee's own employer should notify the Trust Fund Office of an Employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the Trust Fund Office in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When you or your employer notifies the Plan that your health care coverage has ended due to a Qualifying event, **then** the Trust Fund Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered Dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about

how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active Employees and their families, that same change will apply to your COBRA Continuation Coverage.

You and/or Your Dependents may elect:

- medical/prescription drug/substance abuse and mental health benefits, or
- medical/ prescription drug/substance abuse/mental health, dental, and vision benefits.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active Employees and families, plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Your ***first*** payment for continuation coverage must include payments for any months retroactive to the day your and/or your Dependents' coverage under the Trust Fund terminated. This payment is due no later than 45 days after the date you or your Dependents signed the election form and returned it to the Trust Fund Office Eligibility Department.

IMPORTANT

There will be no invoices or reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the Trust Fund Office.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the Trust Fund Office **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due by the 20th of the month prior to the month coverage is provided in order to ensure that your eligibility is accurately reported. There is a grace period of 30 days from the first day of each month for which coverage is provided. If payment is not received by the end of the grace period, all benefits will terminate immediately. Once your COBRA continuation coverage is terminated, it cannot be reinstated.

Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the Employee or Retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an

increase in the amount you must pay for COBRA Continuation Coverage. Contact the Trust Fund Office to add a Dependent.

Loss of Other Group Health Plan Coverage

If, while you (the Employee or Retiree) are enrolled for COBRA Continuation Coverage your Spouse or Dependent loses coverage under another group health plan, you may enroll the Spouse or Dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or Dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA Plan and, when enrollment was previously offered under that pre-COBRA healthcare Plan and declined, the Spouse or Dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Trust Fund Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare (Part A, Part B or both), or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below). NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependents who are Qualified Beneficiaries.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the Trust Fund Office in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered Employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months (except for Retirees who become entitled to COBRA because of a Chapter 11 bankruptcy reorganization proceeding on the part of the Employee's employer.)

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:
   - the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
   - the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

   Notifying the Plan: you or another family member follow this procedure (to notify the Plan) by sending a written notification to the Trust Fund Office of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the Trust Fund Office before the end of the 18-month COBRA Continuation period.
2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.
3. The Trust Fund Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

California COBRA Law

If you are a COBRA Participant enrolled in the medical HMO Plan, California law has two provisions that affect the length of time you may continue coverage. These laws apply only to your medical HMO coverage, not to any other health care benefits usually available under COBRA.

If your Qualifying Event was low hours, termination of your employment, or retirement and you exhaust the 18 months of coverage normally available after such a Qualifying Event (or the 29 months available in the case of disability), you may continue your HMO coverage an additional 18 months (or an additional 7 months in the case of a disability). If this applies to you, you must contact the HMO directly to continue coverage.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the Fund no longer provides group health coverage to any of its Employees;
2. The date the amount due for COBRA coverage is not paid in full on time;
3. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
4. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition the Qualified Beneficiary may have. Such pre-existing condition exclusions will become prohibited beginning with the plan year in 2014.
5. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
6. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Trust Fund Office determines that COBRA coverage will terminate early.

Entitlement to Individual Conversion Coverage for HMO Participants Only

If you and your eligible Dependents are enrolled in the medical HMO and your eligibility for benefits ceases under the Plan, you may apply for conversion of your group coverage to an individual policy.

You should read the material that you receive from the HMO very carefully. The coverage will not be identical to that which you had while a Plan Participant. Benefits under individual policies are usually provided at lower levels than those found in group policies.

In order to take advantage of the individual conversion option, you must notify the HMO as soon as possible following your loss of eligibility. You must submit your conversion application and initial premium within 31 days from your loss of eligibility. You may elect this option instead of the Plan's COBRA program. In addition, when coverage under COBRA is terminated, you may apply for individual conversion at that time.

Choosing Not to Elect COBRA

If you and/or your Dependents do not elect COBRA within the 60-day period allowed, you will forfeit all rights to COBRA continuation coverage and your health care coverage will end. If you are enrolled in the medical HMO, you may apply for an individual conversion policy.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law.

First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans (election of COBRA continuation coverage may prevent such a gap).

Second, if you do not get continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions.

Finally, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

HIPAA Certification of Creditable Coverage When Coverage Ends

When your COBRA coverage ends, the Trust Fund Office will automatically provide you and/or your covered Dependents (free of charge) with a HIPAA Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received

by the Trust Fund Office within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See the Eligibility chapter for the procedure for requesting a HIPAA Certificate of Coverage.

The requirement on the Plan to provide a HIPAA certificate of creditable coverage will be eliminated effective December 31, 2014 because Health Reform prohibits medical plans from applying a pre-existing condition limitation starting with a plan year beginning on or after January 1, 2014.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS AND CHILDREN OF DOMESTIC PARTNERS

Continuation Coverage

Eligible Domestic Partners of Participants and eligible children of Domestic Partners who lose eligibility under the Plan may temporarily continue Plan coverage through self-payment for a limited period of time. These benefits are **NOT** mandated under federal law. The Board of Trustees may terminate this extension of benefits provision at their sole discretion.

The Domestic Partner and children of the Domestic Partner who lose eligibility under the Plan may temporarily continue Plan coverage when eligibility is lost due to any of the following reasons:

1. Termination of your employment (for causes other than gross misconduct);
2. Reduction in your hours;
3. Your death;
4. Termination of the Domestic Partner relationship with you; or
5. Cessation of child's Dependent status under the Plan.

