

**I.A.T.S.E. LOCAL 16
HEALTH AND WELFARE
TRUST FUND**



SUMMARY PLAN DESCRIPTION

JANUARY 2019

I.A.T.S.E. LOCAL #16

HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

JANUARY 2019

I.A.T.S.E. LOCAL 16 HEALTH AND WELFARE TRUST FUND

To All Plan Participants:

We are pleased to provide you with this new booklet describing the benefits provided through the I.A.T.S.E. Local 16 Health and Welfare Trust Fund. This booklet includes all changes made to the Plan through January 1, 2019. **Please review this booklet thoroughly to familiarize yourself with the latest changes.**

We hope that these benefits will protect you and your family members if any of you suffer illness or injury. We also hope that you will use your health benefits wisely, taking advantage of the preferred provider discounts through Anthem Blue Cross for medical benefits and CIGNA for dental benefits while following the rules requiring pre-certification of hospital stays and other cost containment features. By doing so, you will qualify for maximum benefits. At the same time, you will help the Plan to provide benefits in the most cost-effective way possible.

In the pages that follow you will find a summary of benefits, the rules covering eligibility for those benefits, and the procedures that should be followed when making a claim. Contained in the back of the booklet is additional information about the I.A.T.S.E. Local 16 Health and Welfare Trust Fund, as required by law.

Only the Board of Trustees is authorized to interpret the Plan of benefits described in this booklet. No individual Trustee, union representative, or employer representative is authorized to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board of Trustees has authorized BeneSys (the Fund's Third Party Administrator) to respond in writing to written inquiries from Plan Participants. As a convenience to you, BeneSys will provide oral answers regarding coverage on an informal basis. However, no such oral communication is binding on the Board of Trustees.

This booklet contains a summary of the Plan's benefits. In the event a discrepancy exists, the provisions included herein and any insurance contracts issued to the Board of Trustees shall prevail. **Again, we strongly suggest that you read the entire contents of this booklet so that you will be familiar with the comprehensive protection the Plan provides you and your family.** Any questions you may have concerning your benefit coverage should be directed to BeneSys, at (925) 398-7043 within the state of California or (855) 704-5273 for out of state, where the staff will be pleased to assist you. The address for BeneSys is 7180 Koll Center Parkway, Suite 200, Pleasanton, California 94566.

Patient Protection and Affordable Care Act – Notice Regarding “Grandfathered Plan” Status

The Board of Trustees considers your Plan a grandfathered health plan under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provisions of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to BeneSys. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Foreign Language Notice

This booklet contains a summary in English of your rights and benefits under the I.A.T.S.E. Local #16 Health and Welfare Trust Fund. If you have any difficulty in understanding any part of this booklet, you may contact BeneSys, 7180 Koll Center Parkway, Suite 200, Pleasanton, California 94566, telephone number (925) 398-7043.

Aviso En Español

Este folleto contiene un resumen en ingles de sus derechos y beneficios bajo el I.A.T.S.E. Local #16 Health and Welfare Trust Fund. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con BeneSys, 7180 Koll Center Parkway, Suite 200, Pleasanton, California 94566, o llamar a los teléfonos (925) 398-7043.

Sincerely,

THE BOARD OF TRUSTEES

IMPORTANT NOTICE TO EMPLOYEES, RETIREES, SPOUSES AND DEPENDENTS

From time to time, the Fund may mail you updated materials in order to inform you and your dependents of any changes to the Plan. It is important that you file all future notices and updates received from the Fund with this booklet and note the affected sections.

The Trustees shall have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, interpret, modify and/or terminate any provisions of the Plan, this Summary Plan Description and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Trustees shall have the sole and absolute discretionary authority:

1. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
2. To formulate, interpret and apply rules and policies necessary to administer the Plan in accordance with its terms;
3. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
4. To resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents; and
5. To process, and approve or deny, benefit claims and rule on any benefit limitations and/or exclusions.

All determinations made by the Trustees with respect to any matter arising under the Plan, this Summary Plan Description, and any other Plan documents shall be final and binding on all parties.

ABOUT THIS SUMMARY PLAN DESCRIPTION

This Summary Plan Description (SPD) is designed to assist you with the understanding and use of your Health and Welfare Plan.

The SPD is divided into the following parts:

TABLE OF CONTENTS

is a listing of Plan specifics by page number.

ELIGIBILITY RULES

state how initial eligibility is obtained and how eligibility can be maintained.

TERMINATION OF COVERAGE/COBRA CONTINUATION COVERAGE

explains when coverage ceases and self-pay provisions begin, should you desire to continue coverage under COBRA.

COST CONTAINMENT PROGRAMS

explains Plan conditions and methods to obtain maximum benefit payments.

SUMMARY OF BENEFITS

describes benefits, benefit amounts, benefit exclusions and limitations.

HOW TO FILE A CLAIM FOR BENEFITS

describes step-by-step procedures to file claims for benefit consideration.

CLAIMS APPEAL PROCEDURES

describes the procedures a Plan Participant must follow for reconsideration of a partial or full denial of a claim. Plan Participants and dependents are encouraged to contact the Trust Fund office if they have any questions about the Plan.

COORDINATION OF BENEFITS

describes payment procedures when more than one plan is liable for payment.

HIPAA PRIVACY STATEMENT

explains the Health Insurance Portability & Accountability Act of 1996 and the HIPAA Privacy Rule for use & disclosure of your health information.

INFORMATION REQUIRED BY ERISA

includes general information about the Plan and its operation.

STATEMENT OF ERISA RIGHTS

explains your rights and protections as a Plan participant under the Employee Retirement Income Security Act of 1974, as amended.

DEFINITIONS

provide a precise meaning of terms used in the Summary Plan Description.

TABLE OF CONTENTS

	Page
ELIGIBILITY RULES	1
TERMINATION OF COVERAGE	7
COBRA Continuation Coverage.....	7
FAMILY MEDICAL LEAVE ACT	11
UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (“USERRA”)	11
COST CONTAINMENT PROGRAMS	12
Utilization Review Program.....	13
Medical Case Management Program.....	15
Preferred Provider Organization (PPO).....	15
Additional Anthem Blue Cross Features.....	16
SUMMARY OF MEDICAL, SURGICAL AND HOSPITAL EXPENSE BENEFITS	17
Maximum Out-of-Pocket Expenses.....	17
Deductibles	17
PPO Providers.....	18
PHYSICIAN AND RELATED CHARGES	19
HOSPITAL FACILITY BENEFITS	22
Local or Air Ambulance.....	23
HOME HEALTH CARE	24
HOSPICE CARE	25
MEDICAL EXCLUSIONS AND LIMITATIONS	26
PRESCRIPTION DRUG BENEFITS	29
SPECIAL STOP-SMOKING BENEFIT	34
DENTAL BENEFITS (INCLUDING ORTHODONTIC BENEFITS)	35
VISION CARE BENEFIT	38
SUPPLEMENTAL PLAN BENEFITS	39
Alcoholism and Drug Addiction Benefit	39
Supplemental Disability Income Benefit	39
Hearing Aid Benefit.....	40
LIFE INSURANCE BENEFIT	41
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	43
HOW TO FILE A CLAIM FOR BENEFITS	46
HOW CLAIMS ARE PROCESSED	47
CLAIMS APPEAL PROCEDURES	48
COORDINATION OF BENEFITS	52
Subrogation of Claims Against Other Parties for Claims Paid Under the Plan.....	53
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996	56
INFORMATION REQUIRED BY ERISA	61
STATEMENT OF ERISA RIGHTS	65
DEFINITIONS	67

ELIGIBILITY RULES

ELIGIBILITY RULES FOR ACTIVE PLAN PARTICIPANTS AND THEIR DEPENDENTS

INITIAL ELIGIBILITY

Eligibility runs from calendar quarter to calendar quarter and is based on employer contributions made on your behalf. Employer contributions made in one quarter apply for eligibility in the next quarter.

You establish initial eligibility for benefits when an employer signatory to a Local 16 collective bargaining agreement makes at least \$6,200¹ in health and welfare contributions on your behalf over a period of twelve (12) months or less. Coverage starts on the first day of the quarter that begins after receipt of these contributions by the Fund. For example, if employer contributions of \$6,200 are submitted to the Fund for work performed in the months of January through May, your coverage begins July 1.

When you satisfy these initial eligibility requirements you earn two quarters of coverage: (1) the initial quarter of coverage and (2) a free quarter which can be used if future employer contributions are insufficient to satisfy the continuation of eligibility requirements described in the next section of this booklet.

CONTINUATION OF ELIGIBILITY

After satisfying the requirements for Initial Eligibility, your coverage will continue from quarter to quarter thereafter if,

- employer contributions of at least \$1,550¹ per quarter are received by the Fund on your behalf; **or**
- employer contributions of *less than* \$1,550 per quarter are received by the Fund on your behalf and you pay the shortfall after receiving a bill from the Fund for the difference between \$1,550 and any employer contributions received for the quarter. Self-payment is subject to the requirements described below.

Below is a schedule of which worked months are applied to each calendar quarter for eligibility of group health insurance coverage:

Worked Quarter	Quarter Applied to For Eligibility
August . October	January . March
November . January	April . June
February . April	July . September
May . July	October . December

REQUIREMENTS APPLICABLE TO CONTINUATION OF ELIGIBILITY BY SELF- PAYMENT

Plan Participants who continue eligibility by paying the shortfall between employer contributions and the group rate of \$1,550 per quarter required by the Plan are subject to the following requirements:

- You must timely pay the amount billed;
- You can continue eligibility by making up the shortfall in employer contributions only if total employer contributions made on your behalf during the current or previous calendar year meet or exceed \$6,200¹ (or are based on at least \$40,000¹ in covered wages). If employer contributions fall short of this amount, you can continue to make up the difference by self-payment only up to the first quarter of the following year. At the end of the first quarter you will be subject to loss of Eligibility as described below.

¹ These amounts are subject to change by the Board of Trustees based on the financial status of the Plan.

- You cannot continue eligibility by making up the shortfall in employer contributions by self-payment for more than three (3) consecutive quarters, if no employer contributions are made on your behalf during those three quarters. *Also, these three quarters run concurrently with any applicable COBRA period.* After you have used up these three quarters you will be subject to loss of Eligibility as described below.
- Instead of self-payment you may use the free quarter earned when you established initial eligibility. You will be given the option of using the free quarter on your quarterly billing.

LOSS OF ELIGIBILITY

You lose coverage,

- because employer contributions made on your behalf for the quarter fall below \$1,550, but you elect not to self-pay the shortfall (or ineligible to do so under the terms of the Plan) and the free quarter has been applied;
- or**
- because you have made up the shortfall in employer contributions for as long as is permitted by the terms of the Plan and used the free quarter;

The loss of eligibility is a COBRA Qualifying Event as described on pages 7 through 9 of this booklet.

Once you lose coverage you must reestablish eligibility as described on page 1 under the heading Initial Eligibility.

DEPENDENT ELIGIBILITY

ELIGIBLE DEPENDENTS

Your eligible dependents will be covered for benefits when the Plan Participant becomes eligible for coverage or when the individual becomes an eligible dependent. Eligible dependents are the Plan Participant's legal spouse, same-sex domestic partner if approved by the Fund prior to April 1, 2015, biological children, legally adopted children, or stepchildren.

The Fund requires a certified copy of the Plan Participant's marriage license/certificate. Your spouse will become eligible on the first day of the month following the date the Fund receives your marriage license/certificate. A certified copy of each child's birth certificate is required and must be submitted to the Fund office as soon as practicable. A certified copy of a court order of adoption is required and must be submitted to the Fund office as soon as practicable. Your dependent as a result of birth, adoption, or placement for adoption, will become eligible on the date of the birth, adoption, or placement for adoption. A dependent child may be covered to age 26. See definition of Children on page 67.

A domestic partner approved by the Fund prior to April 1, 2015 will be eligible as a dependent, provided he/she satisfies the definition of Domestic Partner on page 67.

Qualified Medical Child Support Orders (including any National Medical Support Notice)

Federal law requires the Plan, under certain circumstances, to provide coverage for your children when you and your spouse divorce. The process begins when the Plan receives a Qualified Medical Child Support Order (QMCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

1. Issues from a court of competent jurisdiction pursuant to a state's domestic relations law;
2. Requires you to provide only the group health coverage available under the Plan for your children, even though you no longer have custody; and

3. Clearly specifies:
 - a. Your name and last known mailing address and the names and addresses of each child covered by the order;
 - b. A reasonable description of the coverage to be provided;
 - c. The length of time the order applies; and
 - d. Each plan affected by the order.

If the Plan receives a judgment, decree or order, the Fund must determine if it is a QMCSO. If it is determined to be a QMCSO, the Plan must permit immediate enrollment. This means the children identified will be included for coverage as your eligible dependents. The child's custodial parent, legal guardian, or a state agency can make application for coverage, even if you do not.

The Plan may pay benefits:

1. to a custodial parent or legal guardian if claim is made for reimbursement of benefits paid for a child named in a Qualified Medical Child Support Order;
2. directly to a provider if a custodial parent or legal guardian has made an assignment to the provider for such benefits.

Payments made to the custodial parent, the legal guardian, or the provider will be treated as discharging the obligations of the Plan. You may obtain a copy of the Plan's QMCSO procedures by calling BeneSys at (925) 398-7043.

ENROLLING NEW DEPENDENTS

For enrolling new dependents, please contact BeneSys. In case of marriage, coverage takes effect the first day of the month following the date the Fund receives your marriage license/certificate. In the case of a dependent's birth, adoption, or placement for adoption, coverage is effective as of the date of the birth, adoption, or placement for adoption.

SPECIAL ENROLLMENT RIGHTS

Although the Fund does not allow you to decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, the law requires that the Plan inform you of your special enrollment rights.

If you terminate your employment with a contributing employer under the Fund and you obtain employment with a new employer which offers a health plan that you decline because of other health coverage (for example: through your spouse), you may in the future be able to enroll yourself and your dependents in your new employer's plan if you lose the other group health coverage. You must request enrollment within 30 days after the loss of your other group health coverage or you will lose this special enrollment right. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Call BeneSys if you would like more information about this right.

CONTINUED COVERAGE FOR DISABLED CHILDREN

A dependent child whose coverage would otherwise terminate solely due to attainment of the limiting age shall continue to be an eligible dependent if he/she is incapable of self-sustaining employment by reason of mental or physical handicap. Eligibility shall continue so long as he/she remains disabled, unmarried and dependent on you for support and maintenance, and provided that written evidence of such incapacity acceptable to the Fund is furnished to the Fund office within thirty-one (31) days after the child reaches age 26. Proof of the continued existence of such incapacity acceptable to the Fund must be furnished upon request by the Fund.

TERMINATION OF DEPENDENT ELIGIBILITY

A dependent's eligibility will terminate when the Plan Participant's coverage terminates, or when the individual ceases to be an eligible dependent as described. Upon a filing for divorce, the Plan Participant must notify the Fund office immediately. **A Plan Participant who fails to provide the Fund with timely notice of the final divorce decree will be held liable by the Fund for all claims paid on behalf of the divorced spouse after the date of divorce (See Notice Requirement on page 8) and/or legal fees incurred by the Fund as a result of such untimely notice.** No coverage is provided for a dependent while in full-time military, naval or air force service.

Dependent eligibility may be continued temporarily as provided for in the section titled "COBRA Continuation Coverage" on pages 7 through 10 of this booklet.

If a domestic partner (approved prior to April 1, 2015) of a Participant has been considered eligible for the same benefits as an eligible dependent, eligibility for the domestic partner will terminate at the end of the month in which the domestic partnership is terminated. A Plan Participant who fails to provide the Fund with timely notice of the termination of domestic partnership will be held liable by the Fund for all claims paid on behalf of the domestic partner after the date of such termination and/or legal fees incurred by the Fund because of such untimely notice. Continuation of health plan coverage by self-payment is not an option for a domestic partner dependent that loses coverage because the domestic partnership has terminated.

DISABILITY AND EXTENDED BENEFITS FOR ACTIVE PLAN PARTICIPANTS AND THEIR DEPENDENTS

EXTENDED BENEFITS

In the event a Plan Participant (or his/her dependents) is Totally Disabled on the date eligibility terminates for any reason, and remains totally and continuously disabled, eligibility will continue with no contribution payment for claims relating to that disability. Termination of coverage will occur at the earliest of the following dates:

1. the termination of the disability; or
2. the expiration of twelve (12) continuous months following termination of eligibility; or
3. coverage by another group plan, which does not exclude coverage for the Plan Participant's disabling condition.

The physician and/or surgeon's written certification of the disability must be received by the Fund within ninety (90) days after eligibility otherwise terminates and at ninety (90) day intervals thereafter.