Premiums

A premium for continuation coverage will be charged to the Domestic Partner or Dependent child or both in amounts established by the Board of Trustees. The premium is payable in monthly installments.

Duration of Continuation Coverage

In the case of your reduction in hours or termination of employment, coverage may be continued on a self-payment basis for up to 18 months from the date of the event that resulted in the loss of eligibility. In all other circumstances, coverage may be continued for up to 36 months from the date of the event that resulted in loss of eligibility.

Continuation coverage will be terminated before the end of the 18-month or 36-month period upon the occurrence of any of the following events:

1. the required premium payment for continuation coverage is not paid when due.
2. the Domestic Partner or Dependent child becomes covered under any other Group Plan (as a participant or otherwise) or becomes entitled to Medicare coverage.

Election and Notice Procedure

The Domestic Partner or child or both must elect continuation coverage within 60 days after the later of:

1. The date of any of the events described above under "Continuation Coverage"; or
2. The date of the notice from the Trust Fund Office notifying the individual of his/her right to continuation coverage.

> You should refer to the information provided in the preceding section on federal COBRA for details about your responsibilities for notifying the Trust Fund Office of changes in your status and paying for your continuing coverage as the rules are the same for this continued coverage for Domestic Partners which is offered by the Trustees as they are for the continuation of coverage that the Trust Fund is required to provide under federal law.

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

Name of the Plan

District Council 16 Northern California Health and Welfare Trust Fund

Name and Address of Entity Maintaining the Plan (Plan Sponsor)

The Plan is sponsored and administered by:

Board of Trustees
District Council 16 Northern California Health and Welfare Trust Fund
c/o ATPA
1640 South Loop Road Alameda, CA 94502
Fax: 510-337-3060

A complete list of the employers sponsoring the Plan may be obtained by participants upon written request to the Trust Fund Office, and is available for examination by Plan Participants.

Participants may receive from the Trust Fund Office, upon written request, information as to whether a particular employer is a Plan Sponsor, and if the employer is a Plan Sponsor, the Sponsor's address.

Employer Identification Number (EIN)

The number assigned to the Plan by the Internal Revenue Service is 41-2261950

Type of Plan

This is a welfare benefit plan that provides life insurance benefits, medical benefits, outpatient prescription drug benefits, mental health and chemical dependency benefits, dental benefits, vision benefits and hearing aid expense benefits.

Plan Number

501

Type of Administration

District Council 16 Northern California Health and Welfare Trust Fund self-funds the group health Plan for eligible medical expenses, indemnity dental expenses, vision expenses, benefits under the Plan. Claims for these benefits are administered by independent claims administrators as listed on the Quick Reference Chart in the front of this document. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

Independent insurance companies (whose name and address are listed on the Quick Reference Chart in the front of this document) administer the fully insured benefits of this Plan (including HMO medical expenses and HMO dental expenses) and provide payment of claims associated with these benefits.

Plan Administrator

The Plan is administered and maintained by the Board of Trustees at the address shown above for Plan Administrator and Plan Sponsor. The Board of Trustees employs a Trust Fund Manager and contract administrator for day to day operations of the Fund. The name of the Trust Fund Office is listed on the Quick Reference Chart.

Agent for Service of Legal Process

For disputes arising under the Plan, service of legal process may be made on the Plan's Legal Counsel:

Isaiah Roter, Esq.
Salzman & Johnson
44 Montgomery Street, Ste 2110
San Francisco, CA 94104
Fax: 415-882-9287

Service of legal process may also be made upon the Board of Trustees or an individual Plan Trustee.

For disputes arising under those portions of the Plan insured by Kaiser or the Pre-paid Dental Plans, service of legal process may be made upon the insurance company at the address listed on the Quick Reference Chart in the front of this document, or upon the supervisory official of the State Insurance Department.

Plan Trustees

The Trustees of the Plan are:

Labor Trustees

Chris Christophersen
District Council 16, IUPAT
2705 Constitution Drive
Livermore, CA 94551

Les Proteau
Bay Area Painters & Tapers Trust Funds
1130 Industrial Avenue, Unit 7
Petaluma, CA 94952

John Sherak
District Council 16, IUPAT
2705 Constitution Drive
Livermore, CA 94551

Joe Upchurch
Glaziers Local 169
8400 Enterprise Way, #118
Oakland, CA 94621

Management Trustees

John Maggiore, Secretary
Royal Glass Company
3200 De La Cruz Blvd.
Santa Clara, CA 95054

Steve Eckstrom
California Drywall
2290 South 10th Street
San Jose, CA 95112

Daryl Stacey
Harry L. Murphy, Inc.
42 Bonaventura Avenue
San Jose, CA 95134

John Kusper (Alternate)
NCPFC
5677 Horton Street
Emeryville, CA 94608

Marian Bourboulis
City Painting
2221 Lake Oaks Court
Martinez, CA 94553

Thomas Heinzelmann (Alternate)
400 Red Street, Box 58032
Santa Clara, CA 95052

Frank Nunes (Alternate)
Wall and Ceiling Alliance
2051 Junction Avenue, Suite 200
San Jose, CA 95131

Plan's Requirements for Eligibility and Benefits

The Plan's requirements with respect to eligibility as well as circumstance that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility chapter in this document. The benefits provided by the Plan are described in the remaining chapters of this SPD/Plan Document (see the Table of Contents) such as in the Schedule of Medical Benefits, Medical Exclusions and the Claim Filing and Appeals Information chapters.

Collective Bargaining Agreements

The District Council 16 Northern California Health and Welfare Trust Fund was established and is continued pursuant to collective bargaining agreements in effect between the local unions affiliated with District Council 16 of the International Union of Painters and Allied Trades and the contributing signatory employers.

Copies of any of the collective bargaining agreements may be obtained upon written request to the Trust Fund Office (a reasonable charge may be made) and are available for examination at the Trust Fund Office during regular business hours. A copy of any of the collective bargaining agreements will also be available for inspection within 10 calendar days after written request at any of the local union offices or at the office of any contributing employer to which at least 50 Plan participants report each day.

Funding Medium

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to Eligible Persons and defraying reasonable administrative expenses. All self-funded benefits are provided directly through the Trust Fund as set forth in this Summary Plan Description.

Contribution Source

All contributions to the Plan are made by employers in accordance with Collective Bargaining Agreements and participation agreements between the Fund and Employers in the industry. The Collective Bargaining and participation Agreements require contributions to the Plan at a fixed rate per hour worked. The Trust Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Eligible Persons working under the Collective Bargaining Agreement, additional information about the Collective Bargaining Agreement, and the Fund's investment of assets and checking accounts.

Plan Year

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

Statement of ERISA Rights

As a participant in the District Council 16 Northern California Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits:

1. Examine, without charge, at the Plan Administrator's office 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 Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
2. 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.
3. 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

1. 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, as described in the COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health Plan if you have creditable coverage from another plan. You should be provided a HIPAA Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

1. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.
2. 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

1. If your claim for a welfare 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, as discussed in the Claims Filing and Appeals Information chapter of this document.
2. 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.
3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim and exhaust the Plan's appeal process **before** filing a lawsuit.
4. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.
5. 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

1. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.

2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration) at Toll-Free: 1.866.444.EBSA (3272).

Plan Amendments or Termination of Plan

The provisions of the Plan may be amended or terminated at any time by a vote of the Board of Trustees.

If the Plan terminates, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of Plan benefits in a manner permitted by ERISA for so long as Trust assets permit.

In the event of Plan termination, expenses incurred after that date will not be paid. Individuals covered by a prepaid plan or an insurance carrier may have the right to extended coverage or convert to an individual policy pursuant to the provisions of the prepaid plan or insurance carrier.

Benefits Are Not Guaranteed

Self-funded medical, prescription drug, mental health and chemical dependency, dental and vision benefits are paid directly from the Trust Fund and are not insured by any contract of insurance. There is no liability on the Board of Trustees or any individual or entity to provide payment over and above the amounts in the Trust Fund collected and available for such purposes.

The benefits provided by the Plan may be increased, decreased, or terminated by the Trustees. No Employee, Dependent, or other person has any vested right in the benefits offered by the Trust Fund or to payments made there from.

Retired participant benefits are not vested, and continued availability of retired participant benefits is not guaranteed. The Trustees reserve the right to amend, modify, or terminate retired participant benefits at any time.

No Liability for Practice of Medicine

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right of Plan to Require a Physical Examination

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a physician, to be examined by a physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. The cost of such an examination will be paid by the Plan.

Women's Health & Cancer Rights Act (WHCRA) and Newborns' & Mothers' Health Protection Act (Newborns' Act)

This Plan complies with the Women's Health and Cancer Rights Act and the Newborns' and Mothers' Health Protection Act. See the information described under Reconstructive services and Maternity services in the Schedule of Medical Benefits chart in this document.

Information you or your Dependents Must Furnish to the Plan (Very Important Information)

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan.

If you fail to do so, you or your covered Dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a Dependent Child who has a physical or mental disability.

Submit such information in writing to the Trust Fund Office at the address shown in the Quick Reference Chart in the front of this document. The information needed and timeframes for submitting such information are outlined below. See also the COBRA chapter for special timeframes applicable to those benefits:

Type of Information Needed	Date Information is to be Submitted to the Plan
• Change of name or address or the existence of other health care coverage for any covered person.	As soon as possible but not later than 60 days after the change or addition of other coverage.
• Marriage, divorce, legal separation, addition of a new Dependent, death of any covered person.	Within 31days
• Covered Dependent (Spouse or child) becomes disabled or is no longer disabled.	Within 31 days of the date the person becomes disabled or is no longer disabled.
• Covered child ceases to be a Dependent as defined by this Plan (*e.g.* over the limiting age of the Plan, etc.)	Within 60 days of the date the child is no longer considered a Dependent.
• Employee receives a determination of disability from the Social Security Administration (SSA) or is no longer disabled according to SSA. • Medicare enrollment or disenrollment.	See the COBRA chapter for timeframe.

Headings, Font and Style do not Modify Plan Provisions

The headings of chapters and subchapters and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related.

Active Employee: The term "active Employee" means an Employee who meets the eligibility provisions as an active hourly bargaining Employee or active monthly non-bargaining Employee, as defined in the ***Becoming a Plan Participant*** section of this booklet.

Allied Health Care Practitioner: The term "Allied Health Care Practitioner" means a licensed physical, occupational, or speech therapist, a Dentist (D.D.S.), licensed Podiatrist (D.P.M.), Psychologist, Physician Assistant, Marriage, Family, Child Counselor (MFCC), Licensed Clinical Social Worker (LSCW) , Registered Nurse (R.N.), Nurse Midwife, Nurse Practitioner or Certified Acupuncturist who are practicing within the scope of their licenses. The term shall not include any person who is the Spouse, Domestic Partner, child, brother, sister, or parent of the Active or Retired Employee.