ELIGIBILITY RULES FOR RETIRED PLAN PARTICIPANTS AND THEIR DEPENDENTS

Eligibility for coverage under the Plan after retirement is based on the requisite years of continuous service in the I.A.T.S.E. Local 16 Pension Plan. To be eligible for coverage as a Retiree, you must be an Active Plan Participant in at least 12 of the 20 quarters immediately preceding your date of retirement, you must be at least 55 years of age, and you must satisfy one of the following conditions:

1. If you retire at age 62 or older with 35 years of continuous service under the I.A.T.S.E. Local 16 Pension Plan, the Fund charges a self-payment of \$300 per quarter, **until you are Medicare eligible and enrolled on Medicare Part A (hospital insurance) and Part B (medical insurance), when self-pay requirement will cease.** If you retire before age 62 years (55 years through age 61 years) with 35 years of continuous service under the I.A.T.S.E. Local 16 Pension Plan, you and your dependents are eligible for Retiree coverage subject to self-payments of \$1,892.86 per quarter (or the amount then determined by the Board of Trustees) until you are Medicare eligible and enrolled on Medicare Part A (hospital insurance) and Part B (medical insurance), when self-pay requirement will cease.

2. **If upon retirement you have accrued at least 25 years of continuous service under the I.A.T.S.E. Local 16 Pension Plan:** you and your dependents are eligible for Retiree coverage subject to self-payments of \$1,892.86 per quarter until you are Medicare eligible and enrolled on Medicare Part A (hospital insurance) and Part B (medical insurance) when self-payments will revert to the current group rate in effect at that time.

A Participant who does not have at least 25 years of continuous service under the Pension Plan is entitled upon retirement to elect COBRA continuation coverage as described on pages 7 through 10 of this booklet.

Periods of disability as recognized by the Plan and approved by the Board of Trustees will not count as breaks in continuous service.

DEPENDENT ELIGIBILITY

The spouse and/or dependents of a Retiree are eligible for Retiree coverage only if they meet the following two (2) requirements:

1. Residence in the same household as the Retiree as of the date of retirement, and
2. Continuous eligibility for benefits under the I.A.T.S.E. Local 16 Health and Welfare Plan at least **36 months** immediately preceding the date of retirement.

Dependent children will remain covered for as long as they meet the requirements established on page 2 for "Children".

If the spouse and/or dependents do not meet the above two (2) requirements for coverage, their eligibility for benefits will terminate upon the Plan Participant's retirement and they will be entitled to continue coverage pursuant to COBRA as described on pages 7 through 10 of this booklet.

Retirees and their dependents eligible for Medicare must be enrolled in both Part A (hospital insurance) and Part B (medical insurance) to be covered under the Plan.

ELIGIBILITY RULES FOR TOTALLY DISABLED RETIRED PLAN PARTICIPANTS AND THEIR DEPENDENTS

If you are "Totally Disabled" as defined by the Plan on page 69 and you retire as a result of your disability, you and your dependents will remain eligible without self-payment if you meet the following conditions:

1. You were continuously working under an I.A.T.S.E. Local 16 Collective Bargaining Agreement and covered in the I.A.T.S.E. Local 16 Health and Welfare Trust Fund for a continuous ten (10) year period immediately preceding the onset of your disability,
2. You are Medicare eligible by virtue of your disability and are collecting Social Security Disability Benefits, and
3. You enroll in Medicare Plan A (hospital insurance) and Plan B (medical insurance).

DEPENDENT ELIGIBILITY

The spouse and/or dependents of a Plan Participant who retires as a result of being Totally Disabled are eligible for Retiree coverage only if they meet the following two (2) requirements:

1. Residence in the same household as the disabled Retiree as of the date of retirement, and
2. Continuous eligibility for benefits under the I.A.T.S.E. Local 16 Health and Welfare Plan for at least 36 months immediately preceding the date of retirement.

Dependent children will remain covered for as long as they meet the requirements established on page 2 for "Children".

If the spouse and/or dependents do not meet the above two (2) requirements for coverage, their eligibility for benefits will terminate and they will be entitled to continue coverage pursuant to COBRA as described on pages 7 through 10 of this booklet.

HEALTH AND WELFARE BENEFITS FOR RETIREES ARE NOT GUARANTEED AND MAY BE CHANGED OR ELIMINATED AT ANY TIME BY ACTION OF THE BOARD OF TRUSTEES. THE BOARD ALSO RESERVES THE RIGHT TO CHANGE THE RETIREE SELF-PAYMENT RATES AT ANY TIME. ANY CHANGES IN THE PLAN, INCLUDING CHANGES IN THE RETIREE ELIGIBILITY RULES, BENEFITS FOR RETIREES, AND RETIREE SELF-PAY RATES, MAY BE APPLIED TO INDIVIDUALS WHO HAVE ALREADY RETIRED AS WELL AS TO FUTURE RETIREES.

CONTINUATION OF DEPENDENT ELIGIBILITY AFTER DEATH OF PARTICIPANT

If the Plan Participant dies before retirement and has continuously worked twenty-five (25) years under an I.A.T.S.E. Local 16 Collective Bargaining Agreement and has 25 years of continuous service under the I.A.T.S.E. Local 16 Pension Plan, the Plan Participant's widow/widower will be entitled to medical, dental, prescription drug and vision coverage without self-payment. This Plan will be the secondary payer (see Coordination of Benefits Section starting on page 52) if the widow/widower is or becomes covered under another group plan or becomes eligible for Medicare.

The dependent children of a deceased Plan Participant who has continuously worked twenty-five (25) years under an I.A.T.S.E. Local 16 Collective Bargaining Agreement and has 25 years of continuous service under the I.A.T.S.E. Local 16 Pension Plan will be covered for medical, dental, prescription drug and vision benefits up to age 26, subject to the requirements described on page 2 of this SPD.

Coverage in the Plan for the widow/widower and/or dependent children will end if the widow/widower remarries.

NOTE: The widow/widower and/or dependent Children of a Plan Participant who dies before retirement and has completed twenty-five (25) years of continuous service are eligible for coverage only if they meet the following two (2) requirements:

1. Residence in the same household as the Plan Participant at the time of the Plan Participant's death, and
2. Continuous eligibility for benefits under the I.A.T.S.E. Local 16 Health and Welfare Plan for at least 18 months immediately preceding the Plan Participant's death.

If the widow/widower and/or dependent Children do not meet the above two (2) requirements for coverage, their eligibility for benefits will terminate and they will be entitled to continue coverage pursuant to COBRA.

TERMINATION OF COVERAGE

Your coverage under the Plan will automatically terminate on the earliest of the following dates: (1) the date the Plan terminates, (2) the last day of the last month of Employer-paid coverage, (3) the date you enter full-time military, naval or air service, or (4) the date you cease to be eligible to continue coverage by self-payment.

Unless otherwise described here, termination of your coverage automatically terminates coverage for your dependents.

If you are hospitalized and eligible for hospital or skilled nursing benefits under the terms of the Plan at the time your eligibility terminates, coverage will continue until you are discharged, hospitalization is no longer medically necessary or the expiration of twelve (12) months, whichever occurs first.

As described in the Eligibility Rules, self-pay continuation coverage applies towards the lengths of COBRA coverage listed below.

COBRA CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you and/or your covered dependents lose coverage, you and/or your dependents may be eligible to continue your medical, prescription drug, dental and vision coverage by self-payment for a temporary period. To be eligible, a qualifying event causing the loss of coverage must take place.

Qualifying Events for Employees

A qualifying event occurs if,

1. your employment ends (for reasons other than your gross misconduct); or
2. your hours are reduced to the point where you lose employer-paid coverage.

You and/or your dependents may continue the coverage you had for up to 18 months following the month in which your termination or reduction in hours occurs. COBRA Continuation Coverage requires a monthly payment of 102% of the cost to the plan for similarly situated individuals who have not experienced a qualifying event.

If while on continuation coverage, your spouse and/or dependents have another qualifying event, your spouse and/or dependents may be entitled to an extended period of COBRA coverage. For example, assume that you, your spouse and children are entitled to continued coverage for 18 months because of your termination of employment; if you died during this 18-month period, your spouse and children may continue coverage for a total of 36 months from the date of termination, provided that they make the necessary COBRA payments and the Fund is informed as outlined under **Second Qualifying Events** (see page 9).

Disability Extension of 18-Month Period

If you or a covered dependent are determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, coverage may be continued for an additional 11 months, for a total of 29 months provided the disability started before the 60th day of COBRA continuation coverage. The Fund must be informed of the Social Security Administration (SSA) determination of disability before the end of the 18-month continuation coverage period. COBRA may be continued for all qualified family members of the disabled individual. The disability determination must be received by the Fund within 60 days after the latest of:

1. the date of the SSA disability determination;
2. the date on which the qualifying event occurs;

3. the date on which the qualified beneficiary loses coverage; or
4. the date on which the qualified beneficiary is informed, through the furnishing of the summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Fund.

If the determination is not received by the Fund within the 60-day period as stated above and before the end of the original 18-month period, COBRA will not be extended and will terminate at the end of the 18 months.

The cost for the additional 11 months is 150% of the plan's total cost of COBRA continuation coverage. In the event you are no longer considered disabled by Social Security, you must notify the Fund within 30 days of the date of the Social Security Administration's determination. Your coverage will terminate the first day of the month that begins more than 30 days after the re-determination.

Qualifying Events for Dependents

If one of the following qualifying events occurs, your spouse's and/or your children's coverage may be continued for up to **36 months**:

1. You die while you and your dependents are covered by the Plan.
2. Your divorce.
3. You become entitled to Medicare (if your dependents lose coverage due to the entitlement).
4. Your child ceases to be a dependent as defined by the Plan.

Multiple Qualifying Events

Although a spouse or dependent child may suffer more than one qualifying event, the maximum duration of COBRA coverage is 36 months from the date of the first qualifying event.

Withdrawal of Contributing Employer

If you or your dependents experience a Qualifying Event and you or your dependents elect COBRA continuation coverage and your former Employer (through which COBRA was elected) later stops contributing to this Fund, you may continue COBRA coverage. However, if your former Employer has an existing plan or establishes a new plan to cover a class of active employees formerly covered under this Fund, your COBRA continuation coverage will be terminated under this Plan since your former Employer is required to provide COBRA continuation coverage for you and/or your dependents.

The withdrawal of a contributing Employer from the Fund is not considered a qualifying event and current employees of the withdrawing Employer will not be allowed to continue coverage under COBRA.

Notice Requirement

If your spouse or child qualifies for continuation of coverage due to a qualifying event such as divorce or reaching an age where he or she is too old to qualify as a dependent under the Plan, you must send written notice to the Fund. This notice should be given within 60 days of the latest of: (1) the date of the qualifying event, (2) the date on which there is a loss of coverage, or (3) the date on which the qualified beneficiary is informed, through the Plan's SPD or the general notice, of his/her obligation to provide notice and the procedures for providing such notice. The written notice must specify the name of the Plan, the name of the former employee, the type of qualifying event, the date of the qualifying event, and the names of the individuals eligible for the extension due to the qualifying event.

If this notice is not provided to the Fund within (sixty) 60 days of the death, divorce or birthday, your dependent's right to continue under COBRA will be lost.

In the case of any other Qualifying Event, the Employer will notify the Fund.

Once the Fund is notified of a Qualifying Event, a letter will be sent to the employees and Qualified Beneficiaries explaining their options to continue coverage. This letter will be addressed to the employee and Dependents at the address of record maintained by the Fund. It is the responsibility of all Qualified Beneficiaries to keep the Fund informed of their current mailing address.

If you are a covered former employee, you may add your newborn or adopted Children to your continuation coverage, provided you add the Child(ren) within *30 days* of the birth or adoption. These Children whom you add to coverage will be considered Qualified Beneficiaries under the law.

Second Qualifying Events

The Fund must be informed within 60 days of the occurrence of a second qualifying event, such as, the death, divorce or legal separation of the former employee or a dependent child ceasing to be eligible as a dependent under the Plan. The notice must specify the name of the Plan, the name of the former employee, the type of qualifying event, and the names of the individuals eligible for the extension due to the qualifying event. If the Fund is not informed within this 60-day period, the right to extend COBRA coverage will be lost.

Election Requirement

You and/or your dependents must make written election on the forms provided by the Fund within 60 days after the later of:

1. The date coverage would end if no continuation was elected; or
2. The date the COBRA election notice is provided.

The election form must be mailed or delivered to the Fund within the stated 60-day period. If mailed; the notice must be postmarked within this 60-day period; otherwise, the continuation option expires. Any Qualified Beneficiary who fails to send the election form to the Fund to continue coverage within the 60-day period will not be permitted to continue any level of coverage.

Waiver of COBRA

If you waive your right to continue coverage under COBRA and if within the 60-day election period you decide that you would like to continue coverage, you may revoke that waiver as long as you send in the election form within that 60-day period, however, your coverage will only be reinstated as of the date of your election. You will not have coverage for any claims that you may have incurred between the date of your loss of coverage due to a qualifying event and the date that you elected COBRA.

Premium Payment

The Board of Trustees may increase the premium payment required on a yearly basis if the cost to the Fund increases. You are responsible for making your monthly premium payments on a timely basis. No bills or notices will be sent

For payment to be considered timely:

1. Your initial premium payment must be received by the Fund within 45 days of the date you elected COBRA. Your initial payment must cover the period from the date of loss of coverage due to the qualifying event up to the date you elected COBRA.
2. Subsequent payments must be received by the Fund by the first day of the month of coverage. If you fail to pay your premium within 30 days of the due date, your coverage will automatically terminate. You will only be provided coverage to the end of the month for which payment was received.

Once cancelled, your COBRA continuation coverage cannot be reinstated.

Notice of Unavailability of Continuation Coverage

The Fund will send written notices of the unavailability of COBRA in cases of the following:

1. If a notice is received about a qualifying event, second qualifying or disability determination and the individual is not entitled to COBRA or further continuation of COBRA;
2. If COBRA will terminate earlier than the end of the maximum period applicable to the qualifying event, i.e., for non-payment of the premium on a timely basis; the qualified beneficiary becomes entitled to Medicare or another group health plan; the qualified beneficiary is no longer disabled; or any other reason that the Plan would terminate coverage for an active employee or participant not under COBRA (such as fraud).

The notice will be sent by mail to qualified beneficiaries at the most current address on file and will include the following information:

1. If unavailable, the reason for the unavailability of COBRA to the individual who requested continuation coverage or why COBRA cannot be extended;
2. If terminated earlier, the reason for the termination of COBRA if earlier than the end of the maximum period;
3. The effective date of the termination; and
4. Any rights that may be available to qualified beneficiaries, such as conversion.

COBRA RIGHTS IN THE EVENT OF BANKRUPTCY

A Retiree and his/her covered dependents are entitled to pay for COBRA coverage until the Retiree's death, if the Retiree would lose his/her Plan coverage because his/her former employer filed for federal bankruptcy protection or if his/her Plan coverage was substantially eliminated within the twelve (12) month period preceding or following the commencement of a bankruptcy action. In addition, if a Retiree on COBRA coverage dies, his/her surviving spouse and any eligible dependents may pay for COBRA coverage for an additional thirty-six (36) months from the date of the Retiree's death.

AUTOMATIC COVERAGE FOR DEPENDENTS

When the covered Plan Participant chooses to continue coverage, coverage for his/her spouse and dependents will continue automatically. But, if the covered Plan Participant chooses not to continue coverage, his/her spouse and eligible dependents may still continue coverage. Each qualified beneficiary has an independent right to elect COBRA. Of course, in all circumstances, anyone electing continued coverage must pay for it.

TERMINATION OF CONTINUED COVERAGE

Continued coverage will end **automatically** as of the date any of the following situations occur:

1. The date the Plan ends.
2. The date your Employer, through which COBRA was elected, is no longer a contributing Employer and has an existing plan or established a new plan to cover any active employees formerly covered under this Plan.
3. The required premiums are not paid on a timely basis.
4. The date a qualified beneficiary becomes, after the date of election, entitled to Medicare or covered under any other group health plan.
5. The first day of the month that begins more than thirty (30) days after the date of the final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.
6. The date the maximum period of continued coverage must be provided, i.e., 18 or 36 months, or in the case of a disability extension, 29 months.

FAMILY MEDICAL LEAVE ACT

The Family Medical Leave Act enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the covered employee.

It is not the role of the Trustees or Fund to determine whether an individual employee is entitled to leave with continuing medical care under the federal statute, any state statute or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the Employer, employee and where applicable, the local union.

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

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (“USERRA”)

Under this Federal act, your Employer must offer to continue coverage for you and your dependents for up to twenty-four (24) months while you are on military leave. If you make this election, you must submit any self-payment necessary, which may include administrative costs, to your Employer. If you do not continue your coverage during a military leave, it will be reinstated at the same benefit level you received before your leave if you meet the eligibility criteria established under USERRA. For more information about this Act, contact your Employer or the Fund.

COST CONTAINMENT PROGRAMS

Benefits are provided only for medically necessary and appropriate services. Cost containment provides you with valuable information so that you can avoid unexpected out-of-pocket costs. When the cost containment programs are properly used, you will know in advance whether the Plan has determined the services are medically necessary and appropriate and therefore eligible for benefits.

Cost containment programs are designed to work together. The utilization review program applies to hospital admissions and outpatient surgery at an ambulatory surgical center. The authorization program applies to certain specialized services or treatments. The personal case management program allows for coordination and management of long-term intensive medical care.

No benefits are payable, however, unless you are covered by the Plan at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this Plan.

Important: Cost containment requirements described in this section do not apply when coverage under this Plan is secondary to another plan providing benefits for you or your dependents.

REMINDER REGARDING THE FOLLOWING SERVICES PROVIDED BY ANTHEM BLUE CROSS

It is important that Plan participants understand that, although Anthem Blue Cross may make a determination on a surgical procedure or hospital stay as being medically necessary, it is not the responsibility of Anthem Blue Cross to determine covered benefits or eligibility issues. This is the responsibility of the Board of Trustees with the assistance of BeneSys.

PRE-AUTHORIZATION REQUIREMENTS

No benefits are payable unless you have received approval *before* treatment for,

- Hospital Admissions: Anthem Blue Cross, the Fund's utilization review organization, must approve any hospital admission . except urgent care admissions - **before** you go to the hospital.
- Treatment for Alcohol or Chemical Dependency.
- Home Care or Alternative Treatment of any kind.
- Procedures (including outpatient procedures) to be performed at a non-Contract Hospital (a hospital not in the Anthem Blue Cross Network).
- Hospice Care.
- Hearing Aids.

For preauthorization for hospital admissions, home or alternative care, procedures to be performed at a non-contract hospital, hospice care, or hearing aids, you (or your doctor) must call Anthem Blue Cross at (800) 274-7767. For preauthorization of prescription drugs (including injectables) you must call OptumRx at (800) 711-4555. For preauthorization of alcohol or chemical dependency you must call the Teamster's Assistance Program (TAP) at (510) 562-3600.

Benefits are provided only for medically necessary and appropriate services. Cost containment provides you with valuable information so that you can avoid unexpected out-of-pocket costs. When the cost containment programs are properly used, you will know in advance whether the Plan has determined the services are medically necessary and appropriate and therefore eligible for benefits.

UTILIZATION REVIEW PROGRAM

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided.

These reviews and certifications are performed by the Anthem Blue Cross Review Center (Review Center) staffed by physicians and other health care professionals. The telephone number to call for utilization review is (800) 274-7767 as shown on your *plan identification card*.

It is your responsibility to see that your *physician* starts the utilization review process before scheduling any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown below under the heading “Effect on Benefits if a Claim is Not Submitted for Pre-Admission Utilization Review”.

UTILIZATION REVIEW REQUIREMENTS

Utilization Reviews are required for,

- All inpatient hospital stays
- Outpatient Surgical Procedures at an Ambulatory Surgical Center
- Obesity Claims (other than the first office visit to diagnose)

Exceptions: Utilization review is not required for inpatient hospital stays for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency hospital admissions and ambulatory surgical center services.
2. **Concurrent review** determines whether services are medically necessary and appropriate when pre-service review is not required *or has not been performed as required*.
3. **Retrospective review** is performed to review services that have already been provided in cases when the Review Center was not notified and therefore was unable to perform a pre-service or concurrent review, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

Effect on Benefits if a Claim is Not Submitted for Pre-Admission Utilization Review

- When pre-service review is not performed as required for a hospital admission or outpatient surgical procedure at an ambulatory surgical center, the benefits to which you would have been otherwise entitled will be subject to a **20% reduction**.
- Services that are not reviewed by the Anthem Blue Cross Review Center through the applicable utilization review procedures will be reviewed when the bill is submitted for benefit payment. If that review results in the determination that part or not all of the services were medically necessary and appropriate, benefits will not be paid for those services. Remaining benefits will be subject to a **20% reduction**.

HOW TO OBTAIN UTILIZATION REVIEW

Remember, it is always your responsibility to confirm that the review has been performed. This is how to obtain a utilization review:

1. You or your physician must initiate the pre-service review at least **three working days prior** to when you are scheduled to receive services.
2. You must **tell your physician that this Plan requires pre-service review**. Physicians who are Anthem Blue Cross Prudent Buyer PPO participating providers will initiate the review on your behalf. A non-participating provider may initiate the review for you, or you may call the Anthem Blue Cross Review Center directly. The Review Center's toll-free number is (800) 274-7767 as printed on your identification card.
3. If you do not receive the certified service within **60 days** of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. **The Anthem Blue Cross Review Center will certify services that it determines are medically necessary and appropriate.** For inpatient hospital stays, the Review Center will, if appropriate, certify a specific length of stay for approved services. You, your physician and the provider of the service will receive a notice showing this information.
5. If the Anthem Blue Cross Review Center determines that the proposed services are not medically necessary and appropriate, your physician will be notified immediately. Written notice will be sent to you and the provider of the service.

Concurrent Reviews

1. If pre-service review was not performed, you, your physician or the provider of the service must contact the Anthem Blue Cross Review Center for concurrent review. For an emergency admission or procedure, the Review Center must be notified within one working day of the admission or procedure, unless extraordinary circumstances¹ prevent such notification within that time period.
2. When they have been informed of your need for utilization review, Anthem Blue Cross Prudent Buyer PPO participating providers will initiate the review on your behalf. You may ask a non-participating provider to call the Anthem Blue Cross Review Center, or you may call the Review Center directly. The Review Center's toll-free number is printed on your identification card.
3. If the Anthem Blue Cross Review Center determines that the service is medically necessary and appropriate, the Review Center will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The Review Center will also determine the medically appropriate setting.
4. If the Anthem Blue Cross Review Center determines that the service is not medically necessary and appropriate, you and your physician will receive written notice.

Retrospective Reviews

1. Retrospective review is performed when the Anthem Blue Cross Review Center has not been notified of the service you received, and therefore has been unable to perform the appropriate review prior to your discharge from the hospital or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

¹ **Extraordinary Circumstances.** In determining ~~extraordinary circumstances~~, we may take into account whether or not your condition was severe enough to prevent you from notifying the Review Center, or whether or not a member of your family was available to notify the Review Center for you. You may have to prove that such ~~extraordinary circumstances~~ were present at the time of the emergency.

It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services that have been retroactively determined not to be medically necessary and appropriate will be retrospectively denied certification.

MEDICAL CASE MANAGEMENT PROGRAM

Extensive, long-term treatment and/or potentially high-cost care may be subject to Anthem Blue Cross Medical Case Management Program. Case management assures that the Participant obtains quality medical care by the most cost-effective use of health care resources. Medical case management services seek alternative settings and providers, coordinate the sequence of care by facilitating communications among providers and patient, and perform continuous monitoring of care.

Benefit Substitution Policy

In some instances, a Participant's medical needs may be best met by offering a service or supply, which is not normally covered by the Plan. When this is the case, the service or supply will be covered by the Plan only if:

- (A) The service or supply is provided in lieu of a more costly service or supply, which is covered by the Plan; and,
- (B) The benefit substitution is supported by Anthem Blue Cross and approved by the Board of Trustees.

DISAGREEMENTS WITH COST CONTAINMENT PROGRAM DECISIONS

If you or your physician disagree with a cost containment program decision, or question how it was reached, you or your physician may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the Anthem Blue Cross Review Center that made the determination. The address and the telephone number of the Review Center are included on your written notice of determination. See pages 48 through 51 regarding Claims Appeal Procedures.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund maintains an agreement with the **Anthem Blue Cross PPO Prudent Buyer Plan** providing for "Preferred Provider" rates for hospitals, physicians, laboratories, chiropractors, physical & occupational therapists, surgery centers and ancillary providers. Because PPO hospitals and physicians have agreed to bill less than their ordinary charges, you benefit directly when you use PPO hospitals and physicians. For example, covered benefits are paid at 80% for PPO physicians and outpatient hospital services, and 50% of Usual, Customary and Reasonable charges for non-PPO physicians and outpatient hospital services. Charges for inpatient PPO hospital services are paid at 90%, and charges for inpatient non-PPO hospital services are paid at 60%.

A current directory of all PPO hospitals and physicians (the PPO Provider List) is provided automatically to all Plan Participants without charge. **However, the PPO Provider List is subject to change.** To ensure that your physician is still a member of the Anthem Blue Cross PPO Prudent Buyer Plan or to receive the most current PPO Provider List free of charge, please call BeneSys at (925) 398-7043 before your initial appointment with a physician listed in the PPO Provider List. You may also access current PPO Provider listings by logging on to the Blue Cross website at www.anthem.com/ca.

ADDITIONAL ANTHEM BLUE CROSS FEATURES

Web Capabilities

Starting off by entering the Anthem Blue Cross website at www.anthem.com, under Member Log In you must first start an account by clicking on **Register Now** which will guide you to create a Username and Password.

From there you will be able to:

1. Find out what the Plan covers and other details;
2. Check the status of claims;
3. Compare cost and quality for common medical procedures;
4. Find a doctor;
5. Take a health assessment to get an accurate picture of where you stand health-wise;
6. Personalize your health record, where you can keep all of your health information in one place;
7. Find discounts on vitamins, health and beauty products, fitness center memberships, weight-loss programs and more;
8. Mobile Options. On the website you can register for and download the Anthem app on an Apple or Android device to:
 - a. Find a doctor or urgent care center and get directions there
 - b. Get cost estimates and provider ratings for procedures
9. Further information on wellness, prevention, weight management and eating healthy can be found at <http://timewellspent-ca.anthem.com/>

LiveHealth Online

LiveHealth Online is a communications tool that lets you talk to board certified doctors online by two-way video on a computer or mobile device. Doctors can answer questions, make a diagnosis and may prescribe basic medications. Doctors are available seven days a week, 24 hours per day. An average fee is just \$49 of which the Fund will cover 80% (\$39.20) and you will be responsible for the remaining 20% (\$9.80). Visit www.livehealthonline.com to get started.

BlueCard

BlueCard® is a program that allows Anthem Blue Cross members to access benefits and receive healthcare services while traveling or living outside their Plan's service area. The program links participating providers and the Blue Cross Blue Shield Association Plans across the United States through a single electronic network for claims processing and reimbursement.

SUMMARY OF MEDICAL, SURGICAL AND HOSPITAL EXPENSE BENEFITS

The Plan provides benefits for services rendered in accordance with generally accepted United States medical standards and which are accepted by the medical community as a whole.

BENEFITS SHALL BE PROVIDED ONLY TO THE EXTENT THAT SERVICES ARE DETERMINED TO BE MEDICALLY NECESSARY. THE INITIAL DETERMINATION OF MEDICAL NECESSITY WILL BE MADE BY THE PLAN. THE FACT THAT A PHYSICIAN OR OTHER PROVIDER PRESCRIBES OR ORDERS THE SERVICES DOES NOT MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE UNDER THE PLAN.

Only usual, customary and reasonable (UCR) charges for physician's services, drugs, medicines, injections, supplies, appliances and rental equipment will be considered covered charges for claim payment. The Plan provides coverage only for services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and that fall within the customary frequency of services for the diagnosed condition.

Benefits will only be furnished for (1) the services of a physician, chiropractor, dentist, optometrist, dispensing optician, podiatrist or psychologist; or, (2) when a physician refers you to the services of a licensed clinical social worker, family or child counselor, physical therapist, speech pathologist, audiologist or occupational therapist (provided that the provider is properly licensed, and services are within the scope of the provider's license, and their services are a benefit of the Plan Participant's coverage and benefits would have been provided under the terms of the Plan if rendered by a physician).

MAXIMUM OUT-OF-POCKET EXPENSES

The out-of-pocket expense threshold per individual for covered medical, surgical and hospital charges is \$6,000 per Plan Year. The out-of-pocket expense threshold only applies to medical benefits (not dental, drug or vision benefits). Once the out-of-pocket expense has reached \$6,000, all future covered PPO claims are paid at 100% and all covered non-PPO claims are paid at 90% of UCR.

The fact that a medical expense is covered by the Plan does not mean that it will be paid in full. If the bill exceeds usual, customary and reasonable (UCR) charges, you will be responsible for the difference between UCR charges and your doctor's charges. This difference will not be counted toward the \$6,000 out-of-pocket expense threshold.

Illustration

For non-PPO charges totaling \$10,000, the Plan would apply usual, customary and reasonable (UCR) charges for these services. If the UCR allowable amount is \$8,000 for these services, the Plan will pay 50% of \$8,000, or \$4,000. The remaining 50% or \$4,000 is the Participant's responsibility and would be applied to the out-of-pocket expense threshold. The \$2,000 over the UCR charges is also the participant's responsibility and would not be applied toward reaching the \$6,000 out-of-pocket expense threshold, as it is not considered covered charges. When the amount of out-of-pocket reaches \$6,000, claims will be paid at 90% of UCR for non-PPO charges, with the Participant paying the remaining 10%. For PPO charges, the Plan will pay at 100% for the remaining PPO charges in the year.

DEDUCTIBLES

Effective each January 1, there will be a \$300 Plan Year medical benefit deductible per individual. The maximum deductible payable per Plan Year per family is \$900. The medical benefit deductible applies to PPO and non-PPO covered charges.

The medical benefit deductible does not apply to prescription drug, dental, life insurance or vision benefits nor to the Out-of-Pocket Expense threshold described on page 17.

PPO PROVIDERS

The applicable percentage of most medical or surgical charges covered by the Plan will depend on whether you use "Preferred Provider Organization" (PPO) hospitals, physicians, pathology laboratories, chiropractors, physical or occupational therapists, surgery centers and mental health specialists. See page 15 for further discussion of the Preferred Provider program.

PHYSICIAN AND RELATED CHARGES

PHYSICIAN VISITS

Benefits are paid at 50% (80% for a PPO provider) of UCR charges for one (1) visit per day made to a physician's office. The term "visit" means a personal visit to the physician that is medically necessary (but including well baby care to age 2) and does not include telephone calls or other situations where you are not personally examined by a physician.

PHYSICIANS' HOSPITAL AND SKILLED NURSING FACILITY VISITS

Benefits are paid at 50% (80% for a PPO provider) of UCR charges for one (1) visit per day made by a physician in a hospital or a skilled nursing facility, except when hospitalized for surgery, in which case charges are included in the surgeon's fee. The term "visit" means a personal bedside visitation by the physician that is medically necessary and does not include telephone calls or other situations where you are not personally examined by a physician.

SURGEON AND ASSISTANT SURGEON

Benefits are paid at 50% (80% for a PPO provider) of UCR covered charges.

PHYSICIAN ANESTHETIST

Benefits are paid at 50% (80% for a PPO provider) of UCR covered charges when entitled to surgical benefits. Coverage will be at 80% of UCR if the surgeon is a PPO provider.

RADIOLOGY AND CHEMOTHERAPY

Benefits are paid at 50% (80% for a PPO provider) of UCR covered charges.

ROUTINE PREVENTATIVE SERVICES

Benefits are paid at 50% (80% for a PPO provider) of UCR covered charges for health assessments that include routine prostate screening, routine pap, routine labs/x-ray, routine mammograms, routine colonoscopy or sigmoidoscopy (does not include breast pump or supplies).

IMMUNIZATIONS AND INOCULATIONS (INCLUDING FLU SHOTS)

Benefits are paid at 80% for a PPO provider and 80% of UCR covered charges for a non-PPO provider for immunizations and inoculations (including flu shots) as recommended by your physician.

MENTAL HEALTH AND FUNCTIONAL NERVOUS DISORDER CARE

A. INPATIENT

Physician charges are paid at 50% (80% for a PPO provider) of UCR covered charges.

B. OUTPATIENT

After referral by a primary care physician, benefits are paid at 50% (80% for a PPO provider) of UCR covered charges.

PREGNANCY AND MATERNITY CARE

Medical, surgical and midwifery charges for pregnancy (including abortion) are covered on the same basis as any other medical and surgical claim for each Active Plan Participant or dependent spouse. Claims for the services of a midwife will be covered only if the midwife is licensed by the State of California Board of Registered Nursing and associated with a credentialed facility with an OB/GYN on staff at the time services are rendered. If you incur covered expenses for medical or surgical treatment with respect to your pregnancy, the amount of the midwifery benefit shall be reduced by the amount of the medical and/or surgical covered expenses payable. Services related to the pregnancy of a dependent child (including abortion) are not covered, although services arising out of the complications of pregnancy are covered.

Group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Plan does not require that a provider obtain pre-authorization for prescribing a length of stay for the birth of a child not longer than 48 hours (or 96 hours in the case of a cesarean.)

SPECIAL DUTY REGISTERED NURSE

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider.)

LICENSED PHYSICAL OR OCCUPATIONAL THERAPIST

Services of a licensed physical or occupational therapist are covered only if you are referred by a primary care physician. Benefits are paid at 50% of UCR covered charges (80% for a PPO provider). Treatment plans exceeding 16 visits per diagnosis must be prior authorized by the Plan.

ALLERGY SERUM

Charges for allergy serum testing, preparation and its administration. Benefits are paid at 50% of UCR covered charges (80% for a PPO provider).

BIOFEEDBACK

Must be prescribed by a physician. Prior-Authorization is required after 12 visits per diagnosis. Benefits are paid at 50% of UCR covered charges (80% for a PPO provider).