Adverse Benefit Determination: See the Claim Filing and Appeal Information chapter for the definition.

Allowed Charge/Allowed Amount/Allowable Charge: means the amount this Plan allows for eligible medically necessary services or supplies. The allowed charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. The dollar amount this Plan has determined it will allow for covered Medically Necessary services or supplies provided by Non-PPO Providers as determined by the Plan's PPO based on appropriate and reasonable charges for the services in the geographical area where the services are provided. With respect to Non-PPO Hospitals or Facilities within the PPO Area for other than an Emergency Medical Condition, the allowed charge will be the same as the Schedule of Allowances (Non-Contract allowance provided by Anthem Blue Cross, American Health Holding, Accelera or other entity designated by the Fund for the allowable amount). The Plan's Allowed Charge is not based on or intended to be reflective of fees that have traditionally been described as usual and customary (U&C), usual, customary and reasonable (UCR) or any other traditional term. Non-PPO Providers' bills often exceed the Plan's Allowed Charge, and in such cases the Plan's benefits will be based on the Allowed Charge not the Non-PPO Providers billed rate. In cases of an Emergency Medical Condition, or when the Patient has not had a reasonable opportunity to select a PPO Provider, the Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the Allowed Charge for the submitted claim. When using Non-PPO Providers, the Participant is responsible for any difference between the actual billed charge and the Plan's Allowed Charge, in addition to any copay and percentage coinsurance required by the Plan.
2. The Non-Contract Provider's actual billed charge.

Any amount in excess of the "allowed charge" amount does not count toward the Plan's annual Out-of-Pocket Maximums. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan.

With respect to Non-network Emergency Room services, the Plan allowance is the greater of: the negotiated amount for in-network providers, or 100% of the Plan's Allowed Charge formula (reduced for cost-sharing) or the amount that Medicare would pay.

Ambulatory Surgical Facility/Center The term "Ambulatory Surgical Facility" or "Outpatient Surgical Facility" means a health facility that is accredited by the Accreditation Association of Ambulatory Health Care.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious

pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This Plan allows payment of an assistant surgeon under the following conditions:

a. the individual functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA), but not an Employee of a hospital or surgical facility or a medical student, intern or other trainee; and
b. the use of an assistant surgeon(s) is determined by the Plan Administrator or its designee to be medically necessary; and
c. the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket maximum and may result in balance billing to you. **Out-of-Network Health Care Providers commonly engage in balance billing a Plan participant for any balance that may be due in addition to the amount payable by the Plan.** Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid balance billing by using In-Network providers.**

Behavioral Health Disorder: A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this chapter. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, a mental health or substance abuse counselor or social worker who has a Master's degree, or a nurse practitioner in independent practice who is qualified to perform behavioral health counseling and, who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, Spouse, Domestic Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Behavioral Health Treatment: Behavioral Health Treatment includes outpatient visits and inpatient services (including room and board given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment) for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which fully meets one of the following two tests:

1. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements: has at least one Physician on staff or on call and provides skilled nursing care by licensed Nurses under the direction of a full-time

Registered Nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

A Behavioral Health Treatment Facility that qualifies as a Hospital is covered by this Plan as a Hospital and not a Behavioral Health Treatment Facility. A residential treatment facility, transitional facility, group home, halfway house or temporary shelter is not a Behavioral Health Treatment Facility under this Plan.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Allowed Charge, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan's exclusions, limitations and maximums.

Board: The term "Board" means the Board of Trustees of the District Council 16 Northern California Health and Welfare Trust Fund.

Calendar Year: The 12-month period beginning January 1 and ending December 31. For the Medical program, all annual Deductibles, Out-of-Pocket Maximums and Annual Maximum Plan benefits are determined during the calendar year.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program.

Chemical Dependency: This is another term for Substance Abuse/Substance Use Disorder. See also the definitions of Behavioral Health Disorders and Substance Abuse/Substance Use Disorder.

Child(ren): See the definition of Dependent Child(ren) and children of Domestic Partner.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, Spouse, Domestic Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

COBRA: means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. and refers to temporary continuation of health care coverage.

Coinsurance: That portion of eligible expenses for which the covered person has financial responsibility to pay.

Concurrent Review: A managed care program designed to assure that Hospitalization and Health Care Facility admissions and length of stay, surgery and other health care services are medically necessary by having the Utilization Review Company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility. Also called Continued Stay Review.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits chapter.

Copayment, Copay: The fixed dollar amount you are responsible for paying for a service before the Plan pays the remaining Allowed Charge.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: The term "Cosmetic Surgery or Treatment" means any surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment

includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance without significantly improving physiological function, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are medically necessary.

Covered Individual: Any Employee, and/or Retiree and that person's eligible Spouse or Dependent Child or Domestic Partner (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan. A covered individual is also referred to as a Plan Participant.

Covered Medical and/or Dental Expenses: See the definition of Eligible Medical and/or Dental Expenses.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of the Deductible is discussed in the Medical Expense Coverage chapter of this document.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse, or Domestic Partner as those terms are defined in this document. See also the definition of Eligible Dependent, Domestic Partner, Domestic Partner child. Note that the daughter-in-law or son-in-law or grandchild of an eligible Employee or Spouse or Domestic Partner is not an eligible Dependent under this Plan.