BIRTH CONTROL

Birth control devices administered in a medical office, such as an IUD, are paid at 50% of UCR covered charges (80% for a PPO provider).

STERILIZATION

Charges for elective or medically required reproductive system sterilization performed by a physician. Benefits are paid at 50% of UCR covered charges (80% for a PPO provider).

DIABETIC SELF-MANAGEMENT

Limited to two visits per lifetime. Benefits are paid at 50% of UCR covered charges (80% for a PPO provider).

FOOT CARE/PODIATRY

Podiatry services are covered if medically necessary; routine foot care covered only for diabetics. Benefits are paid at 50% of UCR charges (80% for a PPO provider).

GROWTH HORMONES

Covered only if medically necessary. Benefits are paid at 50% of UCR covered charges (80% for a PPO provider).

BARIATRIC SURGERY

The first office visit is covered to diagnose; all other procedures are subject to prior authorization. Benefits are paid at 50% of UCR covered charges (80% for a PPO provider).

LICENSED SPEECH PATHOLOGIST OR AUDIOLOGIST

Services of a licensed speech pathologist or audiologist are covered if you are referred by a primary care physician. Benefits are paid at 50% of UCR covered charges (80% if a PPO provider).

CHIROPRACTIC SERVICES

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider) limited to twenty (20) visits per Plan Year. Chiropractic Services includes any treatment or diagnostic testing provided, supervised or directed by a licensed chiropractor (including neuromuscular and physical medicine) and incurred while under the care of a chiropractor, even if prescribed by a doctor of medicine and/or performed by a physical therapist.

ACUPUNCTURE SERVICES

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider) up to a \$1,000 maximum benefit per Plan year.

PRE-ADMISSION, LAB, AND X-RAY EXAMS

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider) if ordered by a physician within seven (7) days of the scheduled hospital confinement not including the day of admission.

DIAGNOSTIC OUTPATIENT X-RAY AND LABORATORY EXAMINATIONS

The Plan will pay 50% of UCR covered charges (80% if a PPO provider) for expenses incurred in connection with diagnostic x-ray examinations or microscopic or other laboratory tests or analysis made or recommended by a licensed physician out of the hospital.

BLOOD TRANSFUSIONS INCLUDING UNREPLACED BLOOD AND BLOOD PLASMA

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider).

DIALYSIS

Benefits are paid at 50% (80% for a PPO provider) of UCR covered charges.

DURABLE MEDICAL EQUIPMENT

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider). Durable Medical Equipment means equipment that: 1) is designed for repeated use; 2) is mainly and customarily used for medical purposes; and 3) is not generally of use to a person in the absence of a disease or injury. Durable medical equipment includes, but is not limited to, such items as: hospital bed; wheelchair; iron lung; traction apparatus; intermittent positive pressure breathing machine; brace; crutch; orthotics (limited to one pair every two years). Coverage also includes cranial prostheses (wigs) up to \$250 per prosthesis where hair loss is the result of a condition covered by the Plan.

FIRST PAIR OF CONTACT LENSES OR EYEGASSES REQUIRED AS A RESULT OF EYE SURGERY

Benefits are paid at 80% of UCR covered charges.

BONE DENSITY TESTING

Bone Density Testing is a covered benefit paid at 50% of UCR covered charges (80% if a PPO provider) for those:

- a. Who are at least age 50, and
- b.
 - i. Who suffer from osteodystrophy or osteoporosis, or
 - ii. Estrogen deficient women at clinical risk for osteoporosis, or
 - iii. Members with vertebral abnormalities, or
 - iv. Members with hyperparathyroidism.

These tests must be ordered by a physician and must fall under procedure codes 76075, 76076 or 76078. These screening tests are covered at health care facilities only (not at health fairs or drugstores, as examples).

BREAST CANCER -- WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Benefits are paid at 50% (80% for a PPO provider) of UCR covered charges.

In conjunction with coverage for medically necessary mastectomies, the Plan covers:

- a. Reconstruction of the breast on which the mastectomy was performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and physical complications of all stages of mastectomy including lymphedemas.

HOSPITAL FACILITY BENEFITS

INPATIENT HOSPITAL BENEFITS

Room and Services

Benefits are paid for the inpatient and outpatient charges of a hospital upon the recommendation of a licensed physician for UCR covered charges within the allowed maximums as described below.

For non-emergency facility charges including pregnancy and maternity care, inpatient hospital benefits are paid at 60% (90% for a PPO facility). Inpatient benefits cover a semiprivate room or intensive care unit, and services necessary for your treatment (or up to the average semiprivate room rate toward other accommodations). Please see the Cost Containment Programs section on pages 12 through 16 for further details.

Newborn Nursery Care

Hospital charges for newborn nursery care are covered on the same basis as other hospital care. Coverage is provided for nursery services and miscellaneous hospital services for well babies from birth until release from the hospital.

OUTPATIENT HOSPITAL BENEFITS

Charges for Outpatient hospital services are paid at 50% (80% for a PPO facility).

EMERGENCY ROOM TREATMENT

Benefits are paid for emergencies as defined on page 68. Hospital and medical-surgical benefits are paid at 80% for a PPO provider, or 80% of UCR covered charges if a non-PPO provider. If admitted as an inpatient after emergency room treatment in a non-PPO hospital, coverage will be reduced to 60% when it is determined that the patient may be safely transferred to a PPO hospital that is within a thirty (30) mile radius. If you are transferred to a PPO hospital, coverage will be paid at 90%. You are also covered at 90% of UCR for charges associated with the transfer.

ANTHEM BLUE CROSS URGENT CARE NETWORK

To address the use of hospital emergency rooms when the injury or illness is not considered life threatening, Anthem Blue Cross has developed a convenient walk-in Urgent Care Center Network. Use of this network instead of the higher cost emergency room for non-life threatening conditions such as ear aches, cuts and sore throats is available when it is not possible to see your primary care physician.

Anthem Blue Cross continues to add and remove facilities that meet or exceed Anthem Blue Cross health care management and contract criteria.

You can find more information about this network by visiting the Anthem Blue Cross website at www.anthem.com/ca. From there you need to follow these simple directions:

1. Select *Find a Doctor* and complete the steps below;
2. On the *Search for a Provider* page, under *Medical Providers* click on *Local California providers*;
3. Either enter your Anthem Blue Cross member ID number or click on the *Visitors* search page;
4. On the *Provider Finder* page select *Medical Employer Sponsored*, select *Blue Cross PPO* (Prudent Buyer Plan) and Provider Type . Urgent Care Centers, Specialty . Urgent Care Networks, then click *next*;

Enter the area information and view the results.

SKILLED NURSING FACILITY

Benefits are paid at 50% (80% for a PPO facility) of UCR covered charges for a semiprivate room, or up to the average semi-private room rate toward higher priced accommodations, up to the number of skilled nursing facility days authorized and services necessary for your treatment, when transfer is ordered by your physician following a covered hospital confinement. Coverage is limited to continuous care for the same condition for which you were hospitalized.

LOCAL OR AIR AMBULANCE

The Plan will pay 80% of UCR for the medically necessary ambulance charges of PPO providers (50% for non-PPO providers) when eligible for emergency room treatment or hospital benefits as a bed patient. Local ambulance service means to or from a hospital or other facility for medical care; air ambulance service means to the nearest hospital qualified to safeguard life or health. The Plan will cover the cost of an ambulance only if medically necessary. If the ambulance that responds to an emergency call is operated by a municipality or county, the claim will be processed as if it is a PPO claim.

HOME HEALTH CARE

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider). Benefits are limited to 120 visits for all providers of service listed below during the 12-month period starting on the date of the first visit.

REQUIREMENTS FOR COVERAGE

1. The Plan Participant or dependent must be confined at home under the active medical supervision of the physician ordering home health care and treating the illness or injury for which that particular care is prescribed.
2. Services must be provided and billed by a Home Health Agency or a Visiting Nurse Association. The provider of service must be recognized as a home health care provider under Medicare.
3. Service must be consistent with the illness, injury, and degree of disability and medical needs of the Plan Participant or dependent. Benefits are provided only for the number of visits medically necessary to treat the Plan Participant's or dependent's illness or injury.

COVERED CHARGES

1. Services of a registered nurse.
2. Services of a licensed therapist for physical therapy, occupational therapy and/or speech therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by or under arrangement with a Home Health Agency or a Visiting Nurse Association. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency or the Visiting Nurse Association as a professional coordinator. The services of a health aide are only covered if the Plan Participant or dependent is also receiving the services listed in (1) or (2) above.
5. Necessary medical supplies provided by the Home Health Agency or the Visiting Nurse Association.
6. Drugs administered at home which are not out-patient prescription drugs or self-administered injectables (covered only through the prescription drug program).

HOSPICE CARE

Benefits are paid at 50% of UCR covered charges (80% if a PPO provider) up to a lifetime maximum of \$20,000.

REQUIREMENTS FOR COVERAGE

1. The Plan Participant or dependent must be suffering from a terminal illness for which prognosis of life expectancy is six (6) months or less, as certified to the Plan by the Plan Participant's or dependent's physician.
2. Palliative care (care which controls pain and relieves symptoms but does not cure) must be appropriate for the Plan Participant's or dependent's illness.
3. The Plan Participant's or dependent's physician must consent to the Plan Participant's or dependent's care by the Hospice and must be consulted in the development of the Plan Participant's or dependent's treatment plan.
4. Services must be those that are regularly provided and billed by a Hospice.
5. The Hospice must submit a written treatment plan to the Plan every thirty (30) days.
6. Periods of disability are considered separate if the cause of each disability is entirely unrelated.

COVERED SERVICES

1. Room and board in an inpatient hospice unit.
2. Services of a registered nurse, licensed practical nurse or licensed vocational nurse.
3. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and/or respiratory therapy.
4. Medically necessary social services.
5. Services of a home health aide.
6. Dietary and nutritional guidance.
7. Nutritional support such as intravenous feeding or hyperalimentation.
8. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a physician.
9. Medical supplies.
10. Oxygen and related respiratory therapy supplies.
11. Bereavement counseling for the Plan Participant's or dependent's family, limited to four (4) visits in the 12-month period after the Plan Participant's or dependent's death.

MEDICAL EXCLUSIONS AND LIMITATIONS

The Plan excludes coverage for the following:

1. Conditions covered by workers' compensation laws or any injury or sickness arising from or sustained in the course of employment. (~~Work Related Injury or Illness~~). You should file a workers' compensation claim with your Employer. In the event your workers' compensation claim is denied by your Employer, you must appeal the denial through your Employer's workers' compensation carrier. The Workers' Compensation Appeals Board will then issue an application for adjudication. In this event only, the Plan will pay benefits on your behalf for the Work Related Injury or Illness provided you: (a) Provide proof of a denial of a workers' compensation claim and a copy of the application for adjudication verifying that you have appealed the denial; and (b) agree to all of the conditions under the section of the Subrogation Claims Against Other Parties for Claims Paid Under The Plan.
2. Custodial or domiciliary care or care in an institution primarily a place of rest for the aged, nursing home or any like institution.
3. Services or hospitalization after eligibility has terminated, except as provided by the Plan.
4. To the extent permitted by federal or state law, any condition for which care or treatment is obtained from a federal government agency or from any state or political subdivision where this care is available without cost to the individual. In addition, any confinement or care in a hospital owned or operated by a federal agency, state or political subdivision is excluded for coverage unless there is an unconditional requirement to pay for this care or confinement.
5. Services or supplies rendered when not medically necessary.
6. Services or supplies when there is no charge.
7. Autistic disease of childhood, learning disabilities, social, communication and behavioral problems.
8. Dental treatment or supplies unless the medical treatment to teeth or gums is necessary to repair or alleviate damage to natural teeth as a result of an accident.
9. Personal comfort or beautification items.
10. Any charges resulting from or directly related to any medical or surgical procedure, which is considered by the Plan to be experimental in nature.
11. Conditions caused by war or military aggression.
12. Professional services provided by a family member or by a person residing in the home (see ~~Doctor~~ on page 67).
13. Sterilization reversal, artificial insemination, in-vitro fertilization, or any other treatments for infertility.
14. Hospitalization primarily for physical therapy or other rehabilitative care; hospitalization primarily for x-ray, laboratory or other diagnostic studies, except where such services cannot be rendered safely and adequately on an outpatient basis.

15. Homeopathic or holistic treatment.
16. Radial Keratotomy or Lasik Surgery.
17. Cosmetic surgery or any services or supplies for beautification unless required to repair or alleviate damage caused by an accident or in compliance with the Women's Health and Cancer Rights Act of 1998, as amended.
18. Charges for breast implants, the removal of breast implants or any complications resulting therefrom unless medically necessary.
19. Treatment for alcohol addiction and/or chemical dependency unless prior-authorized (see special benefit on page 39).
20. Weight control and nutritional counseling when not necessitated by specific medical conditions or morbid obesity and disease etiology.
21. Penile implants unless required as a result of injury or an organic disorder.
22. Professional services rendered or related to marriage counseling, behavioral characteristics, educational or vocational testing or counseling (exception for diabetic self-management benefit).
23. Donor's expenses relating to any transplant procedure unless the organ recipient is covered under the Plan, and such expenses are not covered under the donor's insurance. Transportation and lodging expenses are not covered.
24. Charges for missed or broken appointments, completion of claim forms, medical reports, telephone calls or electronic information.
25. Charges related to Temporomandibular Joint Dysfunction (TMJ). See the Dental Benefit section of this booklet for coverage of this condition.
26. Any charges in connection with injuries or illnesses sustained during the commission of an illegal act.
27. Premarital examinations and physical examinations for licensing, insurance, employment or school admission in excess of regular Plan benefits.
28. Genetic testing to establish paternity of a child or tests to determine the sex of an unborn child.
29. Air conditioners, humidifiers or purifiers.
30. Charges in excess of usual, customary and reasonable charges.
31. Claims not submitted within twelve (12) months after expenses were incurred, except in absence of legal capacity. The twelve month deadline may be extended due only to contract terms of the PPO or any other Fund approved network provider as well as any delay caused by Medicare or any government legislation.
32. Office based injectables (after the first injectable) that are not prior authorized by OptumRx.
33. Out-patient prescription drugs and self-administered injectables (covered only through the prescription drug program . see page 29).

34. Screening and Surveillance for cancers not conforming to American Cancer Society Guidelines.
35. Any supplies or services for which no charge is made or which you are not required to pay which are furnished by or payable under any plan or law of any government.
36. Any services, supplies or procedures which are experimental or investigational or are not otherwise within the standards of generally accepted medical practice as determined in the sole and absolute discretion of the Board of Trustees.

PRESCRIPTION DRUG BENEFITS

(Provided through OptumRx)

The Fund has contracted with OptumRx to provide administration of the prescription drug coverage program. To utilize this drug program, you must get your prescriptions filled at an OptumRx participating pharmacy. If you need assistance in locating the OptumRx participating pharmacy nearest you, please call (800) 797-9791 or visit the OptumRx secure website at www.optumrx.com where, after registering, you can manage your account, look up drug pricing and refill mail order prescriptions.

Simply present your OptumRx identification card along with your prescription to the pharmacist. The pharmacy will verify your eligibility status at the time of purchase. You will then be charged a \$15 generic or \$35 brand name co-payment. Please note, however, that if a generic drug is available and allowed by your doctor, but you insist on the brand name drug, you will be responsible for the cost difference between the generic and brand name price of each drug, in addition to your co-payment. Each prescription is limited to a 30-day supply. **On the third refill of a maintenance medication at retail you will pay double your copayment if you choose retail over the Preferred Mail Service Pharmacy Program described below.**

Preferred Mail Service Pharmacy Program for Maintenance Drugs. OptumRx offers a mail service program, which allows up to a 90-day supply limitation for maintenance medications. Maintenance medications are typically taken every day for conditions such as allergies, high cholesterol, or high blood pressure. The mail service co-payment for generic drugs is \$30 and the mail service co-payment for brand name drugs is \$70 for a 90-day supply of your maintenance drugs. To start a new prescription, you should complete the **Mail Service Order Form**, attach the original prescription, and mail it to OptumRx. Remind your doctor to write 90-day supply plus three (3) refills, when clinically appropriate to maximize your benefit for maintenance medications purchased through the mail service program. OptumRx always fills your prescription for the exact quantity of medication your doctor prescribes. You may contact an OptumRx representative at **1-800-797-9791 (TTY 711)**. You can also ask your doctor to call **1-800-791-7658** with your prescriptions or to fax them to 1-800-491-7997. Be sure to have your member ID number, the name of your prescribing physician, and the names of the prescriptions you wish to fill.

Specialty Pharmacy Program. The Board of Trustees has approved the OptumRx Specialty Pharmacy program (in partnership with BrioVaRx, the newest member to the OptumRx family) to be the Fund's exclusive source for all Specialty drugs. Specialty drugs are those typically priced at more than \$600 per 30 day supply, may require special storage control and/or specific shipping/handling requirements, often require management and/or care coordination by a healthcare provider specializing in treating the member's condition and can include self-administered and professionally administered injectables as well as certain high cost oral medications. Specialty drugs are used to treat complex chronic conditions and are subject to the same exclusions and limitations as well as potential Prior Authorization under Fund rules. If you need to fill a Specialty medication, you and your doctor can reach the OptumRx Specialty Pharmacy program at 1-855-4BRIOVA (1-855-427-4682) or by visiting BrioVaRx.com.

PRESCRIPTION DRUG PROGRAMS THROUGH OPTUMRx

Prescription Drug List – Premium PDL

Helping Members Make Better Decisions

There are thousands of drugs available today and a large number coming to market; many increase cost without providing additional value. As a result, there may be several choices to treat a health condition including over-the-counter (OTC), generic and brand-name medications.

The Plan's Prescription Drug List (PDL/formulary) through OptumRx leverages exclusion capabilities with manufacturers to reduce Fund costs, maintain benefit coverage for members and promote the use of lower-cost alternatives.

What if my Current Prescription is Included on the List of Prescription Drug Exclusions?

Exclusions can be disruptive for members so that's why extra measures are taken to provide members with advanced notification, so they can work with their physicians to find appropriate medication alternatives. Additionally, the following tools and communications help members save on their prescription costs and make the best use of their pharmacy benefit.

Notification Letters

When applicable, OptumRx notifies members of a medication being excluded, educating them on covered alternatives to discuss with their physicians.

Online at Optumrx.com

Members can search for medications and confirm coverage using the [Price a Medication+](#) tool, locate network pharmacies and view real time benefits and claims history by visiting [Optumrx.com](#).

Member Services

Customer service representatives at (800) 797-9791 are available to educate members about their pharmacy benefit.

Clinical Programs and Utilization Management

Prior Authorization

Under the Prior Authorization Program, prescriptions for certain medications require prior authorization, or coverage review, before the Fund will cover them. If your doctor prescribes one of these medications to you, your pharmacist or your doctor must call OptumRx customer service. OptumRx will work with your doctor's office to get the information for the coverage review. If your doctor does not return the information asked for, the Prior Authorization request will be denied. OptumRx will notify you and your doctor if the request is denied.

Any individual or class of medications might require Pre-Authorization to ensure that the following coverage criteria are met:

1. The prescription is for the treatment of a medical condition;
2. There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and on your health outcome;
3. The expected beneficial effects of the prescription outweigh the expected harmful effects;
4. The prescription represents the most cost-effective method to treat the medical condition.

The benefits of Prior Authorization include:

- Promotes safe use of medications.
- Helps manage expensive and/or highly used drug categories.

Here are some examples of drug classes that require a prior authorization. This is not a complete list: Diabetes, Hepatitis C, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis and select pain medications.

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

Appeals

If you wish to appeal a denial regarding Prior Authorization please do not resubmit the prior authorization. Send the appeal to the Appeals Coordinator at:

I.A.T.S.E. Local #16 Health and Welfare Trust Fund

c/o BeneSys

7180 Koll Center Parkway, Suite 200

Pleasanton, California 94566

Telephone: (925) 398-7043 or (855) 704-5273

Fax: (925) 462-0108

Step Therapy

Step Therapy promotes the use of preferred medications as the first step in a prescription treatment plan. The benefits of Step Therapy include:

- Encourages the use of safe and cost-effective medications
- Promotes correct use of medications

Here are some examples of medications or drug classes that are part of Step Therapy. This is not a complete list: Antidepressants, Diabetic Agents, Migraine, Proton Pump Inhibitors, Statins and Asthma medications.

Quantity Limits

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

- Prevents over prescribing or having to take medication longer than needed.
- Manage unsafe medication use.
- Reduces risk of misuse and abuse of certain medications.

Here are some examples of drug classes that are subject to Quantity Limits. This is not a complete list: Oncology, High Cholesterol, Migraines, Antivirals, Asthma, Osteoporosis, Anti-fungal, Erectile Dysfunction and Pain Relief.

Bulk Chemical and Compound Exclusion

What is Pharmacy Compounding?

Pharmacy compounding is a practice in which a pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Pharmacy compounding serves a role in the rare occasion that a patient cannot be treated with a commercially available formulation. For example, an elderly patient or child cannot swallow a pill and needs a medicine in a liquid form that is not otherwise available. There are a number of growing concerns with compounding of certain medications such as:

- Quality, safety, or effectiveness is not evaluated.
- Compounds can be much more expensive and have little to no evidence for use.
- Often include active ingredients that are typically excluded from coverage.
- Can be dispensed at a higher cost than an FDA-approved alternative medication.

How is the I.A.T.S.E. Local 16 Trust Fund Addressing this Issue?

Due to concerns about member safety and drug efficacy, and the potential waste of significant healthcare resources, several things are being done to address this issue:

- The Fund has added a dollar threshold of \$150 on all compound medications unless prior authorization is approved.
- Exclusion of select non-FDA approved bulk chemical ingredients used in compounds.
- Evaluation of compounding pharmacies in the OptumRx pharmacy network.

What is the Value to I.A.T.S.E. Local 16 and its Members?

Excluding select non-FDA approved bulk chemicals and implementing a compound threshold dollar amount requiring prior authorization helps control compound costs and appropriate use.

Eligible persons may receive prescription service for the following covered items subject to the exclusions and limitations set forth herein.

Covered Items:

1. Federal legend drugs: Any medical substance which bears the legend, "Caution: Federal law prohibits dispensing without a prescription";
2. Federal legend birth control products, oral contraceptives, birth control patches and rings, diaphragms, IUDs (generally paid for under medical benefits), cervical caps;
3. Insulin, insulin syringes and needles, glucose test strips and tablets, lancets;
4. Other injectable medications and supplies required to administer the medication (subject to prior-authorization).
5. Dermatological acne products, including, but not limited to Retin A, Azelex, Differin, up to age 35.
6. Anaphylaxis prevention kits (bee sting kits and diabetic rescue kits) including Ana-Kit, Ana-Kit Jr., EpiPen/EpiPen Jr., Glucagon and Glucagon Emergency Kit;
7. Compounds with at least one federal legend or state restricted ingredient. Prior authorization required for medications costing \$150 or more.

Exclusions and Limitations:

1. Medication available without a prescription (over-the-counter) or prescription medications for which there are non-prescription equivalents available, even if ordered by a physician via a prescription, except as listed under Covered Drugs;
2. Medical devices, therapeutic devices or appliances including support garments, ostomy supplies and other non-medicinal substances (unless listed as covered);
3. Smoking cessation products including, but not limited to Zyban, nicotine gum, nicotine patches and nicotine nasal spray;
4. Oral and injectable infertility medications;
5. A covered erectile dysfunction medication is limited to 6 tablets per 30 days if approved by OptumRx.
6. Dietary supplements, including vitamins;
7. Human immune globulin injections;
8. Emergency contraceptive pills and kit, including but not limited to PREVEN, PLAN B.
9. All non-prescription birth control/contraceptive jellies, ointments, foams or devices;
10. Yohimbine;
11. Medication used for diagnostic purposes;

12. Medication for which the cost is recoverable under the Workers Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient;
13. Any charge for the administration of a medication;
14. Medications prescribed for experimental or non-FDA approved indications;
15. Medications received/consumed in connection with medical or dental services, which are not covered by the Plan;
16. Immunization agents, biological sera, blood or plasma products;
17. Infused medications other than self-injectables (covered under medical benefits);
18. Anorexiant (weight loss medications);
19. Medications received/consumed while in a licensed hospital or facility (i.e., skilled nursing facility);
20. Medications to be taken or administered to the eligible member while he is a patient in a hospital, nursing home (skilled nursing care only), rest home, sanitarium, etc.;
21. Medications used for cosmetic purposes including, but not limited to Renova, Rogaine, Vaniga, Penlac, Pigmenting and De-pigmenting agents;
22. Drugs or medicines purchased and received prior to the member's effective date or subsequent to the member's termination;
23. Drugs or medicines delivered or administered to the member by a prescriber or prescriber's staff;
24. All homeopathic medications;
25. Dental related products except Peridex;
26. Charges for stop-smoking programs and supplies (except as described in the special stop-smoking benefit on page 34);
27. Charges for lost or stolen medications.
28. Certain compound medications as noted.
29. Drugs on the Premium PDL exclusion list.

SPECIAL STOP-SMOKING BENEFIT

In an effort to assist those who wish to permanently stop smoking, the Plan provides the following benefit:

1. You must enroll in and complete a stop-smoking program sponsored through a recognized and experienced agency or institution specializing in such programs. The cost of this program will be covered at 75 % to a maximum payment by the Fund of \$200 per treatment program; and
2. You will be reimbursed for the stop-smoking program only after the claims office receives a copy of the certificate issued by the agency or institution upon completion of the stop smoking program.
3. There is a two (2) complete treatment program per lifetime maximum.

For assistance or information, you may call the American Cancer Society at: (800) 227-2345. Their Web site is www.cancer.org. Local offices can be reached by calling:

Alameda, San Francisco and San Mateo Counties:	(510) 893-7900, then press 3
Napa, Marin and Sonoma Counties:	(707) 545-6720, then press 3
Santa Clara County:	(408) 871-1062, then press 3

You may also wish to seek the assistance of the California Smokers Help line at (800) 662-8887.

DENTAL BENEFITS (Including Orthodontic Benefits)

There is a waiting period for all new Plan participants for Dental and Orthodontic benefits. You must be continuously covered for a minimum of 2 years before you qualify for dental and orthodontic benefits.

A calendar year deductible of \$75 per person will be applied to Dental Benefits with the exception of Diagnostic and Preventive Care.

As part of the Dental program, the Fund offers eligible participants access to dentists in the CIGNA Dental DPPO Plus Network. To locate a CIGNA participating network dentist you may call (800) 797-3381 or visit online at www.cignadentalsa.com (select Cigna Dental PPO Shared Administration Plus).

COVERED DENTAL SERVICES

The Dental Plan covers the following services when they are provided by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice.

Maximum payment for all dental care is \$2,500 per person per Plan year. There is no annual maximum payment for children under the age of 18.

1. DIAGNOSTIC AND PREVENTIVE CARE

Percentage of covered charges payable: 90%

Diagnostic - oral examination, bite-wing X-rays, emergency treatment, specialist consultation

Preventive - prophylaxis (cleaning), fluoride treatment for children; limit of two (2) in any calendar year. Space maintainers.

X-rays - other than bite-wing X-rays.

2. BASIC BENEFITS

Percentage of covered charges payable: 70%

Oral Surgery - extractions and certain other surgical procedures including pre-and postoperative care

Restorative - amalgam, synthetic porcelain and plastic restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay). Synthetic porcelain and plastic restorations are not a covered benefit on posterior teeth; an allowance for amalgam will be provided.

Endodontic - treatment of the tooth pulp

Periodontic - treatment of gums and bones supporting teeth. Scaling and root planing is allowable once every 12 months per quadrant

3. MAJOR BENEFITS

Percentage of covered charges payable: 50%

Crowns - crowns, jackets, and cast restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Prosthodontic - procedures for construction or repair of fixed bridges, partial or complete dentures

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

- A. Non-surgical benefits are paid at 70% of UCR covered charges up to a Plan Year maximum of \$1,250; three (3) year replacement limit for appliances.
- B. Mandatory second opinion from a certified TMJ specialist and pre-authorization review required for all surgical procedures exceeding \$1,000. If approved, benefits will be paid at 70% of UCR covered charges. Non-compliance reduces coverage by 50%.
- C. Lifetime Maximum: \$10,000.
- D. TMJ charges do not apply towards the \$2,500 yearly dental maximum.

5. ORTHODONTIA

- A. Percentage of covered charges payable: 50%
- B. Lifetime Maximum: \$4,000.
- C. Orthodontia charges do not apply towards the \$2,500 yearly dental maximum.

DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

The Plan excludes the following:

1. Charges for injuries or conditions which are compensable under Workers' Compensation or Employer's Liability Laws, or charges for services which are provided by any federal or state government agency, or charges which are provided without cost to the individual by any municipality, county or other political subdivision, except Medi-Cal benefits.
2. Charges with respect to congenital (hereditary) or developmental (following birth) malformations, or cosmetic surgery or dentistry for cosmetic reasons, including, but not limited to: cleft palate, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).
3. Replacement of an existing denture, which in the opinion of the attending dentist, is or can be made satisfactory.
4. Dental treatment or supplies related to dental injury resulting from an accident (would be covered under the Medical Plan if medically necessary).
5. Dentures more often than once every three (3) years. Crown replacement more often than every five (5) years.
6. Prescribed drugs, premedication or analgesia, unless necessity is documented.
7. Experimental procedures.
8. Hospital costs and any additional fees charged by the dentist for hospital treatment. For hospital benefits see page 22.
9. Anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services.
10. Extra oral grafts (grafting of tissues from outside the mouth to oral tissues) or implants (materials implanted into or on bone or soft tissue) or the removal of implants, except when provided in connection with a covered prosthetic appliance and pre-approved by the Plan.
11. Charges for missed or broken appointments.

12. Charges for completion of claim forms.
13. Sealants are limited to covered dependents through age 14 only. Other limitations for sealants are as follows:
 - A. Limited to previously restored pits and fissures.
 - B. Limited on the occlusal surface of first and second permanent molars.
 - C. Only one (1) replacement sealant is allowed per tooth every three (3) years.
14. Professional services provided by a family member or by a person residing in the home (see "Doctor" on page 67).
15. Charges for lost or stolen appliances.

THE IMPORTANCE OF PREDETERMINATION OF COSTS

After an examination, your dentist will determine the treatment to be provided. It is **strongly recommended that whenever charges are expected to exceed \$500**, that your dentist submit an attending dentist's statement to BeneSys before proceeding with the proposed treatment. This allows the Plan to advise the dentist ahead of time whether the proposed treatment is covered under this Plan and, if so, the amount to be paid toward the cost of such treatment and the remaining amount that will be your obligation.

VISION CARE BENEFIT

There is a waiting period for all new Plan participants for Vision benefits. You must be continuously covered for a minimum of 2 years before you qualify for vision benefits.

The Vision Plan covers you and your dependents for a regular examination and for lenses and frames when necessary for proper visual function or correction. Benefits are provided for expenses incurred for the following vision care services when they are not covered elsewhere in this Plan. Expense is considered "incurred" on the date you or your dependent receive the service or supply for which the charge is made.

A. PAYMENT

Payment is provided for 80% of the covered expense incurred.

B. MAXIMUM PAYMENTS

Vision care benefits are limited to an aggregate maximum payment of \$400 per Plan year, except for children under the age of 18 who have no annual maximum.

C. COVERED EXPENSES

- a. Complete eye exam, 1 time per calendar year
- b. Standard Pair of Frames and Lenses 1 time in a 2 calendar year period
- c. Prescription contact lenses

D. REQUIREMENTS OF COVERAGE

- 1. Services must be provided by a licensed ophthalmologist, optometrist or dispensing optician.
- 2. Services must be for routine care of the eye, not for surgery or medical care.
- 3. Services must not be provided by a family member or by a person residing in the home.

SUPPLEMENTAL PLAN BENEFITS

ALCOHOLISM AND DRUG ADDICTION BENEFIT

(For Active Plan Participants and their eligible dependents)

The Plan covers treatment for alcoholism or drug addiction. The Trustees have assigned the management of this benefit to the Teamsters Assistance Program (TAP). TAP will provide intake, assessment and referral for treatment programs for substance abuse problems. All communication with the TAP program is strictly confidential as required by law. Costs related to TAP referred treatment programs will be paid by the Fund and the participant (if a copayment is required).

If you or a covered dependent needs treatment for an alcohol or drug problem you **must** contact TAP at **(510) 562-3600** or if outside the San Francisco Bay area at **(800) 253-TEAM** before obtaining treatment. Benefits will not be paid unless obtained through TAP. Treatment may consist of inpatient, residential, day treatment, intensive outpatient or a combination of the foregoing. You may contact BeneSys and ask for a TAP brochure for other services that TAP provides.

Benefit

The benefit is available to Active Plan Participants and their dependents who have remained eligible under the Plan for a consecutive 18 month period immediately preceding use of TAP services. Benefits are paid according to the following:

Percentage of Payable Covered Charges

1 st Treatment Episode:	100%
2 nd and subsequent approved Treatment Episodes:	Inpatient: 90% Outpatient: 80%

Important: Benefits will be paid for alcohol and substance abuse only if your treatment has been authorized by TAP. Treatment not authorized by TAP is **not** covered.

SUPPLEMENTAL DISABILITY INCOME BENEFIT

(For Active Plan Participants only)

This benefit is paid directly by the I.A.T.S.E. Local 16 Health and Welfare Trust Fund. To determine whether you qualify for this benefit, you should submit inquiries and claims to BeneSys.