Dependent Child(ren): Please refer to the Eligibility section for a description of the Dependent children who are eligible for coverage under the Plan.

Disabled/Disability: The inability of a person to be self-sufficient as the result of a physically or mentally disabling injury, illness, or condition (such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis), and the person is permanently and totally disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See also the definition of Totally Disabled.

Domestic Partner: The term "Domestic Partner" means a domestic partner of an active or Retired Employee who provides a Certificate of Domestic Partnership issued by the California Secretary of State or another governmental sub-division within California that has developed regulations for the recognition of such relationships.

> You should consult a tax advisor regarding the tax consequences of receiving benefits from the Trust Fund for your Domestic Partner, as these are considered "imputed income" to you under federal law. You must make payment to the Trust Fund Office for any taxes that are required to be paid on the value of this "imputed income." Failure to do so will result in termination of coverage for your Domestic Partner and your Domestic Partner will NOT be eligible for any extension of coverage.

Durable Medical Equipment: The term "Durable Medical Equipment" means equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness, is not disposable or non-durable and is appropriate for use in the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Emergency Services: means with respect to an Emergency Medical Condition (defined below), a medical screening examination within the emergency department of a hospital including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver a newborn child (including the placenta).
- The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman of her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Enroll, Enrollment: The process of completing and submitting a written enrollment form indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding the mechanics of enrollment.

Essential Health Benefits: The Affordable Care Act defines essential health benefits to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational: The term "Experimental" shall mean any of the following:

- Any medical procedure, equipment, treatment or course of treatment, drug or medicine which is not normally and regularly used or prescribed by the medical community for the reason that it remains under clinical or laboratory investigation or has not been exposed to clinical/laboratory investigation; or
- Any drug, device or medical treatment or procedure which is the subject of on-going phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable Evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the 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 or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Final determination as to whether services are "Experimental" will be made by the Plan Administrator or its designee. The Trustees may rely on the advice of medical consultants in determining whether a service or supply is "Experimental" under this definition.

Note that under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** 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 eligible individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

a. "**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.

b. 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; (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. "Federally funded" clinical trials include those approved or funded by one or more of: 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), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

d. 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.

e. The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process.

Federal Legend Drugs: See the definition of Prescription Drugs.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Formulary: A formulary is a list of drugs approved by the pharmacy benefit manager and available for your doctor to use in prescribing your treatment. After careful review by a group of practicing doctors and pharmacists, drugs that offer value without sacrificing quality are placed in the formulary. Your doctor may still prescribe a non-formulary drug, but you pay the full cost for the drug. The formulary list includes the most cost-effective drugs for treating various classes of conditions and illnesses. The formulary list includes mostly generic medications and some brand name medications.

Fund: means the District Council No. 16 Northern California Health and Welfare Trust Fund.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal

functional abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking or talking at the expected age.

Handicap or Handicapped (Physically or Mentally): See the definition of Disabled.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Outpatient Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities/Long Term Acute Care facilities as those terms are defined in this Definitions chapter.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dentist, a licensed physical, occupational, or speech therapist, a Dentist (D.D.S.), licensed Podiatrist (D.P.M.), Psychologist, Physician Assistant, Marriage, Family, Child Counselor (MFCC), Licensed Clinical Social Worker (LSCW), Registered Nurse (R.N.), Nurse Midwife, Nurse Practitioner or Certified Acupuncturist who are practicing within the scope of their licenses. The term shall not include any person who is the spouse, Domestic Partner, child, brother, sister, or parent of the Active or Retired Employee.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility/Long Term Acute Care facility, as those terms are defined in this Definitions chapter.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets all requirements of PPO Network for a Home Health Care Agency Provider.

Hospice: An agency or organization that administers a program of palliative care and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. The Hospice Agency must be a licensed hospice Provider recognized as such by the Centers for Medicare and Medicaid Services.

Hospital: The term "Hospital" means a state or federally licensed institution that meets the following requirements:

- It is primarily engaged in providing diagnostic, surgical and therapeutic facilities for medical and surgical care of sick and injured persons on an inpatient basis at the patient's expense.
- It continuously provides 24-hour-a-day supervision by a staff of Physicians licensed to practice medicine (other than physicians whose license limits their practice to one or more specified fields) and 24-hour-a-day nursing care by or under the supervision of registered nurses (R.N.s).
- It is not, other than incidentally, a place of rest, a nursing home, a convalescent home, a place for the aged, a pain clinic or a place for recovery from drug or alcohol addictions.

Illness: The term "Illness" means any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician. However, infertility is not an Illness for the purpose of coverage under this Trust Fund. Pregnancy of a covered Employee or covered spouse or Domestic Partner will be considered to be an Illness only for the purpose of coverage under the Indemnity Medical Plan. Prenatal and postnatal visits for a pregnant dependent child will be an illness that is covered by this Plan, but not ultrasounds and other pregnancy-related services of the pregnant dependent child, the delivery and/or newborn expenses.

Injury: Any damage to a body part resulting from trauma from an external source.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO) as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Investigational: See the definition of Experimental and/or Investigational.

Life Threatening: The term "life threatening" means the onset of a medical emergency that is so severe that the patient is admitted to a Hospital as an inpatient for ongoing care.