The Fund will pay a gross amount of \$27.35 per day (the net amount is approximately \$25.00 per day which fluctuates with tax rate changes) for each day an eligible Active Plan Participant receives either state disability (or disability payments from another disability payer) or workers' compensation insurance. Said monies are paid by the Fund when proof of eligibility for state disability (or benefits from another disability payer) or workers' compensation is provided and said Plan Participant is unemployed. The Fund will pay for a maximum of 20 weeks or 140 days in any four (4) year period, for any new claims with a date of disability January 1, 2008 or after.

Workers' Compensation

To be eligible for supplemental disability income benefits payable while you are entitled to receive workers' compensation, you must be an eligible Plan Participant for a minimum of one (1) year.

State Disability

To be eligible for supplemental disability income benefits payable while you are entitled to receive state disability (or disability from another disability payer), you must be an eligible Plan Participant for a minimum of three (3) consecutive years.

Time limitations for retroactive payment of supplemental disability income benefits: Your request for supplemental disability income must be received by the Trust Fund office no later than ninety (90) days after you receive your first state disability (or disability from another disability payer) or workers' compensation check.

Continued Health Benefits for Disabled Participants

Whether or not you qualify for supplemental disability income benefits, upon proof that you are entitled to either state disability or workers' compensation insurance, you remain eligible for all benefit coverage without self-payment for a maximum of **one year** from date of disability if you are an Active Plan Participant for a minimum of eighteen (18) months in the most recent thirty-six month (36) period prior to the onset of your disability. Proof of disability is required by the Plan. This eighteen (18) to thirty-six (36) month period is intended to run concurrently with any applicable COBRA period. For example, if you are eligible for and receive supplemental disability income payments and are subject to coverage without payment for twelve (12) months, you will be entitled to continue coverage by self-payment through COBRA for the six (6) or seventeen (17) months of COBRA eligibility remaining. See pages 7 through 10 for a description of the Fund's COBRA provisions.

HEARING AID BENEFIT

For any Active Plan Participant of three (3) years or more or any Retiree, the Fund will pay 90% of UCR covered charges for the cost of hearing aids up to a maximum of \$2,500 per ear. This benefit is only available once every four (4) years and is subject to the pre-authorization requirement listed under Cost Containment Programs on page 12. This benefit is also available to eligible dependents.

LIFE INSURANCE BENEFIT

(For Active Plan Participants only)

This benefit insured through Sun Life Financial in the amount of \$50,000¹ is payable in full to your designated beneficiary in the event of your death while covered as an eligible Active Plan Participant.

LIFE INSURANCE COVERAGE FOR ACTIVE PLAN PARTICIPANTS WHO BECOME DISABLED (Waiver of Premium Benefit)

You will remain eligible for life insurance if you become totally disabled and unable to work while insured and die before age sixty-five (65). This coverage will be continued without any further payments so long as you remain totally disabled, subject to submission of proof of continued permanent total disability as explained below. The full amount will be paid to the designated beneficiary if permanent total disability continues until the date of death.

If you become totally disabled, you are required to submit proof of total disability to the Fund. You will be required to submit proof of continued total disability as required by the insurance carrier. You must contact BeneSys for the necessary forms to prove total disability for continuation of eligibility for life insurance. Your insurance automatically terminates: (1) after you cease to be permanently and totally disabled; or (2) on the date you fail to furnish proof of continued permanent total disability as explained above; or (3) upon your failure to submit to an examination by a physician designated by the insurance company in accordance with the requirements of the insurance policy.

BENEFICIARY DESIGNATION

You may name any person as your beneficiary and the designation may be changed at any time by submission of the appropriate form to BeneSys. Such changes shall become effective upon receipt by the Fund, and the change in beneficiary shall take effect on the date you sign the form changing the beneficiary. All requests are subject to the approval of Sun Life Financial. A change will take effect as of the date it is signed but will not affect any payment Sun Life Financial makes or action it takes before receiving your notice.

In the event no designated beneficiary survives after your death, or you have failed to name a beneficiary at the time of your death, the amount due a beneficiary will be paid as follows: To your lawful spouse, if living; if not living, to your natural and adopted children, equally; if none survive, to your surviving father or mother or to both equally if both survive; if none of the above survive you, to your estate. The person must be living on the tenth day after your death.

CONVERSION FEATURES OF LIFE INSURANCE COVERAGE

If life insurance terminates because of termination of eligibility, the Life Insurance Benefit will be payable if you die within thirty-one (31) days after your eligibility for benefits under the Plan ends. Because life insurance is not a COBRA-covered benefit, this thirty-one day period runs from the time Employer paid coverage ends. Sun Life Financial or BeneSys must be notified if you wish to convert your group coverage to individual coverage. Sun Life Financial will supply you with a conversion form to complete and return.

During the thirty-one (31) day period, after termination of eligibility, all or any part of the group Life Insurance Benefit may be converted to an individual life insurance policy without a medical examination. The premium cost will be based upon the plan of insurance selected and the class of risk and age at the time of conversion. This conversion privilege may be exercised only once.

¹ Life Insurance Benefits reduce to sixty-five percent (65%) of \$50,000 on the first day of the policy month following the covered participant's sixty-fifth (65th) birthday. This same reduction provision also applies if the participant attained his/her sixty-fifth (65th) birthday prior to becoming covered by the Plan.

If life insurance terminated because of the discontinuance or amendment of the group insurance policy currently in effect, you may exercise the conversion privilege if you have been insured under the policy for at least five consecutive (5) years. The amount of the individual policy is limited to the lesser of:

- (a) \$2,000, or
- (b) the amount of your Life Insurance which stops, minus the amount of other group insurance for which you become eligible within 31 days of the date your insurance stops.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

(For Active Plan Participants only)

Active Plan Participants are insured for \$50,000¹ against death or dismemberment in an accident through an insurance policy with Sun Life Financial.

If Sun Life Financial receives Notice and Proof of Claim that an Employee:

- dies from accidental drowning while insured; or
- sustains an Accidental Bodily Injury while insured, which results in loss of life, sight or limb within 365 days of the date of that injury; or
- sustains a loss of life, sight or limb within 365 days due to an accidental exposure to the elements while insured;

Sun Life Financial will pay, subject to the Exclusions, the following percentage of Accidental Death and Dismemberment Insurance shown in Section I, Schedule of Benefits that was in force on the date of the Accidental Bodily Injury for the following losses:

Life	100%
Sight of one eye	50%
One limb	50%
Speech and hearing	100%
Speech or hearing	50%
Thumb and index finger of the same hand	25%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

The maximum amount of Accidental Death and Dismemberment Benefit payable for losses resulting from any one accident is 100%.

Loss of limb means severance of hand or foot at or above the wrist or ankle joint. Loss of sight, speech or hearing must be total and irrecoverable. Loss of thumb and index finger means severance through or above the metacarpophalangeal joints.

Quadriplegia means the total and permanent paralysis of both upper and lower limbs. Paraplegia means the total and permanent paralysis of both lower limbs. Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.

Seat Belt/Air Bag Benefit

Sun Life Financial will pay an additional Seat Belt/Air Bag Benefit if an Employee dies as a result of an automobile accident and an Accidental Death Benefit is payable under this Policy.

Seat Belt Benefit

The Seat Belt Benefit is payable if the Employee was wearing a seat belt at the time of the accident. The Seat Belt Benefit is 25% of the amount of Accidental Death Benefit payable or \$25,000, whichever is less.

Sun Life Financial must receive satisfactory written proof that the Employee's death resulted from an automobile accident and that the Employee was wearing a seat belt at the time of the accident. A copy of the police report is required.

¹ Accidental Death and Dismemberment Insurance reduces to sixty-five percent (65%) when you reach age 65.

Air Bag Benefit

The Air Bag Benefit is payable if a Seat Belt Benefit is payable and the Employee was positioned in a seat protected by a Supplemental Restraint System which inflated on impact. The Air Bag Benefit is 10% of the amount of the Accidental Death Benefit payable or \$5,000, whichever is less.

Sun Life Financial must receive satisfactory written proof that the Employee's death resulted from an automobile accident and that the Supplemental Restraint System properly inflated. A copy of the policy report is required.

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Supplemental Restraint System means a factory installed air bag which inflates for added protection to the head and chest areas.

Automobile means a motor vehicle licensed for use on public highways.

Disappearance

Sun Life Financial will presume, subject to no objective evidence to the contrary, that an Employee is dead and has died as a result of an Accidental Bodily Injury if:

1. an Employee disappears as a result of an accidental wrecking, sinking or disappearance of a conveyance in which the Employee was known to be a passenger; and
2. the body of the Employee is not found within 365 days after the date of the conveyance's disappearance.

Repatriation Benefit

If an Accidental Death benefit is payable and the Employee's loss of life occurs at least 100 miles from the Employee's permanent place of residence, Sun Life Financial will reimburse the Executor or Administrator of the Employee's estate for the reasonable and customary expenses incurred for the preparation of the body and its transportation to the place of burial or cremation up to a maximum benefit of \$2,000. Written proof of the expenses incurred must be submitted to Sun Life Financial prior to payment.

Exclusions

No Accidental Death or Accidental Dismemberment payment will be made for a loss which is due to or results from:

- suicide while sane or insane.
- intentionally self-inflicted injuries.
- bodily or mental infirmity or disease of any kind, or infection unless due to an accidental cut or wound.
- committing or attempting to commit an assault, felony or other criminal act.
- active participation in a war (declared or undeclared) or active duty in any armed service during a time of war.
- active participation in a riot, rebellion, or insurrection.
- injury sustained from any aviation activities, other than riding as a fare-paying passenger.

- the Employee's voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician.
- the Employee's operation of any motorized vehicle while intoxicated. Intoxicated means the minimum blood alcohol level required to be considered operating an automobile under the influence of alcohol in the jurisdiction where the accident occurred. For the purposes of this Exclusion, ~~M~~Motorized Vehicle+ includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

HOW TO FILE A CLAIM FOR BENEFITS

To file a claim under the Plan, follow these steps:

1. Obtain a claim form. Universal claim forms supplied by hospital and physicians are usually acceptable substitutes for claim processing;
2. Complete your portion of the form and submit it as soon as possible but in no event any later than twelve months of the service date of the claim (the twelve month deadline may be extended due only to contract terms of the PPO or any other Fund approved network provider as well as any delay caused by Medicare or any government legislation);
3. Have the person providing services complete the rest of the form. Then mail it to I.A.T.S.E. Local 16 Health & Welfare Trust Fund, C/O BeneSys, 7180 Koll Center Parkway, Suite 200, Pleasanton, California 94566; and
4. Mail any further bills or statements for any services covered by the Plan to BeneSys as soon as you receive them.
5. The first time you have services performed by a hospital or physician, you must sign a claim form. A signed claim form for each physician you see must be on file with the claims processing office. A claim form with a "signature on file" will not be accepted for your initial visit but will be accepted for subsequent claim forms submitted by the same physician.

COVERAGE WHILE TRAVELING OUTSIDE THE UNITED STATES

Your Plan benefits are provided for emergency or urgent care received anywhere in the world. Please carry your Plan identification card with you at all times.

If you are in a foreign country, you may have to pay the bill and then be reimbursed by the Fund. If you do require medical care, ask for an itemized bill written in English. In order for the Fund to properly process and reimburse for said services, it is advisable that you pay for services utilizing a method (credit card) that documents the current rate of exchange.

The Fund will not provide benefits incurred in a foreign country if you reside outside of the United States.

HOW CLAIMS ARE PROCESSED

Claim forms received by BeneSys are first examined to determine whether all pertinent information has been included. If all information necessary for processing has not been included, BeneSys will request additional information from the Participant or the provider of service (i.e., hospital, physician, etc.) and the claim will be held until the required information is furnished.

Claim forms containing all required information are processed by BeneSys. The resulting benefit payment is made directly to the person or facility providing the medical care if authorized by the Participant or paid directly to the Participant if no such authority is given.

When dental services are provided by a dentist, payments are made directly to the Participant unless the Participant assigns payment to the dentist.

ASSIGNMENT OF MEDICAL OR DENTAL BENEFITS

You may assign benefits due under the Plan to a provider of service by signing the assignment portion of the Fund claim form. In the case of an assignment, the allowable expenses will be paid directly to the provider of services.

CLAIMS APPEAL PROCEDURES

Definitions

Adverse Decision or Adverse Decision on Appeal: A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit. A Notice of an Adverse Decision (or adverse decision on appeal) will be provided in writing and include the following:

- The specific reason(s) for the adverse decision.
- Reference to the specific Plan provision(s) on which the adverse decision is based.
- A statement about your rights to bring a civil action under ERISA following an adverse benefit decision on an appeal of your claim.
- A description of any additional material or information needed to make a full and complete claim, and the reason why it's needed.
- A statement that you may receive, upon request and free of charge, reasonable access to and copies of any documents in the Fund's possession that are relevant to your appeal.
- A copy of any internal rule, guideline or protocol that was relied on to decide your claim (or a statement that a copy is available upon request at no charge).
- For adverse decisions based on the absence of medical necessity or the use of experimental or investigational treatment (or any similar reason) an explanation of the scientific or clinical judgment for the determination as applied to the Plan and your claim (or a statement that this explanation is available upon request).
- An explanation of the Plan's appeal procedures and time limits.

Claim: Any request for Plan benefits made in accordance with the Plan's claims filing procedures.

Claim Concerning Eligibility: A Pre-Service or Post-Service Claim, which concerns the eligibility for benefits of the claimant as a Plan Participant or dependent.

Disability Claim: Claims that require a finding of total disability as a condition of eligibility - the Supplemental Disability Income Benefit and the waiver of premium for the life insurance benefit - are Disability Claims.+

Pre-Service Claim: A claim, which will not be covered by the Plan unless you have asked for and received the Plan's approval before you receive treatment or care of any kind.

Post-Service Claim: Any claim other than a Pre-Service or Disability claim.

Urgent Care Claim: Any claim for medical care or treatment, which if processed according to the ordinary time limits for Pre-Service Claims, (1) could seriously jeopardize your life, your health, or your ability to regain maximum function, or (2) in the opinion of the doctor who has knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment described in your claim.

Filing Urgent Care Claims

Any urgent care claim you submit will be processed as soon as possible and you will be informed of the benefit determination (whether adverse or not) not later than 72 hours after receipt of your claim by the Plan, unless you failed to follow the filing procedure or provide sufficient information to determine the claim. In the case of such a failure, you will be notified within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be given 48 hours to provide the specified information.

You will be notified by the Plan of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- (a) the Plan's receipt of the specified information; or
- (b) the end of the period given to you to provide the specified additional information.

In the case of an adverse benefit determination on a claim involving urgent care:

The information described above and a description of the expedited review process for urgent care claims may be provided to you orally within 72 hours after receipt of your claim by the Plan. The written notice will be furnished to you not later than 3 days after the oral notification.

Expedited review process for urgent care claims:

A request for an expedited appeal for an adverse benefit determination may be submitted orally or in writing by you and all necessary information, including the Plan's benefit determination, will be transmitted to you by telephone, facsimile, or other available expeditious methods.

Filing Pre-Service Claims

Anthem Blue Cross will respond to **Pre-Service Claims** within the following timelines: within *fifteen (15) days* for non-urgent pre-service claims (in cases where more time is required, Anthem Blue Cross will have fifteen additional days to respond, in which case you will be notified why more time is required and when you can expect a reply).

If the Fund needs more time to process your claim because it needs more information from you or your doctor, you and your doctor have up to *45 days* to supply this information. If you do not supply the additional information within 45 days, your claim will be denied. After receipt of the information needed from you or your doctor, the Fund will respond to your claim within *fifteen (15) days*.

Filing Concurrent Care Claims

If you have any claim that results from the termination or reduction of previously granted benefits to be provided over a period of time, the Plan will notify you in advance of the termination or reduction to allow you time to appeal the decision and obtain a determination before the benefit is reduced or terminated.

Also included under this category are requests to extend the course of treatment beyond the initial prescribed period of time or number of treatments for urgent cases. In these situations, the Plan will inform you of the decision within 24 hours after receipt of the claim by the Plan, provided the claim is made to the Plan at least 24 hours before the expiration of the initially approved treatment. If such a claim were denied, it would be appealable as an urgent care claim.

Any request to extend a course of treatment that does not involve urgent care is a claim that is governed by the standards generally applicable to such claims.

Filing Post-Service Claims

If your Post-Service Claim as submitted is complete, you will be notified of the decision concerning the claim within *30 days* of receipt, but the Fund can extend that deadline by an additional *15 days* if more time is needed. If more time is needed, you will be notified before the end of the initial 30 days why the Fund needs additional time and when you can expect to receive a decision on your claim. If more time is needed because you need to submit additional information, you will have *45 days* from receipt of the Fund's notice to supply the requested information. If you do not provide the requested information within 45 days, your claim will be denied. After receipt of the requested information, the Fund will render a decision on your claim within *fifteen (15) days*.