Maximum Allowable Charge (MAC): The Maximum Allowable Charge (MAC) is the highest amount that the Fund will pay for routine total hip/knee replacements, arthroscopic surgeries, cataract surgeries and colonoscopies. The MAC will not apply to colonoscopies at an outpatient surgical center.

Maximum Plan Benefits: The maximum amount of benefits payable by the Plan (and described more fully in the Medical Expense Coverage chapter of this document) on account of medical expenses incurred by any covered Plan Participant. There are two general types of Plan maximums, described below:

- **Limited Overall Maximum Plan Benefits** are the maximum amount of benefits payable on account of certain covered medical services or supplies by the Plan during the entire time a Plan Participant is covered under this Plan and any previous medical expense Plan provided by Fund. The services or supplies that are subject to Limited Overall Maximum Plan benefits and the limits of those benefits are identified in the Schedule of Medical Benefits.
- **Annual Maximum Plan Benefits** are the maximum amount of benefits payable each Calendar Year on account of certain medical expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan. Annual Maximums are identified in the Schedule of Medical Benefits.

Medically Necessary/Medical Necessity:

Services and supplies are "Medically Necessary" or provided due to "Medical Necessity" if such service or supply is determined by the Plan Administrator or its designee to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the injury or illness; and
- Provided for the diagnosis or direct care and treatment of the Illness or Injury; and
- Not Experimental, as defined above, or primarily educational; and
- Within the standards of good medical practice accepted and followed by the medical community; and
- Not primarily for the convenience of the Participant, the Participant's family, any person who cares for the Patient, any health care practitioner, facility, or another provider; and
- The most appropriate supply or level of service that can be safely provided. For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Health; Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Morbidly Obese, Morbid Obesity: The term "morbid obesity" means the presence of morbid obesity that has persisted for at least 5 years, defined as either:

- body mass index exceeding 40; or
- BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:
  - coronary heart disease; or
  - type 2 diabetes mellitus; or
  - (clinically significant obstructive sleep apnea (as determined by the Plan Administrator or its designee); or
  - high blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);

    AND

    - Individual has completed growth (18 years of age or documentation of completion of bone growth);

    AND

    - Individual has participated in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification),

documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:

- Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; AND
- Nutrition and exercise program must be 6 months or longer in duration; AND
- Nutrition and exercise program must occur within the two years prior to surgery; AND
- Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. Note: A physician's summary letter is not sufficient documentation.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-Participating Provider: A Health Care Provider who **does not participate** in the Plan's Preferred Provider Organization (PPO). Also referred to as Non-PPO, Out-of-Network or non-network.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and is not the patient or the parent, Spouse, Domestic Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. The following are not considered to be an office visit: a telephone discussion with a Physician or other Health Care Practitioner, internet/virtual office visit, a visit to a Health Care Practitioner's office where no office visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Out-of-Network Services (Non-Network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Out-of-Pocket Maximum: The maximum amount of coinsurance each covered person or family is responsible for paying during a Calendar Year before the coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of additional coinsurance related to most covered expenses for the remainder of the Calendar Year. See the section on Out-of-pocket Maximum in the Medical Expense Coverage chapter for details about what expenses **do not count** toward the Out-of-Pocket Maximum.

Participating Provider: A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and is not the patient or the parent, Spouse, Domestic Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, Domestic Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter.

Plan, This Plan: The programs, benefits and provisions described in this document.

Plan Administrator: The Board of Trustees who has been designated as the Plan Administrator by the Plan Sponsor and who has the responsibility for overall Plan administration.

Plan Documents: The term "Plan Documents" refers to the Trust Agreement establishing this Trust Fund and all written documents, insurance policies, HMO policies, Evidence of Coverage documents, this Summary Plan Description, Collective Bargaining Agreements, Subscriber Agreements and all other legal documents setting forth the District Council 16 Northern California Health and Welfare Plan. It also includes written policy and procedure documents that have been formally adopted by the Board of Trustees.

Plan Participant: See the definition of Covered Individual.

Plan Sponsor: The Board of Trustees

Plan Year: The twelve-month period from January 1 to December 31 designated to be the Plan Year. The Contract Year is the same as the Plan Year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, Domestic Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Prior Authorization: Prior Authorization is a review procedure performed by the Utilization Review Company **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and

that the service, admission and/or length of stay in a health care facility is appropriate and medically necessary. Prior Authorization is also referred to as pre-service review, precert, precertification, pre-authorization, or preapproval.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug**: means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
5. **Specialty drug**: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a health care practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Examples of specialty drugs can include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer. Specialty drugs may be managed by the Prescription Drug Program under contract to the Plan.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Pulmonary Rehabilitation: Pulmonary Rehabilitation refers to a formal program of controlled exercise training and respiratory education under the supervision of qualified medical personnel capable of treating respiratory emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to their highest functional level of activity/endurance, decrease respiratory symptoms/complications, and encourage self-management and control over their chronic lung problems. Patients are to continue at home, the exercise and educational techniques they learn in this program. Pulmonary rehabilitation services are payable for patients who have a chronic respiratory disorder such as chronic obstruction pulmonary disease (COPD), emphysema, pulmonary fibrosis, asthma, etc.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility chapter of this document.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Services: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. Only care that demonstrates progressive improvement in the patient's functional capacity is covered. No benefits are provided for pervasive developmental delay, learning disabilities or that are primarily provided to enhance academic achievement in Dependent children.

Retired Employee*:* The term "Retired Employee" means an Employee who meets the eligibility provisions as either a Retired hourly bargaining Employee or a Retired monthly non-bargaining Employee.