Filing Disability Claims

If your Disability Claim as submitted is complete, you will be notified of the decision concerning your claim within *45 days* of receipt, but the Fund can extend that deadline by an additional *30 days* if more time is needed. If more time is needed, you will be notified before the end of the initial 45 days why the Fund needs additional time and when you can expect to receive a decision on your claim. If more time is needed because you need to submit additional information, you will have *45 days* from receipt of the Fund's notice to supply the requested information. If you do not provide the requested information within 45 days, your claim will be denied. After receipt of the requested information, the Fund will render a decision on your claim within *thirty (30) days*.

Appeal of an Adverse Decision

If you disagree with the decision on your initial claim, and wish to file an appeal you (or your authorized representative) must file a written appeal within *180 days* after your receipt of the notice of adverse decision. You should include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. If you don't appeal on time, you may lose your right to file suit in a state or federal court, because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court).

The members of the Fund's Board of Trustees will make the decision on appeal. They will not defer to the initial adverse benefit determination and will consider all comments, documents, and records and other information you submit, even if they were not submitted or considered during the initial claim decision. Their decision on your appeal will be made based on the record, including any additional documents and comments you submit.

If your claim was denied on the basis of a medical judgment (such as the absence of medical necessity or the use of an experimental or investigational treatment), the Board will consult a health care professional with training and experience applicable to the relevant field of medicine. Upon request, you can obtain the name of any professional consulted and the advice (if any) given concerning your claim (even if the Board did not rely on this advice in making its decision).

You will receive notice of the decision on your appeal within *30 days* for Pre-Service Claims. Appeals of Post-Service and Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within 30 days of the *next* regularly scheduled Board meeting, your appeal will be decided at the *second* regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the *third* regularly scheduled Board meeting following receipt of your appeal. You will be notified in writing if an extension is necessary. You will be notified of the decision on your appeal as soon as possible but no later than five days after a decision on your appeal is reached. A Notice of Adverse Decision on Appeal will contain the information listed above in the definitions section for Notice of Adverse Decision and a statement regarding alternative dispute resolution options such as mediation.

Exhaustion of Administrative Remedies and One Year Time Limitation for Bringing a Lawsuit for Plan Benefits Under ERISA

You may not file a lawsuit to claim Plan benefits under ERISA Section 502(a) until you have exhausted all of the Plan's administrative remedies, including all of the Plan's Claims and Appeals Procedures.

In the event your claim is denied in the course of your exhaustion of the Plan's administrative remedies set forth in the Plan's Claims and Appeals procedures, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than the first anniversary of the date of the written notice of decision on the appeal denying such claim.

COORDINATION OF BENEFITS

The Plan cannot afford to provide primary medical coverage to a spouse that can obtain health insurance through his/her employer (even though the employer might not cover 100% of the cost of that coverage). Furthermore, if your spouse's employer covers Children at no extra charge to you, then this Plan will no longer be the primary payor on the Children, should your spouse's birthday fall earlier in the year than your birthday. The Trustees have adopted rules regarding the Fund's role as primary insurer (payor) on behalf of either an active employee and/or his/her spouse and eligible dependents, or a Retiree and his/her dependents:

1. If the eligible individual is the Plan Participant, covered benefits will be provided without reduction by this Plan. If you or your dependents are entitled to benefits from another group plan or a government plan, the benefits provided hereunder will be paid in accordance with the following provisions, not to exceed 100% of the expenses incurred.
2. If your spouse is enrolled in an indemnity (fee-for-service) medical plan similar to the I.A.T.S.E. Local #16 Health and Welfare Trust Fund, then this Plan will coordinate benefits as a secondary payor only. This means that after the primary coverage has paid its share of a medical claim (after any deductible is satisfied), the balance will be paid by the I.A.T.S.E. Local #16 Health and Welfare Trust Fund (as long as the procedure or service is covered under this Plan). There will be no coordination of benefits by this Plan should your spouse be enrolled in a Health Maintenance Organization (an HMO). If your spouse declines coverage through that employer for any reason, any claim submitted to the I.A.T.S.E. Local #16 Health and Welfare Trust Fund will be denied in its entirety, which means you will be solely responsible for paying the entire amount of the claim.
3. If one parent has financial responsibility for health care expenses, as designated by court decree, and the other parent has custody, then the carrier of the parent with financial responsibility is primary, the other parent's carrier is secondary, and the carrier of the stepparent with custody is third.

When a child is covered by the plans of both parents, unless they are divorced or legally separated, the plan of the parent whose birthday occurs earlier in the calendar year, regardless of the year of birth, will pay first. However, if the other group plan's Coordination of Benefits (COB) provision does not use the parent's birthdays to determine which of the parents' plans pay first, the other group plan's provisions will determine the order of payment.

Please note that the plan that covers the claimant as an Active Plan Participant must provide coverage before the benefits of any plan covering the claimant as a laid-off or Retired Plan Participant.

Coordination of Benefits Provisions for Retired Plan Participants

If you meet the requirements for Retiree coverage in the I.A.T.S.E. Local #16 Health and Welfare Trust Fund, this Plan will not provide primary coverage in the following two instances for you and your eligible dependents:

1. If you are a Retiree between the ages of 55 and 65 and secure employment with any employer that offers medical coverage primarily paid for by that employer or,
2. If you are a Retiree and are or become self-employed or employed by an entity you own, in whole or in part.

In case #1 above, should you be enrolled in an indemnity (fee for service) plan similar to the I.A.T.S.E. Local #16 Health and Welfare Trust Fund (and as long as you continue to make any required self-pay premiums into this Plan), the I.A.T.S.E. Local #16 Health and Welfare Trust Fund will coordinate benefits as a secondary payor only. This means that after your primary coverage has paid its share of a medical claim (after any deductible is satisfied), the balance will be paid by the I.A.T.S.E. Local #16 Health and Welfare Trust Fund (as long as the procedure or service is covered under this Plan). There will be no coordination of benefits by this Plan should you be covered through a Health Maintenance Organization (an HMO).

If you decline coverage through that employer for any reason, any claim submitted to the I.A.T.S.E. Local #16 Health and Welfare Trust Fund will be denied in its entirety, which means you will be solely responsible for paying the entire amount of the claim.

In case #2 above, the I.A.T.S.E. Local #16 Health and Welfare Trust Fund will only provide coverage in a secondary payor position. This means that you will need to find primary medical coverage through another means. If you fail to secure insurance and still submit a claim to this Plan, the I.A.T.S.E. Local #16 Health and Welfare Trust Fund will deny payment on the claim in its entirety, which means you will be solely responsible for paying the entire amount of the claim.

In both cases #1 and #2 above, once employment and other medical coverage cease, you will be eligible to return to primary coverage under the I.A.T.S.E. Local #16 Health and Welfare Trust Fund upon timely notification to BeneSys.

MEDICARE COORDINATION OF BENEFITS

Medicare Coordination of benefits applies before any other COB provision of the Plan and is applicable when the covered person

1. has health coverage under the Plan; and
2. is eligible for insurance under Medicare Parts A and B (whether or not the covered person has applied for or is enrolled in Medicare).

For Active Plan Participants eligible for Medicare, the Plan will pay benefits first. For Retired Plan Participants eligible for Medicare, the Plan is secondary after Medicare benefits are paid. For claims payable under both Medicare and the Plan, the Plan will not pay any more than if there was no Medicare coverage.

If Retired Plan Participants eligible for Medicare choose to use service providers who have opted out of Medicare, the Plan shall pay no more than it would pay if these non-Medicare service providers were Medicare service providers.

SUBROGATION OF CLAIMS AGAINST OTHER PARTIES FOR CLAIMS PAID UNDER THE PLAN

The Fund reserves the right to recover claim payments made under any of its Plans on behalf of an employee or dependent where the claim results from or is related to an injury or illness that is the responsibility of a third party. You are obligated to reimburse the Fund in full for any claims paid relating to such injury or illness. If you recover any amount from a third party and fail to repay the Fund for the claims it has paid, the Plan will deduct the amount paid from any of your future benefit claims as a set off.

What is a third party and when are they responsible for your injuries or illness? Here are some examples:

- If you are in an auto accident and the other driver is at fault, the third party is the other driver and his/her insurance company.
- If you are in an auto accident and the other driver is uninsured, your auto insurance policy's uninsured motorist provision is a third party for this purpose.

- If you are injured in an auto accident and covered under a ~~no~~ fault provision of your own insurance policy, your policy is the third party.
- If you are injured on the job, your employer's workers compensation policy is the third party. However, the Plan will only pay benefits on your behalf for such an injury or illness pursuant to item 1, under the Medical Exclusions and Limitations section of the Plan.
- If you fall in a store because there was a spill near a shelf that no one bothered to clean up, the store is the third party.

THE PLAN WILL PAY CLAIMS FOR EXPENSES INCURRED BECAUSE OF AN ILLNESS OR INJURY FOR WHICH A THIRD PARTY IS (OR MAY BE) RESPONSIBLE AS LONG AS YOU AND/OR YOUR DEPENDENTS SIGN A LOAN AGREEMENT WITH THE FUND. YOU SHOULD KNOW THAT BY SUBMITTING THE CLAIM FOR PAYMENT BY THE PLAN YOU (AND A COVERED DEPENDENT IF HE OR SHE SUFFERS THE ILLNESS OR INJURY) ARE DEEMED UNDER THE PLAN TO HAVE AGREED TO EACH OF THE FOLLOWING CONDITIONS:

- You and/or your dependents must contact the Fund immediately after you and/or your dependents have suffered an illness or injury and request a copy of the I.A.T.S.E. Local 16 Health and Welfare Trust Fund Loan Agreement. By signing the Loan Agreement, you and/or your dependents and your legal counsel recognize that the Fund has no obligation to pay any benefits and that any benefits paid shall be considered a loan that you must reimburse to the Fund from any recovery received related to the illness or injury. ***The Fund reserves the right to refuse to pay claims for expenses incurred because of an illness or injury for which a third party is (or may be) responsible unless you and/or your dependents and your legal counsel sign the Loan Agreement.***
- If you or your dependents sue or recover compensation, reimbursement, damages or any other payment of any kind from the third party for the illness or injury, the Fund has a lien (a ~~security interest~~) on any amount(s) you or your dependents receive or may become entitled to receive from the third party (or the third party's insurance company) up to the amount of the Plan benefits paid because of the illness or injury. You must advise the third party that this is a condition of the Plan.
- You or your dependents will furnish the Fund with a copy of any complaint you or your dependents file to recover damages from a third party within no more than two days of the date of filing.
- If you or your dependents receive payment(s) of any kind from the third party (or from the third party's insurance company), you and/or your dependents will promptly reimburse the Fund for any claims paid because of the illness or injury. If you or your dependents sue or recover payment of any kind from a third party for an illness or injury (whether or not these payments are characterized in any way as compensation for your injuries or for health care claims), the Fund shall have the right of first reimbursement out of the amount recovered. The Fund explicitly rejects the ~~Make Whole Doctrine~~. This right of first reimbursement shall apply even if the amount you or your dependents receive from the third party is less than your actual loss resulting from the illness or injury.
- The Fund explicitly rejects the ~~Common Fund Doctrine~~ with respect to attorney's fees and other costs of litigation and assumes no responsibility for any expenses incurred to obtain a settlement, award, remedy, recovery, or payment of any kind from a third party . including legal costs and attorneys fees. Expenses related to any recovery from a third party shall not reduce the amount due the Fund.
- If you or your dependents do not sue the third party for the illness or injury, the Fund reserves the right to sue the third party for the amount of Plan benefits paid on your or your dependents' behalf, and for the Fund's attorney's fees.

- You and your dependents will help the Fund recover the Plan benefits from the third party by taking every reasonable step necessary to secure payment from the third party and/or assisting the Fund to recover payment from the third party; including expressly agreeing that the Fund may join your lawsuit as a party and/or intervenor.
- You and your dependents will sign any and all papers that will help the Fund recover Plan benefits from the third party.
- You and your dependents will not do anything to interfere with the Fund's rights to recover Plan benefits from the third party.
- You and your dependents will tell the Fund immediately when you receive payment from a third party in connection with the illness or injury by calling the BeneSys phone number listed on page 62 of this Summary Plan Description.
- If you or your dependents have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an illness or injury caused or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.

If you or your dependents fail or refuse to assist the Fund in recovering damages from a third party, then the Fund may:

Offset what is paid on your and/or your dependents' future claims against the claims paid for which the Fund should have been reimbursed because of the illness or injury caused by the third party until the Fund is completely reimbursed for the cost of these claims, including but not limited to costs incurred in collection, including:

- Filing a lawsuit against you or your dependents to fully recover the amount the Fund should have been reimbursed; and/or
- Taking any other action deemed appropriate by the Board of Trustees.

If you or your dependents do not receive payment from a third party to reimburse you for an illness or injury caused by the third party, you do not have to reimburse the Fund for any benefits properly paid to you or your dependents. If you do receive payment from the third party, you do not have to pay the Fund more than the amount the third party paid to you or your dependents.

If you have questions about how to comply with these third party liability rules, please contact BeneSys.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Your Health Information and Privacy

The health benefits offered under the Plan use health information about you and your covered dependents only for the purposes of providing treatment, paying claims, and related functions. The Plan's Privacy Notice is printed here.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective April 14, 2003, the health benefits offered under the Plan will comply with the applicable health information privacy requirements in Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the applicable Federal regulations issued by the Department of Health and Human Services. Specific procedures related to the security of electronically transmitted Protected Health Information (PHI) effective April 20, 2005, are also described below.

Privacy Rule

The Plan has been amended to conform to the Privacy Rule as described as follows.

Use and Disclosure of Health Information

The Plan may use your health information, that is, information that constitutes Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA, for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

The Plan may also disclose health information over the telephone to your spouse, another family member, or a personal representative (such as a Union business agent or Employer representative), for purposes of making or obtaining information about treatment or claims if you provide your oral authorization to the Plan to speak to this person on your behalf. If you do not wish the Plan to release your health information to your spouse, family member or personal representative without prior *written* authorization, please follow the instructions under the Right to Make Restrictions found in this notice.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all Plan Participants. For example, the Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment. The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the plan may disclose that you are eligible for benefits to a health care provider who contacts the Plan to verify your eligibility.

For Treatment Alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

Public Health Risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

For Disclosure to the Plan Sponsor. The plan sponsor represents that adequate separation exists between the Plan and plan sponsor so that PHI will be used only for Plan administration. As a jointly trustee multiemployer trust fund which contracts with a third party administrator, the plan sponsor has no employees. No person under the control of the plan sponsor has access to your PHI. The Plan may disclose your health information to the plan sponsor for Plan administration functions performed by the plan sponsor on behalf of the Plan. Such administration shall include, but is not limited to, the following purposes: appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and Plan design. The Plan also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan.

As a condition for obtaining PHI from the Plan and other insurers that may participate in the Plan, the plan sponsor agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the plan sponsor may provide PHI to agree to the same restrictions and conditions that apply to the plan sponsor with respect to PHI.
- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other employee benefit plans sponsored by the plan sponsor.
- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your PHI available for purposes of your request for inspection or copying.
- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as is allowed under the Privacy Rule.
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Plan and to the Secretary of the U.S. Department of Health and Human Services (HHS) for the purpose of determining the Plan's compliance with the Privacy Rule.

- If feasible, return to the Plan or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the plan sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- Use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

When Legally Required. The Plan will disclose your health information when it is required to do so by any Federal, state or local law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Conduct Health Oversight Activities. The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release your health information to funeral directors as necessary to carry out their duties.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. Any disclosure would be to someone able to help prevent the threat.

For Specified Government Functions. In certain circumstances, Federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

For Workers' Compensation. The Plan may release your health information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.

Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your health information without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information

You have the following rights regarding your health information that the Plan maintains:

- **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer at BeneSys.
- **Right to Receive Confidential Communications.** You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer at BeneSys. The Plan will attempt to honor your reasonable requests for confidential communications.
- **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer at BeneSys. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.
- **Right to Amend Your Health Information.** If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the Plan maintains the information. A request for an amendment of records must be made in writing to the Privacy Officer at BeneSys. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.
- **Right to an Accounting.** You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Officer at BeneSys. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.
- **Right to a Paper Copy of this Notice.** You have a right to request and receive a paper copy of this Privacy Notice at any time, even if you have received this Privacy Notice previously or agreed to receive the Privacy Notice electronically. To obtain a paper copy, please contact the Privacy Officer at BeneSys.

Duties of the Plan

The Plan is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Privacy Notice and will provide a copy of the revised notice to you within sixty (60) days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to the Privacy Officer at BeneSys. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact:

Ms. Melanie Flowers
I.A.T.S.E. Local #16 Health & Welfare Trust Fund
c/o BeneSys Administrators
700 Tower Drive, Suite 300
Troy, Michigan 48098
(248) 813-9800

Effective Date

The Plan's privacy policies and procedures became effective April 14, 2003.

Security Rule Effective Date

The following are the Plan's security rules with regard to the creation, receipt, maintenance, storage and transmission of Protected Health Information (PHI) via electronic means (ePHI).

Use and Disclosure of ePHI. The Plan may use and disclose ePHI, including ePHI for treatment, payment and operations, and such other uses and disclosures as are permitted and required under the HIPAA Privacy Rule and Security Rule, and the representatives of the Plan shall have access to such PHI, including ePHI, as is necessary for them to perform their duties for the Plan.