Skilled Nursing Facility: The term "Skilled Nursing Facility" means a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
- It provides services under the supervision of Physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
- It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
- It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
- It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of the Indemnity Medical Plan.

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and is not the patient or the parent, Spouse, Domestic Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability subchapter in the chapter on Coordination of Benefits for an explanation of how the Plan may use the right of subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical and/or dental benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Total Disability, Totally Disabled: The term "total disability" or "totally disabled" means for active Employees, a disability caused by injury or illness that wholly and continuously prevents the active Employee from performing the substantial and material duties of his occupation or employment. For a Retired Employee or eligible Dependent, the term means a disability caused by injury or illness that wholly and continuously prevents the Retired Employee or the eligible Dependent from engaging in the substantial and material activities engaged in prior to the start of disability.

Value Based Site: The term "Value Based Site" means a PPO Hospital or ambulatory surgical center (ASC) in California that will hold costs under the Maximum Allowable Charge.

You, Your: When used in this document, these words refer to the Employee who is covered by the Plan. They do **not** refer to any Dependent of the Employee.

EXHIBIT A: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of Notice

Effective date. The effective date of this Notice is March 1, 2013.

This Notice is required by law. The **District Council 16 Northern California Health and Welfare Trust Fund** (the "Plan") is required by law, including the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI),
- Your rights to privacy with respect to your PHI,
- The Plan's duties with respect to your PHI,
- Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Plan's privacy practices.

This Notice applies to your health information held by the **District Council 16 Northern California Health and Welfare Trust Fund** and outside companies that help administer the Plan. You will also receive a separate privacy notice if you have selected an HMO for your health Plan.

Your Protected Health Information Definitions

a) Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health conditions, the provision of health care to you, or to past, present, or future payment for the provision of health care to you. PHI includes information transmitted, created or maintained by the Plan in oral, written, or electronic form.

b) De-Identified PHI

This Notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Your Personal Representative

You may exercise your rights through your Personal Representative. Your Personal Representative will be required to produce evidence of authority to act on your behalf before the Personal Representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be: (1) a notarized power of attorney for health care purposes; (2) a court-appointed conservator or guardian or (3) any other document approved by the Trust Fund's legal Counsel.

The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as Personal Representatives without you having to provide proof of authority as described above. The Fund will consider a parent or guardian as the Personal Representative of an

unemancipated minor unless applicable law requires otherwise. A parent may act on an unemancipated minor's behalf, including requesting access to their PHI. All participants, including unemancipated minors, may request that the Plan restrict information that goes to family members by filling out a form to request restrictions on uses and disclosures of your PHI as described in Section 3 of this Notice.

You should also review the Plan's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Plan will automatically consider an individual to be a Personal Representative.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is required to give you access to certain PHI if you request it in order to allow you to inspect and/or copy it, or to provide an accounting to you, under certain circumstances as provided by law. (See Section 3 of this Notice).

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization, and without giving you an opportunity to object, under the following circumstances:

- As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- For treatment, payment or health care operations. The Plan and its business associates may use PHI in order to carry out treatment, payment or health care operations.
  - **Treatment** is the provision, management or coordination of health care and related services with health care providers or other covered entities. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.
  - **Payment** includes, but is not limited to, actions to make eligibility or coverage determinations or undertake collection activities (including billing, claims management, subrogation, Plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and prior authorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."
  - **Health care operations** includes, but is not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program or a well-pregnancy program, to project future benefit costs or to audit the accuracy of its claims processing functions. Please note that no genetic information will be used for underwriting purposes.
- **Disclosure to the Plan's Trustees**. The Plan may also disclose PHI to the Board of Trustees of the **District Council 16 Northern California Health and Welfare Trust Fund** (the "Plan Sponsor") for purposes related to, but not limited to, treatment, payment, and health care operations. For example, the Plan may disclose protected health information to the Board of Trustees of the Plan to allow them to decide an appeal of a benefit claim or for other reasons regarding the administration of this Plan, including review of a subrogation claim.
- **Disclosure to the Plan Sponsor** (by the HMO or group health plan).
- **When required by applicable law**.

- **Public health purposes**. To an authorized public health authority if required by law or for public health and safety purposes. For example, the Plan may disclose your PHI when necessary to enable product recalls or repairs. The Plan may also use or disclose your PHI if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- **Domestic violence or abuse situations**. If a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence, the Plan may report information about abuse, neglect or domestic violence to public authorities (1) when required by law; (2) if you agree to such disclosure; or (3) when the Plan is authorized by law and the disclosure is necessary to prevent serious harm to you or other potential victims. In such case, the Plan will promptly inform you or your Personal Representative that such a disclosure has been or will be made unless that would place you at a risk of serious harm or if the Plan would be informing a Personal Representative that it reasonably believes is responsible for the abuse. In the case of child abuse, it is not necessary for the Plan to inform the child of such disclosure.
- **Health oversight activities**. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers); civil, administrative, or criminal proceedings or actions; and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- **Legal proceedings**. When required for judicial or administrative proceedings, as authorized by law. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- **Law enforcement** health and emergency purposes. We may disclose PHI to law enforcement officials for the following purposes:
  - When required for law enforcement purposes (for example, to report certain types of wounds or other physical injuries);
  - Identifying or locating a suspect, fugitive, material witness or missing person;
  - Disclosing information about an individual who is or is suspected to be a victim of a crime. This only applies if the Plan is unable to obtain the individual's agreement because of incapacity or other emergency circumstances;
- **Determining cause of death and organ donation**. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation and transplantation purposes.
- **Funeral purposes**. When required to be given to funeral directors to carry out their duties with respect to the decedent, after or in reasonable anticipation of the individual's death.
- **Research**. For research, subject to certain conditions.
- **Health or safety threats**. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat or it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Workers' compensation programs**. The Plan may disclose PHI to your employer and others, when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- **Specialized government functions**. When required, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

When the Disclosure of Your PHI Requires Your Written Authorization

Except as otherwise indicated in this Notice or as permitted by law, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization in writing.