Trustees' Use and Disclosure of ePHI. To the extent permitted by law, the Trustees may receive, use and disclose ePHI, if, in the sole discretion of the Trustees, such ePHI is necessary for the Trustees to perform their fiduciary or administrative duties as Trustees. In all cases, the Trustees shall receive, use and disclose the minimum amount of ePHI necessary for the Trustees to perform their functions under the Fund, and shall safeguard such ePHI as required by the Privacy and Security Rules. Each Trustee who receives ePHI from the Fund shall keep such information in strict confidence and shall not use or further disclose the ePHI received from the Fund other than as permitted or required by law and this Agreement or upon the express written permission of the Participant who is the subject of the ePHI.

Procedures. The Fund will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Fund, and will ensure the adequate separation within the meaning of 45 C.F.R. Sec. 164.504(f)(2)(iii) of the data.

INFORMATION REQUIRED BY ERISA

NAME OF PLAN. The name of the Plan is:

I.A.T.S.E. Local 16 Health and Welfare Trust Fund
Employer Identification Number: 94-6138741
Plan Identification Number: 501

TYPE OF PLAN. The following benefits are for Active and Retired Plan Participants and their eligible dependents:

Hospital, Medical and Surgical Care
Dental Care
Orthodontic Care
Vision Care
Prescription Drugs
Inpatient and Outpatient Mental Health Benefits
Home Health Care
Hospice Care
Durable Medical Equipment
Immunizations and Inoculations
Hearing Aids

The following benefits are for Active Plan Participants and their eligible dependents only:

Alcoholism and Drug Addiction Benefits

The following benefits are for Active Plan Participants only:

Supplemental Disability Income Benefits
Life Insurance Benefits
Accidental Death and Dismemberment Benefits

PLAN ADMINISTRATOR. The Plan Administrator is the Board of Trustees of the I.A.T.S.E. Local 16 Health and Welfare Trust Fund. The Board of Trustees of the Fund is responsible for the operation of the Fund and is made up of an equal number of Trustees appointed by the participating Employers and by the Union.

BOARD OF TRUSTEES

The current members of the Board of Trustees are:

UNION TRUSTEES

Steve A. Lutge
I.A.T.S.E. Local 16
240 Second Street
San Francisco, CA 94105

James Beaumonte
I.A.T.S.E. Local 16
240 Second Street
San Francisco, CA 94105

Scott A. Houghton
I.A.T.S.E. Local 16
240 Second Street
San Francisco, CA 94105

Kenneth M. Ryan
I.A.T.S.E. Local 16
240 Second Street
San Francisco, CA 94105

EMPLOYER TRUSTEES

Debra Bernard
San Francisco Ballet
455 Franklin Street
San Francisco, CA 94102

Robert Sauter
Moscone Center
747 Howard Street, 5th Floor
San Francisco, CA 94103

Greg Holland
Shorenstein Hays-Niederlander
1182 Market Street, Suite 200
San Francisco, CA 94102

Lance "R.B." Hughston II
Hughston Engineering Inc.
150 Starlite Street
South San Francisco, CA 94080

TYPE OF ADMINISTRATION

Certain administrative services are provided to the Fund through a contract with a Third-Party Administrator who is retained by the Board of Trustees and compensated by the Fund under the direction of the Board of Trustees.

The Third-Party Administrator processes all claims for benefits (except for life insurance, accidental death and dismemberment benefits) covered under the Plan on behalf of the Plan Participant(s).

Records concerning eligibility to Participants in the Plan are maintained by the Fund. For purposes of receipt of employer contributions and determination of eligibility, the Plan is self-administered.

ADDRESS OF THE FUND AND THE THIRD PARTY ADMINISTRATOR

I. A. T. S. E. Local 16 Health and Welfare Trust Fund
c/o BeneSys
7180 Koll Center Parkway, Suite 200
Pleasanton, California 94566
Telephone: (925) 398-7043 or (855) 704-5273
Fax: (925) 462-0108
E-mail: funds@local16.org

AGENT FOR SERVICE OF LEGAL PROCESS

Ms. Rachel Mora is designated by the Board of Trustees as the Agent of the Trust Fund for service of legal process. She can be reached at:

BeneSys
7180 Koll Center Parkway, Suite 200
Pleasanton, California 94566

Service of legal process may also be made upon any Fund Trustee.

COLLECTIVE BARGAINING AGREEMENTS

The I.A.T.S.E. Local 16 Health and Welfare Trust Fund is maintained pursuant to collective bargaining agreements between I.A.T.S.E. Local 16 and the Employers who are parties to these bargaining agreements. Copies of the bargaining agreements may be obtained by making written request to the Fund where the agreements are available for inspection during normal business hours.

As a Participant in this Plan you may obtain, upon written request to the Fund, information as to whether or not a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

SOURCE OF CONTRIBUTIONS

Contributions to the Plan are made by Employers in accordance with collective bargaining agreements with I.A.T.S.E. Local 16, pursuant to the provisions of the Trust Agreement.

The collective bargaining agreements require contributions to the Plan based on a percentage of gross wages including vacation pay.

SOURCES OF PLAN BENEFITS

Hospital, medical, dental and vision benefits are paid in accordance with the Plan provisions out of Fund assets, which are used solely for that purpose and for defraying reasonable administrative expenses. Prescription drug benefits are administered by OptumRx, who is the Fund's Pharmaceutical Benefit Manager, and paid by the Fund.

Life Insurance and Accidental Death and Dismemberment benefits are paid through an insurance policy between the Fund and Sun Life Financial. Medical benefits are insured for total covered medical claims covered by the Fund exceeding \$200,000 per individual per Plan Year. Neither the Fund nor its Board of Trustees assume any liability to provide payment for claims over and beyond the amounts in the Fund available for the purpose of paying claims.

Addresses for the providers directly servicing participants are as follows:

Anthem Blue Cross of California
21555 Oxnard Street, 5-D
Woodland Hills, CA 91367

Teamsters Assistance Program of Northern California
300 Pendleton Way
Oakland, California 94621-2102

OptumRx
5995 Plaza Drive
Cypress, CA 90630

CIGNA Dental
701 Fifth Avenue, Suite 4900
Seattle, Washington 98104

Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

PLAN YEAR. The Plan Year starts each January 1 and ends each December 31.

TRUST FUND RECORDS

The financial records of the Plan are kept on a Plan Year basis.

TRUST FUND PROFESSIONALS

In accordance with prudent management standards, the following professionals are retained by the Fund to assist the Board of Trustees in the operation of the Plan:

1. A consulting actuary, who assists the Board of Trustees in technical matters relating to the operations of the Fund, such as the design of benefit programs and eligibility provisions, analysis of emerging loss experience, benefit expense, projections, specifications for competitive bids when necessary, and defining adequate reserve requirements.
2. Legal counsel, who assists and counsels the Board of Trustees on all legal matters, including interpretations of the many laws and regulations under which the Fund operates.
3. A Certified Public Accountant is responsible for auditing the records of the Fund and final preparation of financial statements in accordance with generally accepted auditing and reporting standards.
4. An investment consultant who assists the Board of Trustees in the investment of the Fund's assets.

DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES

Nothing in this booklet is meant to extend or change in any way the provisions of the Plan or the insurance policies or service agreements. The Board of Trustees of the Fund reserves the right to amend, modify or discontinue all or part of the Plan whenever, in its judgment, conditions so warrant.

The Board of Trustees reserves the right to make any determination of fact necessary or proper to the administration of this Fund. Further, the Trustees shall have the power to construe and interpret the provisions of the Trust Agreement and Plans of Benefits relating to eligibility of Active Plan Participants, Retired Plan Participants, their dependents and beneficiaries to receive benefits. Such determinations shall be final and binding upon all parties, including Plan Participants, Retired Plan Participants, their dependents and beneficiaries.

FUTURE OF THE PLAN AND TRUST

The Board of Trustees anticipates that the Plan and the Trust will continue as long as collective bargaining agreements so provide or until the bargaining parties elect to discontinue the Plan or Trust. If the Plan or Trust is terminated, the remaining assets will be used to continue to provide benefits until there are no assets remaining. In no event will termination of the Plan or Fund result in the reversion of assets to any Employers.

STATEMENT OF ERISA RIGHTS

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- You can examine, without charge, at BeneSys and at other specified locations (such as worksites and local unions) all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain, upon written request to the Board of Trustees or BeneSys, copies of all 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 an updated summary plan description. (A reasonable charge may be made for the copies.)
- You should receive a summary of the Plan's annual financial report. The Fund is required by law to provide a copy of this summary annual report to each Plan Participant.

Continued Group Health Plan Coverage

You can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial.

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 your copies within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the Plan's claims and appeals procedures starting on page 46, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. In the event your claim is denied in the course of your exhaustion of the Plan's administrative remedies set forth in the Plan's Claims and Appeals procedures, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than the first anniversary of the date of the written notice of decision on the appeal denying such claim.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court if Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights.

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 (e.g., if it finds your claim is frivolous.)

Assistance With Your Questions

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

DEFINITIONS

"ACTIVE PLAN PARTICIPANT"

means an employee covered under a Local 16 I.A.T.S.E. collective bargaining agreement providing for contributions to the Fund.

"THE BOARD"

means the Board of Trustees of I.A.T.S.E. Local 16 Health and Welfare Trust Fund.

"CHILDREN"

means the Plan Participant's biological children, stepchildren, or legally adopted children who are ages 25 or younger.

"COBRA"

means the Consolidated Omnibus Budget Reconciliation Act of 1985, which allows employees and their dependents who lose eligibility under a group health plan to make contributions to continue their coverage for a limited amount of time.

"COLLECTIVE BARGAINING AGREEMENT"

means those agreements entered into by I.A.T.S.E. Local 16 and various Employers requiring contributions on behalf of employees to the Fund.

"COMPLICATIONS OF PREGNANCY"

means all physical effects suffered, which have been directly caused by pregnancy but that would not be considered from a medical viewpoint to be the effects of a normal pregnancy, including, but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy (which terminated), cesarean section, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, and similar medical and surgical conditions.

"CONTRIBUTIONS"

means the amounts agreed to be paid to the Fund by individual Employers (under collective bargaining agreements) with I.A.T.S.E. Local 16.

"COVERED CHARGES"

under the Health Plan are based on usual, customary and reasonable fees (see definition of "UCR").

"DEPENDENTS"

means the legal spouse of the Plan Participant, eligible children and eligible same-sex domestic partners.

"DESIGNATED BENEFICIARY(IES)"

means the individual(s) named by the Plan Participant with respect to life insurance benefits.

"DOCTOR" (PHYSICIAN)

means doctor of medicine or doctor of osteopathy. To the extent that benefits are provided and while practicing within the scope of his/her license, Doctor will include a dentist, podiatrist, chiropractor, acupuncturist, optometrist or psychologist. The term "Doctor" will also include any other licensed or certified practitioner, who upon referral by a doctor of medicine or doctor of osteopathy, performs services: (1) that are covered under the terms of the Plan and (2) that are within the scope of his/her license or certificate. Doctor will not include the Plan Participant or his/her dependents or any person who is the spouse, parent, child, brother or sister of the Plan Participant or his/her dependent(s).

"DOMESTIC PARTNER"

means an adult unmarried person of the same sex as the Plan Participant, (1) with whom the Participant shares his/her place of residence, and (2) who is fully registered as the Plan Participant's domestic partner in accordance with applicable state law and was approved by the Fund prior to April 1, 2015.

"DURING ANY DISABILITY"

as it applies to the Plan Participant, means all periods of disability arising from the same cause, including any and all complications therefrom, except that if the Plan Participant completely recovers or returns to active full-time employment, any subsequent period of disability from the same cause will be considered a new disability.

"ERISA"

means the Employee Retirement Income Security Act of 1974 (as amended).

"EMERGENCY"

means a sudden onset of a medical condition, which in the absence of immediate medical attention could reasonably place the Plan Participant's or his/her dependent's health in jeopardy, cause serious medical consequences, cause serious impairment to bodily functions, or cause serious and permanent dysfunctions of any bodily organ or part.

"EMPLOYER"

means an employer signatory to an agreement with I.A.T.S.E. Local 16 providing for contributions to the Fund.

"EXPENSE INCURRED"

means only fees and prices usually, customarily and reasonably ("UCR") charged for medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained.

"FUND"

means the I.A.T.S.E. Local 16 Health and Welfare Trust Fund.

"HOSPITAL"

means a licensed and accredited institution, which provides, under the supervision of licensed physicians, inpatient diagnostic and therapeutic services for medical diagnosis and surgical care, treatment and care or rehabilitation services and provides 24-hour nursing service or supervision by a registered nurse. It also includes a licensed psychiatric health facility. **Hospital does not include a rest home, nursing home, skilled nursing facility, convalescent home, home for the aged or a place for the treatment of alcohol or chemical dependency.**

"MEDICAL NECESSITY" or "MEDICALLY NECESSARY"

means services or supplies provided by a hospital, Doctor or other qualified provider, and are:

- a. Appropriate for the symptoms and diagnosis or treatment of the condition, disease, illness or injury; and
- b. Provided for the diagnosis, or the direct care and treatment of the condition, disease, illness or injury; and
- c. In accordance with the standards of good medical practice; and
- d. Not primarily for the convenience of the patient, or the patient's Doctor or other provider; and
- e. The most appropriate supply or level of service that can safely be provided to the patient. When applied to hospitalization, this also means that the patient requires acute care as a bed patient due to the nature of the services rendered or the patient's condition, and the patient cannot receive safe and adequate care as an outpatient.

"MEDICARE PLAN"

means the basic hospital portion and voluntary supplemental medical portion of U.S. Public Law 89-97, "Health Insurance for the Aged Act", as amended.

“MENTAL HEALTH” (and “FUNCTIONAL NERVOUS DISORDERS”)

means a disorder or condition that affects thinking, perception, mood and/or behavior. Such disorders or conditions are recognized by psychiatric symptoms that appear as distortions of normal thinking and/or perception, moodiness, sudden and/or extreme changes in mood, depression, and/or usual behavior.

"PLAN PARTICIPANT" OR "PARTICIPANT"

means an "Active Plan Participant" or a "Retired Plan Participant" as defined.

"PLAN"

means that document, describing benefits adopted by the Board of Trustees on behalf of I.A.T.S.E. Local 16 Health and Welfare Trust Fund.

"PLAN ADMINISTRATOR"

is the Board of Trustees of I.A.T.S.E. Local 16 Health and Welfare Trust Fund.

"PLAN YEAR" OR "YEAR"

means the period of twelve (12) consecutive months beginning with the first (1st) day of each January and ending on the thirty-first (31st) day of each December.

"PPO"

means Preferred Provider Organization.

"PREFERRED PROVIDER HOSPITALS"

are hospitals which have agreed to participate in the Fund's PPO.

"PREFERRED PROVIDER PHYSICIANS"

are physicians who have agreed to participate in the Fund's PPO.

"PHYSICIAN" see "Doctor".

“PRIMARY CARE PHYSICIAN”

means the medical doctor selected by the participant as an initial contact for medical treatment. The Primary Care Physician is a Family/General Practitioner, Internist or Pediatrician.

"RETIRED PLAN PARTICIPANT" OR "RETIREE"

means a person who meets the "Eligibility Rules for Retired Plan Participants and Their Dependents" as described starting on page 4. Please note that certain benefits, including the "Supplemental Plan Benefits" (other than the Hearing Aid Benefit) as described starting on page 39, the "Life Insurance Benefits" as described starting on page 41, and the "Accidental Death and Dismemberment Benefits" as described starting on page 43 are available only to Active Plan Participants.

"SKILLED NURSING FACILITY"

is an institution that provides continuous skilled nursing services licensed according to state and local laws and recognized as a Skilled Nursing Facility under Medicare.

"SPOUSE"

means the Plan Participant's spouse under a legally valid marriage.

"TOTALLY DISABLED"

means that you are unable because of illness or injury to carry on the regular and customary activities of a person in good health of the same age and sex and are not, in fact, engaged in any employment or occupation whatsoever for compensation, gain or profit. Disabilities resulting from purposefully self-inflicted injuries, participation in the commission of a felony, and injuries or illness due to service in the Armed Services for which the Plan Participant is eligible to receive a military pension do not qualify as total disability under the terms of the Plan. The Plan will rely on outside and independent sources for determination of disability such as Social Security Administration, State Disability, Workers' Compensation or documentation submitted by Board certified physicians or surgeons.

"UCR"

means Usual, Customary and Reasonable.

1. The Usual fee is that fee regularly charged for a given service by a medical provider or facility.
2. The fee is Customary when it is within the range of usual fees charged by medical providers or facility of similar training and experience for the same service within the same geographical area as the medical provider or facility that provided the service.
3. A fee is Reasonable when it meets the two other criteria or if reviewed by a committee of the responsible physician's professional society, and the reviewing committee deems the fee to be justified based on the special circumstances of the case so referred.

NOTES