- Psychotherapy Notes: Psychotherapy notes are separately filed notes in any medium about your conversations with your mental health professional during a private, group, joint, or family counseling session. Psychotherapy notes do not include medication prescription and monitoring, results of clinical tests, or any summary information about your mental health diagnosis, functional status, symptoms, prognosis, progress or treatment. Although the Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.
- If the Health Plan Provides Health Information to a Companion Pension Plan: The Plan also requires your written authorization to share PHI with the pension plan.
- Other uses and disclosures not described in this Notice will only be made with your written authorization.
- You may revoke a prior authorization granted for psychotherapy notes, marketing, sales or any other authorized use and disclosure provided under the regulations.

Use or Disclosure of Your PHI To Relatives and Friends:

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose to identify is allowed under federal law if:

- The information is directly relevant to the family member, other relatives, or a close personal friend's involvement with your care or payment for that care, or
- The information is used or disclosed to notify, or assist in the notification of, a family member, Personal Representative, or another person responsible for your care, your location, general condition, or death.

If you are present for, or otherwise available prior to a use or disclosure permitted above, and you have the capacity to make health care decisions, the Plan will not use or disclose your PHI to your family and friends unless it:

- obtains your agreement,
- provides you with an opportunity to object to the use and disclosure of your PHI and you express no objections to such use and disclosure, or
- the Plan can reasonably infer from the circumstances that you do not object to such use and disclosure.

Other Uses or Disclosures

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Individual Privacy Rights

a) ***You May Request Restrictions on PHI Uses and Disclosures***

You may request the Plan to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan may comply with your request at the discretion of the Plan Administrator or Privacy Official. The Plan is not required to agree to a requested restriction. If the Plan agrees to a restriction you have requested, it may terminate the restriction under certain circumstances. Make such requests in writing to **the Privacy Officer**:

Associated Third Party Administrators
1640 South Loop Road, Alameda, CA 94502
Phone: (510) 864-6406 or (800) 893-2200
Fax: (510) 337-3353

You May Request Confidential Communications

The Plan will accommodate any individual's reasonable request to receive communications of his or her PHI by alternative means or at alternative locations.

You or your Personal Representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Officer specified above.

b) ***You May Inspect and Copy PHI***

You have a right to inspect and obtain a copy of your PHI contained in a Designated Record Set (defined below) for as long as the Plan maintains the PHI.

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included. If the Plan uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format, and direct that such PHI be sent to another person or entity.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your Personal Representative will be required to complete a form to request access to the PHI in your Designated Record Set. A reasonable fee may be charged. Requests for access to PHI should be made to the Privacy Officer, specified above.

If access is denied, you or your Personal Representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and the United States Department of Health and Human Services.

c) ***You Have the Right to Amend Your PHI***

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in the Designated Record Set for as long as the PHI is maintained in the Designated Record Set subject to certain exceptions. See the Plan's Right to Amend Policy for a list of exceptions.

You or your Personal Representative should make your request to amend PHI to the Privacy Officer, specified above. You or your Personal Representative will be required to complete a form provided by the Plan to request amendment of your PHI.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denies your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your Personal Representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI. You may also file a complaint with the Plan and/or HHS. See Section 5, below.

d) ***You Have the Right to Receive an Accounting of the Plan's PHI Disclosures***

At your request, the Plan will also provide you with an accounting of certain disclosures of your PHI by the Plan. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Plan's Accounting for Disclosure Policy for the complete list of disclosures for which an accounting is not required.

You should direct your request to the Privacy Officer specified above.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Plan's Duties

a) ***Maintaining Your Privacy***

The Plan is required by law to maintain the privacy of your PHI and to provide you with Notice of its legal duties and privacy practices.

b) ***Right to Amend***

This Notice is effective on March 1, 2008 and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided via mail to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI via mail.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this Notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your written authorization,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan

Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Your Right to Receive Notice

If your "Unsecured" PHI is accessed, acquired, used or disclosed in a manner that is impermissible under the HIPAA Privacy Rule and that poses a significant risk of financial, reputational or other harm to you, the Plan must notify you within 60 days of discovery of such "Breach" (as such terms are defined in the HIPAA Privacy Rule).

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of:

The Privacy Officer
Phone: (510) 864-6406 or (800) 893-2200 or Fax: (510) 337-3353
Associated Third Party Administrators
1640 South Loop Road, Alameda, CA 94502

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"). Please contact the nearest office of the Department of Health and Human Services, listed in your telephone directory, visit the HHS website at www.hhs.gov, or contact the Privacy Officer for more information on how to file a complaint.

The Plan will not retaliate against you for filing a complaint.

If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Officer, specified above, at the Trust Fund Office.

The federal Health Insurance Portability and Accountability Act, known as HIPAA, regulates PHI use and disclosure by the Plan. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations.

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